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Editorial

Starting biologic therapy in rheumatoid arthritis. A Colombian experience

Inicio de la terapia biológica en la artritis reumatoide. Experiencia colombiana

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Rheumatoid arthritis (RA) is a fascinating and challenging disease that rheumatologists treat every day. Important therapeutic and conceptual advances have occurred in the last 20 years. Ideas such as early treatment, treat to target, sustained remission, treatment of comorbidities, diminishing toxicities, improving functioning, quality of life and life expectancy and the availability of new therapeutic options are melt together in clinicians mind and health care systems to improve RA treatment. How this is implemented in real life clinical practice is something that has not been properly evaluated.

An original article by Machado-Alba in this number of the journal evaluates the time to and factors associated with initiation of biological therapy in patients with rheumatoid arthritis in Colombia.[1] After a careful study of 3880 RA patients, 6% of them initiated a biologic therapy in a mean initiation time of 17.5 months. Some interesting findings arised. In a multivariate analysis, being male, have received glucocorticoid therapy or comedication, living in Bogota or in the Atlantic coast were associated with an increased risk of receiving a biologic therapy while the use of methotrexate, chloroquine or antihypertensive therapy were protective against the use of it.

Some important lessons have to be emphasized while reading and interpreting this article. We must note that RA treatment is a very dynamic process and therapeutic guidelines emphasize the importance of disease control and treatment of comorbidities.[2] This paper does not have measures of disease activity to properly judge how adequate therapeutic decisions were made. This should be included in future studies.

As a clinician, the number of 6% of RA patients who initiated a biologic treatment seems to be a low number that should raise possible explanations. This could be due to the year when the study was started, some access difficulties, some barriers in prescription, and other practical aspects.

If male RA subjects have an increased risk of receiving a biologic therapy, gender inequity, disease activity, and work productivity pressure are some variables that have to considered. This is something that needs further evaluation.

The use of conventional synthetic disease modifying antirheumatic drugs such as methotrexate of chloroquine was useful to minimize the use of biologic therapy. A clear message to all rheumatologists who treat these patients in a region where resources are limited and should be optimized.

This type of studies are clearly needed, not only to evaluate prescription practices but to better understand how we can improve RA treatment in our countries.[3]

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