

Rheumatoid arthritis: why to treat only arthritis, knowing that comorbidities are common and determine morbidity and mortality?

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Recent years have witnessed a number of advances in the management of patients with rheumatoid arthritis (RA). It is worth noting the possibility of diagnosing the disease at an earlier phase, due to the new 2010 classification criteria elaborated by an EULAR (European League Against Rheumatism) committee and the American College of Rheumatology, and to the new laboratory tests, such as the detection of anti-cyclic citrullinated peptide antibodies.^{1,2} Another advance regards the change in the treatment of those patients, using combinations of synthetic and biological disease-modifying antirheumatic drugs (DMARDs).³

Considering such advances in diagnosis and specific treatment of RA, should we be satisfied with what we have been offering those patients? The answer is no. The number of hospitalizations, untreated comorbidities and mortality is still high.^{4,5}

Rheumatoid arthritis is more than a joint disease, and several systemic inflammatory changes have been reported. The cytokines most frequently expressed in the joints of patients with RA, such as tumor necrosis factor (TNF), interleukin (IL) 1, IL6, and IL17, are also elevated in the blood, being implicated in a number of processes, such as increased insulin resistance and vascular endothelial lesion.⁶

In the population without RA, inflammation is known to play a major role in the development of the atherosclerotic plaque, with increased T lymphocyte infiltration and higher expression of cytokines derived from the activation of Th1 lymphocytes. Thus, it is easy to understand why patients with RA, a systemic inflammatory disease, have a higher prevalence of atherosclerosis and cardiovascular events.⁷

The following non-articular clinical conditions are also important, being contemplated in that consensus on RA comorbidities: diabetes mellitus; insulin resistance; systemic arterial hypertension; venous thrombosis; osteoporosis; and neoplasias.⁸ The presence of those comorbidities in patients with RA has an important impact on those patients' survival and quality of life, often justifying an individualized treatment from that of the joint condition, in face of the implications of the different effects of antirheumatic drugs on those comorbidities.

Considering the need for a better treatment for patients with RA, the Brazilian Society of Rheumatology RA Committee has published the third of four articles about the management of patients with RA. The objective of the article on comorbidities published in this issue was to elaborate recommendations for the correct management of comorbidities in RA and to detail the most prevalent comorbidities and their association with RA and its treatment. We believe that the rheumatologist should recognize, at an early phase, those comorbidities, which often have a subclinical expression as compared with the severity of the joint complaints and might show modifications in their clinical course determined by RA and its treatment. It is worth noting that comorbidities often result directly from the presence of RA. For example, systemic arterial hypertension in patients with RA is associated with systemic inflammation and medications used for RA, such as non-steroidal anti-inflammatories, corticoids, and DMARD, such as leflunomide and cyclosporine.⁹

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