REVIEW

Early referral recommendation for newly diagnosed rheumatoid arthritis: evidence based development of a clinical guide

P Emery, F C Breedveld, M Dougados, J R Kalden, M H Schiff, J S Smolen

Ann Rheum Dis 2002;**61**:290–297

> 6 weeks

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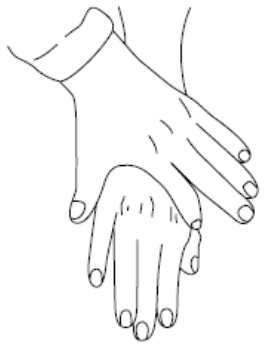

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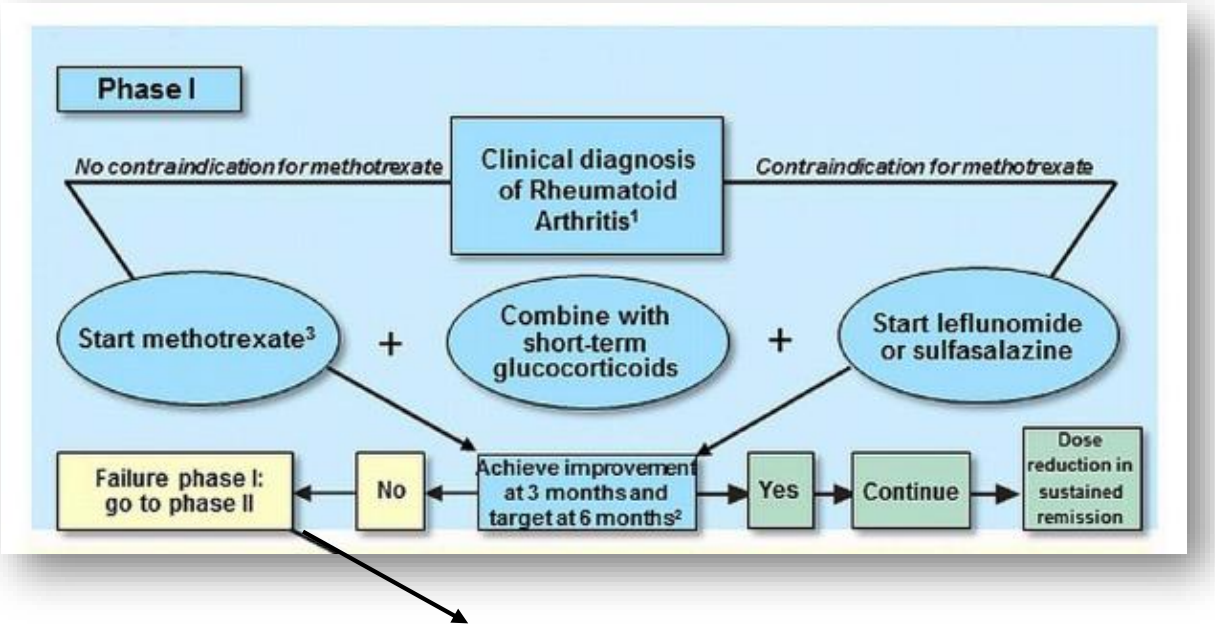
First, published on March 17, 2017 as 10.1136/annrheumdis-2016-210715

Recommendation

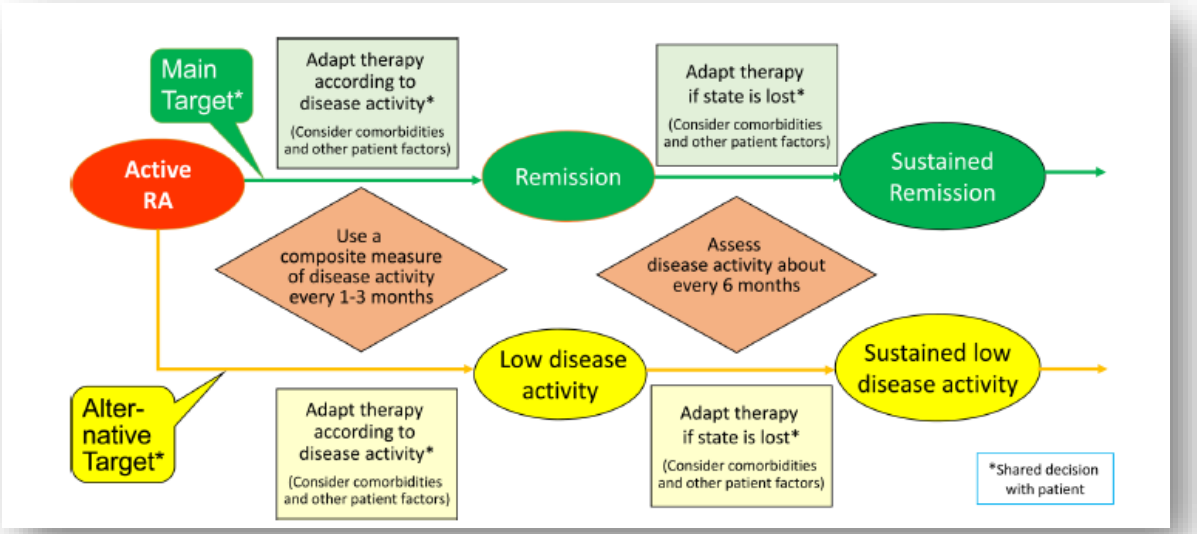
EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update



Recommendation

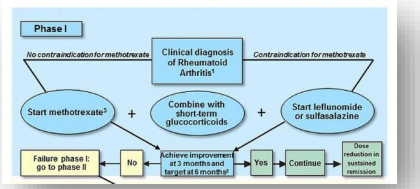
EXTENDED REPORT

Treating rheumatoid arthritis to target: 2014 update of the recommendations of an international task force

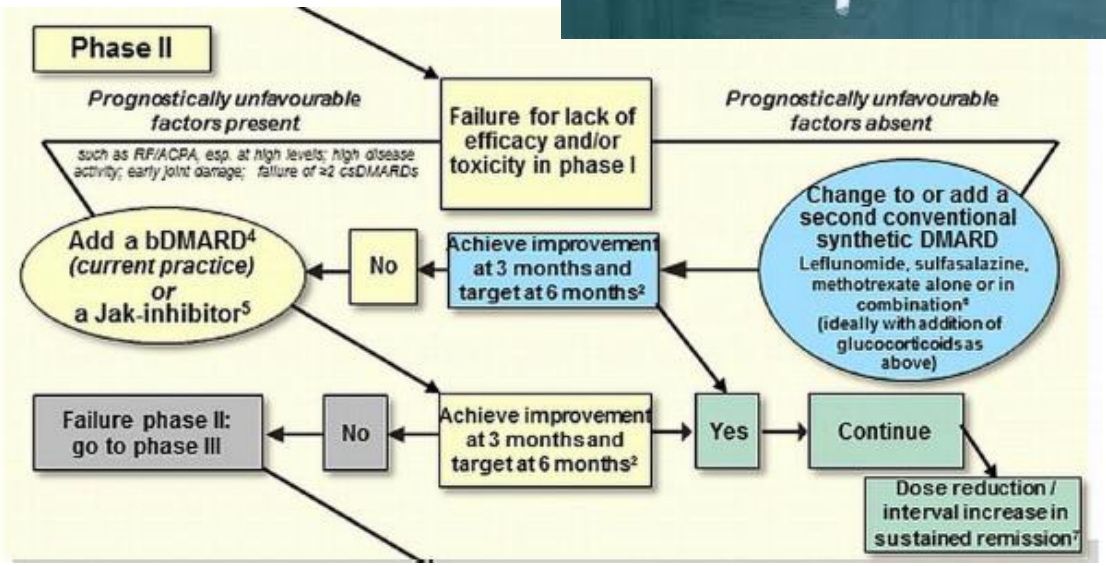


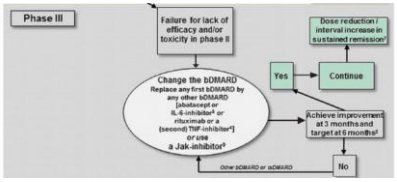
Smolen JS, *et al. Ann Rheum Dis* 2016;**75**:3–15. doi:10.1136/annrheumdis-2015-207524


REGIONE PIEMONTE
TORINO
GOLDEN PALACE
Via dell'Arcivescovado, 18
3 DICEMBRE 2019
FOCUS
ARTRITE REUMATOIDE
MOTORE SANITÀ


Phase I
No contraindication for methotrexate
Clinical diagnosis of Rheumatoid Arthritis¹
Contraindication for methotrexate
Start methotrexate²
Combine with short-term glucocorticoids
Start leflunomide or sulfasalazine
Failure phase I: go to phase II
No
Achieve improvement at 3 months and target at 6 months²
Yes
Continue
Dose reduction in sustained remission


80% | 20%


Phase II
Prognostically unfavourable factors present
such as RF/ACPA, esp. at high levels; high disease activity; early joint damage; failure of ≥2 csDMARDs
Failure for lack of efficacy and/or toxicity in phase I
Prognostically unfavourable factors absent
Change to or add a second conventional synthetic DMARD
Leflunomide, sulfasalazine, methotrexate alone or in combination⁴
(ideally with addition of glucocorticoids as above)
Add a bDMARD⁴
(current practice)
or
a Jak-inhibitor⁵
No
Achieve improvement at 3 months and target at 6 months²
Failure phase II: go to phase III
No
Achieve improvement at 3 months and target at 6 months²
Yes
Continue
Dose reduction / interval increase in sustained remission⁷


Phase III
Failure for lack of efficacy and/or toxicity in phase II
Change the bDMARD
Replace any first bDMARD by any other bDMARD
[abatacept or IL-6-inhibitor⁴ or rituximab or a (second) TNF-inhibitor⁴]
or use a Jak-inhibitor⁵
Yes
Continue
Dose reduction / interval increase in sustained remission⁷
Achieve improvement at 3 months and target at 6 months²
No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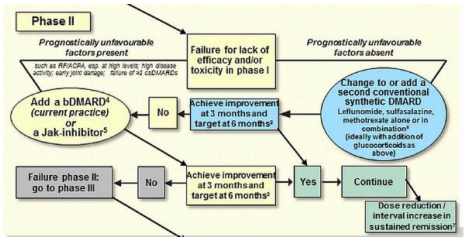
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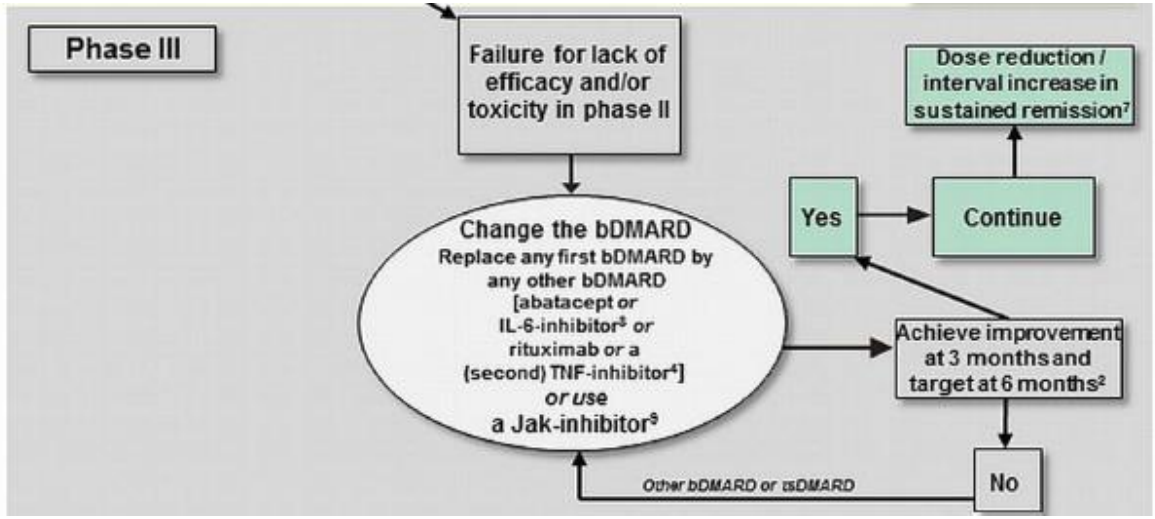
Prognostically unfavourable factors present
such as RF/ACPA, esp. at high levels; high disease activity; early joint damage; failure of ≥2 csDMARDs
Failure for lack of efficacy and/or toxicity in phase I
Prognostically unfavourable factors absent
Add a bDMARD[4] (current practice) or a Jak-inhibitor[5]
No
Achieve improvement at 3 months and target at 6 months[2]
Change to or add a second conventional synthetic DMARD
Leflunomide, sulfasalazine, methotrexate alone or in combination[6] (ideally with addition of glucocorticoids as above)
Failure phase II: go to phase III
No
Achieve improvement at 3 months and target at 6 months[2]
Yes
Continue
Dose reduction / interval increase in sustained remission[7]


Phase III
Failure for lack of efficacy and/or toxicity in phase II
Dose reduction / interval increase in sustained remission[7]
Yes
Continue
Change the bDMARD
Replace any first bDMARD by any other bDMARD [abatacept or IL-6-inhibitor[3] or rituximab or a (second) TNF-inhibitor[4]] or use a Jak-inhibitor[5]
Achieve improvement at 3 months and target at 6 months[2]
Other bDMARD or tsDMARD
No

REVIEW

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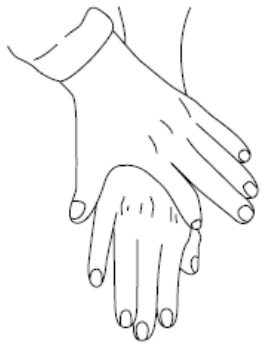

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PRIMA VISITA REUMATOLOGICA		
	ATTESA MASSIMA DA GARANTIRE	**"PAROLE CHIAVE" INDICATE DAL GRUPPO DI LAVORO**
TIPO U	**48 ore**	* ARTRITE DI RECENTE COMPARSA ASSOCIATA A SINTOMI SISTEMICI: febbricola, astenia, calo ponderale inspiegabile (4-5%) * Manifestazione clinica indicativa di RIACUTIZZAZIONE DI CONNETTIVITE O VASCULITE GIA' DIAGNOSTICATA (riacutizzazione artritica, viscerite, vasculite cutanea, alterazioni ematologiche significative, …) * CEFALEA FEBBRILE NELL'ANZIANO DI RECENTE INSORGENZA con alterazione delle arterie temporali (tumefazione, tortuosità, iperpulsatilità) e/o disturbi visivi di recente insorgenza e/o claudicatio masseterica e/o dolore con rigidità simmetrica alle articolazioni dei cingoli scapolari e pelvici * PAZIENTI CON EFFETTI IATROGENI SEVERI da farmaci biologici e/o DMARDs (farmaci di fondo) * RACHIALGIA DA SOSPETTA SPONDILODISCITE SETTICA (rachialgia intensa con febbre settica e/o persistente)
TIPO B	**15 gg**	* ARTRITE ASSOCIATA ALLA PRESENZA DI SINTOMI OCULARI: Congiuntivite associata a xeroftalmia; Episclerite in malattia reumatologica; Uveite (almeno 2 episodi) da causa non accertata. * PRESENZA DI LESIONI CUTANEE O MUCOSE: Noduli dermo-ipodermici dolenti (Eritema Nodoso); Porpora palpabile; Eritema a farfalla al volto o Fenomeno di Raynaud con interessamento cutaneo associati a sintomi sistemici (artralgie o febbricola o astenia o calo ponderale); Aftosi orale e genitale contemporanea. * ALTERAZIONI FLOGISTICHE E/O DISIMMUNI DEGLI ESAMI DI LABORATORIO in Pazienti con segni o sintomi di patologia reumatica. * ARTRITE O DATTILITE (dito a "salsicciotto" dolente) in Paziente psoriasico, con sospetta artrite reattiva o malattia cronica dell'intestino * ARTRITE DI RECENTE INSORGENZA SENZA SINTOMI SISTEMICI.
TIPO D+ P (da indirizzare allo specialista reumatologo solo se vi sono difficoltà diagnostiche e/o terapeutiche)	**30 gg**	* **Fenomeno di Raynaud** isolato * **Presenza di sintomi orali** : Xerostomia persistente (non farmaco-dipendente) accompagnata da xeroftalmia; aftosi orale ricorrente che non regredisce entro le 2 settimane * **Polialgia** in giovane donna, senza segni di flogosi, con disturbi del sonno (una volta escluse patologie sistemiche) * **Lombalgia infiammatoria** * **Artromialgie senza segni di flogosi** * **Riscontro occasionale di alterazioni disimmuni** non correlato a segni/sintomi di patologia infiammatoria

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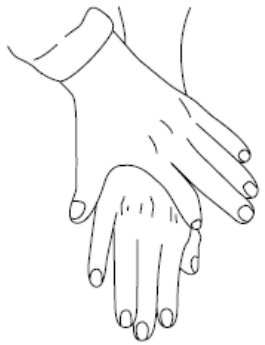

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Agenzia Regionale per i Servizi Sanitari
Ente strumentale della Regione Piemonte
Istituito con L.R. n. 10 del 16.03.1998

REGIONE PIEMONTE

Percorso Diagnostico Terapeutico Assistenziale in

REUMATOLOGIA

L'ARTRITE REUMATOIDE DIAGNOSI PRECOCE

2013

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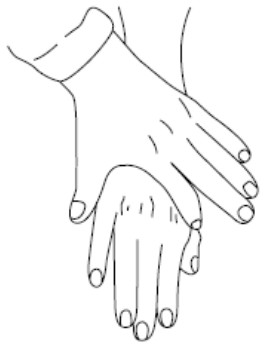

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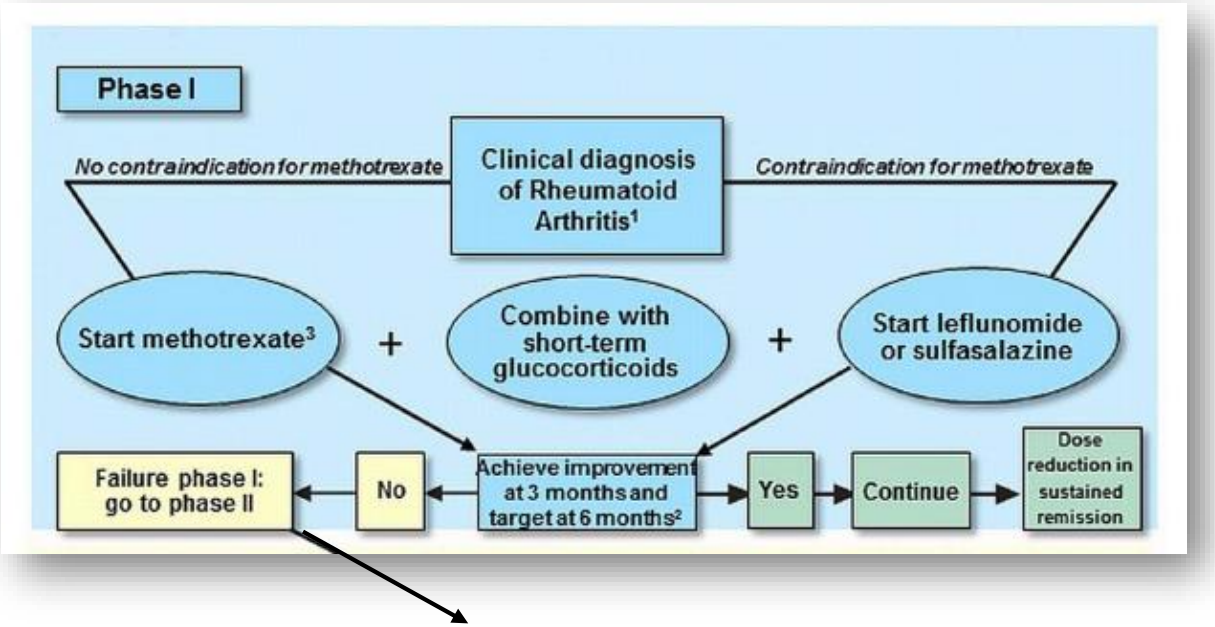


REGIONE PIEMONTE

Rete Reumatologica Piemontese

Percorso

diagnostico terapeutico assistenziale

L'Artrite in fase precoce (Early Arthritis)

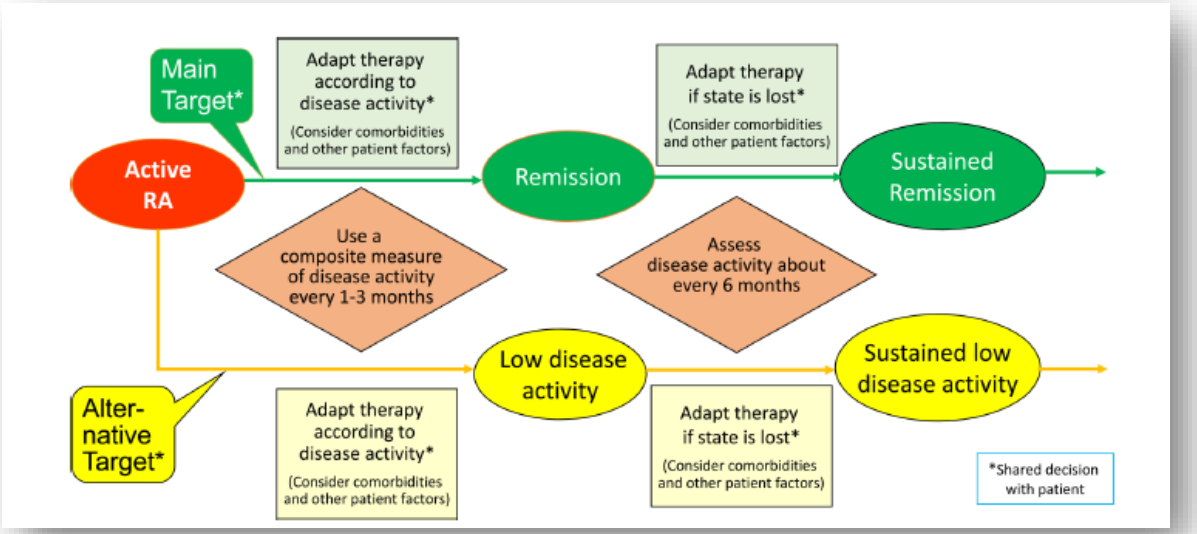
Bozza ad uso interno

Novembre 2019

Recommendation

EXTENDED REPORT

Treating rheumatoid arthritis to target: 2014 update of the recommendations of an international task force



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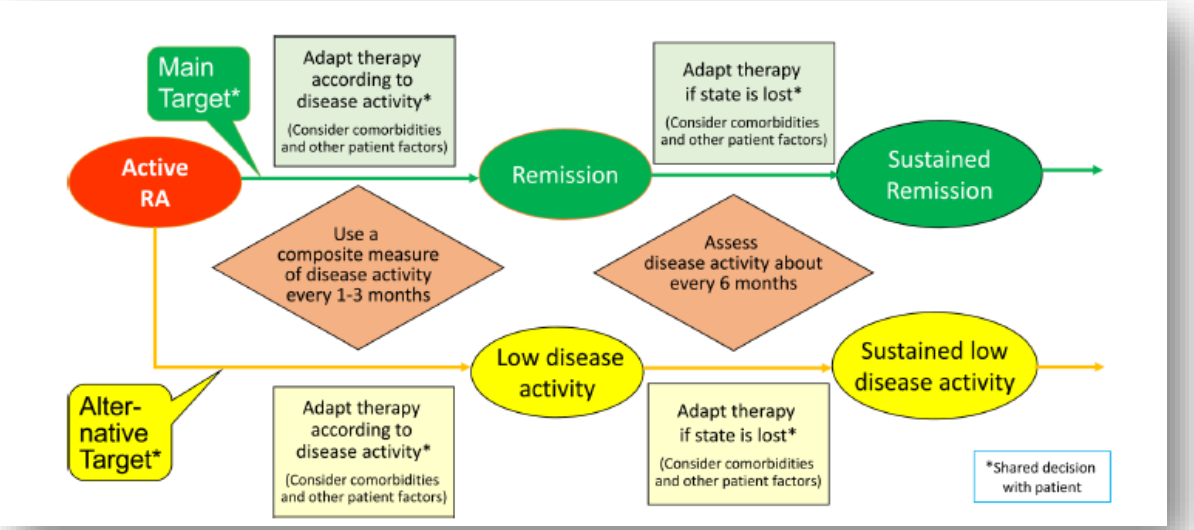

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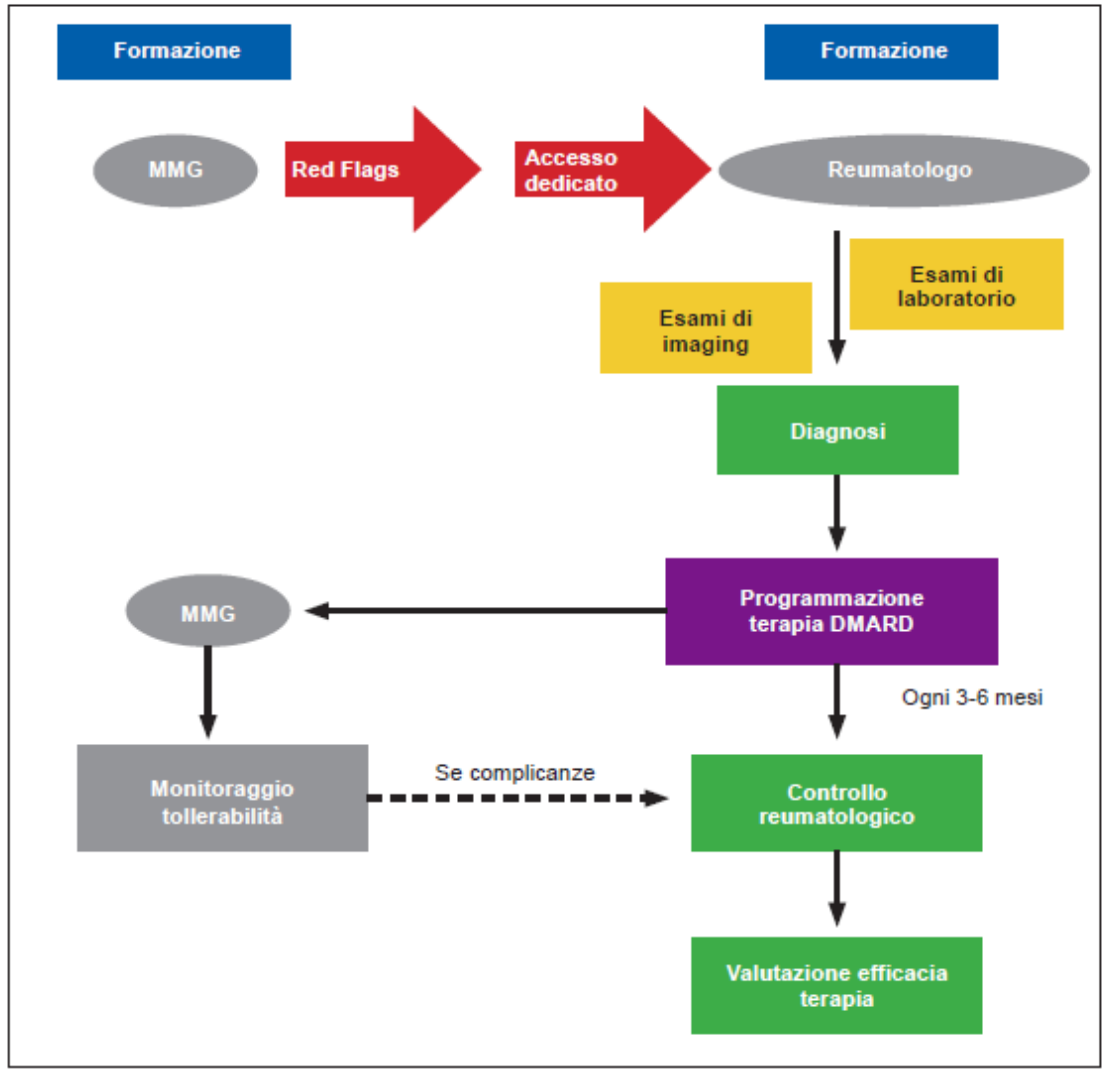
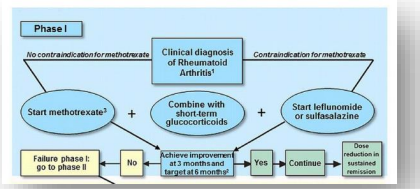
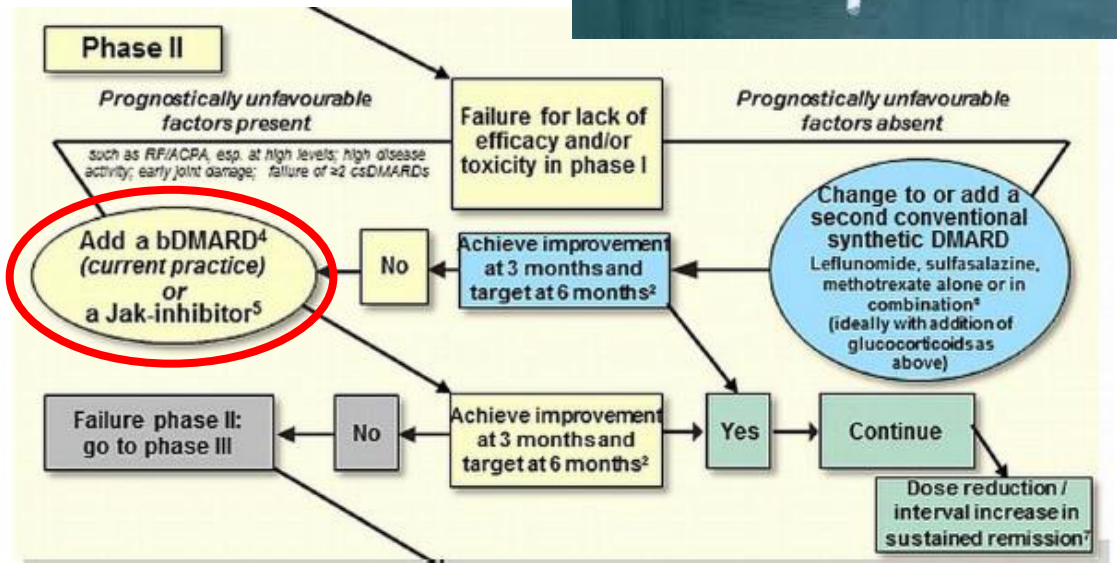
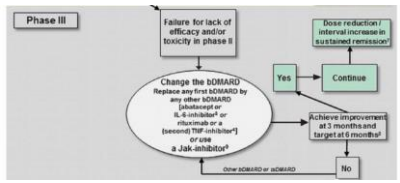
Figura 2. Algoritmo clinico-organizzativo per la diagnosi precoce e la strategia Treat to Target nell'artrite reumatoide







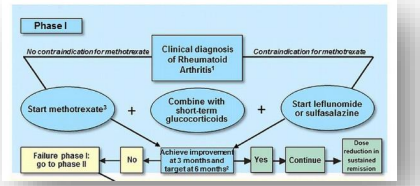


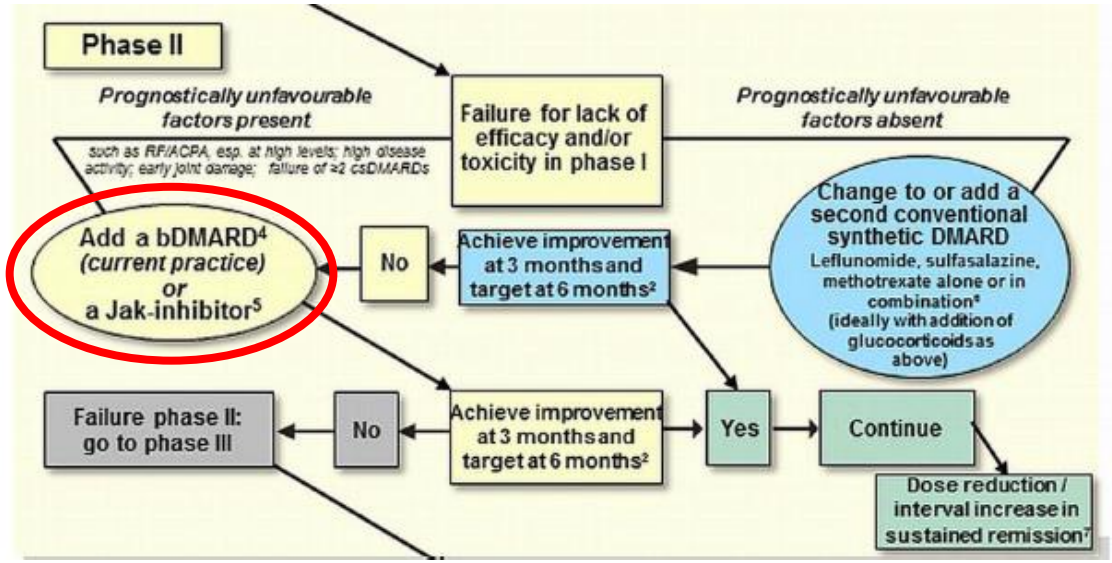
REGIONE PIEMONTE

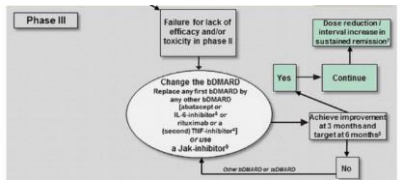
Farmaci biosimilari di Adalimumab

Linee di indirizzo sull'utilizzo per le malattie reumatiche

16 gennaio 2019







REGIONE PIEMONTE

Farmaci biosimilari di Adalimumab

Linee di indirizzo sull'utilizzo per le malattie reumatiche

- **prescrizione in paziente naive**
  Nell'ottica di un corretto utilizzo delle risorse disponibili, il clinico è invitato a considerare l'aspetto economico e pertanto a utilizzare il farmaco biotecnologico disponibile a minor costo per il SSN, fermo restando che la scelta prescrittiva del medico può indirizzarsi verso altri principi attivi disponibili per il trattamento delle malattie reumatiche secondo il particolare profilo del paziente

Consensus-based recommendations for the use of biosimilars to treat rheumatological diseases

Jonathan Kay,[1] Monika M Schoels,[2] Thomas Dörner,[3] Paul Emery,[4] Tore K Kvien,[5] Josef S Smolen,[2,6] Ferdinand C Breedveld,[7] on behalf of the Task Force on the Use of Biosimilars to Treat Rheumatological Diseases

Table 1 Overarching principles (A–E) and consensus recommendations (1–8) for biosimilars

		Agreement* (%)	Level of evidence†	Grade of recommendation‡
Overarching principles				
A.	Treatment of rheumatic diseases is based on a shared decision-making process between patients and their rheumatologists.	100	5	D
B.	The contextual aspects of the healthcare system should be taken into consideration when treatment decisions are made.	100	5	D
C.	A biosimilar, as approved by authorities in a highly regulated area, is neither better nor worse in efficacy and not inferior in safety to its bio-originator.	88	5	D
D.	Patients and healthcare providers should be informed about the nature of biosimilars, their approval process, and their safety and efficacy.	96	5	D
E.	Harmonised methods should be established to obtain reliable pharmacovigilance data, including traceability, about both biosimilars and bio-originators.	100	5	D
Consensus recommendations				
1.	The availability of biosimilars must significantly lower the cost of treating an individual patient and increase access to optimal therapy for all patients with rheumatic diseases.	100	5	D
2.	Approved biosimilars can be used to treat appropriate patients in the same way as their bio-originators.	100	1b	A
3.	As no clinically significant differences in immunogenicity between biosimilars and their bio-originators have been detected, antidrug antibodies to biosimilars need not be measured in clinical practice.	100	2b	B
4.	Relevant preclinical and phase I data on a biosimilar should be available when phase III data are published.	100	5	D
5.	Since the biosimilar is equivalent to the bio-originator in its physicochemical, functional and pharmacokinetic properties, confirmation of efficacy and safety in a single indication is sufficient for extrapolation to other diseases for which the bio-originator has been approved.	100	5	D
6.	Currently available evidence indicates that a single switch from a bio-originator to one of its biosimilars is safe and effective; there is no scientific rationale to expect that switching among biosimilars of the same bio-originator would result in a different clinical outcome but patient perspectives must be considered.	96	1b	A
7.	Multiple switching between biosimilars and their bio-originators or other biosimilars should be assessed in registries.	100	5	D
8.	No switch to or among biosimilars should be initiated without the prior awareness of the patient and the treating healthcare provider.	91	5	D

ARD Online First, published on October 3, 2017 as 10.1136/annrheumdis-2017-211937

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Consensus recommendations				
1.				
2.				
3.				
4.				
5.				
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