Patients' own ability to assess activity of their rheumatoid arthritis

Sir, Increasingly patients are able to access their Rheumatology Department via nurse-led Rheumatology helplines and, due to the over-booking of our clinics and the long distances patients have to travel to attend, there clearly is a potential for departments to develop a telephone follow-up service for patients with rheumatoid arthritis (RA). Published work on Rheumatology telephone follow up concentrates on a doctor- rather than nurse-led service [1] and we have been unable to find any literature on patients’ ability to assess their own disease activity on the telephone, although there is work on patients’ assessment of Disease Activity Score (DAS) using a mannequin [2]. We therefore undertook a pilot study to assess this fact. We chose DAS28 as a measure of disease activity as it is a validated score for both the early and the established RA [3] and has been shown to be sensitive to change [4].

Patients attending the nurse consultant, nurse specialist and the specialist registrar clinics at Worcestershire Royal Hospital over the summer of 2005 with a diagnosis of RA were invited to participate in this study. They were asked to count the number of their tender and swollen joints using only verbal clues as to which joint, and then gave a numerical global health assessment from 0–100. The health care practitioner (HCP) then undertook a standard DAS28 assessment with global health assessment measured on a visual analogue scale and later calculated both the scores. Changes in medication and investigations requested were also noted. A total of 50 patients were recruited (of which 32 were female; age: mean and median 59 yrs; range 31–83). The disease duration ranged from 6 months to 32 yrs with a mean of 12 and a median of 11 yrs. Of the 50 patients, 39 were on one disease modifying drug (DMARD), six were on two and five on none. Two patients were also taking an anti-TNF therapy.

The results of verbal DAS28 (vDAS28) and standard DAS28 were distributed normally with a mean vDAS28 score of 4.2 with a range of 0.46–8.54, and a mean DAS28 of 3.99 with a range of 0.76–6.68. The correlation between the scores was good with an R value of 0.895. Bland Altman plot analysis did not suggest whether the patients were more or less likely to overestimate DAS28 score at differing levels of disease activity.

Interestingly vDAS28 correlated best with verbal tender joint count, R = 0.729, and least well with actual swollen joint count, R = 0.294, whereas DAS28 correlated best with global health assessment, R = 0.681, and least well with actual swollen joint count, R = 0.46. Verbal tender joints correlated relatively poorly with actual tender joints, R = 0.57, as did verbal swollen joints with actual swollen joints, R = 0.46.

Ten patients were prescribed an increase in medication at the clinic, seven were to start, restart or increase methotrexate, two were to start leflunomide and one to start sulphasalazine. One patient was advised a reduced dose of oral steroid and one, a reduced dose of methotrexate due to mildly deranged liver function tests. An abdominal ultrasound and a pulmonary function test were requested.

These results suggest that it may be possible for patients to assess their own disease activity and that vDAS could form a part of a nurse-led telephone follow-up consultation. There are limitations to this study in that patients might have had non-verbal clues and the HCP may not have looked at inter-observer error. We also recognize the limitations of DAS28 as an assessment tool, particularly in patients who have a predominantly lower limb disease. However, we intend to assess the vDAS28 further by contacting patients the day before they attend our nurse-led anti-TNF clinic and if there is a good correlation between the vDAS and standard DAS at the clinic visit, we will aim to offer the alternate mode of consultation through the telephone. Such a strategy would require dedicated clinic slots for patients who are identified as needing more detailed assessment, investigations or a change in therapy. Funding for such clinics would also need to be identified by healthcare commissioners.

The authors have declared no conflicts of interest.

T. Potter, A. Wild, K. Edwards, A. Rai, I. F. Rowe
Department of Rheumatology, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester, WR5 1DD, UK
Accepted 9 February 2006
Correspondence to: Tanya Potter. E-mail: tanyapotter@uhcw.nhs.uk


doi:10.1093/rheumatology/kel1160
Advance Access publication 22 May 2006

Polymorphisms of the FCRL3 gene in a Spanish population of systemic lupus erythematosus patients

Sir, Receptors for the Fc portion of IgG (FcγRs) are essential mediators of the inflammatory effect of immune complexes and cytotoxic antibodies [1, 2]. FcγRs are candidate genes to the susceptibility to autoimmune disease. A new family of FcRs, Fcγ-like (FcRL) or FcR homologous (FcRH) genes, with similarity in structure and sequence to the classical FcγRs, has been recently identified [3]. They map in the chromosomal region 1q21–32, which has showed evidence of linkage with systemic lupus erythematosus (SLE) and other autoimmune diseases [4, 5]. A very recent study reported an association of the FCRL3 gene with several autoimmune diseases [6]. The aim of this study was to investigate the association of the FCRL3 and SLE in a large cohort of SLE Spanish patients.

We analysed a Spanish Caucasian case-control panel consisting of 520 SLE patients meeting the American College of Rheumatology (ACR) criteria for SLE [7, 8], and recruited from five Spanish hospitals. Samples were obtained from subjects after they provided written informed consent. The study was approved by all local ethical committees of the corresponding hospitals. A total of 540 matched blood and bone marrow donors were included as healthy controls. Among the patients, 59.9% had anti-dsDNA antibodies, 35.9% developed lupus nephritis and 37.5% were DRB1*03 positive. No significant differences in the frequency of the different alleles of the three polymorphisms studied were observed among the patient groups or the control groups from different cohorts. Hence, we combined all cohorts to form a SLE case-control group, which was used in further analyses. The control study population was found to be...