Again, we recognized that these are important issues. However, in giving authoritative guidance, we considered it important that two important principles are sustained. Firstly, it is essential that guidance reflects the facts as currently known rather than opinion or data from a single source. Secondly, guidance is intended to provide a sound basis for initiating and managing the treatment. Specialists must retain some freedom to make alterations or additions to the treatment according to the clinical circumstances; in our view, therefore, it is appropriate to lay down a core of rational treatment leaving the details for clinicians to determine. We included within our report a clear indication, however, that the guidelines will be updated and extended as the evidence base grows. Such a review process is in place.

Meanwhile, we are grateful for all input to the continuing guideline development process.

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Drug survival in rheumatoid arthritis

SIR, We have read with interest the editorial of Treharne et al. [1] on drug compliance/adherence in rheumatology patients, highlighting the complex processes underlying this behaviour and, indeed, the variety of sometimes expensive/complex methods for measurement. We have examined another relevant measure of medication continuation in patients with rheumatoid arthritis (RA), which has the advantage of being cheap and easy to measure, requiring no complex questionnaires or expensive measuring devices. ‘Drug survival’ measures the length of time a patient continues to take a particular drug: it is a well-recognized measure of drug effectiveness, which encompasses factors such as adverse drug reactions and side-effects, poor adherence, loss of efficacy and others [2]. To measure drug survival, it is simply necessary to ask the patient when starting on a new medication to note the date they stop taking the medication regularly. Although drug survival has been examined in a variety of medical situations, it has not previously been extensively studied in RA.

We examined the influence of medication beliefs and psychosocial factors on drug survival in 68 patients with RA starting their first disease modifying anti-rheumatic drug (DMARD) [3]. Forty-seven patients were drug survivors, continuing to take their prescribed DMARD regularly 1yr after initiation. Although medication beliefs, as measured by the Beliefs About Medications Questionnaire [4], did not predict drug survival, both age and anxiety levels (measured using the Spielberger State-Trait Anxiety Inventory – Short Form (STAI-SF) questionnaire [5]) did. Specifically, drug survivors were younger and more anxious than those who discontinued taking their DMARD within the first year, a group characterized by older age and lower anxiety levels.

Drug survival is cheap and easy to measure: understanding the factors that contribute to drug survival can only add to our understanding of compliance/adherence. In this case, if we assume that drug survival is a ‘good’ outcome, we need to target our counselling at those who are older/less anxious. Given that beliefs about medications do not appear to influence drug survival, these somewhat counter-intuitive and intriguing findings challenge our approach to promoting compliance/adherence/drug survival in our rheumatology patients.

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Re: Drug survival in rheumatoid arthritis—an interesting method but not a measure of adherence or concordance

SIR, Mulherin and Wong’s [1] description of ‘drug survival’ of disease-modifying anti-rheumatic drugs (DMARDs) is an interesting approach to medication taking among people with rheumatoid arthritis (RA). The authors highlight how this purportedly simple binomial approach does not distinguish the multitude of causes that lead to DMARD discontinuation. We believe the approach to be far from simple and would like to raise some questions about it. This approach might be considered akin to the recording of overdoses as a measure of major depression. Many depressed people do not take an overdose and many overdoses are not suicide attempts. In addition to the fact that not all DMARD discontinuers were non-adherent we would expect that not all DMARD continuers are adherent.

An issue that we would like to see clarified is the exact definition of ‘regularly’ taking DMARDs required for Mulherin