

NEW ZEALAND RHEUMATOLOGY ASSOCIATION (NZRA)

TOP FIVE RECOMMENDATIONS ON LOW-VALUE PRACTICES

The NZRA is the organisation that represents the rheumatologists of New Zealand.

Their main function is to promote and maintain the standards of rheumatology practised in New Zealand. This is done by:

- Working with the Royal Australasian College of Physicians to oversee the training of rheumatologists.
- Providing continuing medical education to rheumatologists in the form of the NZRA Annual Scientific Meeting.
- Lobbying to improve the access of rheumatology patients to rheumatology services and treatments.

1. Do not perform arthroscopy with lavage and/or debridement or partial meniscectomy for patients with symptomatic osteoarthritis of the knee and/or degenerative meniscal tear

There is consistent evidence to indicate that arthroscopic lavage and/or debridement to treat people for symptomatic knee osteoarthritis, and/or partial meniscectomy for patients with a degenerative meniscal tear (with or without underlying osteoarthritis), is no more effective than placebo surgery or non-operative alternatives. The evidence for this is now so developed that a recent guideline makes a strong recommendation against knee arthroscopy in almost all patients and states that further research is unlikely to change this recommendation.

There is also a high rate of conversion from knee arthroscopy to total knee arthroplasty, which rises with increased age, further suggesting arthroscopic surgery should be avoided in people over the age of 50 years.

SUPPORTING EVIDENCE

- Khan M, Evaniew N, Bedi A, et al. Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. CMAJ 2014; 186(14):1057-1064.
- Siemieniuk RAC, Harris IA, Agoritsas T, et al. Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline. BMJ. 2017 10;357:j1982.
- Sihvonen R, Paavola M, Malmivaara A, et al. Arthroscopic partial meniscectomy versus sham surgery for a degenerative meniscal tear. N Engl J Med 2013; 369: 2515-2524
- Wai EK, Kreder HJ, Williams JI. Arthroscopic débridement of the knee for osteoarthritis in patients fifty years of age or older: utilization and outcomes in the Province of Ontario. J Bone Joint Surg Am. 2002;84-A(1):17-22..

2. Do not prescribe more than the minimum effective dose of glucocorticoid (GC) therapy (10–20 mg daily) for initial treatment of polymyalgia rheumatica (PMR)

Only the minimum effective individualised glucocorticoid (GC) dose should be prescribed for initial treatment of polymyalgia rheumatica (PMR). The dosage should balance benefits and harms after assessing:

- risk factors for GC-related adverse events;
- comorbidities that may affect the impact of GC therapies (e.g. diabetes, osteoporosis, glaucoma, etc);
- concomitant medications; and
- the risk of relapses and/or prolonged therapy.

One recent guideline indicates a range of 12.5–25 mg prednisone (or equivalent) daily for the initial treatment, while other studies indicate that PMR remission can be achieved with prednisone treatment at a dose of 15 mg/d in most patients. Overall, we support a range of 10–20 mg daily for initial treatment of PMR with the caveat that ultimately these dosages need to be individualised for the patient.

SUPPORTING EVIDENCE

- DeJaco C, Singh YP, Perel P, et al. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. *Ann Rheum Dis*. 2015;74(10):1799-807.
- Hernández-Rodríguez J, Cid MC, López-Soto A, et al. Treatment of polymyalgia rheumatica: a systematic review. *Arch Intern Med*. 2009 Nov 9;169(20):1839-50.

3. Do not repeat dual-energy X-ray absorptiometry (DEXA) scans for diagnosis of osteoporosis more frequently than every 5 years in patients in good health, with no risk factors for accelerated bone loss or fracture and with T scores greater than -2.00.

There is still uncertainty over the most appropriate intervals for repeating Dual-energy X-ray Absorptiometry (DEXA) scans for monitoring bone density. Because changes in bone density over short intervals are often smaller than the measurement error of most DEXA scanners, frequent testing of less than 2 years is unnecessary in most patients. The baseline T score (which indicates osteoporosis development) is the most important determinant of a BMD testing interval. For instance, one study estimated that among older postmenopausal women with T scores above -1.50, less than 10 per cent will develop osteoporosis over a 15-year period; while among those with T scores between -1.50 and -1.99, less than 10 per cent will develop osteoporosis over a 5-year period.

The equivalent periods are slightly longer for older men. Based on this and other recent evidence on cumulative incidence of osteoporosis over time, we recommend against DEXA scan monitoring more frequently than every 5 years in patients with T scores above -2.00, who are in good health and have no additional risk factors for accelerated bone loss. Risk factors for accelerated bone loss include (but are not limited to): hyperparathyroidism, aromatase inhibitor therapy, androgen deprivation therapy, steroid therapy and Vitamin D deficiency.

SUPPORTING EVIDENCE

- Gourlay ML, Fine JP, Preisser JS, et al. Study of Osteoporotic Fractures Research Group. Bone-density testing interval and transition to osteoporosis in older women. *N Engl J Med* 2012;366:225–33.
- Gourlay ML, Overman RA, Fine JP, et al. Time to Osteoporosis and Major Fracture in Older Men: The MrOS Study. *Am J Prev Med*. 2016 Jun;50(6):727-736
- US Preventive Services Task Force. Screening for osteoporosis: U.S. preventive services task force recommendation statement. *Ann Intern Med* 2011; 154:356–364
- White VG, Franks P, Robbins JA, Fenton JJ. Incidence and Predictors of Repeat Bone Mineral Densitometry: A Longitudinal Cohort Study. *J Gen Intern Med*. 2017 Oct;32(10):1090-1096.

4. Do not order extractable nuclear antibodies (ENA) testing in patients with negative antinuclear antibodies (ANA)

Testing for antibodies to extractable nuclear antibodies (ENA) is only advised after detecting a positive antinuclear antibody (ANA) in patients with symptoms consistent with a rheumatic disease. However, in some cases ENA testing may be advisable even after a negative ANA – e.g. where there is a high pre-test probability of a rheumatic condition such as Sjogren's syndrome or where there are anti-Jo-1 antibodies for clinically suspected inflammatory myopathies.

SUPPORTING EVIDENCE

- Agmon-Levin N, Damoiseaux J, Kallenberg C, A et al. International recommendations for the assessment of autoantibodies to cellular antigens referred to as anti-nuclear antibodies. *Ann Rheum Dis* 2014, 73(1):17-23.

5. Do not order anti-double stranded (ds) DNA antibodies in antinuclear antibodies (ANA) negative patients unless clinical suspicion of systemic lupus erythematosus (SLE) remains high.

International recommendations advise testing for anti-dsDNA antibodies only after detecting a positive antinuclear antibody (ANA) in patients with symptoms consistent with systemic lupus erythematosus. In patients who are ANA negative, anti-dsDNA should only be ordered in clinical situations where the pre-test probability of SLE is high.

SUPPORTING EVIDENCE

- Agmon-Levin N, Damoiseaux J, Kallenberg C, et al. International recommendations for the assessment of autoantibodies to cellular antigens referred to as anti-nuclear antibodies. Ann Rheum Dis 2014, 73(1):17-23.

How was this list created?

A working group of NZRA Fellows was established and developed an initial list of recommendations on 44 rheumatology-related tests and treatments that might be low-value informed by an evidence review by the Royal Australasian College of Physicians Policy and Advocacy unit. This list was reduced to 26 items following further discussions, and a shortlist of 15 items was agreed following further polling of the group. Brief synopses of the evidence were written for each of the 15 recommendations and an anonymous online survey was created based on these. All NZRA members were invited to participate and assign a score for each of the recommendations based on the criteria of (i) whether the practice was still being undertaken in significant numbers (ii) strength of the evidence for the recommendation (iii) importance of the recommendation to safety and cost (iv) whether progress in implementing the change would be measurable. Based on the results of the survey, the top 5 was selected and approved by the NZRA working group and the NZRA President in June 2018.