HAUTE AUTORITÉ DE SANTÉ

CLINICAL PRACTICE GUIDELINES

Rheumatoid arthritis

Medical, social and organisational aspects of treatment (excluding surgery and drugs)

March 2007

The full scientific report (in French) can be downloaded from
www.has-sante.fr

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This document was validated by the Board of the Haute Autorité de Santé in March 2007

Summary

1. Introduction

1.1 Subject and aims of the guidelines

► Subject of the guidelines

These guidelines on rheumatoid arthritis (RA) were requested by the health insurance funds CNAMTS[1] and CANAM[2] and the National Association for Research and Evaluation in Chiropody and Podology (ANREP).

RA is a chronic, inflammatory rheumatic condition involving progressive joint destruction, with functional, psychological and social repercussions, which are sometimes serious for the patient[3]. RA is the most common form of inflammatory rheumatism. Its burden is substantial in terms of health economics.

The main objective of RA treatment is to control disease activity, reduce pain, prevent and control joint destruction, prevent the loss of function in daily activity and at work, and to optimise the quality of life. In order to achieve this, global management is necessary. Medical, physical, psychological and surgical management are complementary and cannot be dissociated from social and professional measures. To this end, HAS is producing 3 clinical practice guidelines on RA:

- rheumatoid arthritis: early management (in preparation, 2007)
- rheumatoid arthritis: ongoing disease management (in preparation, 2007)
- rheumatoid arthritis: medical, social and organisational aspects of treatment (excluding surgery and drugs) (this document).

► Aims of the guidelines

- to acquaint professionals better with the evidence-based effects of non-drug treatment so as to propose an optimal management aiming

[1] CNAMTS: *Caisse nationale d'assurance maladie des travailleurs salaries* [National health insurance fund for salaried employees]
[2] CANAM: *Caisse nationale d'assurance maladie des professions indépendantes* [National health insurance fund for the independent professions]
[3] Early signs are pain in the joints, morning stiffness, and swelling (synovitis). A typical patient would present with an inflammatory syndrome, joint involvement (erosions, in rare cases joint destruction), and maybe non-articular involvement (e.g. rheumatoid nodules). The disease progresses by acute episodes (flare-up) and results in handicap if not treated.

to limit as far as possible the consequences of the disease in terms of pain, joint and muscle dysfunction, functional capacity, and quality of life;

- to enable all patients with RA to have access to coordinated and adapted therapeutic, social and professional management;
- to harmonise the methods by which care is organised.

These guidelines address the following questions:

- What are the indications for the following types of non-drug management of patients with RA?
  - physical treatments and rehabilitation (passive and active techniques, physiotherapy, massage, balneotherapy and spa therapy, occupational therapy, orthoses, chiropody and podology);
  - educational interventions (therapeutic patient education, education in movement), psychological management (cognitive-behavioural and psychodynamic) and other types of intervention (relaxation, hypnosis);
  - other non-drug treatment (acupuncture, dietetics, osteo-pathy);
  - social and professional management.

  Drugs, as well as surgical and post-surgical treatments, are not addressed.
- Which treatment strategy to adopt? i.e. the relative contributions of various techniques according to disease activity and stage, and to the practical aspects of management
- Which strategies to adopt for social and professional management? i.e. the role of occupational health, social assistance, and patients' associations.

1.2 Patients concerned

All adult patients affected with RA[4].

1.3 Professionals concerned

The guidelines are targeted at all healthcare professionals and social workers involved in prescribing or managing non-drug treatment, especially:

[4] Most clinical studies use the classification criteria of the American College of Rheumatology (ACR) as inclusion criteria. However, the diagnostic criteria for RA are different from these classification criteria ("Rheumatoid arthritis: Early management" , HAS 2007 (in preparation)).

- general practitioners, rheumatologists, doctors specialising in physical and rehabilitation medicine, and specialists in occupational health;
- social workers, dieticians, occupational therapists, physiotherapists, chartered orthotists, orthoprosthetists, chiropodists, podologists, podo-orthotists, and psychologists.

1.4 Grading of the guidelines

The proposed guidelines were graded as indicated in Appendix 2. In the absence of scientific evidence, the guidelines are based on professional agreement among members of the working group and peer reviewers. No evidence does not signify that the guidelines are not relevant but, whenever possible, should encourage the carrying out of further studies.

2. Global management of patients with RA

The treatment of RA requires global management. This includes medicinal, physical, educational, psychological, dietary and surgical management, and is inseparable from social and professional measures.

Non-drug treatment is an adjunct to drugs or surgery and is not a substitute for them. It should be systematically planned during the elaboration of a global treatment plan regardless of disease stage.

There are many different non-drug treatments for RA. They include physical treatments, educational and psychological management, as well as interventions such as acupuncture or diet plans. These interventions follow a thorough clinical examination[5] which enables the therapeutic objectives to be defined with the patient according to disease activity and stage, and the benefits obtained from the treatment to be monitored.

3. Indications for physical treatments

[5] The clinical examination includes a clinical assessment of pain, functional defects and incapacities, psychological well-being, and the social and professional environment of the patient. It is performed by the prescribing doctor and by the appropriate health professionals according to specialty. The tools for the clinical evaluation of RA are not covered in this document.

Physical treatments call upon techniques of rehabilitation : physiotherapy, occupational therapy, chiropody, podology, and orthotics. Their main objectives are to decrease pain, prevent or treat deformities, maintain or restore mobility and joint stability, maintain muscular performance and aerobic capacity, and enable functional adjustment as the handicap progresses.

3.1 Massage and passive techniques of physiotherapy

► Massage

Massage should not be used on its own (professional agreement).

Massage is an adjuvant[6] to physical treatment. Professionals and patients are aware of its short-term analgesic and relaxant effects. The indication and choice of massage technique should take into account skin fragility, inflammation and the pain threshold.

► Passive mobilisations and postural exercises

Passive mobilisations and postural exercises should be used to maintain or restore range of motion (professional agreement).

They are indicated when limitations in joint range of motion are due to retraction of peri-articular soft tissues. Amplitude can be restored only if the limitations are recent and not fixed. These techniques are introduced gradually after total or partial failure of active postural exercises and assisted active mobilisations. They can be carried out at any stage of the disease including active phases of RA, provided that account is taken of the patient's pain threshold. Prophylactic analgesic treatment may be prescribed before the sessions to improve the comfort of the patient and rehabilitation efficacy.

3.2 Active techniques of physiotherapy

► Strengthening exercices

Strengthening exercices are recommended at all stages of RA (grade B). The exercises should be adapted to the patient's general health and to the joint defect.

[6] The term "adjuvant" means that massage may be combined with a primary physical treatment (e.g. joint mobilisation). It may facilitate the application of this treatment or provide an additional analgesic effect.

Strengthening exercises concern all patients with RA but in particular those with an isolated or global decrease in muscular strength.

The following methods are effective (evidence level 2):

- analytical or global strengthening exercise programme;
- isometric or dynamic, including isokinetic, strengthening;
- strengthening of moderate or strong intensity (50 to 80% of the maximum voluntary contraction).

Dynamic strengthening is well tolerated. It does not reactivate RA nor accelerate radiological joint destruction (evidence level 2). However, caution has to be exercised when placing a mechanical strain on severely damaged joints as sufficient, especially long-term, data are lacking (professional agreement). Thus, when a joint is the site of major destruction or of an inflammatory flare-up, the peri-articular muscles should be strengthened (professional agreement):

- under isometric conditions
- against light or moderate resistance
- with load alleviation in the case of weight-bearing joints
- taking account of the pain threshold.

► Aerobic activities

All patients with RA should carry out regular aerobic physical activity[7] for cardiopulmonary endurance (grade B). Activity should be adapted to the patient's general health and to the condition of their heart and joints.

Aerobic activities of moderate or high intensity (60-85% of maximum heart rate), including weight-bearing activities with a moderate impact on the joints[8] are recommended for patients with stable RA (grade B) and even those with active RA[9] (professional agreement).

Aerobic activities of moderate or high intensity in patients with stable RA and with no history of severe cardiac disease have proven efficacy on aerobic capacity (evidence level 2). However, the effects on muscular strength, functional capacity, psychological status and quality of life were inconsistent in group comparisons, although they did improve after aerobic activity (evidence level 4).

[7] Aerobic physical activities are global physical activities requiring cardiopulmonary endurance (e.g. walking, running, swimming, Tai Chi, cycling, etc.).
[8] Examples: rapid walking, endurance running, some forms of dance.
[9] RA is active if the DAS 28 score is > 3.2. For details on calculating the DAS 28 and the thresholds for assessing disease activity and treatment response, see "Rheumatoid arthritis: Early management" , HAS 2007 (in preparation).

Aerobic activities contribute to lessening comorbidity, in particular cardio-vascular comorbidity.

They do not have any impact, in particular a negative impact, on disease activity nor on radiological joint destruction (evidence level 4).

Aerobic activities with low impact on the joints or with load alleviation[10] should be preferred when the RA is very active or when there is severe involvement of the joints of the lower limbs. In the event of flare-up, these restrictions are only temporary and are adjusted to the patient's clinical status (professional agreement).

Aerobic activities can be carried out with or without supervision. A periodical medical opinion is necessary to assess the level of activity and encourage the patient to improve compliance (professional agreement).

► Functional activities

Physiotherapy techniques to maintain mobility (transfers[11], walking) are recommended for all severe cases with restricted daily life activities (grade C).

These active techniques are combined with the required rehabilitation measures (e.g.assistive devices).

3.3 Balneotherapy and spa therapy

► Balneotherapy

Balneotherapy may be proposed as a complement to active (grade C) or passive physiotherapy techniques, in particular when these techniques should be carried out with load alleviation.

Balneotherapy uses the physical properties of water and covers all passive or active rehabilitation techniques that are carried out while immersed in warm water[12]. It is well tolerated, at least outside of episodes of highly inflammatory flare-up. It should be carried out in a pool that is sufficiently deep for total immersion of the body in order that exercises are performed without load-bearing.

Balneotherapy has proven efficacy towards the end of treatment (evidence level 2) with respect to:

[10] Examples: walking (activity with low impact on the joints) or balneotherapy (activity with load alleviation).
[11] Transfers are movements of the body from one position to another (e.g. from a seated to a standing position).
[12] The temperature of the water is usually about 35°C (95°F).

- functional capacity
- some quality of life criteria.

However, the effects on pain, muscular force, and aerobic capacity were inconsistent in group comparisons, even if they did improve after balneotherapy (evidence level 4).

Balneotherapy may be proposed in order to (professional agreement):

- obtain an analgesic and relaxant effect
- improve range of motion
- contribute to muscle strengthening
- promote a return to normal physical activity by providing aerobic activity with no risk of increasing disease activity.

According to published data, exercises performed while immersed in warm water are effective but the impact of just immersion in warm water is not known. Immersion allows the use of physiotherapy techniques without load-bearing which would otherwise not be possible.

There are no contraindications to balneotherapy that are specific to RA. However, specific precautions should be taken in immunosuppressed patients or patients with cutaneous lesions, especially of the feet.

► Spa therapy

Spa therapy appears to provide an analgesic and functional benefit to patients with stable or long-established and non-progressive RA (grade C). It is not indicated when RA is active (professional agreement).

Published data have not established whether the benefits of spa therapy are due to the chemical composition of the water in the baths, to the interventions carried out, or to just rest.

3.4 Physical agents

Physical agents[13] should not be used on their own. They may be used as adjuvant treatment to physiotherapy or symptomatic analgesic treatment after assessment with the patient of the 'expected benefit versus constraints' ratio (professional agreement).

Ionisation therapy should not be used because of the increased risk of burns due to skin fragility secondary to corticoid therapy (professional agreement).

Physical agents should not be prescribed without taking into account their rather modest and short-lasting benefits, and their disadvantages

13 Physical agents delivering energy include electrotherapy, electromagnetic and mechanical (ultrasound) waves, heat treatment.

(equipment cost, potential side-effects). Their use, in particular the number of sessions with a professional, should depend on regular validated clinical assessments.

The expected or established effects of adjuvant physical agents differ according to technique:

► **Effects on strength**

- *Electromyostimulation or excito-motor electrostimulation* can help maintain or restore the strength of certain muscle groups (professional agreement).

► **Analgesic effects**

- *heat treatment.* The application of heat (hot mud or paraffin packs) has a temporary sedative, analgesic and relaxant effect on weakly or non-inflamed joints and can be combined with physical exercise (evidence level 4). Local application of cold for analgesic purposes can be proposed in rare cases (professional agreement). Heat treatment by the direct application of hot or cold compresses provides the best 'expected benefits versus constraints' ratio (professional agreement),
- *transcutaneous analgesic electrostimulation*. Very-low frequency high-intensity currents have a proven short-term analgesic effect on the hands (evidence level 2), but are less well tolerated by the patient than conventional TENS type currents[14] (evidence level 4),
- *electromagnetic waves*. Only the effects of laser therapy have been studied. Its effect on pain and morning stiffness of the hands is modest and of short duration after 4 weeks of treatment (evidence level 2),
- *ultrasound*. A single placebo-controlled study – on hands only - showed an analgesic effect that had little clinical relevance at the end of treatment (evidence level 4).

3.5 Occupational therapy

Every person with RA should be referred, if required, to an occupational therapist (professional agreement).

Occupational therapy is used to teach the rules of joint protection (body movement, how to spare the joints), how to choose or construct assistive

[14] Conventional transcutaneous electrical nerve stimulation (TENS) is electro-stimulation by 50 -100 Hz frequency currents for the purposes of analgesia.

devices, and how to adapt the environment. It has a key role in rehabilitation of affected hands (see Section 3.8).

In 2007, referral to an occupational therapist is still difficult in France. Occupational therapists tend to practise in rehabilitation centres. Independent practice is marginal, partly because of problems related to reimbursement[15].

3.6 Orthoses

The wearing of orthoses is recommended for analgesic, functional or corrective purposes after clinical assessment for the following indications:

- **temporary immobilisation of very inflamed joints (orthosis worn during rest periods)**
- **stabilisation of destroyed joints (orthosis worn during activities)**
- **correction of deformities that can be reduced.**

Health professionals should regularly assess the benefit of orthoses (professional agreement).
Assessment covers tolerance, analgesic effect, effect on deformities, and compliance. No preventive effect of orthoses on deformities has been demonstrated.

Customized orthoses are generally better adapted than off-the-shelf orthoses (professional agreement).
The orthosis needs to be adjusted and adjustable (according to the extent of local inflammation), and easy to use and maintain. Thermoformable materials usually meet these requirements. Customized orthoses are produced by qualified professionals. They concern mostly the neck, knees, feet and, above all, the hands and wrists.

3.7 Assistive devices and adapting the environment

► Assistive devices

Assistive devices should be used to facilitate the carrying out of daily activities that are painful or difficult (grade C).

[15] Reimbursement may be granted after prior agreement from national health insurance *("demande d'entente préalable")* as a service that does not fall in the scope of current legislation.

Assistive devices for upper limbs are indicated in order to facilitate daily activities. Their use reduces pain (evidence level 4) and strain on the joints. They are palliative and improve autonomy in the case of severe joint involvement. No preventive effect on deformities has been demonstrated. The prescription must take account of the patient's clinical status and environment.

Prescription of assistive devices for walking or mobility is recommended when walking is painful or difficult, in order to improve functional autonomy, facilitate movement and reduce sedentarism. The choice of a walking aid[16] is established after clinical assessment of the patient's capabilities, and takes into account upper-limb deficiencies and the patient's environment.

In 2007, in France, access to assistive devices that have been prescribed may be difficult as reimbursement tariffs are much lower than the real costs for the patient.

► Adapting the environment

Adapting the environment is recommended in cases of severe and definitive functional incapacity (professional agreement).

This concerns the home (especially its accessibility, the kitchen and bathroom), transport, and the workplace (with the help of the workplace doctor). The options are established by the occupational therapist, together with the physiotherapist and the doctors in charge of the patient. Referral to an occupational therapist is not always possible. The possibility of obtaining any financial help should be assessed with the social worker.

3.8 Treatments for the hand and wrist

► Specific programmes for joint protection

Every patient with RA should benefit from an educational programme on joint protection that is adapted to the disease stage, patient and environment (grade B).

A joint protection programme includes:

- movement training to facilitate daily manual work by decreasing pain and reducing strain on the joint, prevent deformity, and maintain functional capacity. Training concerns mainly - but not only - manual activities;
- provision of information on assistive devices, means of adapting the environment, and orthoses.

[16] Different types of walking sticks, rollator, possibly personalised.

Educational programmes on joint protection have proved effective with respect to morning stiffness, pain and functional capacity (evidence level 2).

► Therapeutic exercises for the hands

Every patient whose hands are affected by rheumatism should do regular exercises for the hands (grade C). The exercises are taught by a health professional and then carried out by the patients on their own (professional agreement).

Hand exercises are indicated in order to:

- maintain articular range of motion (evidence level 4)
- improve muscle strength (evidence level 2)
- prevent ankylosis of reducible deformities (professional agreement)
- reduce functional incapacity (professional agreement).

► Orthoses for the wrist and hand

Rest orthoses should be prescribed for flare-ups involving local inflammation of the hands (grade C).

The most common orthosis is a global static orthosis for the wrist, hand and fingers which immobilises the inflamed joints - if possible in a functional position - either overnight or for several hours during the day. Its preventive effect on deformities has not been demonstrated outside of flare-ups.

Functional orthoses should be prescribed to facilitate the conduct of daily activities (professional agreement).

Corrective orthoses should be prescribed to correct deformities that may be reduced (professional agreement).

Corrective orthoses are worn during rest periods, and sometimes during activity if they improve function.

► Physical agents for the hands

Physical agents[17] should not be used on their own. They may be used as an adjuvant to physiotherapy or to symptomatic treatment with analgesics after an assessment with the patient of the 'expected benefits versus constraints' ratio (professional agreement).

17 Physical agents, that deliver energy, are: electrotherapy, electromagnetic and mechanical (ultrasound) waves, heat treatment.

3.9 Treatments for the feet

The feet, footwear and orthoses should be regularly examined (professional agreement).

► Patient education

Every patient with RA should be informed of the rules of foot hygiene and of the potential benefit of referral to a chiropodist or podologist. They should be advised about footwear (professional agreement).

► Chiropody

A chiropodist-podologist should be consulted to treat nail anomalies and hyperkeratoses on the feet of patients with RA (professional agreement).

Such care should be undertaken with caution and under conditions of strict asepsis because of the serious risk of infection and healing problems in patients with RA.

In 2007, in France, access to chiropody that has been prescribed may be difficult as reimbursement tariffs are much lower than the actual cost to the patient.

► Foot orthoses

Customized orthotic insoles are recommended in case of weight bearing pain or static foot problems (professional agreement).

Appropriate monitoring of the feet and orthoses is recommended on account of the great fragility of the rheumatic foot, particularly when corrective orthoses are worn (professional agreement).

Orthotic insoles are indicated:

- to reduce pain (evidence level 4)
- to correct load-reducible deformities (professional agreement);
- to alleviate the load on pathological or painful bearing areas (palliative purpose) (professional agreement).

The orthoses should be customized, possibly thermoformed or thermomoulded from a non-aggressive material (professional agreement).

Customized toe splints may be corrective or palliative to enable the wearing of shoes (professional agreement).

Renewal of the prescription for foot orthoses should be based on an objective assessment of compliance and individual benefit (reduced pain, maintained or improved functional capacity).

► Footwear

Extra-wide off-the-shelf shoes or therapeutic shoes thermoformed on the patient's foot are recommended when the feet are deformed and painful, or if it is difficult to put on shoes (grade C).

Such shoes reduce pain on walking and improve functional capacity (evidence level 4).

Off-the-shelf therapeutic thermoformed shoes[18] are indicated when other types of footwear have failed. Palliative customized therapeutic shoes may be prescribed when the feet are seriously affected.

4. Indications for therapeutic patient education and psychological management

4.1 Informing the patient

The patient should be informed as soon as the diagnosis is made. The information should be personalised and coordinated by the rheumatologist and the GP in charge of the patient[19] (professional agreement).

The aim is to improve the patient's knowledge about the disease and its management. This is a prerequisite for therapeutic patient education. The information is given orally, possibly together with written or video material. These need to be regularly updated. Information is also supplied by various health professionals and patients' associations upon request from patients.

4.2 Therapeutic patient education

Every patient with RA should receive therapeutic patient education[20] (grade B).

[18] In certain cases off-the-shelf therapeutic shoes for temporary or prolonged use obtained on medical prescription can be reimbursed by national health insurance (e.g. shoes thermoformed on the patient's foot.)

[19] For details on the information to be given to patients diagnosed with RA, see "Rheumatoid arthritis: Early management" HAS 2007 (in preparation).

[20] Therapeutic patient education is a permanent patient-centred part of the care process. It helps patients acquire or maintain the skills needed to live with a chronic condition (see methodological guide "How to prepare a therapeutic patient education programme in the area of chronic diseases" HAS 2007 (in preparation).

Therapeutic patient education should enable patients to acquire the skills needed for self-care and adaptation, and helps prevent avoidable complications. It helps improve or maintain the health status and quality of life of patients and relatives. It is complementary to medical management and is carried out if possible by a multidisciplinary team. For RA, it is carried out with the agreement of the rheumatologist and the GP.

Therapeutic patient education helps the patient:

- know and understand the disease and its treatment (drug and non-drug)
- acquire the movements that protect joints
- establish changes in lifestyle (diet, physical activity programme, etc.)
- prevent avoidable complications
- cope with problems caused by the disease, etc
- involve relatives in the management of their disease, its treatment, and of any repercussions.

Therapeutic patient education has proved its efficacy in improving quality of life in patients with RA (evidence level 2). However, the observed benefits with respect to pain, functional capacity and coping are of weak clinical relevance.

No specific content or method of therapeutic patient education can be recommended for RA. According to published data, no method is superior to any other (individual or collective, with or without the patient's relatives, didactic or interactive, long or short, given by doctors or patients, etc.).

4.3 Psychological management

Medical management of any patient with RA should always take the psychological impact of the disease into account (professional agreement).

Whether to see a psychologist or psychiatrist is the patient’s decision, after advice from the GP or specialist (professional agreement).

The aim is to provide psychological management:

- either to induce a change in behaviour by suggestive interventions such as cognitive behavioural therapies,
- or to take into account the affective impact (of the disease, care and of any existential issues) through psychodynamic management.

The choice of methods for psychological management must be personalised. The types of interventions indicated in RA are:

- psychodynamic interventions to take into account the affective impact of the disease (professional agreement);
- cognitive and behavioural therapies to improve the patient's perception of their disease and their ability to cope (evidence level 2).

The efficacy of hypnosis and of relaxation in RA does not appear to have been specifically demonstrated according to published data.

In 2007, in France, referral to a psychologist may be difficult because it is not reimbursed.

5. Indications for other non-drug interventions

5.1 Dietetics

Diet to control pain or disease activity, including diets rich in omega 3, are not recommended to patients with RA on account of their inconsistent and modest clinical efficacy on pain and stiffness and the risk of deficiencies induced by unbalanced diets (grade B).

Exclusion diets, to control pain or disease activity, in particular diets deficient in dairy products, are not advised (professional agreement).

Nevertheless, appropriate dietary measures are necessary to correct nutritional deficiencies and prevent or treat comorbidities (overweight, osteoporosis, cardiovascular disease, diabetes), some of which can be iatrogenic and due to corticoid therapy.

5.2 Acupuncture

Acupuncture may be proposed as an adjuvant treatment for chronic pain (professional agreement).

The efficacy of acupuncture in RA does not appear to have been specifically demonstrated according to published data.

5.3 Osteopathy

Osteopathy is not recommended in RA (professional agreement).

6. Treatment strategy

6.1 Contribution of non-drug treatment to the global strategy

Non-drug treatment is an adjunct to drugs or surgery and is not a substitute for them. It should always be considered during the elaboration of a global treatment plan. The aim is to limit the consequences of the disease, not to reduce its activity as it has no impact on disease activity.

Like drug treatment, non-drug treatment should be defined, adapted and should take account of the patient's life-plan. It requires a clinical assessment of pain, functional damage and incapacities, the psychological status and the social and professional environment of the patient. This assessment enables personalised therapeutic objectives to be established.

6.2 The place of non-drug treatment according to disease activity, disease stage, and objectives

Non-drug treatment is frequently prescribed at all stages of RA, but the chosen therapeutic methods depend on disease activity and stage (Fig. 1) and objectives (Table 1). As with drug treatment, it is necessary to distinguish "symptomatic" treatments, with immediate and short-lasting effect (analgesic treatments) and "basal" interventions with a delayed but lasting effect (active techniques of physiotherapy, structured education, etc.).

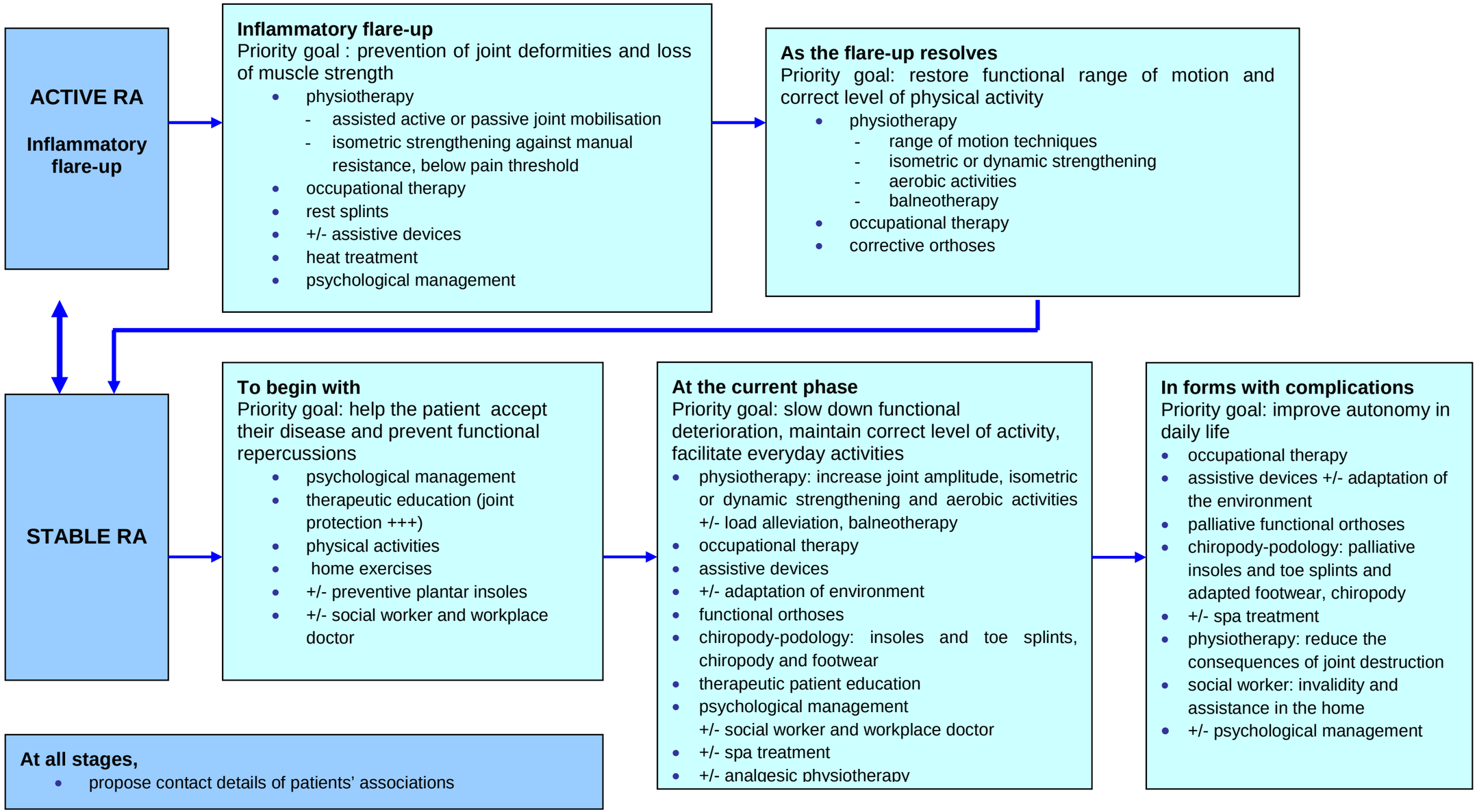
ACTIVE RA
Inflammatory flare-up
Inflammatory flare-up
Priority goal : prevention of joint deformities and loss of muscle strength
physiotherapy
- assisted active or passive joint mobilisation
- isometric strengthening against manual resistance, below pain threshold
occupational therapy
rest splints
+/- assistive devices
heat treatment
psychological management
As the flare-up resolves
Priority goal: restore functional range of motion and correct level of physical activity
physiotherapy
- range of motion techniques
- isometric or dynamic strengthening
- aerobic activities
- balneotherapy
occupational therapy
corrective orthoses
STABLE RA
To begin with
Priority goal: help the patient accept their disease and prevent functional repercussions
psychological management
therapeutic education (joint protection +++)
physical activities
home exercises
+/- preventive plantar insoles
+/- social worker and workplace doctor
At the current phase
Priority goal: slow down functional deterioration, maintain correct level of activity, facilitate everyday activities
physiotherapy: increase joint amplitude, isometric or dynamic strengthening and aerobic activities +/- load alleviation, balneotherapy
occupational therapy
assistive devices
+/- adaptation of environment
functional orthoses
chiropody-podology: insoles and toe splints, chiropody and footwear
therapeutic patient education
psychological management
+/- social worker and workplace doctor
+/- spa treatment
+/- analgesic physiotherapy
In forms with complications
Priority goal: improve autonomy in daily life
occupational therapy
assistive devices +/- adaptation of the environment
palliative functional orthoses
chiropody-podology: palliative insoles and toe splints and adapted footwear, chiropody
+/- spa treatment
physiotherapy: reduce the consequences of joint destruction
social worker: invalidity and assistance in the home
+/- psychological management
At all stages,
propose contact details of patients' associations

Figure 1. Contribution of various techniques to the treatment strategy according to disease activity and stage

Table 1. Indications for non-drug interventions as a function of therapeutic objectives

	Interventions							
Non-drug intervention	**for the purposes of analgesia**	**targeting the joints**	**targeting the muscles**	**for functional purposes**	**for educational purposes**	**for psycho-logical purposes**	**for social & professional purposes**	**with other objectives**
Recommended[1] for all patients	-	Self-exercise (hands++)[C]	Aerobic activities[B] Home-exercise[PA]	Aerobic activities[B]	Information[PA] Therapeutic education (joint protection++)[B]	Assessment of psychological status[PA]	Request for 100% insurance cover (long-term disease)[PA]	Giving contact details of patients' associations[PA]
Recommended on the basis of clinical findings, social or professional assessment	Orthoses[C] Chiropody-podology including footwear	Techniques to increase amplitude[3] including balneotherapy[PA] Orthoses[C] Chiropody-podology[PA]	Dynamic and/or isometric muscular strengthening[B] Adaptation of aerobic activities with or without load-bearing, including balneotherapy[C]	Adaptation of aerobic activities[B], Occupational therapy[PA] Orthoses[C] Functional physiotherapy[4] programmes[C] Chiropody-podology[PA] Assistive devices[C] Adaptations of the environment[PA]	-	Psychological intervention[PA] (psychodynamic or cognitive-behavioural)	Meeting with social worker, workplace doctor[PA] Adaptation of work conditions[PA] Social security measures	Dietetics[PA]
Possible adjuvant treatment[2]	Balneotherapy[C] Massage[PA] Physical therapy[PA] Acupuncture[PA]	Massage[PA] Physical therapy[PA] Posture therapy[PA]	-	Spa treatment[C]	-	-	-	-

[1] Grading of the recommendations: [A]: grade A ; [B]: grade B ; [C]: grade C ; [PA] : professional agreement
[2] Adjuvant treatment: medicinal or non-medicinal treatment combined with the recommended treatment in the case of insufficiency, failure or intolerance of the latter, or if it facilitates the use of the recommended treatment.
[3] Techniques to gain amplitude: autopostures, active aided mobilisations, passive mobilisations; postures if the former have failed

7. Social and professional aspects

7.1 Request for relief from patient contributions

After discussion with the patient and their agreement, the GP should send off the request for relief from patient contributions as soon as a rheumatologist has confirmed the patient's eligibility to the chronic conditions scheme (ALD scheme)[21] (professional agreement).

The GP should produce the care protocol in collaboration with the rheumatologist (professional agreement).

7.2 Procedures for work planning

► When to inform the workplace doctor?

An appointment should be arranged for the patient with the workplace doctor as soon as the RA has notable and persistent repercussions on the patient's job, but only after discussion with the patient and their agreement (professional agreement). The aim is to keep the patient in work.

This appointment can take place whilst the patient is still off work (return-to-work visit) in order to plan any changes that may need to be made, should the patient not be able to work under the same conditions as before.

After discussion with the patient and their agreement, the GP or rheumatologist should provide the patient with all the information needed to assess the severity and course of the disease so that they can hand this information over to the workplace doctor (professional agreement).

► When to request certification of disabled worker status?

The patient should be advised to request certification of disabled worker status as a result of a lasting change in their physical capacity as soon as they can no longer hold their job under the usual conditions

[21] The GP establishes the care protocol (Social Security law of 13 August 2004). However, in order not to delay 100% cover when the medical conditions are satisfied, the hospital doctor or specialist can establish the care protocol requesting 100% cover and then inform the GP (if one has been designated). He/she gives the patient the paper to be signed. Full cover is initially given for 6 months.

or apply for a job without adaptations being made (professional agreement). This certification is confidential and its communication to the employer is left to the patient's discretion.

Certification is obtained following an opinion from the committee for the rights and autonomy of disabled persons (CDAPH)[22], which has jurisdiction over homes for disabled persons within a French *département* (county). It enables both patients and companies to obtain financial aids in relation to jobs.

► When to request invalidity status, early retirement or retirement due to incapacity?

When the stabilised health status requires total or partial cessation of work, an appointment with a social worker should be requested before commencing the procedures to obtain invalidity status, early retirement, or retirement due to incapacity (professional agreement).

No general recommendation can be made without an individual assessment of the patient's rights because of the multitude of French social security systems which vary considerably according to the type of company and the patient's professional status.

7.3 Social security procedures

An appointment with a social worker should be planned (professional agreement):

- If the patient's social situation is precarious or difficult, particularly in the absence of complementary insurance or retirement cover, and whilst awaiting 100% cover for costly treatments and care (delay in the administrative processing of the ALD file);
- if an interruption from work of more than 3 months is anticipated, so that the patient can rapidly know their rights and the adaptations that may be needed to keep them in employment;
- if a request is made for certification of disabled worker status, invalidity or early retirement;
- if there are persistent problems in carrying out the activities of daily life - at work or at home - in order to assess the patient's needs and to refer them to a unit for the disabled where they can submit all the

[22] CDAPH : This committee has replaced Cotorep (*Commission technique d'orientation et de reclassement professionnel* [Committee for technical guidance and professional reclassification])

necessary dossiers, and to assist the patient in arranging the human or material help they need.

7.4 Contact with patients' associations

Every patient with RA should be informed of patients' associations as soon as the diagnosis has been formally established, and should be given the contact details upon request (professional agreement).

8. Organisation of care

There is no reliable evidence from the literature on any differences in the efficacy or cost-effectiveness of ways of organising the care on offer.

8.1 Health professional involvement

Each patient with RA should be followed up by a rheumatologist and his/her GP. In agreement with the patient, they establish a joint treatment plan that is adapted to the patient's needs (professional agreement).

Implementation of non-drug treatment is coordinated by a doctor (GP or specialist). However, when a patient requires the intervention of several professionals, non-drug treatment should be coordinated by a clinician specialising in physical and rehabilitation medicine, when such access is possible (professional agreement). In this instance, coordination occurs jointly with the GP and the rheumatologist.

8.2 Multidisciplinary management

Access to multidisciplinary management is recommended when the patient's clinical status requires the intervention of several professionals (professional agreement).

Multidisciplinary management is defined as coordinated work around the patient by a team of professionals with complementary competencies, who intervene in a synergistic and coordinated manner, most often at the same location. Besides medical and pain management, therapeutic patient education sessions, a programme of rehabilitation and adjustment, dietary advice, psychological follow-up, meetings with a social worker, and surgical consultations can be proposed in line with the patient's needs.

In 2007, no study distinguishes among the efficacies of different ways of organising multidisciplinary management. In France, such management is mainly conducted within care establishments (traditional or day hospital care).

8.3 Care networks

Care networks are one way of implementing multidisciplinary management and might lead to better management by facilitating access to health professionals and the use of certain treatments, and by ensuring better communication. Clinical and organisational assessment of their function and results is necessary using the general criteria for care networks [23].

[23] For more details, see the methodological guide “Guide to the evaluation of health networks" (in French), ANAES 2004.

Appendix 1. Future activity or research

This report led to several observations that could be points for consideration in future research in order to improve our scientific understanding of the efficacy of non-drug treatments or of different methods of care organisation in the global management of RA.

► Improving access to care

There are differences in the multidisciplinary management of patients with RA and access to certain categories of professionals according to region in France. Access to ergotherapists and psychologists is particularly difficult for outpatients.

Multidisciplinary management of patients with RA should be promoted within existing structures (services and centres for rehabilitation) and outpatients should have access to all the professional categories.

► Codifying therapeutic patient education

Therapeutic patient education for RA varies widely among establishments in France. It should be codified, and specific facilities for such education should be set up, possibly within the traditional places for following up patients with RA (outpatient facilities, health centres) or integrated into centres for spa treatment.

► Developing clinical research into non-drug treatment

The lack of clinical studies into non-drug treatment, and the difficulties in conducting such studies, means that techniques that are well codified in practice and that are recognised by patients are not scientifically acknowledged. Such research should be encouraged and supported.

► Evaluating the relevance of care networks within the context of RA

The lack of studies assessing the efficacy of care networks in managing RA in France means that their impact cannot be measured. Assessment of their function and of their clinical results should be encouraged.

Appendix 2. Assessment method used to produce the clinical practice guidelines

Clinical guidelines have been defined as proposals established using an explicit method to help healthcare professionals and patients find the most appropriate care in a given clinical situation.

The *clinical practice guidelines (CPG)* method is one of the methods used by HAS to produce clinical guidelines. It is based on critical analysis and review of the available medical literature as well as on the opinion of a multidisciplinary group of professionals involved with the subject of the guidelines.

Choosing subjects for guidelines

The HAS Board chooses the subjects for clinical guidelines. In selecting subjects the Board takes into account public health priorities and any requests from ministers responsible for health and social security. The HAS Board can also accept subjects proposed by learned societies, the French national cancer institute, the French Association of National Health insurance funds, the French National Association of Healthcare Professions, organisations representing health care professionals or establishments or registered user groups.

Steps of the working method

Steering committee
HAS sets up a steering committee made up of representatives of the learned societies, professional or user organisations and, if need be, of the relevant health agencies and institutions. The committee defines exactly the subject of the guidelines, the questions to be discussed, the patient populations and the professionals for whom the guidelines are intended. It draws attention to relevant publications, particularly existing guidelines. It proposes suitable professionals to take part in working groups and act as peer reviewers. Finally it takes part in the peer review.

Working group
HAS sets up a multidisciplinary and multiprofessional working group made up of healthcare professionals who practice within the French national health service or privately and who come from different geographical backgrounds or represent different schools of thought and, if appropriate, of other concerned professionals and representatives of patient and user

organisations. HAS appoints a working group chair to coordinate the group's work in collaboration with the HAS project manager. A report author is also designated by HAS to select, analyse and review the relevant medical and scientific literature (see box). The report author drafts the scientific report and assigns the chosen studies levels of evidence, under the supervision of the HAS project manager and the working group chair.

Sources for drafting the scientific report

- Medical and scientific databases searched systematically over an appropriate time period for the subject (languages: French, English). In particular, search for clinical practice guidelines, consensus conferences, medical decision-aid articles, systematic reviews, meta-analyses and other assessments.
- If appropriate, more specific databases (e.g. health economics)
- All useful internet sites (government agencies, learned societies, etc.)
- Grey literature (documents which cannot be accessed through conventional channels)
- Legislative and regulatory texts which could be related to the subject
- Cited references in the articles retrieved (manual search)
- Articles provided by the members of the working group and by peer reviewers.

Searches are updated regularly until the project is complete.

Producing the draft guidelines

The working group produces draft guidelines based on the report and the opinions expressed during the meetings of the working group (usually two meetings). Guidelines are graded A, B or C on a scale proposed by HAS according to the level of evidence on which they are based.[24] The grading used for the guidelines is given in the box below. The draft guidelines are then submitted to the peer reviewers.

Peer reviewers

[24] For more information on the method of producing clinical practice guidelines, see ANAES 1999 guide (in French): "*Recommendations pour la pratique clinique - Base méthodologique pour leur réalisation en France*". www.has-sante.fr.

HAS appoints the peer reviewers using the same criteria as for working group members. The peer reviewers are consulted by post and give an opinion on the content and structure of the report and guidelines, in particular on whether the guidelines are easy to read, to understand and to apply. Members of the HAS specialist committee responsible for professional guidelines (Committee for the Assessment of Healthcare Strategies*)* also peer review the guidelines.

Grading of guidelines

Grade	Scientific evidence level
A	trials of a high level of evidence (level of evidence 1), e.g. high-power randomised controlled trials (RCTs) free of major bias and/or meta-analyses of RCTs or decision analyses based on level 1 trials.
B	studies of an intermediate level of evidence (level of evidence 2), e.g. RCTs with some bias, meta-analyses based on questionable methodology, well-conducted non-randomised controlled trials or cohort studies;
C	studies of a lower level of evidence, e.g. case control studies (level of evidence 3) or case series (level of evidence 4).

In the absence of reliable publications, the guidelines are based on professional agreement among members of the working group and peer reviewers.

Final version of the guidelines

The working group analyses the peer reviewers' comments, amends the report if necessary, and produces the final version of the guidelines and a quick reference guide (QRG), during a working session.

The final version of the report and guidelines and the procedure used to produce them are discussed by the Committee for the Assessment of Healthcare Strategies which may ask the working group to make amendments before submitting its opinion to the HAS Board.

Validation by the HAS Board

The HAS Board validates the final report and authorises its distribution.

Distribution

HAS makes available on its website (www.has-sante.fr), free of charge, the report, the guidelines and the Quick Reference Guide (QRG). HAS may decide to print both the QRG and the guidelines.
www.has-sante.fr

Participants

Learned societies and professional associations

The following learned societies and professional associations were approached for the production of these guidelines:

- *Agence française de sécurité sanitaire des produits de santé (Afssaps, French Medicines Agency)*
- *Association des diététiciens de langue française (ADLF, Association of French-speaking Dieticians)*
- *Association des diététiciens libéraux (ADL, Association of Independent Dieticians)*
- *Association française de lutte anti-rhumatismale (Aflar, French Association against Rheumatism)*
- *Association française des polyarthritiques (AFP, French Association for Rheumatoid Arthritis Patients)*
- *Association française pour la recherche et l'évaluation en kinésithérapie (Afrek, French Association for Research and Evaluation in Physiotherapy)*
- *Association nationale de défense contre l'arthrite rhumatoïde (Andar, National Association against Rheumatoid Arthritis)*
- *Association nationale française des ergothérapeutes (ANFE, French National Association of Occupational therapists)*
- *Association nationale des kinésithérapeutes salariés (ANKS, National Association of Salaried Physiotherapists)*
- *Association pédagogique nationale pour l'enseignement de la thérapeutique (Apnet, National Pedagogic Association of Therapeutic Education)*
- *Collège français d'acupuncture (CFA, French College of Acupuncture)*
- *Collège français des enseignants de rhumatologie (Cofer, French College of Educators in Rheumatology)*
- *Conseil national de l'ordre des pharmaciens (Cespharm, National Council of Pharmacists)*
- *Fédération nationale des podologues (FNP, National Federation of Podologists)*
- *Groupe Intervention-Recherche "Psychologues et Santé Publique" (GIRPsySP, Group for Intervention and Research "Psychologists and Public Health")*
- *Société d'étude et de traitement de la douleur (SETD, Society for the Study of Pain Therapy)*
- *Société française d'immunologie (SFI, French Society of Immunology)*
- *Société française de biochimie et d'immunochimie (SFBC, French Society of Biochemistry and Immunochemistry)*

- *Société française de kinésithérapie (SFK, French Society of Physiotherapy)*
- *Société française de médecine générale (SFMG, French Society of General Medicine)*
- *Société française de médecine physique et de réadaptation (Sofmer, French Society of Physical and rehabilitation medicine)*
- *Société française de nutrition (SFN, French Society of Nutrition)*
- *Société française de radiologie et imagerie médicale (Sfrim, French Society of Radiology and Medical Imaging)*
- *Société française de rhumatologie (SFR, French Society of Rheumatology)*
- *Société française de santé publique (SFSP, French Society of Public Health)*
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Declarations of conflict of interest

The participants of the organising committee and working group have communicated their declaration of interests to HAS.

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Acknowledgements

HAS also wishes to thank all the persons listed below for their involvement in the editing of certain paragraphs or appendices of the report or for internal peer review at HAS

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Descriptive leaflet

TITLE	**Rheumatoid arthritis: Medical, social and organisational aspects of treatment (excluding surgery and drugs)**
Method of production	HAS' method for the production of clinical practice guidelines
Date of online publication	May 2007
Date of publication in print	Available only as a pdf file: www.has-sante.fr
Objective(s)	• To acquaint professionals better with the demonstrated effects of non-drug treatments for RA in order to propose an optimal management aiming to limit the consequences of the disease in terms of pain, joint dysfunction, functional capacity, and quality of life. • To enable all patients with RA to access coordinated and individually adapted therapeutic, social and professional management. • To harmonise the methods by which care is organised.
Professional(s) concerned	All health professionals and social workers in charge of patients with RA, in particular: • general practitioners, rheumatologists, doctors specialising in physical and rehabilitation medicine, and specialists in occupational health • chiropodists, dieticians, occupational therapists, chartered orthotists, orthoprosthetists, physio-therapists, podologists, podo-orthotists, psycho-logists, and social workers
Requested by	National Health Insurance funds National Association for Research and Evaluation of Chiropody and Podology (Anrep)
Promoter	Haute Autorité de Santé (HAS)
Funding	Public funds
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Literature search	From 1985 to December 2006 1,819 articles identified, 817 articles analysed of which 382 cited
Report authors	Joëlle André-Vert, project manager, HAS Pascal Guillez, occupational therapist, Berck Dr Olivier Scémama, project manager, HAS
Validation	Opinion of the Committee for Evaluation of Health strategies Validation by the Board of HAS on 7 March 2007
Other formats	Quick reference guide (in English) Scientific report (in French only) Can be downloaded free of charge from www.has-sante.fr
Related documents	(in French) • Rheumatoid arthritis: Early management (HAS 2007) • Rheumatoid arthritis: management of the current status (HAS 2007) • Methodological guide “How to prepare a therapeutic patient education programme in the area of chronic diseases” (HAS 2007)

Version posted online on 20 November 2007