Early rheumatoid arthritis (ERA) is a chronic inflammatory disease affecting about 0.8% of the population.

Recommended care vs Actual care
To treat ERA, the focus is set on achieving clinical remission as soon as possible with an early and intensive treatment.

We identified in a previous qualitative study a heterogeneous set of barriers to intensive-combination treatment strategies with glucocorticoids (ICTS) for ERA in daily clinical practice. For the development of tailored improvement interventions, a better understanding of the importance of the identified barriers is required.

1. What is the relative importance of barriers related to the provision of ICTS in ERA from the rheumatologists’ perspective?
2. Possible association of certain rheumatologists’ characteristics (e.g., gender, work experience, type of clinical setting) with importance scores?

1. Mean relative importance scores (RIS) of barriers to ICTS

The dominant barriers hindering ICTS prescription were patient-related barriers and barriers related to the complexity of prescribing a combination therapy including glucocorticoids.

The higher the score, the more important the barrier. By taking a cut-off at half of the highest mean score eight barriers were ranked as most important.

2. RISs depending on rheumatologists’ characteristics

No statistically significant differences were found based on gender, experience with clinical studies or consideration of ICTS-GCs as appropriate treatment. However:

• Rheumatologists graduated at the two largest universities in Flanders put different weight on the importance of the barrier “need for patient education” (p=0.047).
• Rheumatologists who never applied ICTS assigned a lower importance to the barriers “contraindicated for some patients (e.g., patients with comorbidities, older patients)” (p=0.032) and “patients’ resistance” (p=0.036).

1. More years since graduation, the less a rheumatologist feared complications in certain patients (correlation coefficient=0.375).

 CONCLUSIONS

The actual prescribing process of ICTS may be facilitated by interventions to improve the familiarity of rheumatologists with ICTS and patient education. Moreover, patients’ experiences with ICTS should be taken into account.

Quality improvement interventions do not need to be tailored to subgroups of rheumatologists based on demographic characteristics or educational background. In fact, interventions should address rheumatologists’ lack of familiarity with ICTS and their lack of motivation and skills to prescribe ICTS.