Rheumatoid arthritis (RA) is a progressive disease with a natural history of radiographic damage, functional declines, work disability, and premature mortality in most patients. \cite{1,2,3} There are significant costs associated with each of the above aspects. Tight control of RA with Disease modifying anti rheumatic drugs (DMARDs) is the order of the day and a favourable benefit/risk ratio has been demonstrated. \cite{4}

The DMARDs need to be started early, prior to development of joint damage, to obtain maximum efficacy. Data from clinical cohorts, observational studies and RCTs indicate that status and outcomes of RA patients have improved over the past decades concomitantly with implementation of early and active treatment strategies. \cite{5,6} Improvements have been seen in disease activity, functional capacity, radiographic scores, and other clinical measures including lower mortality rates in patients who responded to methotrexate and to biological therapies, lower rates of joint replacement surgery at this time compared to earlier decades, and lower work disability rates in patients who responded to DMARD. One metaanalysis indicated that disease duration at the time of DMARD initiation was the primary predictor of the response to DMARD treatment. \cite{7} In the FIN-RACo trial, delay of 4 months of the initiation of a DMARD diminished the likelihood of remission. \cite{6} All these data therefore suggest that the optimal “window of opportunity” exists in the first 3-12 months from the onset of illness, when one can achieve the best results including possible remission. Irrespective of the treatment strategy adopted, the earlier the DMARDs are instituted, the better the outcome is likely to be. The principle of treating within the “window” exists for other rheumatic disorders as well like spondyloarthropathies, but nowhere is it better exemplified than RA, hence I shall restrict my discussion to RA only.

The DMARD naïve period looks at the time lag from onset of illness to the institution of DMARDs. The longer this period, the greater is the cumulative inflammatory burden experienced by the patient and worse would be the long term sequelae in all the domains mentioned above. In a recent study, the time to institution of DMARDs was correlated with radiological outcome amongst patients with at least 5 years of disease duration. \cite{9} The median DMARD naïve period found in this study was 1 year. A time lag of > 1 year was seen to be associated with a significant joint damage compared to those started on DMARDs earlier. In some of the other studies in patients with RA from India that have looked at radiological erosions and osteoporosis, the median DMARD naïve periods have ranged from 2-4 years. \cite{10,11} A large percentage of our patients present to the rheumatologists well outside the “window of opportunity”, some as late as 10-12 years.

In this era of Biologicals and effective DMARDs, where remission in RA is being discussed and early arthritis clinics seem to be the order of the day, having a DMARD naïve period of many years is a matter of deep concern. Studying “DMARD Naïve period” might thus help us identify and focus attention on the fault lines associated with delivery of quality rheumatology care at the national level and might enable us to proffer solutions for the same. Many factors are possibly responsible for this inordinately long period in India. To begin with, there are just not enough trained rheumatologists in the country. With a prevalence of 0.5%-0.8%, there are an estimated 4-7 million adult patients of
RA in India. Almost 12-15,000 rheumatologists would be needed to treat RA alone while the actual numbers available is possibly < 2 % of this number.

Patients in India have two major beliefs about RA, firstly that it is incurable through “Allopathic” medicine and secondly, that the available medicines are full of side effects. They are often unaware as to whom to consult. Directed by their belief and perception, they usually consult practitioners of complementary and alternate medicine (CAM) first. These practitioners are easily accessible and cheaper to consult, especially in rural areas and impoverished urban settings. They invariably highlight the “side effects” angle of modern medicine, reinforcing the patients belief, and claim to provide cure with CAM without any “adverse effects” whatsoever. Steroids use and misuse is often rampant, providing symptomatic relief, while the disease continues to progress. Patients often seek an “allopathic” doctor after some time when no relief occurs and functional disability gets worse. In the absence of rheumatologists, the patients are treated by physicians, orthopaedic surgeons, general practitioners, other specialists, quacks and many a times by the friendly chemist. Amongst various practitioners of modern medicine, the knowledge of rheumatology is minimal, fear of “side effects” of DMARDs is high and undertreatment is the norm. The awareness of long term sequelae of RA, when not treated aggressively, is a veritable blind spot. Throughout this journey, the patient remains “DMARD naïve”.

What can be done about this? A multipronged approach seems to be in order. In the long term, the country definitely needs many more Rheumatologists. But increasing the needs many more Rheumatologists. But increasing the awareness of rheumatology, reinforcing the knowledge of rheumatology amongst undergraduates (UG) and post graduates (PG) is far lesser compared to their baseline knowledge of other subjects like cardiology, neurology etc. Considering the high musculoskeletal burden in the community and the fact that most Doctors will anyway be handling rheumatic diseases in their day to day practice, the undergraduate and post graduate curriculum needs a revamping with a far greater representation of rheumatology. The Doctors of tomorrow need to be far more conversant with the subject of rheumatology than the present ones. Lastly, there is a need to train “helping hands” in the form rheumatology nurse practitioners and rheumatology associates. Very few centers in the country have these specialties of paramedical personnel. Both can be trained faster and in greater numbers in training centers in the country have these specialties of paramedical personnel. Both can be trained faster and in greater numbers.

The window of opportunity in treating RA is in months unlike coronary artery disease and cerebrovascular accidents where it is in hours. However, this window is systematically missed in a majority of patients in India. The whole system needs to be galvanised to systematically work in providing effective rheumatology care across the nation. The DMARD naïve period may be an ideal parameter to monitor this change.

REFERENCES