The Great Debate

By Volodko Bakowsky, MD, FRCPC, on behalf of Cory Baillie, MD, FRCPC; Louis Bessette, MD, MSc, FRCPC; Michelle Batthish, MD, MSc, FRCPC; and Anne MacLeod, PT, MPH, ACPAC

Be it resolved that Canadians with new inflammatory arthritis should have access to all therapeutic options at disease onset to induce remission.

The Great Debate team (from left to right): Anne MacLeod and Drs. Cory Baillie, Volodko Bakowsky (chair), Louis Bessette, and Michelle Batthish.

One of the nicest things about the CRA Annual Scientific Meeting once again returning to a live format was being able to share the stage with some of the greatest minds in Canadian rheumatologic care for the Great Debate. These eminent intellectuals were able to present their arguments in such an approachable fashion that even the chair (universally accepted as not a great mind) was able to follow along. The CRA faithful also witnessed the tallest (Dr. Bessette) and second tallest (Dr. Baillie) Canadian rheumatologists on stage together at the same time.

Dr. Cory Baillie and Anne MacLeod both spoke in favour of the motion. In the absence of any guidelines or evidence to defend their position, the affirmative side was forced to turn to smoke, mirrors and obfuscation. Among the pillars of their initial argument was a survey of 39 Canadian rheumatologists which found that 81% would prefer to be started on biologic monotherapy or biologic combination therapy by their rheumatologist if they themselves were diagnosed with moderate-to-severe rheumatoid arthritis (RA). The affirmative speakers also presented data about the prevalence of intolerance to methotrexate and other traditional disease-modifying anti-rheumatic drugs (DMARDs) in adults and children, the effectiveness of biologics on reducing disability, the cost savings of both biosimilars and biologic tapering making early biologic treatment more affordable, and the amount of general government waste which trivializes the costs of biologics for rheumatic disease patients.

Canadian data on access to care, in both adult and pediatric rheumatology, indicate system issues with meeting benchmarks created by the Wait Time Alliance in 2014. Research also confirms that wait times in certain urban areas, such as Toronto, are shorter than elsewhere in the province of Ontario. Recent studies concluded that there is a trend towards improvements in access to RA diagnosis and early treatment over time; however many gaps remain, including suboptimal DMARD dispensation. In this modern era of advanced therapeutic options, we still have issues with access to care and timely use of medications. So, should all Canadians with new inflammatory arthritis have access to all therapeutic options at disease onset . . . the answer was suggested to be a resounding yes.

Drs. Louis Bessette and Michelle Batthish spoke against the motion, and their side certainly benefited from an extensive body of information to support their argument. According to them, the current scientific evidence does not support the use of targeted synthetic/biologic disease-modifying antirheumatic drugs (ts/bDMARD) as first-line therapy in early inflammatory arthritis. In treat-to-target (T2T) studies, patients initially treated with conventional synthetic disease-modifying antirheumatic drugs (csDMARDs) have similar long-term clinical disease activity, functional capacity, and joint damage progression as the groups initially treated with a ts/bDMARD. Furthermore, starting with a biologic does not improve the chances of achieving drug-free remission and is not a cost-effective strategy. According to CATCH (Canadian early ArthriTis CoHort) data, more than 50% of RA patients are in remission after one year of using csDMARDs. Moreover, 75% of Canadian RA patients who started csDMARDs as first-line therapy do not require ts/bDMARDs to control their disease during the first five years of follow-up. Similarly, in the CAPRI (Canadian Alliance of Pediatric Rheumatology Investigators) JIA (juvenile idiopathic arthritis) registry, 81% of newly diagnosed JIA patients achieve clinically inactive disease and most are only on a csDMARD.

Safety needs to be considered in this argument as well. A systematic review revealed that the odds of developing a serious infection while on a biologic were 1.48 times greater than while on a csDMARD. In addition, there are no published guidelines that recommend the use of a ts/bDMARD as first-line therapy for csDMARD-naive patients. The scientific evidence shows that starting a csDMARD with a T2T strategy and adding a ts/bDMARD if necessary, the patient would have the same chance of achieving disease control without long-term functional impact as starting with a ts/bDMARD.

Sadly, all things come to an end (other than advanced therapy application forms), and it was time to vote. The winner was decided by an old-fashioned applausometer, with the "against" side (Drs. Bessette and Batthish) clearly crowned the winners. However, given the lopsided nature of the evidence (taking nothing away from Cory Baillie's phone-a-friend statistical analysis), the "for" team deserves a shout-out as well.

Among the cogent arguments were elements of humour sprinkled throughout, including the requisite poking fun at Carter Thorne. The Great Debate seeks to achieve a good balance between science and fun, and this year the debaters knocked it out of the park.

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