

ADHERENCE TO TREATMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Nowadays, educational programs for patients are widely spread in many internal diseases, the use of which can significantly increase the effectiveness of drug therapy, reduce the frequency of exacerbations and improve the quality of life of patients. Schools for patients with various chronic diseases have been actively functioning for decades [1–6]. In recent years, this approach has also been used in rheumatoid arthritis (RA). Educational programs (on changing the stereotype of motor and functional activity, etc.), along with physical therapy, orthopedic aids, achievement and maintenance of the recommended body weight, balanced diet, physiotherapy, sanatorium-resort treatment, are the basis of non-medication treatment of RA patients [7,8,9]. At the same time, the attitude to disease monitoring has also changed. International indices acceptable in routine clinical practice, including DAS28 (Disease Activity Score 28), have been developed for regular assessment of disease activity and timely correction of therapy in RA [8,16,17]. At present, the use of new classification criteria for RA (2010) makes it possible to establish the diagnosis at earlier stages of the disease than the American College of Rheumatologists ACR 1987 criteria [11]. [11]. Remission, which is the main goal of RA therapy, is quite achievable at the present stage, since rheumatologists have a sufficient arsenal of baseline anti-inflammatory drugs (BIDs) and genetically engineered biological drugs (GIBPs) that can effectively suppress disease activity [9]. A number of education models for patients with arthritis have been proposed, aimed not only at increasing knowledge about the disease, but also at developing the correct behavioral stereotype and improving psychological status [12,13,14,18,19]. However, the issues of early initiation of educational programs, their structure and methodology, and effectiveness require substantiation and further study.

The problem of low adherence of patients with chronic diseases to the treatment prescribed by a doctor has recently attracted more and more attention. The World Health Organization recognizes inadequate adherence to treatment as “an international problem of astonishing magnitude”, noting that “adherence to long-term therapy in chronic diseases fluctuates within 50%” [12]. In real life, with a low proportion of patients adhering to physician recommendations, the results of treatment with drugs whose high clinical efficacy has been proven in specially designed randomized clinical trials (RCTs) may be significantly worse. Thus, low adherence to treatment is an important public health and clinical practice problem. Without patient-physician collaboration on treatment, neither timely diagnosis nor

provision of modern medications can be sufficiently effective. It has been found that in the United States, 11.7% of all health care expenditures are attributed to hospitalizations due to low adherence of chronic patients to prescribed therapy, costing the country approximately \$100 billion per year [13]. One of the most severe chronic human diseases is rheumatoid arthritis (RA), which is characterized by severe inflammation with proliferation of the synovial membrane of joints, damage to internal organs and systems, long-term persistence of inflammatory activity and gradual destruction of joint structures and periarticular tissues [18,19]. This disease is a convenient model for studying adherence to treatment in chronic diseases and its influence on their outcomes, including the time of permanent disability, because the clinical scenario of RA in the absence of adequate therapy usually unfolds very quickly. Already during the first 5 years of the disease, more than 40% of RA patients become disabled due to severe joint destruction [19]. This fact makes it possible to study the influence of insufficient adherence on the rate of disease progression in a rather short period of time. Treatment of RA is focused on suppression of disease activity and progression and includes a number of strategies, the effectiveness of which has been proven. These primarily include early administration of pathogenetic treatment to all patients; 4 multi-year controlled treatment with continuous assessment of activity and progression of RA and careful monitoring of tolerability [8,9]. The goals of treatment are to reduce the severity of arthritis symptoms and extra-articular manifestations; to prevent destruction, impaired joint function and deformity; to preserve (improve) the quality of life; to achieve remission and increase life expectancy to the population level [6]. The main role in achieving these goals is played by pathogenetic treatment with so-called baseline anti-inflammatory drugs that suppress immune inflammation. This therapy should be administered to all patients with definite RA without exception, and its duration is not limited even despite the decrease in disease activity and achievement of remission. RCTs have shown that baseline therapy prescribed at an early stage preserves (improves) the quality of life of an RA patient, increases its duration, and reduces the total cost of medical care [7,8,18]. Obviously, such an effect can be expected only if the patient is committed to treatment, which is always high in RCTs. In real life, according to a number of foreign authors, from 35% to 55% of RA patients have problems with adherence to treatment, scientists, noted low adherence to treatment in Russian patients. Having analyzed the data available in the literature, we have not received an unambiguous answer about the influence of adherence to treatment on clinical outcomes of RA. Determinants of nonadherence require detailed characterization. These facts, as well as the lack of information in the domestic literature on the frequency and causes of RA patients' nonadherence to treatment with baseline anti-inflammatory drugs determined the purpose of this study. Identification of the causes of low adherence of RA patients to treatment will allow to make necessary corrections in the system of medical care for this contingent of patients and outline the main ways

to improve adherence to treatment in various chronic non-infectious diseases, including RA.

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