The many guises of uveitis associated with JIA

The severity of uveitis... can help us predict prognosis of juvenile idiopathic arthritis

Sometimes improved prognosis is a mirage induced by early detection. The prognosis for uveitis associated with JIA would mistakenly appear improved if more vigilant screening in 1998 allowed the ophthalmologist to diagnose the child with a mild cellular response in the anterior chamber that was destined to disappear regardless of treatment, while this same scenario in 1982 did not come to the attention of an ophthalmologist. Shifting diagnostic criteria may also explain an apparent change in disease prognosis over time. The term “juvenile idiopathic arthritis,” was coined by the International League Against Rheumatism Task Force for Classification Criteria in 1997, when recognising the inadequacy of previous terminology, it developed a system for classification of childhood arthritis. This umbrella term acknowledges that different forms of arthritis are subsumed within it. Despite revision in 1997, the system continues to receive criticism and further revision is suggested. Further, it is clear that clinicians and scientists remain confused in the classification. For example, one might argue that in the study by Edelsten and co-workers, patients classified as “non-standard” because they had uveitis associated with psoriatic arthritis did, in fact, belong to the “standard” group, if psoriatic arthritis is considered a form of JIA as recommended by current classification criteria.

Edelsten and colleagues appropriately recognise the limitations of their study. Extrapolations to an individual practice must be made cautiously if the physician has a different threshold for initiating methotrexate, if follow up visits are scheduled less frequently, and if the definition of “severe disease” varies from that used in this report. Prognostic information is always based on probability. Patients are rarely interested to learn that the probability of blindness is 6%, if the unfortunate individual in the examination chair today is that unlucky one person out of 17.

With the publication of this report by Edelsten and co-workers, we know more about prognosis of JIA associated uveitis than we ever have before. We also know that we have much more to learn about this eye disease.
Corneal transplantation

Outcome of corneal transplantation

Melissa M Brown, Gary C Brown

Value based ophthalmology

In their article in this issue of the BJO (p 57) Saunders and colleagues describe a methodology by which they evaluate the visual health state of patients with severe corneal disease requiring transplantation surgery. Rather than dealing with visual acuity as the only preoperative and outcome parameter, they evaluate patients according to three criteria: (1) visual acuity, (2) ocular pain, and (3) visual function. Concerning the latter criterion, visual function, they utilise a tool called the VFA (visual function assessment), which they have previously described; it is essentially a modification of the VF-14 and predominantly measures ocular function characterised by the ability to perform tasks such as driving, reading, cooking, etc. They found that patients who had a high preoperative priority score, as measured by the three above criteria, were more likely to have a good outcome. One measure in the study that is somewhat unclear, though, is how the results incorporate vision in the eye that did not receive a transplant. All too often our clinical trials and other studies fail to address the status of the second eye, perhaps a factor more important to the patient than the ocular intervention itself. The authors noted that 72.4% of patients demonstrated an improved VFA after transplant, but it is uncertain whether this was measured using only the operated eye or in a real world situation in which both eyes were used during the assessment.

The authors should be congratulated upon bringing more than visual acuity alone into the decision making process. Most ophthalmologists believe that the central visual acuity is the most important factor related to the quality of life of an ophthalmic patient. And over a century of experience suggests that they are probably right. But measurement of the visual acuity alone, while it typically is the primary benchmark for most evidence based data, does not necessarily provide the best value based data.

So the question arises, what is the difference between evidence based medicine and value based medicine, or in this case, evidence based ophthalmology and value based ophthalmology? Evidence based medicine incorporates the most reliable and reproducible data from clinical studies, particularly clinical trials. Value based medicine takes clinical efficacy delineated by evidence based data one step further and incorporates the evidence to measure the actual value of the therapy to a patient.

While the concept of value based medicine may sound nebulous, it is far from it. The concept of value can be quantified by assessing the improvement in length of life and/or quality of life conferred by an intervention. For there is really nothing else we do, or should do, in health care other than improve length and/or quality of life. With ophthalmological interventions, in which death is infrequently encountered, the value of an intervention can be essentially measured by the improvement in quality of life.

Why is value important? Every society has finite scarce resources that, in the best interest of its people, should be maximised to yield the highest return. This endeavour can be quite difficult in health care, in fact impossible unless value based health care is considered. As an example, suppose a financial officer responsible for a healthcare budget at a large company poses the following question to an ophthalmologist: “Doctor, you have just told me that laser treatment for macular oedema associated with branch retinal vein obstruction improves the average person’s vision from 20/70 to 20/45. What does this mean in terms of value?” The cardiologists were in here just before you and said that their evidenced based therapy improves the cardiac ejection fraction from 35% to 45%. What is the comparable value of your treatment and theirs?”

8 Fantini F. Classification of chronic arthritis of childhood [juvenile idiopathic arthritis]: criticisms and suggestions to improve the efficacy of the Santiago-Durban criteria. J Rheumatol 2001;28:456-9
in which a patient is asked how many expected remaining years of life he or she would be willing to trade in return for a perfect health state. The proportion of years traded is then subtracted from 1.0 to yield the utility value. For example, if a person with 20/40 vision is willing to trade 4 of 20 hypothetical remaining years in return for perfect vision, the utility value would be 1.0 − 4/20 = 0.80. Unlike many of the quality of life tools in health care that primarily measure function, utility analysis is theoretically more all inclusive in that it encompasses function, as well as other important parameters such as fear of the unknown, pain, psychological overlay, family support systems, socioeconomic status, and others. Of utmost importance is the fact that utility analysis can also be combined with the costs of an intervention in cost-utility analysis. Cost-utility analysis has the ability to assess the resources expended for the value received from an intervention and can effectively compare interventions across all healthcare fields.

Patient perceived value is a basic component in the evaluation of what we do in health care, perhaps one of the most critical. Data from ophthalmic populations to date indicate indeed that our interventions in ophthalmology are highly valued by patients. This information is of unsurpassed importance to stakeholders in the healthcare arena: patients, decision makers, planners, and providers as well. It should indeed be gratifying to those of us in the profession that the services we perform are so highly valued by the most important people in the process, our patients.

Many in health care refer to “evidence based medicine” as a very positive progression from the more anecdotal practice of medicine 20 years ago. But those in the business world and on the cutting edge of innovation speak of value. There is little doubt that, while “evidence based medicine” was the buzz phrase of the 1990s, moving forward it will be teamed with patient perceived value and cost-utility analysis to take healthcare quality to a yet higher level, “value based medicine”—the paradigm for the 21st century.

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REFERENCES


Cardiovascular disease

Atherosclerotic cardiovascular disease and diabetic retinopathy

Jorge G Arroyo

Risk for the development and progression of retinopathy

Ophthalmologists are well aware of the strong association between longstanding hyperglycaemia and the microvascular manifestations of diabetic retinopathy. The relation between macrovascular large vessel disease and diabetic retinopathy is less well understood, and is the subject of Klein et al’s paper in this issue of the BJO (p 84). These authors seek to shed light on the association between arteriosclerotic cardiovascular disease and diabetic retinopathy in a cohort of patients from the Cardiovascular Health Study (CHS).

In their paper, Klein et al found an association between cardiovascular disease, elevated plasma LDL cholesterol and gross proteinuria, and diabetic retinopathy. These associations were independent of age, sex, race, blood sugar, and duration of diabetes. They did not, as one might expect, find an association between internal carotid artery wall abnormalities or subclinical atherosclerosis and diabetic retinopathy. Although there was a significant association between elevated systolic blood pressure and retinopathy in the univariate analysis, this relation lost significance in the multivariate analysis. In contrast, elevated blood pressure has been found to be significantly associated with diabetic retinopathy in various large prospective and cross sectional studies. Klein et al found a significant relation between elevated plasma LDL cholesterol and retinopathy, which is consistent with other studies. This finding will be more definitively answered in ongoing prospective randomised controlled clinical trials of lipid lowering drugs. Finally, the association between gross proteinuria and diabetic retinopathy found by Klein et al corroborates the findings of other investigators.

As the authors point out, there are some limitations to their study. Firstly, and probably most significantly, is the fact that only about one half of the patients with diabetes, 296 out of 538 people classified as having diabetes in the CHS, were evaluated. The diabetic participants excluded from the study were in general older and sicker than the participants who were studied. Therefore, the younger and healthier diabetic participants in the study were not representative of the entire cohort of diabetic people in the CHS. Secondly, the cohort of diabetic participants studied is relatively small. Finally, the non-mydriatic non-stereoscopic fundus photograph of one eye of each participant probably underreported the prevalence of diabetic retinopathy and macular oedema in the participants.

More definitive demonstration of the relation of atherosclerotic cardiovascular disease and diabetic retinopathy will require long term prospective studies begun at or before the onset of diabetes. Until these studies are actualised, Klein et al’s findings provide us with tantalising evidence of an association between atherosclerosis and diabetic retinopathy. If their results are confirmed by future studies, diabetic patients with evidence of atherosclerosis may have a higher risk for the development and progression of
retinopathy and may require more frequent examinations and interventions.

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