GUIDELINES & PROTOCOLS
ADVISORY COMMITTEE

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SUMMARY OF GUIDELINE

Rheumatoid Arthritis: Diagnosis and Management

For full Guideline please go to website: http://www.bcguidelines.ca

Notes:
1. Early treatment with new agents and combination therapies can change the course of this disabling disease.
2. Distinguish between two types:
   - Early rheumatoid arthritis (ERA) = symptoms of < 3 months duration
   - Established disease = symptoms due to inflammation and/or joint damage

Recommendation	Topic	Details

1. Making a diagnosis

Topic: Inflammatory versus non-inflammatory arthritis

Feature	Inflammatory arthritis	Non-inflammatory arthritis
Joint pain	With activity and at rest	With activity
Joint swelling	Soft tissue	Bony
Joint deformity	Common	Common
Local erythema	Sometimes	Absent
Local warmth	Frequent	Absent
Morning stiffness	More than 30 minutes	Less than 30 minutes
Systemic symptoms	Common, especially fatigue	Absent

2. Making a diagnosis

Topic: RA versus other inflammatory arthritides

- RA likely with: morning stiffness > 30 minutes; painful swelling of ≥3 joints; involvement of hands (MCP joints) and feet (MTP joints); and/or duration ≥4 weeks.
- Differential diagnosis: crystal arthropathy, psoriatic arthritis, SLE, reactive arthrtis, spondyloarthropathies, and infectious causes.
- Consider an alternative diagnosis with: mucosal ulcers, photosensitivity, psoriasis, skin rashes; Raynaud's; ocular inflammation; urethritis; inflammatory bowel disease; infectious diarrhea; nephritis; or isolated distal interphalangeal (DIP) joints.
- Severe disease and its accompanying prognosis is associated with extra-articular manifestations. (See table below)

Cutaneous	Ocular	Pulmonary	Cardiac	Neurological	Hematological
Nodules	Sicca	Pleuritis	Pericarditis	Peripheral neuropathy	Leukopenia
Vasculitis	Episcleritis	Nodules	Atherosclerosis	Cervical myelopathy	Anemia of chronic disease
	Scleritis	Interstitial lung disease	Myocardial infarction		Lymphadenopathy
		Fibrosis			

3. Testing

Topic: RA is a clinical diagnosis. Tests are generally for monitoring.

<u>Making the diagnosis</u>

- ESR and C-Reactive Protein (CRP) only indicate inflammation and have low specificity.
- Rheumatoid Factor (RF) has low sensitivity and specificity for RA (those who are seropositive have worse prognoses).
- Antinuclear factor (ANA) is positive in cases of severe RA, SLE or other connective tissue diseases but most people with positive ANA do not have these disorders. A negative ANA usually excludes SLE.
- On X-ray, diagnostic erosions are rarely seen with disease of < 3 months duration.
- Joint aspiration is indicated if infection or crystal arthropathy is suspected.

<u>Disease activity monitoring</u>

- ESR is often useful for monitoring disease and response to treatment.
- RF, ANA, and joint aspiration are of no value.
- Serial X-rays over years may show disease progression and indicate the need for medication change.

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4. Management of ERA (early RA)	Ensure early aggressive treatment to alter disease progression	• Ensure patient education including the setting of self-management and lifestyle goals, and connecting with resources.
		• Arrange urgent referrals to physiotherapy (PT) and occupational therapy (OT).
		• Arrange baseline CBC, creatinine, electrolytes, and BP prior to starting medications.
		• Start NSAIDs for pain management.
		• Arrange urgent specialist referral.
		• Start hydroxychloroquine (up to 6.5 mg/kg lean body weight; ensure monitoring via ocular exam q6-12 months).
		• Combination therapy is the standard of care. If confident of diagnosis and management and patient is not pregnant, start:
		  ▪ Sulfasalazine 1000 mg bid (do CBC and AST monthly x 3) and
		  ▪ Methotrexate 7.5-25 mg/week PO, IM, or SC (perform Hepatitis B & C serology pre-treatment and CBC, AST, ALT, creatinine monthly x 3, then q6-8 weeks).
		• Start low-dose prednisone (up to 10 mg/day) if symptoms are severe while awaiting specialist assessment.

5. Management of established RA	Object is to suppress inflammation and prevent joint damage	• Ensure follow-up by GP q3-6 months and specialist q6-12 months. • Most patients require long-term therapy with disease modifying arthritis drugs (DMARDs). • Monitor current drug therapies and adverse effects, plus co-morbidities and extra-articular manifestations. • Assess for active joint inflammation/disease activity as per Recommendation #1 and doing an ESR or CRP. • Differentiate inflammation from damage, focusing on the most troublesome joints. • With inflammation, change medications as needed; consider referrals to a specialist and PT and/or OT with RA expertise. • With joint damage administer pain relieving modalities; consider referral to PT and/or OT, and an orthopedic surgeon. • For surgical procedures, consider neck instability, increased infection risk, and medications (especially steroids).
6. Chronic disease considerations		A multi-disciplinary approach coordinated by the GP is ideal, covering: • Self-management support. • Pain management. • Psychosocial issues. • Immunizations (influenza and pneumococcal). • Osteoporosis assessment and prevention. • Risk factors for coronary heart disease including dyslipidemia.