SIGN

Management of early rheumatoid arthritis

Quick Reference Guide

CLINICAL FEATURES OF EARLY RHEUMATOID ARTHRITIS (RA)

Symptoms

- *Joint pain/swelling*
- *Stiffness following inactivity*
- *Systemic 'flu-like' features*

Signs

- *Synovitis*
- *Joint swelling/tenderness*
- *Extra-articular features*

INFLAMMATORY POLYARTHRITIS

Differential diagnosis

- Viral arthritis
- Reactive arthritis
- Seronegative spondyloarthropathy
- Connective tissue disease
- Polymyalgia rheumatica
- Polyarticular gout
- Fibromyalgia
- Medical conditions presenting with arthropathy

Helpful investigations

- Erythrocyte sedimentation rate (ESR) /C-reactive protein (CRP)
- Full blood count
- Urea & electrolytes
- Liver function tests
- Uric acid/synovial fluid analysis
- Urinalysis
- Rheumatoid factor
- Anti-nuclear antibody
- Radiology

Adverse prognostic features in early RA

- Many active joints
- High ESR or CRP at outset
- Positive rheumatoid factor
- Early radiological erosions
- Poorer scores of function at outset
- Adverse socio-economic circumstances and lower educational level

EARLY INITIATION OF TREATMENT

B **RA should be treated as early as possible with disease modifying anti-rheumatic drugs (DMARDs) to control symptoms and delay disease progression.**

☑ All patients with persistent inflammatory joint disease (>6-8 weeks duration) already receiving simple analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs) should be considered for referral for specialist rheumatology opinion and DMARD therapy, preferably within 12 weeks.

THE ROLE OF THE MULTIDISCIPLINARY TEAM

☑ All patients with early RA should have access to a range of health professionals, including general practitioner, rheumatologist, nurse specialist, physiotherapist, occupational therapist, dietitian, podiatrist, pharmacist and social worker.

C **Skilled occupational therapy advice should be available to those experiencing limitations in function.**

C **Resting and working splints can be used to provide pain relief.**

B **Patients should be encouraged to undertake simple dynamic exercises.**

☑ Podiatry referral should be offered to all patients.

KEY A B C D indicates grade of recommendation ☑ good practice point

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PHARMACOLOGICAL MANAGEMENT OF EARLY RA

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

B **The lowest NSAID dose compatible with symptom relief should be prescribed. NSAIDs should be reduced and if possible withdrawn when a good response to DMARDs is achieved.**

B **Introduce gastro-protection in RA patients >65 years and in those with a past history of peptic ulcer.**

☑
- Simple analgesics should be used in place of NSAIDs if possible and DMARDs should be introduced early to suppress disease activity.
- Only one NSAID should be prescribed at a time.
- Prescribers should be aware of the many potential interactions with NSAIDs and the side effect profiles of different drugs.
- Consider intra-articular corticosteroids, particularly when disease is localised.
- NSAIDs should be avoided in patients taking anticoagulants or corticosteroids.

DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDs)

B **Early DMARD therapy in RA is important to maintain function and reduce later disability.**

B **DMARD therapy should be sustained in inflammatory disease in order to maintain disease suppression.**

☑ DMARD choice should take into account patient preference and existing co-morbidity.

B **Sulphasalazine, methotrexate, IM gold, and penicillamine are equally effective DMARDs.**

B **Sulphasalazine and methotrexate are the current DMARDs of choice due to their more favourable efficacy/toxicity profiles.**

B **At present the balance of evidence does not support the routine use of combination DMARD therapy in early RA.**

☑ Patients should be counselled about the benefits and risks of specific DMARDs, and should be provided with additional written information.

☑ Clear advice about monitoring of specific DMARDs should be available to the patient, GP and practice nurse.

CORTICOSTEROID THERAPY

B **Oral corticosteroids are not recommended for routine use, as there is no sustained clinical or functional benefit and there is high risk of toxicity with long term use.**

D **The lowest possible dose of corticosteroid should be used for the shortest possible time.**

D **Monitor patients closely for adverse corticosteroid effects. Be alert to the possibility of diabetes, cataract and infection. Inform patients not previously infected of the danger of chicken pox/shingles exposure.**

☑ Inform patients of the risks of corticosteroids prior to prescription and issue a steroid warning card.

Derived from the national clinical guideline recommended for use in Scotland by the
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Available on the SIGN website: www.sign.ac.uk