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Dear Referring Practitioner please get some new info on the run... *General Medicine Bulletin 2*

Rheumatoid Arthritis

Here is a few *clinical pearls* that our practice would like to share with you to refresh and update your knowledge on this very important subject for 2015.

1. If a patient complains of a swollen/painful joint, ask whether the patient has morning stiffness.
   If a patient has **stiffness/pain** after immobilisation it is probably an inflammatory arthritis.
   In contrast **pain/stiffness** after physical activity is more likely to be degenerative disease.

2. Quick screening tool

   Squeeze test – squeeze on the MCP and/or MTP joints – if painful → the patient need a work up for RA and probably specialist referral.

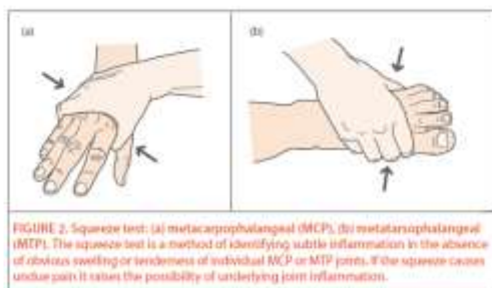

FIGURE 2. Squeeze test: (a) metacarpophalangeal (MCP), (b) metatarsophalangeal (MTP). The squeeze test is a method of identifying subtle inflammation in the absence of obvious swelling or tenderness of individual MCP or MTP joints. If the squeeze causes undue pain it raises the possibility of underlying joint inflammation.

3. New diagnostic guidelines

2010 ACR/EULAR Criteria

	Criteria	Score
Joint Involvement	1 Large Joint	0
	2-10 Large Joints	1
	1-3 Small Joints	3
	>10 Joints (at least 1 small joint)	4
Serology	Negative RF and anti-CCP	0
	Low-Positive RF or anti-CCP	2
	High-Positive RF or anti-CCP	3
Acute-Phase Reactants	Normal CRP and ESR	0
	Abnormal CRP or ESR	1
Duration of Symptoms	<6 weeks	0
	≥6 weeks	1
***Total score of greater than 6 is classified as RA**		

4. Approach to an inflammatory arthritis

Determine if there is *morning stiffness*
Is it more than *six weeks duration*
Which *joints* are affected
Is there swollen *joints (sinovitis)* on exam
X-rays - hand/feet, involved joints, ± CXR
Bone density → ? osteoporosis

Blood tests:
* ESR, CRP → ? inflammation
* AntiCCP, RF → ? RA
* ANA, anti DS DNA → ? SLE
* Uric acid → ? gout
* HLAB27 → ? Ank spond - if back pain

Anti-ccp: Highly sensitive marker for RA, could be positive long before there are clinical signs

Anti-ccp: VERY HELPFULL TEST FOR THE DIAGNOSIS OF RA

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5. Treatment Update

Methotrexate: Start Methotrexate on 25 mg weekly. Don't start on a low dose and up titrate

Nivaquine: Remember baseline + yearly fundoscopy / ophthalmologist referral
Dosage: In patients < 60 kg reduce the dose to 200 mg only weekdays.
Omit Saturday and Sunday for less eye complications
NVQ is quite a useful drug especially for SLE that involves the skin ± joints

Steroids: If it is a young patient → rather try other treatment options and try to avoid steroids / talk to us. Steroids should only be used as bridging therapy while waiting for the DMARD effect (6 weeks) Remember the long term side effects of steroid use. Options: (1) Intra-articular steroids; (2) Depot Medrol 80 mg IMI stat; or (3) Depot Medrol 500 mg bd IVI x 3/7 (if infection is excluded)

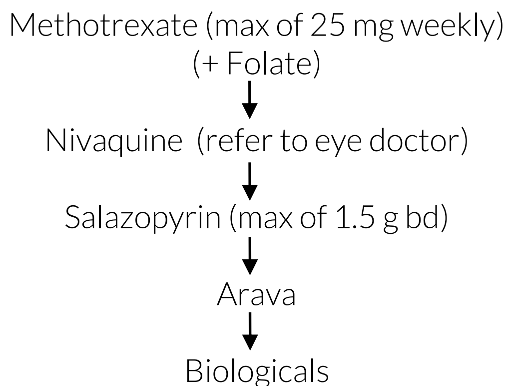
6. Osteoporosis

RA can cause osteoporosis. Steroids can also cause osteoporosis. Remember Calcium and vitamin D supplementation in these patients at risk.
If a patient is going to be on ≥ 7.5 mg of steroids for ≥ three months a bisphosphonate should be seriously considered. Patients on chronic steroid therapy need 6 monthly bone density scans.

7. Treat RA early and aggressively to prevent bone damage

After you made the diagnosis of RA, you have to **stop the progress of the disease**
To just treat symptomatically with NSAID or analgesic is not enough.
One have to give DMARDs in order to stop the activity and progression of the disease that could potentially lead to dysfunctional destroyed joints.

Regular follow up (6-8 weekly) is very important with stepwise uptitration →



Notes from the dietician

- Mono-unsaturated fats mainly those found in **olive and canola oil** may reduce the inflammatory response and provide some relief
- A diet **low in saturated fats from meat and animal products and HIGH in omega-3 fatty-acids** from fatty-fish (mackerel, salmon, sardines), walnuts and flaxseeds and vegetable oil (canola, flaxseed, soybeen) helps to reduce inflammation in the joints.
- Intake of **vitamin C, E and carotenoids** DEFEND against oxidation in the body. Sources include: carrots, pumpkin, sweet potato, spinach, winter squash, cabbage, yellow and red bell peppers, guavas, kiwis, berries, tomatoes, peas, papaya, nuts, sunflower seeds, avocado, broccoli.

Aim of therapy = to have no pain, no morning stiffness = > no disease activity/progression
I believe a RA patient should not wait for a follow up date - an acute flare = **immediate attention**

Please phone us anytime if you want to discuss treatment or need advice!

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