bpacnz PRIMARY CARE UPDATE SERIES

RHEUMATOID ARTHRITIS (RA): A COLLABORATIVE APPROACH TO MANAGEMENT

In the early stages, rheumatoid arthritis (RA) can be challenging to differentiate from other types of inflammatory polyarthritis, as many of the "text-book" features, e.g. rheumatoid nodules, extra-articular manifestations and radiological evidence of joint erosions, occur primarily in patients with long-term poorly controlled disease. Therefore, a working diagnosis usually relies on combining the relevant components of the patient's history and clinical examination with supporting evidence from laboratory investigations. Diagnosis is then confirmed, usually in conjunction with a rheumatologist. Although most patients with RA are initially managed in secondary care, optimal patient outcomes are achieved when secondary and primary care clinicians work collaboratively to promptly diagnose, initiate treatment and monitor disease progression and adverse effects of medicines.

Key practice points:

- RA should be considered as a possible diagnosis in patients presenting with synovitis lasting at least six weeks, particularly if multiple small joints in the hands or feet are affected
  - Elevated levels of inflammatory markers (e.g. C-reactive protein [CRP], erythrocyte sedimentation rate [ESR]) and autoantibodies (e.g. rheumatoid factor [RF], anti-cyclic citrullinated peptide antibody [anti-CCP]) should further increase the suspicion of RA
  - X-rays of the hands/feet are often recommended as part of the diagnostic work up and to monitor disease progression, but are not required to make a diagnosis
- Medicines often need to be initiated immediately for managing acute symptoms before a diagnosis of RA is confirmed, and re-initiated at times throughout treatment if disease activity remains uncontrolled
  - A NSAID (plus paracetamol, if needed) is usually sufficient for patients with mild disease activity; corticosteroids may be suitable for those with more severe disease activity or who do not respond sufficiently to NSAIDs
  - Only use these medicines for short periods until disease-modifying anti-rheumatic drugs (DMARDs; see below) take effect; they do not alter the clinical course of RA
- Early confirmation of the diagnosis by a rheumatologist, followed by prompt initiation of a DMARD is associated with improved long-term outcomes in patients with RA, i.e. less joint damage, less functional impairment
- Methotrexate is the first-line DMARD for treating patients with RA and is taken once weekly
  - Methotrexate can usually be used concurrently with NSAIDs; doses for treating inflammatory conditions are substantially lower than for chemotherapy and therefore unlikely to exacerbate the adverse renal effects of NSAIDs unless the patient's renal function is impaired
  - Other DMARD options include leflunomide, sulfasalazine or hydroxychloroquine, all of which can be used in either dual or triple combinations depending on the patient's characteristics and level of disease activity
- Different DMARDs have different dosing schedules and efficacy/safety profiles; patients should be familiar with the DMARD(s) they are taking, and made aware of symptoms/signs that need to be immediately reported if they occur during treatment
- The long-term objective with DMARD treatment is remission (no disease activity); a management plan should be agreed between the patient, rheumatologist and general practitioner, that defines who is primarily responsible for co-ordinating and monitoring laboratory investigations, and how disease activity should be monitored
  - Cardiovascular disease (CVD)-risk reduction should be encompassed in long-term management plans as patients with RA have a 50% increased risk of CVD-related morbidity and mortality compared to the general population
- If conventional DMARDs are insufficient to control disease activity, biologic DMARDs (biologics) can be trialled with Special Authority approval, e.g. adalimumab, etanercept