Early Referral Recommendations in Rheumatoid Arthritis

Tool for Family doctors to identify potential patients with active RA

Case illustration

• 65 year old female
• knee pain and swelling 8 years
• 1 year history polyarthritis MCP and PIP
• CRP 88
• Rheumatoid factor positive
• Severely damaged knees unable to walk
• X-rays damage MCP
• Unable to do ADL
Rheumatoid arthritis

- 0.5-1% of the global population
- Most common form of inflammatory arthritis
- Economic impact similar to CAD
- 90% of patients with RA some form of disability within two decades of symptom onset
Barriers

• Delay on part of the patient in seeking treatment
• Delay in primary care non specific symptoms
Early referral leads to early diagnosis and treatment

- Decrease in morbidity and mortality
- Structural damage occurs early in RA
- Early DMARD therapy prevents or delays progression
Clinical criteria

• >= 3 swollen joints
• MCP and MTP involvement
• Morning stiffness > 30 minutes
Benefits of early referral

- Immediate treatment
- Greater functional status over the long term
- Better health outcomes
- New specialized treatment
- Monitoring treatments for maximal efficacy and safety
Methods

• Literature search Medline
• Prospective studies
• Clinical progression radiographs approx. 75% develop erosions within 2 years
• joint damage progresses at a consistent rate  25% of the disability
• Strongest with disease duration greater than 8 years
• BMD decreases early
Imaging

- Bone scan
- Ultrasound
- MRI
- Contrast MRI
- All of these superior to conventional radiographs at detecting early soft tissue changes and destructive joint processes
Investigations addressing prognostic factors for radiographic progression and disability

- Involvement of large joints
- Disease duration $\geq$ 3 mo
- Involvement of hand joints
- $>\text{or}=\text{than}$ 2 swollen joints
- High disease activity at baseline
- RF positive
- High CRP