Resource

Getting the most from your initial consultation with your GP

Early treatment has been shown to provide improved disease outcomes in RA. It is therefore essential that people with suspected RA get the most out of initial consultations with their GP , putting them on track for earlier referral, diagnosis and treatment.

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Rheumatoid arthritis (RA) affects more than 450,000 adults in the UK. There is increasing evidence that early introduction of disease modifying anti-rheumatic drugs (DMARDs) such as methotrexate is effective in reducing rheumatoid activity thus leading to a reduction in joint pain and

deformity, long term disability and cardiovascular problems. Such beneficial effects result in an improvement in measures of quality of life. Failure of DMARD therapy is now followed by consideration of biological agent use such as tumour necrosis factor (TNF) inhibitors. Consequently, it is essential that the patient with suspected RA gets the most out of their initial consultations with their GP in order to gain access to appropriate therapy, which is usually initiated by a hospital consultant. ?

In the year 2000, 1.9 million GP consultations for inflammatory arthritis (IA) were recorded. Despite this volume of activity there continues to be a lack of emphasis on training in musculoskeletal medicine for both medical students and GPs (musculoskeletal disorders are diseases that affect muscles and bones and include various types of arthritis, including RA). Registrars in general practice may receive only two hours of formal teaching in musculoskeletal conditions during their training. Moreover, what hospital-based post-graduate training there is, often does not reflect the fact that key RA symptoms can be hidden within a myriad of misleading complaints presented to the GP within one consultation. Even with the large volume of IA consultations mentioned above, only 1 in 60 adults presenting with a musculoskeletal problem has RA. It is therefore not surprising that a GP with not enough training, and few patients with active joint inflammation on which to base experience, has difficulty in diagnosing RA. In spite of this, studies have verified that GPs' awareness of the importance of early DMARD therapy is high. This situation is not unique to the UK, but prevalent throughout the world. Feedback from GPs and charitable organisations to the Royal College of General Practitioners' curriculum planners is expected to lead to an increased emphasis on the need for an adequate musculoskeletal component to GP training.

Following on from recent changes in the GP Contract, patients are now registered with the practice rather than an individual GP. If you suspect you have RA ask whether any of the GPs at your practice have an interest or have held a position in the fields of rheumatology, orthopaedics or musculoskeletal medicine. There are a number of reasons why RA can be difficult to diagnose, for example:

•???RA begins in different ways in different people.?
•???RA does not only affect joints.?
•???The majority of people with painful joints do not have RA.?
•???There is no single definitive test to prove the diagnosis of early RA.?

Tell your GP if you have a family history of inflammatory arthritis such as RA or Lupus. Onset varies and may be gradual or more rapid, and symptoms can come and go or be more constant, so it can make diagnosis difficult. However, if you experience any of the symptoms below, tell your doctor, as this may prompt a request for investigations to exclude RA.

- ?Joint pain and swelling, often hands, wrists and soles of feet.
- ?Early morning joint stiffness for more than thirty minutes.
- ?Inability to perform daily activities such as washing or dressing.
- ?Difficulties in performing work-related tasks.

Also report the presence of the following symptoms, which are less specific for RA.

- ?Dry eyes or mouth
- ?Fever
- ?Weight loss

- ?Muscle pain

- ?Fatigue
- ?Malaise
- ?Nodules – fleshy lumps
- ?Pins and needles
- ?Breathlessness

You may be asked questions in order to establish the pattern of joints affected and the timing of associated symptoms. Advice on lifestyle (e.g. stop smoking), working, joint protection and pain relief medication may be given. Dependent on your history and findings on examination, your GP may feel it is appropriate to refer you to an early arthritis screening centre to establish a diagnosis. If this will introduce a long delay on a waiting list, your GP may request some or all of the investigations below.

Blood tests:

- ?ESR, CRP or Plasma viscosity?- measures of inflammation.
- ?Rheumatoid factor – a positive or negative result does not prove or rule out a diagnosis of RA.
- ?Anti-CCP antibodies – currently used in hospital to support a diagnosis of RA in Rheumatoid Factor negative patients may with time become available to your GP.

- ?FBC?- to exclude anaemia which can be associated with RA.
- ?Autoantibodies – antibodies which act against the body's own tissue.
- ?Immunoglobulins – another measure of inflammation.

X rays:

- Hands and feet?- which may demonstrate the presence of erosions due to RA even in the absence of symptoms at these sites. However, normal x-rays do not exclude RA.

- Symptomatic joints.

Whilst waiting for diagnosis confirmation and the introduction of definitive DMARD treatment your GP will likely discuss the role of non-steroidal anti-inflammatory drugs (NSAIDs) in providing pain relief and the potential adverse effects of such drugs including effects on the kidney, cardiovascular and gastrointestinal systems. If a diagnosis of RA is made, your GP is also likely to be involved in monitoring for potential DMARD adverse effects and increasingly, in the assessment of overall cardiovascular risk, the latter by way of cholesterol, glucose?and blood pressure monitoring. Your GP is there to help, so make the most of your initial consultations. A structured and informed approach to your GP may save both time and disability in the long run.?

Further reading

NRAS article: Laboratory tests used in the diagnosis and monitoring of RA

NRAS website information on the assessment of cardiovascular risk

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