Resource

Making a diagnosis of rheumatoid arthritis

Diagnosis of RA is not straight forward as there is no individual test for RA. A diagnosis tends to be made by a consultant rheumatologist on the basis of tests, examination and ruling out other possible causes for symptoms.

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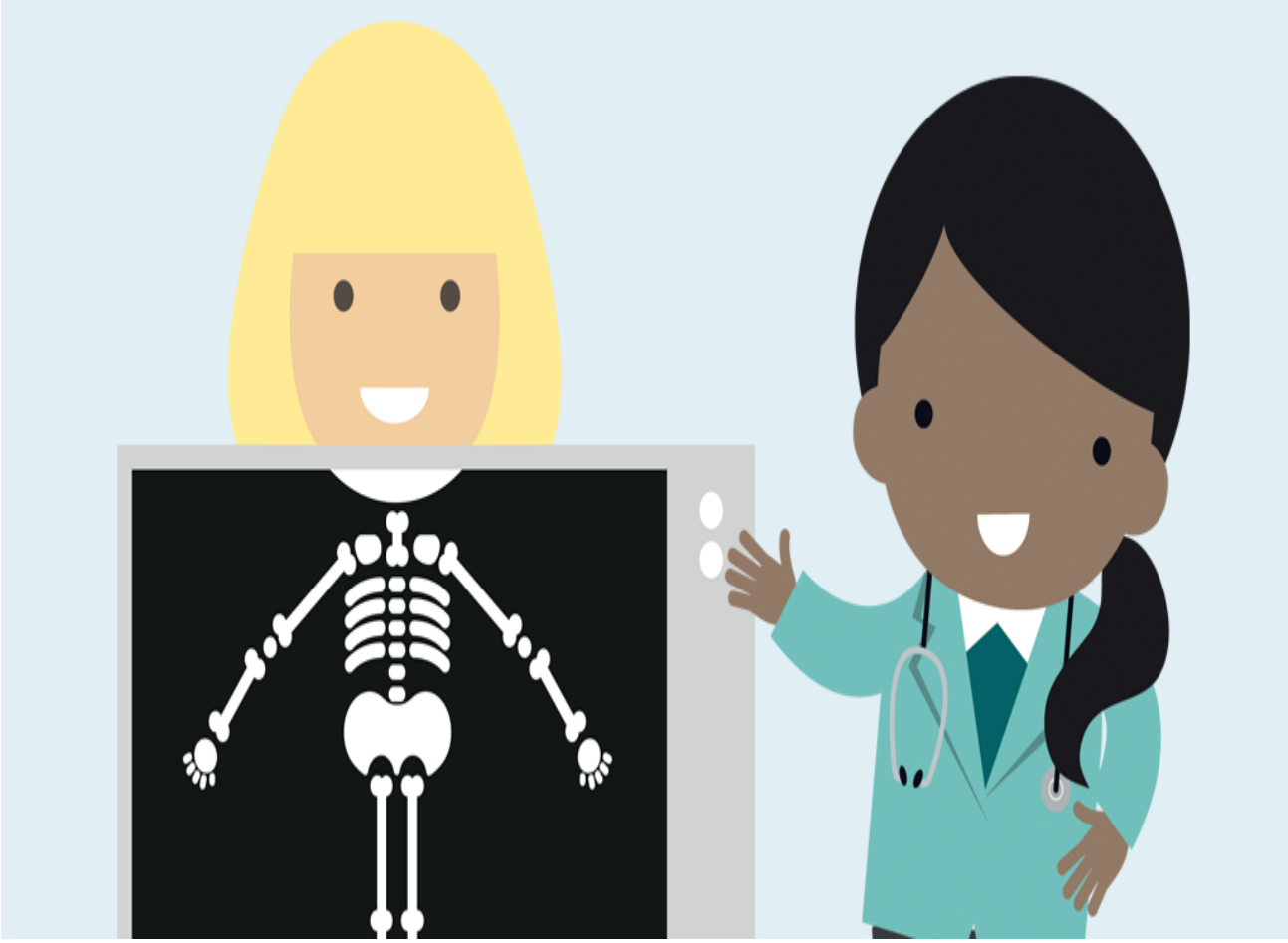

Sometimes it is clear from symptoms and initial blood tests that someone has rheumatoid arthritis, but not always.? Specialist criteria have been developed jointly by American and European experts to try to help make a diagnosis of rheumatoid arthritis in people presenting with new-onset swollen, painful joints (called synovitis) with no obvious cause (ACR/EULAR 2010 Rheumatoid Arthritis Classification Criteria).? These should be used with care though as people with osteoarthritis or a crystal arthritis

(see below) could meet the criteria and end up being incorrectly diagnosed with rheumatoid arthritis, which could have significant consequences for treatment.? They have also been developed to classify, not diagnose, rheumatoid arthritis and so should not be used to decide who gets referred.??

As already mentioned above, there are a number of other conditions that can cause very similar symptoms to rheumatoid arthritis and your GP will have to consider these when assessing each case.?

What conditions may be confused with RA?

Fibromyalgia

People with this condition often feel pain “all over”, in all their muscles and joints, and have multiple tender points when examined. They will also often have a degree of early morning stiffness.
Poor unrestorative sleep is often present, with associated fatigue and low mood, and often there are associated symptoms of headaches and irritable bowels and bladder.? Investigations tend to be normal.? It is important to distinguish this condition from rheumatoid arthritis as their management is very different, although sometimes both conditions are present.?

Polymyalgia Rheumatica (PMR)

This condition causes pain and stiffness of the shoulders and thighs and tends to occur in people over 65 years of age. It is more common in females. Sometimes elderly people with RA present with similar symptoms.? PMR is treated by a course of steroid tablets where the dosage is gradually reduced over months and can generally be stopped after about 18 months – 2 years.? In people with RA presenting with PMR type symptoms, the correct diagnosis of RA usually becomes apparent when the patient is unable to reduce the steroid dosage below 10mg.?

Post-viral arthritis

An acute, post-infective, self-limiting arthritis can follow influenza and other viral illness, particularly parvovirus. It may be extremely painful with swollen ankles, wrists or knees. This usually resolves over several weeks or months. A clue may be that other family members or friends were also affected by symptoms of a viral infection around the same time.

Osteoarthritis

Osteoarthritis (OA) is the most common type of joint disease which can affect any joint but the most commonly affected areas are the hips, knees, back, hands and feet. ? Hands affected by OA often have small lumps (nodes) on either side of the finger joints, most commonly found at the ends of the fingers, near to the fingernails (called Heberden's?nodes). The base of the thumb is also frequently affected.? OA hands usually function quite well, even though they may look unsightly, i.e. look larger, squarer and have hard lumps. Osteoarthritis can usually be distinguished from rheumatoid arthritis, although some people can suffer from both types of arthritis.? Patients with hand OA can respond to steroids (though usually, the response is not prolonged). Therefore a response does not necessarily imply there is an underlying auto-immune driven pathology such as rheumatoid arthritis.?

Crystal Arthritis

There are two different types of crystal arthritis.? The first, gout, is caused by the deposition of monosodium urate crystals in the joint.? Gout is the most common cause of inflammatory arthritis in the UK (1.6million people in the UK have gout) but usually presents in a very different manner to rheumatoid arthritis and so they can be easily differentiated.

The second type of crystal arthritis is calcium pyrophosphate disease (CPPD), getting its name from the crystal that causes it. If it occurs in people with hand osteoarthritis, CPPD can present in a very similar way to rheumatoid arthritis and so can be mistaken for RA. Chondrocalcinosis (the calcification of joint cartilage) on X-rays can confirm the diagnosis of calcium pyrophosphate disease, and ultrasound can be used to detect evidence of crystal deposition in or around joints.

Other types of inflammatory arthritis

There are other causes of auto-immune driven inflammatory arthritis- such as vasculitis, connective tissue diseases and inflammatory joint problems associated with psoriasis/inflammatory bowel disease.? Usually, there are other features pointing to an alternate diagnosis to RA, but these still need to be referred for urgent specialist assessment.

What should be done if rheumatoid arthritis is suspected?

Any person who is suspected of having RA should be referred to a specialist rheumatologist. Early referral is important so that disease modifying anti-rheumatic drugs (DMARDs) may be prescribed as soon as possible so as to slow or halt the disease process.? Delay in referral or receiving a definitive diagnosis and treatment can result in significant costs to the individual, particularly those who are employed. This is because joint damage occurs most rapidly in the early stages of the disease, and often the treatment drugs can take several months to work.

Investigations can be normal in rheumatoid arthritis, particularly early in the disease, and therefore there is no need to wait for results before the referral. ?In cases where it is felt that the most likely diagnosis is one of the conditions mentioned above then it is probable that you would be reviewed with the results of your investigations as these do not require an urgent referral.? The Scottish equivalent of NICE (Scottish Intercollegiate Guidelines Network) also advises early referral.? Both guidelines emphasise the importance of the history of what has been happening.? As there is a strong genetic element to rheumatoid arthritis, it is very helpful to let your GP know if other members

of your family are also affected by RA or another auto-immune condition.

Many areas now offer “Early Arthritis Clinics” where a rapid assessment is performed by specialists/specialist nurses in order to limit any delays.? An ultrasound of the affected joints may be performed during this assessment. ?

NICE recommends a treat to target strategy with the target being remission or if this is not possible then low disease activity. You are more likely to achieve this target if DMARDs have been started within 3 months of you developing persistent joint inflammation.? Pain control is extremely important and can be started by your GP straightaway.? This may require non-steroidal anti-inflammatory drugs (NSAIDs or COX 2 drugs) either alone or in combination with analgesic drugs (painkillers). The choice of drug will depend on the person’s comorbidities (other conditions) such as cardiovascular risk and gastrointestinal disease. All NSAIDs should be given for the shortest time possible with a proton-pump inhibitor drug to protect the stomach. Other analgesic drugs may also be required (paracetamol, co-codamol, tramadol, etc.). The dose of which can be varied from day to day depending upon symptoms or what activities are planned for a particular day.?

If your symptoms are particularly severe when you first see your GP, then they may refer you urgently but also ring to speak to one of the local rheumatologists to ask for assistance in how to best help you in the meantime.?? Sometimes people are started on treatments other than those mentioned above, e.g. steroid tablets or a steroid injection, prior to being seen, in order to improve their condition.? This though can affect what the specialists see and find at the first appointment, which can potentially delay their making a diagnosis or there may be increased uncertainty of the diagnosis.

How else can your GP surgery help?

Your GP surgery can be involved in your RA care in many different ways.? They continue to look after you in general and may want to keep a close eye on your blood pressure, cholesterol and blood glucose levels as there is a higher risk of heart disease in people affected by rheumatoid arthritis.? This is often done as an annual review with one of the practice nurses.? Many GP surgeries are involved in doing the blood monitoring for the specific drugs used in controlling and treating the joint inflammation (DMARDs), so you may get your regular blood tests performed by your surgery.

Rheumatoid arthritis, along with many of the treatments used (including DMARDs and biologics) affects the body’s immune response to infections.? Your surgery may therefore contact you to offer you annual influenza (flu) jab and also a Pneumovax for pneumonia (a one-off vaccination).? With some of these treatments live vaccines should be avoided so please ensure you contact your Doctor’s surgery if you are planning to travel abroad.

Practical Help

A new diagnosis of RA can be a time of emotional distress due to the potential impact on the quality of life and the difficulties that accompany living with disease and being on long-term treatment. This includes concerns about drugs, family life, no longer being able to enjoy a favourite hobby, no longer able to work, etc. Fear, loneliness, depression, anger and anxiety are common and, if unacknowledged, can be overwhelming and disabling. The best ways to tackle these problems are by your medical team providing:

- good symptom control (pain relief), which is essential

- simple strategies of listening, acknowledging the normality of distressing emotion, helping people to recognise and develop simple coping strategies, e.g. pacing, distraction, relaxation, gentle exercise
- provision of practical help, e.g. helping to get financial support, childcare, disabled badges for parking, devices to aid activities of daily living, help with employment
- some people may require more specialist skilled help from trained counsellors or psychologists.

There may be a need to change occupation or reduce working hours; for further information see the NRAS guide for people with RA and their employers, which cover aspects of fatigue, benefits and driving (DVLA) advice. The ‘Access to Work’ programme can also be used to provide practical support for adjustments needed to return to work.

On another practical note, footwear is also important; comfortable, air-cushioned shoes (such as Hotter, Ecco or Clarks Springer sandals) will help. Try to avoid slip-on shoes, slippers or bare feet as this can put more stress on the joints. Don’t be afraid to ask for advice. Fatigue may be a problem but try to continue with hobbies and develop new ones.?

Many patients will also look for ways to help their condition themselves through diet, exercise and complementary therapies. Further information about this is available in other articles, in the lifestyle section of the NRAS website.

Conclusion

Fortunately, the management of RA has undergone a revolution in care during the past decade and continues to be an area of great research interest, with many new treatments currently in trial stages. There is now a much greater medical understanding of the disease, better ways to assess disease activity, effective strategies such as a treat to target and, for the first time, targeted therapies that have a real prospect of inducing disease remission.?

Management has many more facets than mere drug treatments, but drugs remain the mainstay. Drug management may be likened to a pressure cooker. The pressure cooker represents the disease of RA. DMARDs are represented by the weights on the top of the pressure cooker but whilst there is steam hissing out of the vent the patient has to take analgesics and NSAIDs / Cox-2s to control the everyday pain and stiffness. Biologic drugs/JAK inhibitors appear to have the potential to turn the heat off under the pressure cooker, i.e. if a patient responds to these drugs, then the disease is virtually turned off.

Despite these advances, recent studies have shown that it can sometimes be difficult for people in the early stages of rheumatoid arthritis to access the healthcare that they need. If you are concerned that you may have RA, you should consult your GP about getting relevant blood tests and subsequent referral to a specialist.? Likewise, if you are currently receiving care but are concerned that it isn’t working as well as you need it to, you should also discuss your concerns with your GP or rheumatologist.?

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