The Royal Australian College of General Practitioners

Early diagnosis and management of rheumatoid arthritis

This algorithm applies to men and women aged more than 16 years presenting with joint pain and swelling. Refer to RACGP *Clinical guidelines for musculoskeletal diseases* for more information on recommendations and grading of evidence
www.racgp.org.au/guidelines/musculoskeletaldiseases

SUSPECTED RA

Consider any of the following:

History (B)

- Joint pain and swelling and/or fever
- Morning stiffness >30 minutes
- Previous episodes
- Family history of RA
- Systemic flu-like features and fatigue

CLINICAL EXAMINATION (B)

- Three or more tender and swollen joint areas
- Symmetrical joint involvement in hands and/or feet
- Positive squeeze at MCP or MTP joints

RA may present in other ways. Investigations to consider based on clinical judgment

- Clinical history and examination to rule out other causes
- Consider a range of infections (eg. hepatitis B and C, rubella, parvovirus, enteric infections or fibromyalgia) that may cause polyarthritis

Diagnostic investigations (A)

- Raised ESR and/or CRP
- Positive rheumatoid factor (RhF) and/or anti-cyclic citrullinated peptide antibodies (anti-CCP)

Absence of any of these key symptoms, signs or test results does not necessarily rule out RA

INITIAL THERAPY

Pharmacological interventions

- Simple analgesics (eg. paracetamol) **(B)**
- Fatty acids: omega-3 supplements **(A)**, higher doses of omega-3 are likely to be of greatest benefit (up to 12 g/day), gamma linoleic acid supplements **(C)**
- NSAIDs/COX-2 inhibitors **(A)**
- DMARDs **(A)**
- Corticosteroids **(oral: A, intra-articular: B)**

Nonpharmacological interventions

- Weight control **(B)**
- Patient education and self management programs **(B)**
- Occupational therapy **(B)**
- Exercise (eg. dynamic, aerobic, tai chi) **(C)**
- Psychosocial support **(C)**
- Sleep promotion **(B)**
- Appropriate foot care **(C)**
- Thermotherapy (eg. heat and/or ice packs) **(D)**

Consider DMARDs when there are several swollen joints, especially if tests for RhF and/or anti-CCP are positive (in conjunction with referral to a rheumatologist)

If persistent swelling beyond 6 weeks (even if RhF and/or anti-CCP negative) and/or inadequate pain relief consider referral

Refer to rheumatologist or specialist (A)

- Immediately when multiple swollen joints, particularly if RhF and/or anti-CCP antibody are positive
- If still requiring NSAIDs beyond 6 weeks after initial treatment

OR in consultation with rheumatologist or specialist (if immediate access is not available)

- DMARDs (eg. methotrexate once weekly) **(A)**
- Short term low dose oral corticosteroids (7.5 mg/day) **(A)**

ONGOING MONITORING

(shared care between patient, GP and rheumatologist)

- Joint effects: number, tenderness and swelling
- Extra-articular (eg. nodules, rash)
- CVD: BP and other risk factors, and renal function
- Risk of infection (immunomodulators)
- Toxicity: monitor for potential toxicity (eg. skin, lungs, GIT, heart, blood and/or urine tests)
- Lifestyle (eg. smoking, weight, BMI)
- Activities of daily living (eg. function, sleep, mood, fatigue)
- Annual foot review
- Medication adherence
- If long term corticosteroids, review osteoporosis risk, BP, lipids, cataracts

ADVANCED THERAPY

(prescribed by a rheumatologist)

For example: eflunomide, cyclosporin, biological agents, etanercept, adalimumab, infliximab, anakinra, rituximab

SELECTED PRACTICE TIPS (SEE THE FULL GUIDELINE FOR MORE TIPS AND FURTHER DETAILS)

www.racgp.org.au/guidelines/rheumatoidarthritis

Intervention	Recommendation
Pharmacological management	
Simple analgesics	• Prescribe paracetamol in regular divided doses to a maximum of 4 g/day for treating persistent pain
Fatty acid supplements (omega-3 and gamma-linolenic acid)	• Omega-3 supplementation as an adjunct for management of pain and stiffness in patients with RA **(Recommendation 13 A)** • Higher doses of omega-3 are likely to be of greatest benefit (up to 12 g/day) • Fatty acid intervention may provide supplementary or alternative treatment to NSAIDs in some patients. They can also enable a reduction of NSAIDs • The recommended dose for gamma-linolenic acid (GLA) is 1400 mg/day of GLA or 3000 mg of evening primrose oil
Traditional NSAIDs and COX-2 inhibitors	• Consider using conventional NSAIDs or COX-2 inhibitors for reducing pain and stiffness in the short term treatment of RA where simple analgesia and omega-3 fatty acids are ineffective **(Recommendation 15 A)** • Only one NSAID or COX-2 inhibitor should be prescribed at any one time
DMARDs	• Investigations before DMARD therapy: chest X-ray, FBC, ESR, CRP, hepatitis B and C, renal and liver function tests • Commence DMARDs within 12 weeks of onset in consultation with a rheumatologist • Once weekly methotrexate is first choice as a single or combination therapy unless contraindicated • DMARDs require at least 2–3 months to take effect • Cease smoking and limit alcohol if on methotrexate or leflunomide **(Recommendation 17 and 18 A)**
Corticosteroids	• Intra-articular for individual joints to suppress synovitis • Oral, IM or IV for general flare while waiting for DMARD action • Low dose oral corticosteroids (7.5 mg/day) may have DMARD action but long term use is not recommended • Ongoing monitoring for medication safety and comorbidities is an important shared GP role • Discuss medication interactions (including over-the-counter preparations and complementary medicines)
Nonpharmacological interventions	
Complementary therapies	• Inform patients about insufficient volume of evidence available on treating RA with complementary therapies **(Recommendation 21 B)**
Tripterygium wilfordii	**WARNING: DO NOT recommend the Chinese herb *Tripterygium wilfordii* due to risk of serious adverse effects (Recommendation 22 B)**
Exercise	• Encourage regular, dynamic physical activity, compatible with the patient's general abilities, in order to maintain strength and physical functioning **(Recommendation 24 C)**
Weight Disease monitoring and comorbidities	• Encourage weight control and dietary modification **(Recommendation 23 B)** • Assess and treat CV risk factors such as smoking, obesity, physical activity, hypercholesterolaemia, hypertension and diabetes • Monitor at least 3 times per year: CVS, GIT and renal function **(Recommendation 16 A)**
WARNING: Aggressive early treatment prevents joint damage. However, treatment may cause serious adverse effects including death. Physicians and patients must monitor for signs and symptoms of potential toxicity through regular clinical and laboratory review	

FOR DETAILED PRESCRIBING INFORMATION

Therapeutic Guidelines **www.tg.com.au**
Australian Medicines Handbook **www.amh.net.au**
National Prescribing Service **www.nps.org.au**

PATIENT SERVICES

Arthritis Australia **www.arthritisaustralia.com.au**
Australian Rheumatology Association **www.rheumatology.org.au**

GPs may utilise EPC items to facilitate access to appropriate services **www.health.gov.au/epc**. Eligible services include, but are not limited to, those provided by physiotherapists, occupational therapists and exercise physiologists; and refer for HMR with pharmacist for medication education and management **(Recommendation 5 B)**; psychological support **(Recommendation 9 C)**; podiatrist for foot care **(Recommendation 27 C)**

NHMRC grades of recommendations

A Body of evidence can be trusted to guide practice
B Body of evidence can be trusted to guide practice in most situations
C Body of evidence provides some support for recommendation(s) but care should be taken in its application
D Body of evidence is weak and recommendation must be applied with caution

Note: A recommendation cannot be graded A or B unless the volume and consistency of evidence components are both graded either A or B

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