SOURCES OF FURTHER INFORMATION

Arthritic Association
One Upperton Gardens
Eastbourne
East Sussex BN21 2AA
Freephone: 0800 652 3188
Tel: 01323 416550
Fax: 01323 639793
Email: info@arthriticassociation.org.uk
Web site: www.arthriticassociation.org.uk

Arthritis and Musculoskeletal Alliance
Bride House, 18-20 Bride Lane
London EC4Y 8EE
Tel: 0207 842 0910/11
Fax: 0207 842 0901
Email: info@arma.uk.net
Website: www.arma.uk.net

Arthritis Care in Scotland
Unit 25A, Anniesland Business Park
Glasgow G13 1EU
Tel: 0141 954 7776 • Fax: 0141 954 6171
E-mail: Scotland@arthritiscare.org.uk
Website: www.arthritiscare.org.uk/InyourArea/Scotland/

Arthritis Research UK
Copeman House
St Mary's Court, St Mary's Gate
Chesterfield
Derbyshire S41 7TD
Tel: 01246 558033 • Fax: 01246 558007
Email: enquiries@arthritisresearchuk.org
Website: www.arthritisresearchuk.org

National Rheumatoid Arthritis Society
Unit B4, Westacott Business Centre
Maidenhead Office Park, Westacott Way
Littlewick Green
Maidenhead SL6 3RT
Tel (helpline): 0800 298 7650
Tel (general): 01628 823524
Fax: 0845 458 3971
Email: enquiries@nras.org.uk
Website: www.rheumatoid.org.uk

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 123 Management of early rheumatoid arthritis.**

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

SIGN
Scottish Intercollegiate Guidelines Network
Part of NHS Quality Improvement Scotland

NHS Quality Improvement Scotland

123 Management of early rheumatoid arthritis

Quick Reference Guide

February 2011

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

DIAGNOSIS

The diagnosis of early rheumatoid arthritis (RA) relies on the accurate interpretation of medical history and clinical investigations.

B **Anti-CCP2 antibody may be used as part of the assessment of a patient suspected of early rheumatoid arthritis.**

PRINCIPLES OF MANAGEMENT

The principles of management include:

- Patient education
- Multidisciplinary team working
- Early treatment
- Assessing disease activity
- Treat to target

B **Early initiation of treatment with DMARDs is recommended to control the symptoms and signs of RA as well as limiting radiological damage.**

☑ All patients with suspected inflammatory joint disease should be referred to a specialist as soon as possible to confirm the diagnosis and evaluate disease activity.

☑ Patients with early RA should have their disease activity quantified.

B **Patients with moderate to severe disease activity should:**

- **be assessed for disease activity using a standardised scoring system such as DAS/DAS 28**
- **be reviewed monthly until remission or low disease activity score is achieved**
- **have treatment with DMARDs, adjusted with the aim of achieving remission or a low DAS/DAS28 score.**

☑ All patients should have access to such a range of professionals, including general practitioner, rheumatologist, nurse specialist, physiotherapist, occupational therapist, dietitian, podiatrist, pharmacist and social worker.

PHARMACOLOGICAL MANAGEMENT

Minimising the risk of NSAID side effects

B
- **The lowest NSAID dose compatible with symptom relief should be prescribed.**
- **NSAID dose should be reduced and if possible withdrawn when a good response to DMARDs is achieved.**

B **Gastro-protection should be introduced for patients with RA at risk of NSAID-associated gastro-duodenal ulcers.**

☑
- Only one NSAID should be prescribed at a time.
- Long term NSAID use should be reviewed periodically.
- NSAIDs least likely to cause gastrointestinal and/or cardiovascular effects should be prescribed.

Systemic corticosteroids

A **Low dose oral corticosteroids can be used in combination with DMARD therapy for short term relief of signs and symptoms, and in the medium to long term to minimise radiological damage.**

☑ Consideration should be given to the risk-benefit ratio of corticosteroids, particularly the long term side effects. Patients should be informed of the risks prior to prescription and issued with a steroid warning card.

☑ Guidelines for managing osteoporosis in patients taking oral corticosteroids should be followed.

☑ Intra-articular injections

- can be used for rapid, and sometimes sustained, symptomatic relief in 'target' joints.
- to any one joint should not be given more than three to four times in one year.

☑ When administering intra-articular injections:

- use sterile technique
- advise patients on how to seek help if the joint fails to settle after an injection.
- always consider possible septic arthritis in the differential diagnosis of mono-oligo flare in RA.

Disease modifying anti-rheumatic drugs (DMARDs)

A **Methotrexate and sulfasalazine are the DMARDs of choice due to their more favourable efficacy and toxicity profiles.**

B **DMARD therapy should be sustained in patients with early RA to control signs and symptoms of disease.**

A **A combination DMARD strategy, rather than sequential monotherapy, should be considered in patients with an inadequate response to initial DMARD therapy.**

☑ Where parallel or step down strategies are employed, DMARDs should be carefully and slowly withdrawn in patients who are in remission

☑ Practical prescribing of DMARDs

- The choice of initial DMARD should take into account patient preferences and existing comorbidities.
- Patients should be informed of the potential benefits, risks and monitoring requirements of DMARDs
- Monitoring of toxicity should follow the recommendations of the British National Formulary and the manufacturers data sheets.
- Effective liaison between primary and secondary care is essential. Rheumatology nurse specialists have an important role in this aspect of care.

Biologic response modifiers

Use of theTNF-α inhibitors for the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with methotrexate or other DMARDs is not recommended.

ROLE OF MULTIDISCIPLINARY TEAM

C **Skilled occupational therapy advice should be available to those experiencing limitations in function.**

Exercise therapy

B **Patients should be encouraged to undertake simple dynamic exercises.**

☑ Exercise should be prescribed under the guidance of a qualified practitioner commencing with low intensity exercise. Due care should be taken to monitor disease activity to avoid exacerbations of symptoms.

Splinting

C **Resting and working splints can be used to provide pain relief.**

☑ Podiatry referral should be offered to all patients.

PROVISION OF INFORMATION

These key messages are not intended for direct dissemination to patients, but are provided for possible use by clinicians in discussing treatment options with patients who have RA.

- in RA joints become inflamed making them painful, swollen and stiff
- the cause of RA is unknown
- there is no single test to diagnose RA
- RA cannot be cured at present, but in many cases it can be controlled
- the progression of RA is different in each person
- RA can be treated - reducing pain, stiffness, swelling, and damage to joints
- the sooner RA is treated the better, the earlier treatment is started the less damage takes place in the joints, meaning less restriction on carrying out normal activities
- treatment with DMARDs should begin as soon as possible after diagnosis
- DMARDs take several weeks to start working and should be continued indefinitely
- the treatment of RA requires input from a range of health professionals
- people living with RA can achieve good quality of life with support and skills to manage their condition effectively. There are organisations set up to provide these skills and peer support (see section 8.1 for details of relevant organisations).