

key points

SELECTED BY

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There are many potential causes of joint pain in older patients. The most likely aetiology is osteoarthritis. However, the differential diagnosis includes conditions which should not be missed such as septic arthritis and inflammatory disease.

The pattern of joint involvement points to the diagnosis. Bilateral symmetrical small joint pain, swelling and stiffness should arouse the suspicion of rheumatoid arthritis. The wrist and knee are commonly affected by pseudogout and the first metatarsophalangeal joint or knee joint involvement may represent gout. Stiffness in the shoulder and hip girdles, worse in the morning, suggests polymyalgia rheumatica.

In straightforward cases of OA no specific investigations are required. If doubt exists, however, tests may be necessary including FBC, ESR and CRP, uric acid for suspected gout and radiographs of the affected joints especially following trauma, or pseudogout.

Patients with OA should be offered education, advice and access to information about their condition as well as strengthening exercises and aerobic fitness training (if physically possible). If the patient is overweight, weight loss is critical, especially in OA of the knee. Paracetamol and topical NSAIDs are the first-line pharmacological treatments. Other useful medications include topical capsaicin, oral NSAIDs, intra-articular corticosteroids and opioids. All of these, however, may be associated with a degree of toxicity.

Elderly onset RA differs from younger onset RA in the following ways: a more balanced gender distribution; a higher frequency of acute onset; an association with systemic features; more frequent involvement of the shoulder girdle and higher disease activity. DMARD therapy should be used according to disease severity, as in younger onset RA. The current approach is for early, intensive intervention with combination therapy. Corticosteroids may be very effective in the elderly, however, prolonged use and/or high dosage may lead to marked toxicity especially osteoporosis and diabetes. Ischaemic heart disease is the leading cause of death in the RA population and RA is an independent risk factor for the development of coronary artery disease.

During an acute attack of gout, the BSR guidelines recommend resting the affected joint and the use of NSAIDs or colchicine if tolerated. In pseudogout, NSAIDs and intra-articular steroids are helpful to reduce the inflammation and shorten the duration of acute episodes.