

key points

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Rheumatoid arthritis (RA) is a common, chronic

systemic inflammatory disease of unclear aetiology leading to synovial hypertrophy and joint inflammation. It typically presents with symmetrical polyarthritis of small joints of the hands or feet, but can also involve larger joints, and have associated extra-articular manifestations. Diagnosis is based on duration of symptoms, joint distribution, level of inflammatory markers and autoantibodies i.e. rheumatoid factor (RhF) and anti-cyclic citrullinated peptide (CCP) antibodies. The presence of synovitis or effusion, either clinical or subclinical, seen on ultrasound or MRI, is essential for diagnosis.

RA can sometimes present with a large joint monoarthritis

or oligoarthritis. Although this is an atypical presentation, a diagnosis can be made in the presence of suggestive serology and/or histology. In cases presenting with monoarthritis, careful assessment for differential diagnoses is needed, particularly in the elderly population where other conditions such as gout, calcium pyrophosphate deposition disease and osteoarthritis are common.

RhF has a relatively low specificity and can be found at

low titres in other autoimmune rheumatological conditions, infective disorders, non-autoimmune conditions and malignancies. RhF can also be found in healthy people, in up to 15-20% of the population, and the prevalence increases with age. Anti-CCP antibodies are much more specific with a specificity of 95-98% and sensitivity of 70-80%. A positive RhF does not equate to a diagnosis of RA.

Early referral of patients with suspected synovitis via

the rapid access early inflammatory arthritis clinic results in significant improvements in long-term outcomes. Hence it is important to consider early referral for individuals with synovitis, particularly if this is affecting small joints.

NSAIDs or COX-2 inhibitors may be used for symptom

relief. A short course of oral, intramuscular or intra-articular corticosteroids can be offered for the rapid control of inflammation following diagnosis. Introduction of DMARD therapy within three months of symptom onset, with a 'treat to target' approach (either remission or low disease activity) has been shown to improve disease control and reduce progression of disease. Combination DMARD therapy including methotrexate is the first-line approach for newly diagnosed RA. Biologic/biosimilar therapies targeting specific molecules involved in the RA inflammatory pathway are used for treating severe RA. They are usually given in combination with methotrexate. Age alone is never a contraindication to DMARD and biologic therapy where indicated by disease activity.