

key points

SELECTED BY

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Elderly onset rheumatoid arthritis (EORA) is defined as rheumatoid arthritis (RA) with age of first onset ≥ 65 years. It comprises an acute onset proximal or large joint arthritis with a prominent systemic syndrome represented by constitutional symptoms and a higher ESR than in the younger patient with RA. Currently available evidence indicates that EORA is a distinct subgroup of RA which may have a significantly different cytokine profile.

Diagnosis is difficult because of the higher prevalence of seronegative disease and a range of other conditions have a similar presentation. These include crystal arthritis, inflammatory osteoarthritis, polymyalgia rheumatica and less commonly, paraneoplastic arthritis. Investigations should focus on trying to establish the cause and ruling out differential diagnoses. They should include inflammatory markers, serum uric acid, full blood count, rheumatoid factor/anti-CCP antibodies, and X-rays of the affected joint as well as the hands and feet. The possibility of malignancy should always be borne in mind. PSA screening should be considered in older men with new onset inflammatory arthritis.

Referral to a rheumatologist should be considered if no alternative explanation can be found for the symptoms. Outcomes and disability from untreated disease are similar in EORA and young onset RA so early treatment is imperative. NICE recommends urgent referral of all suspected cases. In EORA the treatment guidelines for RA should be followed but with more careful tailoring to the individual patient taking account of any comorbidities.

The backbone of treatment remains methotrexate which is a conventional synthetic disease modifying drug (DMARD). Other options in this category include leflunomide, sulphasalazine and hydroxychloroquine. Since the onset of action of these medications can take up to 12 weeks, glucocorticoids can be used as bridging therapy. In cases of failure to achieve remission or low disease activity with conventional DMARDs, addition of biologic DMARDs is recommended, although generally not as monotherapy.

All adults with RA should be followed up regularly in secondary care with frequent monitoring in the initial stages which can be extended to 12 monthly once the disease and treatment regimen have become stable. Regular blood monitoring is necessary for patients on DMARD therapy (excluding hydroxychloroquine). An annual review is recommended for all patients to assess disease activity, functional ability, development of comorbidities (hypertension, ischaemic heart disease, osteoporosis, depression) or complications (vasculitis, disease of the cervical spine, lung or eyes) and the impact the disease is having on the patient's life.