key points

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In order to achieve remission, rapid diagnosis of rheumatoid arthritis (RA) is a key priority. The new RA classification system allows a diagnosis to be made much earlier than previously. The criteria focus on clinical, biochemical and immunological features associated with persistent and/or erosive disease. Following presentation to primary care, patients with symptoms and signs of an inflammatory arthritis should be referred to a rheumatologist.

Any patient with suspected persistent synovitis of undetermined cause should be referred for specialist opinion and urgent referral if any of the following apply: the small joints of the hands or feet are affected; >1 joint is affected; there has been a delay of >3 months between onset of symptoms and seeking medical advice.

Early treatment results in a greater chance of inducing remission. Ideally, this should be within 6 weeks of symptom onset. Patients who develop severe persistent inflammatory arthritis who have normal investigations at disease onset should be referred regardless. Similarly, referral should not be delayed pending investigations.

Lifestyle measures form an integral part of the treatment strategy. A fundamental shift in the approach to treating RA has occurred with the archaic 'start low, go slow' management pyramid having been rejected. One tactic is to use combination DMARD therapy, incorporating methotrexate with corticosteroids, at the outset.

EULAR recommends initiating traditional DMARDs as soon as the diagnosis of RA is made aiming to achieve the target of remission or low disease activity as rapidly as possible. Once prolonged and satisfactory levels of disease control have been achieved, drug doses may be cautiously reduced to levels that still maintain disease control.

EULAR guidelines state that if the treatment target is not achieved following the first traditional DMARD strategy, in the presence of poor prognostic factors, or in patients responding insufficiently to DMARDs, then biologic therapy should be considered. NICE states that to be eligible for biologic drugs, patients with RA should have a baseline DAS-28 score reflecting high disease activity, sustained over two points, one month apart, despite an adequate trial of at least two DMARDs (of which one should be MTX). This hurdle is high and does not reflect the available evidence. The BSR recently revised their eligibility criteria for RA patients starting their first biologic agent advocating introduction of these agents earlier in the treatment paradigm, in line with Europe and the USA.

Treatment with a biologic requires strict monitoring under the guidance of a specialist. GPs should become familiar with these drugs as their use is increasing in rheumatology and other disciplines. Evidence now supports tight disease control, specifically inflammation, by reviewing the patient regularly and adjusting medications until a predefined target is achieved.