Diagnosis and management of rheumatoid arthritis:

Andrew Harrison
Rheumatologist HVDHB and Bowen Specialist Centre
Associate Professor University of Otago Wellington
Clinical Leader Research C&CDHB

Diagnosis and management of rheumatoid arthritis:

as told by *clickbait*

Andrew Harrison
Rheumatologist HVDHB and Bowen Specialist Centre
Associate Professor University of Otago Wellington
Clinical Leader Research C&CDHB

Clickbait

The Tragic Transformations Of The 15 Cutest Child Stars Ever

What These 80s Mega Stars Look Like Now Will Shock You

CELEBRITY | March 1, 2016 | By Kenny Serrera

Photo Credit: Brightside Me

ALF

23 Celebrities You Would Never Guess Are Actually Black

Clickbait


clickbait Old Testament
Dist. by Universal Uclick
What this guy said he did in less than a week will make you question everything!
© John Atkinson, Wrong Hands
Why did this man order 300 cubits of gopher wood? The reason will shock you!
Israelites are halted at the Red Sea. You won't believe what happens next!
Top ten commandments. No. 7 will blow your mind!
© John Atkinson, Wrong Hands • gocomics.com/wrong-hands • wronghands1.com

9 practice-hacks for GPs that will improve the outcome of rheumatoid arthritis

(Number 7 will blow you away)

Andrew Harrison

CONTINUE ON NEXT PAGE

1. Diagnose as early as possible

8 telltale signs that might indicate your patient has RA
(Number 5 may shock you)

1. Peripheral joint involvement
2. Hands and feet involved, esp. MCPs, PIPs fingers, and MTPs
3. Positive lateral squeeze test
4. History of smoking
5. Recklessly low alcohol intake
6. Female gender
7. Laboratory tests – CRP, ESR, RF, anti-CCP
8. Normal x-rays (or erosions)

CONTINUE ON NEXT PAGE

2. Refer to rheumatology as early as possible

Suspected RA should be triaged as urgent for FSA

Some cases may be diagnosed with other conditions
e.g. Viral arthritis, OA, FMS

Delays in diagnosis may delay commencement of treatment

Early treatment in the immune phase may improve long-term outcome

OK to start prednisone if findings are documented and blood tests are taken first

CONTINUE ON NEXT PAGE

3. Measure anti-CCP

Anti-CCP has similar sensitivity, but higher specificity for RA than rheumatoid factor

Positive RF *and* anti-CCP have very high specificity for RA

RF can be positive in healthy people, in chronic infection, and in autoimmune diseases such as lupus and Sjögren's syndrome.

Requesting anti-CCP can clarify the significance of a positive RF, especially when it is only just raised.

CONTINUE ON NEXT PAGE

4. Check lab monitoring tests before re-prescribing DMARDs

Methotrexate, sulfasalazine, leflunomide, and cyclosporine must be monitored with regular lab tests

Some patients struggle to adhere to the testing regimen

Sign-off is usually primarily with the rheumatologist, but GPs can help prevent serious toxicity by requiring a blood test within the last month before writing a script

CONTINUE ON NEXT PAGE

5. Keep vaccinations up to date

Rheumatic diseases and certain immunosuppressive drugs are associated with increased risk of infection

Annual seasonal flu vaccine should be given to all RA patients

Consider vaccinations for Herpes zoster and pneumococcus

These can all be given to patients taking oral DMARDs

Live vaccines should not be given to patients using bDMARDs

CONTINUE ON NEXT PAGE

6. Monitor and manage cardiovascular risk

Patients with RA have an increased risk of CVD similar to diabetes

Excess mortality in RA is attributable to CVD, not infection or medication

Control of inflammation, especially with HCQ, MTX and bDMARDS reduces risk

Traditional risk factors should managed with rigour similar to diabetes

This is best managed collaboratively

CONTINUE ON NEXT PAGE

7. Be positive about MTX and don't blame everything on it

Methotrexate gets bad press from some lay people, pharmacists, GPs and specialists

This is based on misconceptions about the nature and effects of this drug

MTX is an important drug in RA, and use of it is associated with a better outcome by nearly any parameter that can be measured

6 facts about MTX that may surprise you

1. MTX is a not chemotherapy drug, it's practically a vitamin
2. MTX does not increase the risk of cancer
3. RA patients can get infection, even if they are not on MTX
4. MTX tablets can be handled by patients and caregivers
5. Most causes of dyspnoea in RA patients are not caused by MTX
6. MTX does not impair surgical recovery (and may improve outcome)

CONTINUE ON NEXT PAGE

8. Use corticosteroids for flares, but taper to zero

Corticosteroids are commonly used to treat exacerbations of inflammation, or as a bridge to remission in patients starting DMARDs

The current evidence does not support long-term low-dose corticosteroid treatment, except in the palliative setting

Avoid the temptation to titrate the steroids up and and down against the symptoms, especially when the symptoms may not be inflammatory in origin

Set definite reduction schedules and stick to them

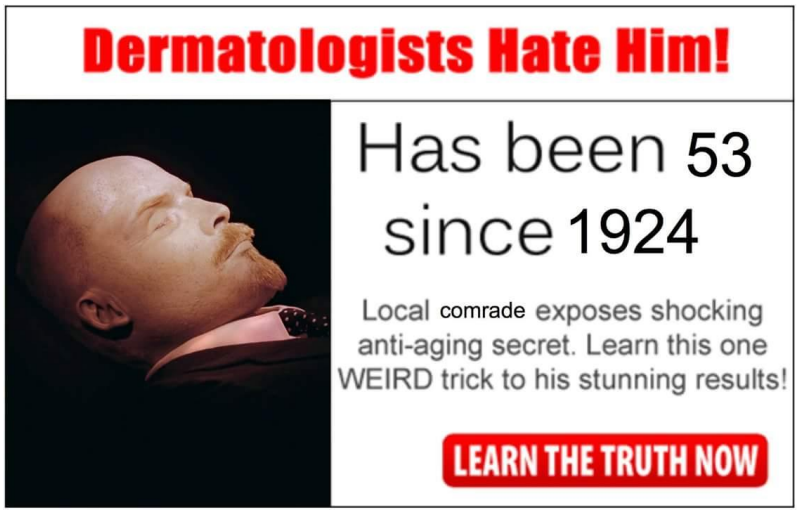
CONTINUE ON NEXT PAGE

9. Stay in touch with the rheumatology department

Successful management of RA patients depends on a collaboration between rheumatologists and primary care

Helpful to keep lines of communication bidirectional

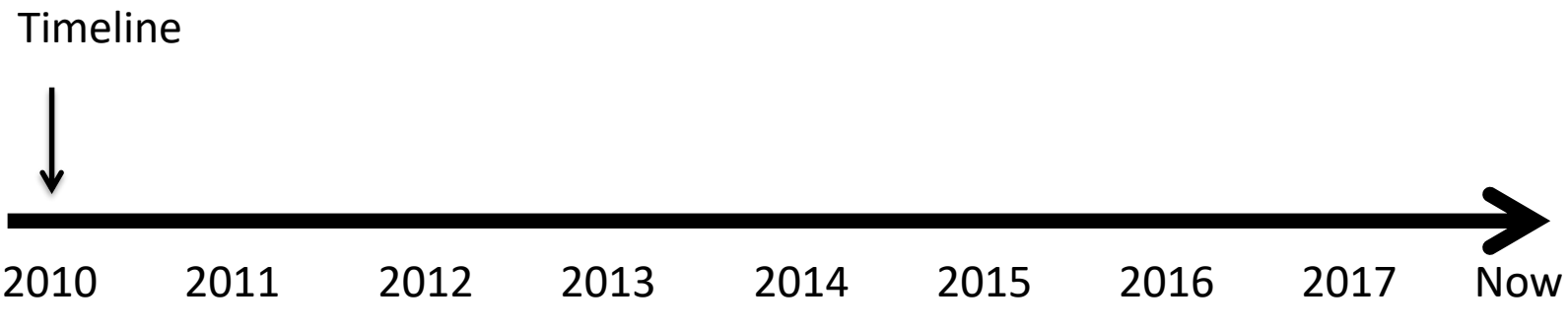
We are happy to provide advice by telephone, email, and via the EDI system



Case history - LH 38 F

- 1 month history synovitis wrists MCP and PIP joints hands and MTP joints feet
- RF 20, CRP 8

- What now?



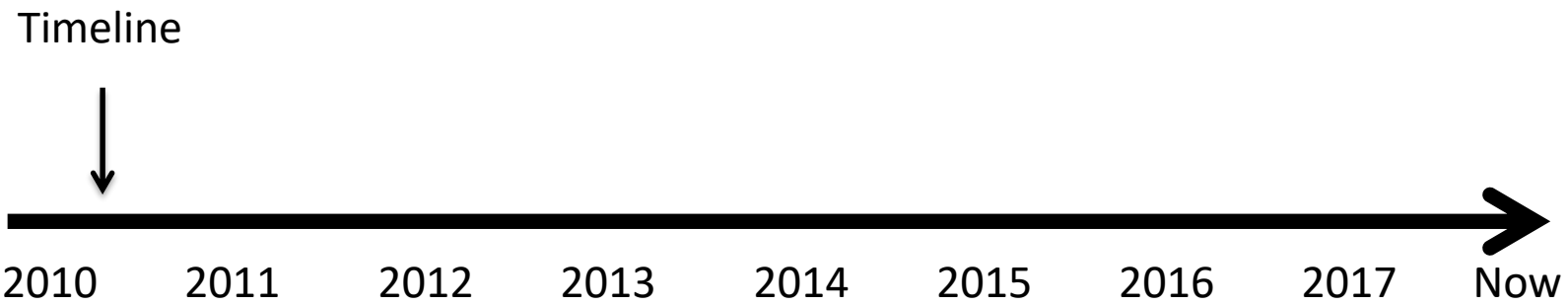
Case history - LH 38 F

- 1 month history synovitis wrists MCP and PIP joints hands and MTP joints feet
- RF 20, CRP 8

- What now?

- Anti-CCP>97, RF 22, CRP 4

- What now?



Case history - LH 38 F

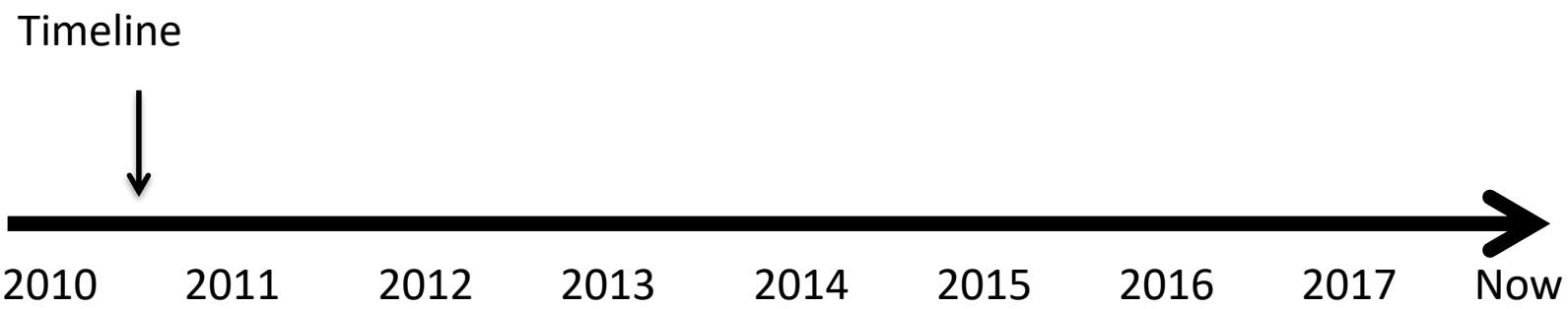
- 1 month history synovitis wrists MCP and PIP joints hands and MTP joints feet
- RF 20, CRP 8

- What now?

- Anti-CCP>97, RF 22, CRP 4

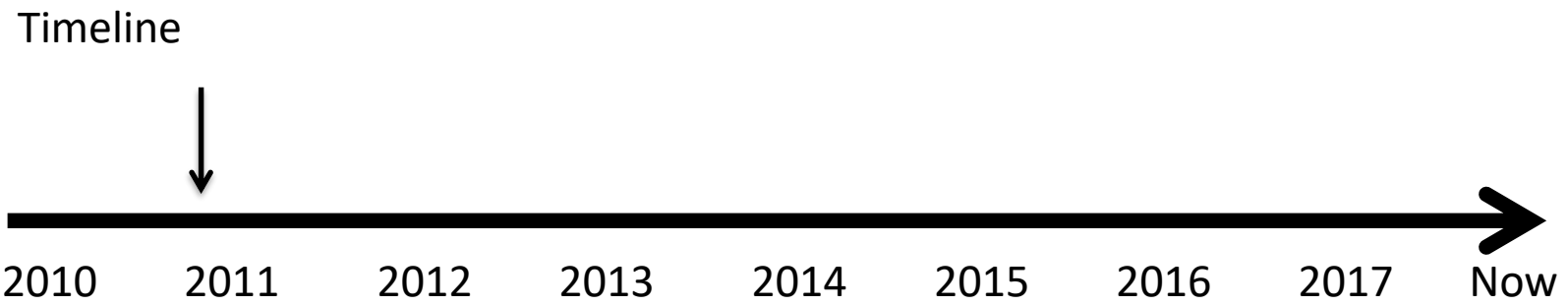
- What now?

- Prednisone 20 mg daily, reducing by 5 mg each week
- MTX 20 mg weekly, folic acid 5 mg weekly



Case history - LH 38 F

- Flare in symptoms when prednisone < 5 mg
- GP increased dose back to 20 mg
- SSZ added to treatment
- Slower taper of prednisone (↓ by 2.5 mg per week)

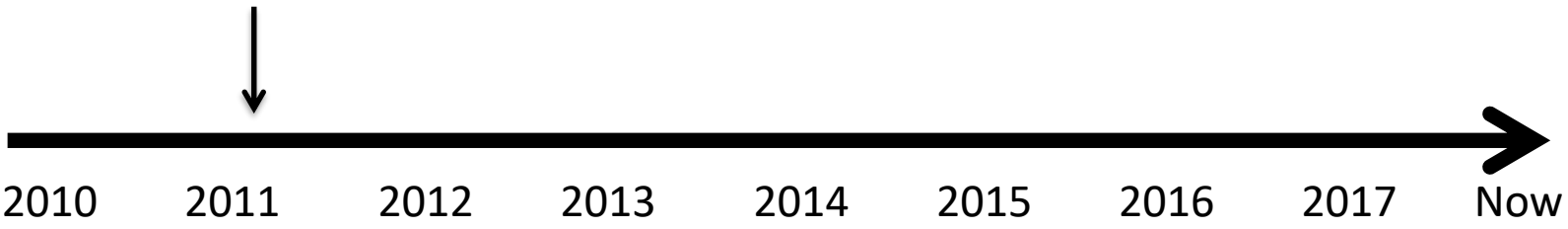


Case history - LH 39 F

- Flare in symptoms when prednisone < 5 mg
- GP increased dose back to 20 mg
- SSZ added to treatment
- Slower taper of prednisone (↓ by 2.5 mg per week)

- Continuing pain with synovitis MTP joints
- HCQ added
- Joints injected

Timeline



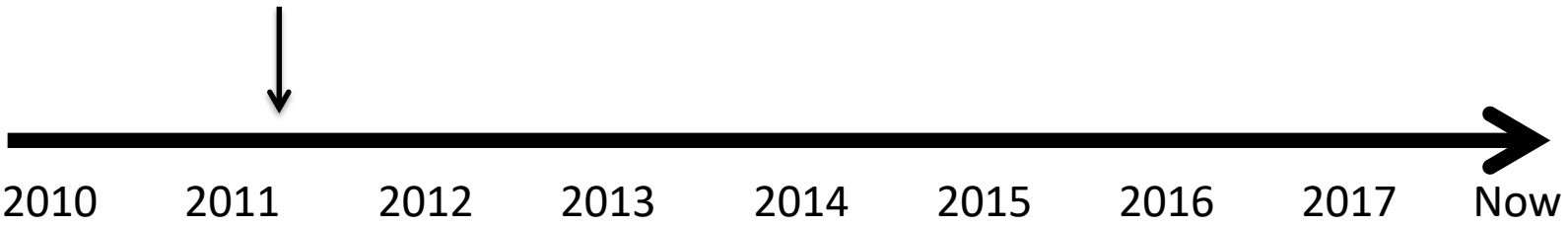
Case history - LH 39 F

- Flare in symptoms when prednisone < 5 mg
- GP increased dose back to 20 mg
- SSZ added to treatment
- Slower taper of prednisone (↓ by 2.5 mg per week)

- Continuing pain with synovitis MTP joints
- HCQ added
- Joints injected

- Partial response
- SSZ dose ↑ to 2.5 g daily

Timeline



Case history - LH 39 F

- Better, but grumbling symptoms and low-grade flares
- Leflunomide added

Timeline

Case history - LH 40 F

- Better, but grumbling symptoms and low-grade flares
- Leflunomide added

- LFTs mildly abnormal
- Episodic inflammatory joint symptoms

- What now?

Timeline

Case history - LH 40 F

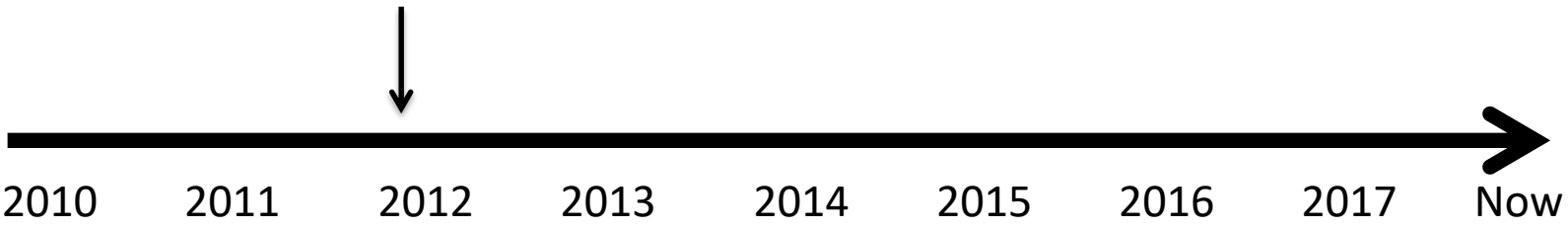
- Better, but grumbling symptoms and low-grade flares
- Leflunomide added

- LFTs mildly abnormal
- Episodic inflammatory joint symptoms

- What now?

- LEF stopped
- MTX PO → SC

Timeline



Case history - LH 41 F

- Continuing joint pain
- Severe nausea within 10 minutes of MTX injection
- X-rays – no erosions

- MTX dose ↓ to 15 mg weekly

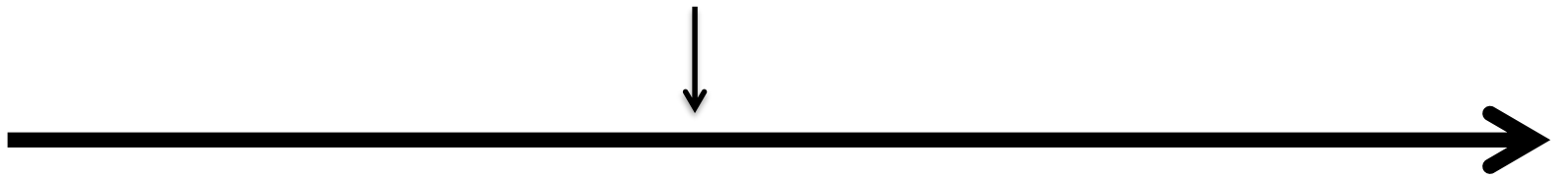
Timeline

Case history - LH 41 F

- Continuing joint pain
- Severe nausea within 10 minutes of MTX injection
- X-rays – no erosions

- MTX dose ↓ to 15 mg weekly
- Folic acid ↑ from 5 mg weekly to 5 mg daily 6 days per week
- Prednisone 5 mg daily

Timeline



Case history - LH 41 F

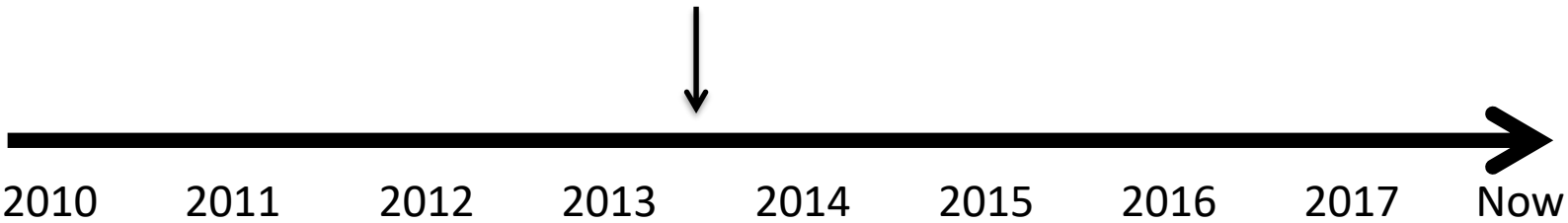
- Continuing joint pain
- Severe nausea within 10 minutes of MTX injection
- X-rays – no erosions

- MTX dose ↓ to 15 mg weekly
- Folic acid ↑ from 5 mg weekly to 5 mg daily 6 days per week
- Prednisone 5 mg daily

- Worsening joint inflammation, including L wrist, R shoulder, both ankles
- CRP < 3

- Options limited – what now?

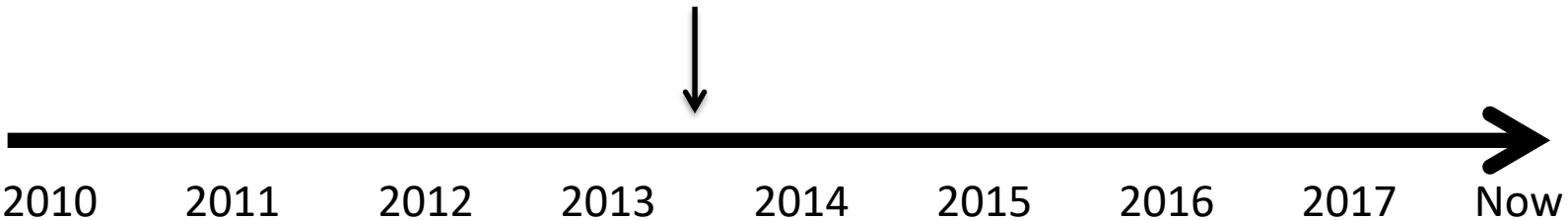
Timeline



Case history - LH 41 F

- Screened for latent TB and viral hepatitis
- Commenced adalimumab (Humira) 40 mg fortnightly subcut inj

Timeline

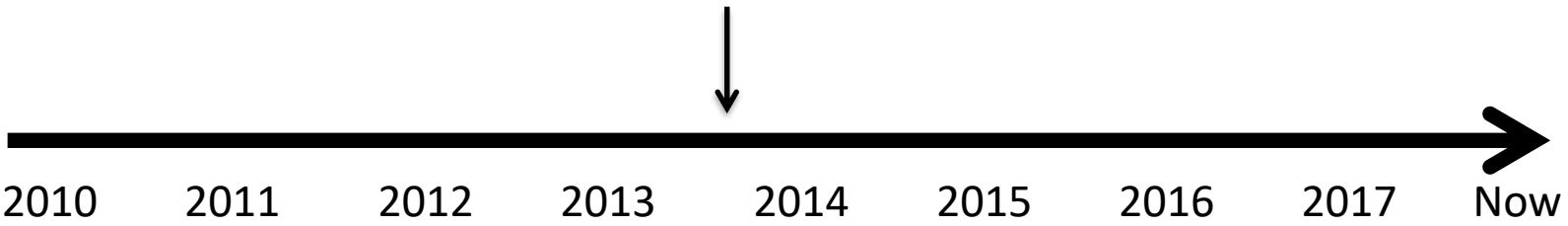


Case history - LH 41 F

- Screened for latent TB and viral hepatitis
- Commenced adalimumab (Humira) 40 mg fortnightly subcut inj

- Good response to Humira
- Prednisone tapered and discontinued
- No synovitis

Timeline



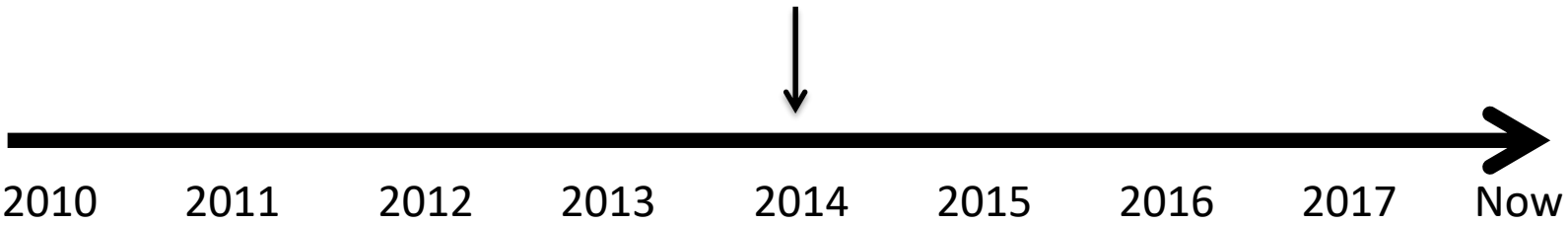
Case history - LH 42 F

- Screened for latent TB and viral hepatitis
- Commenced adalimumab (Humira) 40 mg fortnightly subcut inj

- Good response to Humira
- Prednisone tapered and discontinued
- No synovitis

- Medications fine-tuned to manage nausea – MTX 18.75 mg weekly

Timeline



Case history - LH 43 F

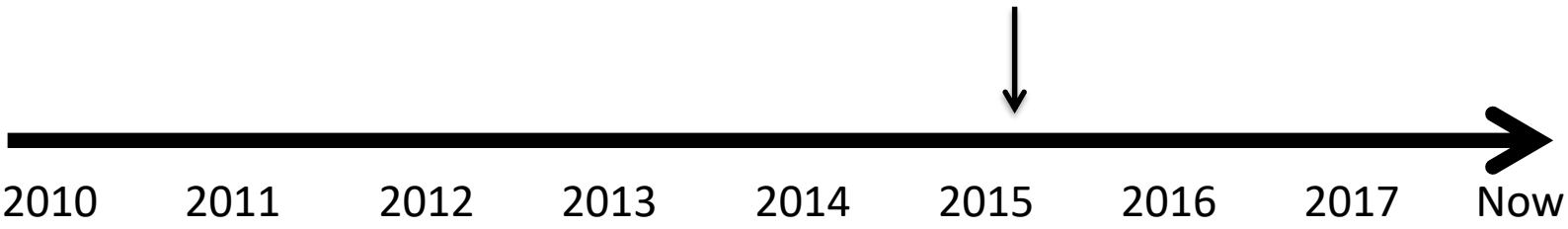
- Screened for latent TB and viral hepatitis
- Commenced adalimumab (Humira) 40 mg fortnightly subcut inj

- Good response to Humira
- Prednisone tapered and discontinued
- No synovitis

- Medications fine-tuned to manage nausea – MTX 18.75 mg weekly

- …then SC → PO and split 10 mg bd one day per week 😊

Timeline



Case history - LH 43 F

- Screened for latent TB and viral hepatitis
- Commenced adalimumab (Humira) 40 mg fortnightly subcut inj

- Good response to Humira
- Prednisone tapered and discontinued
- No synovitis

- Medications fine-tuned to manage nausea – MTX 18.75 mg weekly

- …then SC → PO and split 10 mg bd one day per week 😊

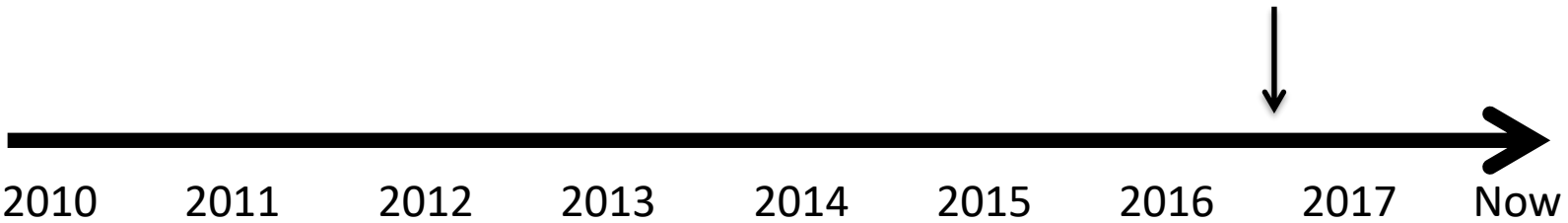
- RA in remission on ADA, MTX, SSZ, HCQ
- But nausea continues

Timeline

Case history - LH 45 F

- MTX reduced to 7.5 mg bd weekly

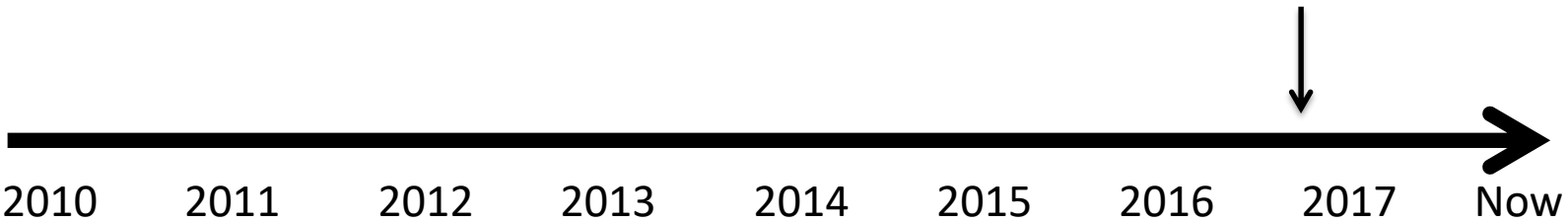
Timeline



Case history - LH 46 F

- MTX reduced to 7.5 mg bd weekly
- Ondansetron 4 mg prn daily

Timeline



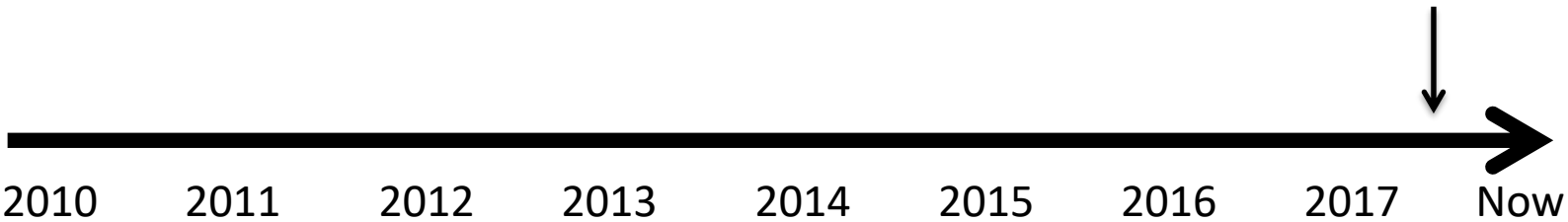
Case history - LH 47 F

- MTX reduced to 7.5 mg bd weekly
- Ondansetron 4 mg prn daily

- Minor flare managed with an increase in SSZ back to 2.5 g daily

- Currently well
- Remains in full time employment

Timeline



Rheumatologist stuns audience with brilliant presentation.

Leaves stage to rapturous applause and standing ovation

LEARN THE TRUTH NOW