Module 1: Disease and recognition of rheumatoid Arthritis (RA)

Key Facts:

- Rheumatoid arthritis is the most common autoimmune disease in Australia and the most common inflammatory condition (affects 2% of the Australian population)
- Demographics: greatest onset 25-50 yrs. of age; female to male ratio 2.5:1
- Rheumatoid arthritis is a chronic systemic progressive inflammatory disorder associated with substantial disability and increased mortality ***IF NOT TREATED EARLY***

Subjective features	Clinical findings
Fluctuating joint pain and joint tightness	Symmetrical joint involvement
Pain worse at night	Synovial joint swelling
Insidious onset of joint pain and swelling	Synovitis presenting as swelling, pain
>30 minutes morning joint stiffness	Bursitis
Stiffness after inactivity	Tenosynovitis
Feeling of heat in the joints	Heat, Redness
Symptoms of malaise and fatigue	Reduced AROM and PROM
Triggers: e.g. a major life stress event may trigger auto-immune responses	Synovial joint deformity* – postural, subluxation, dislocation
Declining functional ability	Joint instability*
	Joint degeneration* (may need MRI, CT to assess)

* Predominantly small joints in hands and feet plus or minus larger joints.

What should I do if I suspect a patient has RA?

- **RECOGNISE: Early recognition and on-referral is key** – best practice involves early management of symptoms and commencement of disease modifying anti-rheumatic drugs (DMARDs) or biologic DMARDs (bDMARDs) **within the first 12 weeks**. Delayed management increases risk of poor prognosis including, for example, death, cardiovascular disease, need for joint replacement and reduced capacity to work.
- REFER: Refer EARLY to a **rheumatologist** to optimise outcomes and prognosis.
- SCREEN: Use **Diagnostic Tools**(see below) to determine likelihood of an RA diagnosis – if in doubt, don't delay - refer to a medical practitioner.
- EXAMINE: Perform a comprehensive examination at the first appointment (see module 1 RAP-eL)
- COMMUNICATE: See an example referral letter to a medical practitioner: hyperlink here

Useful Assessment and Diagnostic tools:

Tool	Use of the Tool
Early Inflammatory Arthritis (IA) Detection Tool	This is a quick patient administered tool with Yes/No answers. The higher the score, the higher the index of suspicion that early IA is possible. If a high score immediate on-referral to the GP recommended. http://www.biomedcentral.com/1471-2474/11/50/figure/F4
European League Against Rheumatism (EULAR) Definition Criteria	Score ≥6/10 required for a definite classification of RA (Physiotherapists can complete parts A & B, parts C & D relate to blood testing/serology) http://rap-el.com.au/documents/RAP-eL-EULAR-guidelines.pdf
Joint Count	Current active joint count – useful for baseline disease activity, monitoring disease activity, communicating with medical practitioners. Can be used as part of CDAI, EULAR and DAS28 scoring http://rap-el.com.au/documents/RAP-eL-joint-count-form.pdf
Clinical disease activity index (CDAI)	Joint count plus disease activity scoring (one patient-scored VAS, one physician-scored VAS). Maximum score = 76. Max 28 for joint swelling, 28 for joint tenderness, 10 for VAS patient and 10 for VAS physician. http://rap-el.com.au/documents/RAP-eL-EULAR-guidelines.pdf
DAS 28	The most commonly used RA assessment tool in Australia. Combines joint count, ESR/CRP levels and VAS disease activity. Used to monitor improvement over time. Improvement >1.2 = good response, improvement <0.6 = no response. http://rap-el.com.au/documents/RAP-eL-disease-activity-score-in-28-joints.pdf