Practice summary sheet

RAP-eL

Module 3: The chronic stage of rheumatoid arthritis (RA) (> 2 years post diagnosis)

Key concepts of management:

- *'Therapeutic windows'* create opportunities for physiotherapy treatment
- *Periodic flares* in symptoms are to be expected
- *Pregnancy* – some women experience remission; up to 20% experience worsening symptoms. Also increased risk of pre-eclampsia, Caesarean section and premature or low birth weight neonates. Conception, pregnancy and breast feeding have implications for drug therapy regimens (see the ARA website). Women with RA who are pregnant or caring for an infant may need strategies for continuing activities of daily living.

Safety issues NOT to miss… (including red flags)

Joint instability (see Cervical Spine Instability below)	Recognising **upper cervical spine** instability is critical – instability can lead to sudden, unexpected death or quadriplegia. The most frequent instability in the cervical spine is atlanto-axial subluxation (**AAS**) occurring in up to 50% of cases NOTE –AAS can be asymptomatic so clinical vigilance is critical: manual examination and treatment techniques are contraindicated in this case **Look for**: clunking or clanking on neck movements; paraesthesia of the lips and tongue, global restriction of range (which may alternate with increased ROM), cord signs, vertebrobasilar signs, facial sensory alterations, dysphagia **IMMEDIATELY** on-refer to the GP or rheumatologist if you suspect AAS
Vasculitis driven dysfunction in other body systems	**IMMEDIATELY** on-refer to GP or rheumatologist if changes in **visual**, **neurological**, and **cardiopulmonary** conditions
Treatment-mediated conditions	**Osteoporosis** secondary to treatment must be considered in your management plan and treatment selection: this is a safety issue
Disease flares	Symptoms include pain, inflammation, fatigue, malaise and impaired function. Flares require: **Responsive** and **timely physiotherapy** to ameliorate acute symptoms **Communication** with other care team members including updating interdisciplinary team care plans during/following a disease flare

Cervical spine instability

- If you suspect RA, or know it is RA, **specific screening** is required prior to any manual assessment or management
- If suspected AAS **NO** manual treatment of the cervical spine until the patient is reviewed by a medical professional and the status of upper cervical stability established
- Cervical Spine Instability can be viewed on plain film radiographs of the cervical spine (flexion/extension views). The anterior atlanto-dens interval (AADI) is abnormally increased on flexion and is reduced with cervical extension
- For more detailed information see Slater et al (2013)

What happens in chronic RA?

- Systemic inflammation – causes destruction of bone, cartilage, synovial and connective tissues. This leads to joint deformities and impaired joint function.

- Joint subluxations/dislocations, muscle wasting, pain, tendon ruptures/imbalances may be evident and patients may report pain.

The role of the physiotherapist

- *Monitoring* – see (Anderson et al, 2012). In addition to self-reports of the patient's progress and functional capacity other tools include:

  Clinical Disease Activity Index 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.

  Disease Activity Score 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.

  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

  Simplified Disease Activity Index
  Combines a current active joint count, disease activity scoring (one patient score/10 and one practitioner score/10) and CRP levels. Score indicates whether a patient is in remission (0.0-3.3), low activity (3.4-11.0), moderate activity (11.1 – 26.0) or high activity (26.1-86.0)

- *Managing* – aim to improve symptoms and function using physiotherapy approaches e.g. exercise, stabilisation, manual therapy and 'therapeutic windows'. Encourage compliance with medication regimens and monitoring schedules e.g. blood tests

- *Encouraging* use of joints, maintaining function, physical activity, strength and fitness. **Monitor cardiovascular response to exercise* see Module 4 for more information*

- *Team working* – including working with the patient, family, other health professionals and seeking help from their treating rheumatologist if side effects become apparent

- *Promoting self-management:* see the self management support website from the Department of Health WA for more information

- Psychosocial support, and on-refer where appropriate