EARLY INFLAMMATORY ARTHRITIS IN CROYDON

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WHAT IS EARLY INFLAMMATORY ARTHRITIS?

• EARLY RHEUMATOID ARTHRITIS
• BUT PRACTICALLY INCLUDES
  • UNDIFFERENTIATED INFLAMMATORY ARTHRITIS
  • PSORIATIC ARTHRITIS
  • SERONEGATIVE SPONDYLOARTHRITIDES WITH PERIPHERAL JOINT INVOLVEMENT
  • CRYSTAL ARTHRITIDES- GOUT, CPPD
  • CONNECTIVE TISSUE DISEASE WITH PERIPHERAL JOINT INVOLVEMENT
WHAT WE DON’T WANT TO SEE IN EIA CLINICS.

• ANYONE WITH SYMPTOMS FOR LONGER THAN A YEAR
  • ( <6 MONTHS IS BETTER, <3 MONTHS IS IDEAL)

• BACK PAIN

• ONE SWOLLEN JOINT

• NO SWOLLEN JOINTS

• OBVIOUS FIBROMYALGIA
WHY BLOOD TESTS ARE USEFUL

• FBC, U AND E, LFT
  • WHICH DMARDS CAN WE START STRAIGHT AWAY

• ESR AND CRP
  • IF THESE ARE ABNORMAL- CAN HELP WITH PROGNOSIS AND DISEASE STRATIFICATION

• RF, ANA ANTI- CCP
  • HELP DIAGNOSIS
  • MORE IMPORTANTLY CAN HELP GIVE THE PATIENT AN IDEA OF PROGNOSIS WHEN WE SEE THEM
  • RF + AND CCP+ - MORE likely TO ERODE, AND HISTORICALLY MORE likely TO BECOME DISABLED
WHY ARE X-RAYS USEFUL?

• CXR
  • CAN WE START METHOTREXATE THE SAME DAY

• HAND AND FEET XRAY
  • CAN BE PROGNOSTIC
  • IF ALREADY EROSIIVE- WE NEED TO BE MORE AGGRESSIVE
  • IF EROSIONS ARE PRESENT- GOUTY AND RA EROSIONS LOOK DIFFERENT
**THE FORM**

**Email** – ch-tr.specialistmedicine1@nhs.net

**Telephone number**: 0208 401 3973

Do not delay referral for blood test or x-ray results.

NICE standards are for referral within 3 days of primary care visit.

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<table>
<thead>
<tr>
<th>Date of Symptom Onset (must be less than 1 year)</th>
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<tbody>
<tr>
<td><strong>Patient Details</strong></td>
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<tr>
<td>Name:</td>
</tr>
<tr>
<td>NHS number:</td>
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<tr>
<td>DOB:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Postcode:</td>
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<tr>
<td>Contact number:</td>
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<tr>
<td><strong>GP Details</strong></td>
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<tr>
<td>Name:</td>
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<tr>
<td>Practice:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Contact &amp; Fax no:</td>
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<tr>
<th><strong>Both required</strong></th>
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<tr>
<td>1. Persistent joint inflammation</td>
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<td>2. 6 weeks and &lt; 1 year in 2 or more joints</td>
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<td>Tenderness over the joint line</td>
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<td>Joint swelling</td>
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<td>Painful limited RoM</td>
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<th><strong>At least one required</strong></th>
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<tr>
<td>3. MCP and / or MTP positive squeeze test</td>
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<td>4. Positive RF (or Anti-CCP)</td>
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<td>5. Raised inflammatory markers (ESR or CRP)</td>
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**Clinical History** – please attach either a letter detailing your recent symptoms or describe briefly below, and attach a printout of current medications and previous medical history.

ESR  CRP  RF  CCP
van den Bosch WB, Mangnus L, Reijnierse M, et al
The diagnostic accuracy of the squeeze test to identify arthritis: a cross-sectional cohort study
THE TWO HANDED SWELLING TEST

Figure W-11. Palpating IP joints

http://bjdonline.org/the-wrist-hand/
CROYDON EARLY INFLAMMATORY ARTHRITIS SERVICE

WHAT DO WE SEE?
## EIA PATIENTS 2014-2015

### Table 1: Clinical features

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<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Female</td>
<td>72.7%</td>
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<tr>
<td></td>
<td>Male</td>
<td>27.3%</td>
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<tr>
<td><strong>Inflammatory markers</strong></td>
<td>CCP+</td>
<td>23.0%</td>
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<tr>
<td></td>
<td>RF+</td>
<td>32.9%</td>
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<tr>
<td></td>
<td>CCP+ &amp; RF+</td>
<td>21.7%</td>
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<tr>
<td><strong>Bloods</strong></td>
<td>ESR(_{\text{mean}})</td>
<td>17.3 ± 18.7 (range 2 - 118)</td>
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<tr>
<td></td>
<td>CRP(_{\text{mean}})</td>
<td>13.7 ± 21.5 (range 1 - 98)</td>
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THE EIA DIAGNOSES IN CROYDON

Figure 1: Diagnoses

- Rheumatoid Arthritis
- Psoriatic Arthritis
- Undifferentiated Inflammatory Arthritis
WE USE COMBINATION AND MONOTHERAPY.

Figure 2: DMARD Regime

- Monotherapy
- Combo Therapy
- No DMARDs
WE BENCHMARK TO BEST PRACTICE

- CAMBRIDGE BEST PRACTICE AWARD WINNER 2013
- 6 MONTHS REMISSION 38%
- CROYDON 2014-2015
- 6 MONTHS REMISSION 36%
- 1 YEAR 30.3%
WE HAVE EIA ULTRASOUND

- FOR DIAGNOSTIC DILEMMAS- SUBCLINICAL SYNOVITIS
- TO CHANGE A DIAGNOSIS FROM UIA TO RA
- PICK UP DIFFERENTIAL DIAGNOSES
- SERONEGATIVE RA HAS BEEN SHOWN TO HAVE WORSE ULTRASOUND SYNOVITIS THAN SERO-POSITIVE PATIENTS
- ENGAGES PATIENTS IN THEIR DIAGNOSIS AND NEED FOR TREATMENT
NORMAL HANDS
An email, a week later…
ARTHRALGIA WITH SWOLLEN PIPS
EARLY INFLAMMATORY ARTHRITIS
MCP SQUEEZE AND MTP SQUEEZE POSITIVE
GOUT

- Synovial hypertrophy
- Cartilage
- Double contour sign
ADVANCED RHEUMATOID ARTHRITIS
WHAT IF IT ISN’T EIA?
Figure 1. Comparison of EIA patients referred that actually did not have EIA

- EIA: 228
- Not EIA: 140
Figure 2. The final diagnosis of those who did not have EIA

- Polymyalgia rheumatica: 4
- SLE: 5
- Fibromyalgia/Hypermobility: 7
- Gout: 7
- Soft tissue abnormality: 11
- No Rheumatological Diagnosis: 16
- Osteoarthritis: 29
Figure 4. The majority of patients were not discharged within 6 weeks

- Discharges within 6 weeks
- Not discharged within 6 weeks
Welcome to the National Early Inflammatory Arthritis Audit (NEIAA) website

The National Early Inflammatory Arthritis Audit will collect information on all new patients over the age of 16 years seen in specialist rheumatology departments with suspected inflammatory arthritis in England and Wales. Information will be gathered over the first 12 months of specialist care for all patients with rheumatoid pattern inflammatory arthritis (including psoriatic arthritis of the rheumatoid type) and from the first appointment for all patients with suspected inflammatory arthritis and/or axial spondyloarthropathy. The aim is to improve the quality of care for people living with inflammatory arthritis by assessing the performance of rheumatology units across England and Wales against NICE Quality Standards. There is compelling evidence that early intensive treatment greatly improves the outcome of these disabling diseases, which predominantly affect people of working age.

GP- to refer within 3 days of initial presentation
Inflammatory arthritis represents a group of diseases which includes rheumatoid arthritis, peripheral & axial spondyloarthritis and psoriatic arthritis. These diseases are characterised by dysfunction of the immune system, and inflammation within joints, tendons or ligaments.

There is a need to improve the healthcare of people with inflammatory arthritis, particularly reducing delays in recognition and referral. We know that delays in diagnosis can causes patients more symptoms, results in disease which is more difficult to treat, and increases the risk of disability and inability to work.

This toolkit aims to be a user-friendly guide to inflammatory arthritis for primary care professionals, people affected by arthritis and clinical commissioning groups.

CONTRIBUTORS

Antony Pulikal,
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Questions?