

Naval Medical Center Portsmouth Referral Guidelines

Inflammatory Arthritis

Diagnosis/Definition

Joint pain is a very common finding in the primary care clinic. Arthralgia is joint pain without evidence of inflammation. Inflammatory arthritis is joint pain suggested by inflammation (swelling, warmth, erythema and tenderness). When inflammatory arthritis is seen this should prompt the treating physician to initiate a thorough evaluation to identify the etiology. The inflammatory arthropathies encompass a very broad differential of diseases, including diffuse connective tissue diseases (CTDs), seronegative spondyloarthritis, crystal induced arthritis, metabolic conditions, and arthritis associated with infectious agents. Inflammatory arthritis symptoms generally are present for greater than 6 weeks.

Initial Diagnosis and Management

- A thorough history and physical are the cornerstone to the evaluation of rheumatic complaints and should specifically address:
 - Number and distribution of joints involved, small or large joints, symmetric or asymmetric, systemic symptoms, recent infections, trauma, medications, chronological history of symptoms, family history of CTDs and a complete review of systems looking for other associated conditions.
- A full general physical exam is essential with attention to the skin, scalp, nails and mucosal surfaces. The presence of subcutaneous nodules, rashes, telangiectasia, tophi, ulcers, psoriasis, emboli, vasculitic changes and onycholysis often suggest a rheumatic process. Pulmonary findings can accompany systemic lupus erythematosus (SLE), rheumatoid arthritis (RA) and systemic sclerosis.
 - A thorough physical exam includes: examination of all joints (not just the symptomatic ones) for signs of inflammation, assessment of range of motion, deformity, function, pain on motion (passive and active) and presence of effusion or synovial thickening. Pain due to inflammatory arthritis is generally localized to the joint space, or sometimes the periarticular structures.
- Lab evaluation is helpful, but rarely definitive in evaluating rheumatic complaints. There is no such thing as a rheumatology panel.
 - Acute phase reactants (ESR, CRP) are commonly elevated in inflammatory arthropathies and CTDs, but are neither sensitive nor specific and can be elevated in patients with any chronic disease (to include infections) as well as in patients who are obese. They can also be elevated due to age. They are not elevated only in rheumatic diseases.
 - Specific immunological tests are best used to confirm a condition when there is clinical suspicion and should not be ordered when there is a low clinical suspicion for rheumatologic disease. RF, ANA and HLA B27 can be found in the normal population and when positive do not always represent disease. ANA and extractable nuclear antigens are useful to further evaluate when there is suspicion for SLE, RF/CCP are helpful to further evaluate suspected RA.
 - Normal serum uric acid levels do not exclude gout nor do high levels confirm it.

- Routine testing of CBC, renal function, LFTs, and urinalysis can help evaluate for systemic disease as well as common viral etiologies such as HIV, HBV and HCV.
- Plain radiographs of the affected joint are rarely helpful in the early evaluation of inflammatory disease but can be helpful when symptoms have been ongoing for greater than 6 weeks.

Ongoing Management and Objectives

- NSAIDs are the treatment of choice for inflammatory arthritis symptoms while the evaluation is in progress in patients without contraindications. Many causes of arthritis are self-limited and frequently subside within weeks to 1 month with symptomatic therapy.
- In acute monoarthritis, infection or crystal induced disease are the likely causes and arthrocentesis is required to differentiate.
- A symmetric small joint polyarthropathy which is progressive, lasting for longer than 6 weeks and accompanied by prolonged morning stiffness, suggests RA. Generally these patients benefit from aggressive disease modifying therapy and should be referred early to a Rheumatologist if the diagnosis is strongly suspected.

Indications for Specialty Care Referral

- Patients found to have a chronic CTD such as SLE or RA should be referred to the Rheumatology Clinic for further evaluation. Many patients will be managed jointly by the primary care physician and Rheumatology specialist.
- Other patients who are not improving with symptomatic therapy should be referred, especially when the etiology of the condition is not clear.

Last Review for this Guideline: **August 2016**

Referral Guidelines require review every three years.

Maintained by the Naval Medical Center Portsmouth - Quality Services Division
Clinical Practice and Referral Guidelines Administrator