

Madigan Army Medical Center

Referral Guidelines

Inflammatory Arthritis

Diagnosis/Definition

The inflammatory arthropathies encompass a very broad differential of diseases, including diffuse connective tissue diseases (CTDs), spondyloarthropathies, metabolic conditions, and arthritis associated with infectious agents. The hallmarks of inflammation (swelling, warmth, erythema and tenderness) should initiate a thorough evaluation in the patient with joint pain.

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 for 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 searching for 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. Physical exam should examine all joints (not just the symptomatic ones) for the signs of inflammation; assess range of motion, deformity, function, pain on motion (passive and active), and presence of effusion or synovial thickening. Pain should be localized to the joint space, or periarticular structures if possible.
- Lab evaluation is helpful, but rarely definitive in evaluating rheumatic complaints. Acute phase reactants (ESR, CRP) are commonly elevated in CTDs, but are neither sensitive nor specific. Specific immunological tests are best used to confirm a condition when there is clinical suspicion: ANA and extractable nuclear antigens for SLE, RF/CCP in RA. Normal serum uric acid levels do not exclude gout nor do high levels confirm it. Routine testing of CBC, renal function, LFTs, UA can help evaluate for systemic disease.
- Plain radiographs of the affected joint are rarely helpful in the early evaluation of inflammatory disease.

Ongoing Management and Objectives

- NSAIDs for symptoms while the evaluation is in progress. Many causes are self-limited and frequently subside within a week to 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 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 primary care and specialist.
- Other patients who are not improving with symptomatic therapy should be referred, especially when the etiology of the condition is not clear.

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Referral Guidelines require review every three years.

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