Clinical Pearls: Rheumatology

Rheumatology I

- Rheumatoid arthritis and osteoarthritis are the most prevalent polyarticular joint diseases that present to internal medicine physicians, and distinguishing between them is important, as rheumatoid arthritis has many immune-based treatment options.
- Diagnosis of rheumatoid arthritis depends, in large part, on the history of persistent pain and swelling in the small joints of the hands and wrists and physical examination findings of pain and swelling in those joints.
    - The hand joint exam can be helpful in distinguishing: RA involves the wrists and MCPs, whereas OA involves the 1st CMC and DIPs.
    - Laboratory tests for rheumatoid factor and anti-CCP antibody can be helpful, but radiographs are often normal at the time of diagnosis.
- The management of acute gout is different from, but should not interrupt, the management of chronic gout. Treatment of acute and chronic gout depends on number of joints involved and comorbid conditions.
    - NSAIDs, colchicine, and oral or intra-articular steroids may be used to treat an acute gout attack but urate lowering medications, such as allopurinol, should not be stopped when an acute gout attack occurs.
    - Monoarticular gout involvement ideally is treated with corticosteroid injections; gout patients with significant renal insufficiency should avoid NSAIDs.
- Septic arthritis can mimic crystal arthritis and also occurs in immunosuppressed patients and in patients with prosthetic joints. Joint aspiration with gram stain/culture is key in scenarios where there other reasons for inflammatory joint pain.

Rheumatology II

- It is increasingly recognized that disordered pain perception and CNS processing with resultant central sensitization is the mechanism for widespread pain in fibromyalgia. Central pain (fibromyalgia) has an evidence-based approach to treatment. While fibromyalgia is not an autoimmune disease, it can be seen at increased frequency in patients with rheumatoid arthritis, lupus and psoriatic arthritis.
    - Pain management in such patients should include appropriate nonpharmacologic interventions in addition to appropriate immunosuppressive medications.
    - First line therapy involves validation, CBT, and a supervised aerobic exercise program. Subsequently, medications (such as NSRIs and alpha-2-calcium channel delta ligands) can be offered.
- Hydroxychloroquine is a critically important baseline management of systemic lupus erythematosus. It prevents disease mortality, disease flares, and manages mucocutaneous, arthritic, and vascular symptoms/morbidities.
- When vasculitis is being considered as an etiology for multiorgan dysfunction, appraisal for large/medium/small vessel involvement is appropriate, as they present very differently.
    - If small vessel organ involvement is present, distinguishing between immune-complex vs pauci-immune involvement will guide treatment.
- The presentation of lupus is variable and virtually never includes all of the so-called “Classification Criteria”.
    - In assessing the patient, it is important to consider the symptoms, examination findings and laboratory test results that the patient has and whether or not they go for or against the diagnosis of lupus, rather than starting with the “Classification Criteria” list and seeing if the patient “checks the boxes”.