APPENDIX VII:

ADULT HOSPITAL LEVEL STANDARD TREATMENT GUIDELINES FOR RHEUMATOID ARTHRITIS, 2012 EDITION

GENERAL MEASURES
Manage by co-ordinated multidisciplinary care.
The primary objective is to improve and maintain functional status.
Early use of non-drug measures, especially nursing, physiotherapy and occupational therapy, is essential.
Acute flare-ups: rest affected joints and consider the use of day and/or night splints

MEDICINE TREATMENT
All patients with suspected RA should be seen at an early stage by a specialist. Evaluate all patients with suspected RA for disease-modifying anti-rheumatic drug (DMARD):
- Methotrexate, (preferred initial therapy)
- Chloroquine sulphate
- Sulfasalazine

Use DMARDs only with regular monitoring for toxicity, particularly retinal toxicity caused by chloroquine and adverse effects of methotrexate i.e. bone marrow, liver toxicity, etc.

Assess response by monitoring the number of swollen and tender joints, restricted to 28 joints (shoulders, elbows, wrists, 5 metacarpophalangeal joints, 5 proximal interphalangeal joints and knees bilaterally) together with ESR or CRP.
Titrate the dose of sulfasalazine and methotrexate gradually to maintenance dose.

- Methotrexate, oral, 7.5 mg once per week. Specialist consultation.
  - Increase dose gradually to a maximum of 25 mg per week.
  - Monitor: Liver function and FBC before and 12 weekly during treatment.

PLUS
- Folic acid, oral, 5 mg per week with methotrexate at least 24 hours after the methotrexate dose.

AND/OR
- Chloroquine sulphate, oral, 150 mg (as base) daily for 5 days of each week for 2–3 months.
  - Then reduce dose if possible and administer 5 days a week with an annual drug holiday for 1 month.
  - Do ophthalmic examination annually to monitor for ocular damage.

AND/OR
- Sulfasalazine, oral, 500 mg 12 hourly.
o Gradually increase over one month from 500 mg to 1 g 12 hourly.
o Liver function and FBCs monthly for first 3 months then every 3–6 months.

**Oral corticosteroids**
Indications:
» As bridging therapy while waiting for DMARDs to take effect.
» The elderly if threatened by functional dependence and intolerant to NSAIDs.
» Extra-articular manifestations, e.g. pleural effusion, scleritis.

- Prednisone, oral, 40 mg daily for 2 weeks.
o Theafter gradually reduce the dose to £ 7.5 mg daily.
o The continued need for systemic steroids should always prompt review of treatment.

Patients requiring corticosteroids for longer than 3 months should be educated to take in enough calcium in their diet.

For pain:
- Paracetamol, oral, 1 g 4–6 hourly when required to a maximum of 4 doses per 24 hours.

**NSAIDs**
Use for active inflammation with pain. NSAIDs are used for symptomatic control only, as they have no long-term disease modifying effects.
NSAID dose should be reduced and then stopped once the DMARDs have taken effect.
Reduce NSAID doses in the elderly.
NSAIDs are relatively contra-indicated in patients with significantly impaired renal function, i.e. eGFR < 60 mL/minute.

Concomitant use of more than one oral NSAID has no additional clinical benefit and only increases toxicity.

NSAID, e.g.:
- Ibuprofen, oral, 800 mg 8 hourly with meals.
o If not tolerated: 400 mg 8 hourly.

An extra **nighttime** dose of a NSAID may be added in some patients with severe nocturnal pain/morning stiffness.

**Note:**
When an additional nighttime dose is added to the patient’s regimen, the risk of NSAID induced toxicity increases. A reduction in the daytime dose of NSAIDs is recommended as the nighttime dose will often exceed the recommended total daily NSAID dose.
If a reduction in daytime dose cannot occur then the use of the nighttime dose must be for the shortest period possible.

In high-risk patients: i.e. patients > 65 years and those with a history of peptic ulcer disease:
- Omeprazole, oral, 20 mg daily whilst on an NSAID.
Adjunct for pain control:
· Amitriptyline, oral, 10–25 mg at night.
  o Titrate dose according to response.
  o Initial dose in the elderly: 10 mg at night.
  o Maximum dose: 75 mg at night.
  o Use with caution in patients with angle closure glaucoma, prostatic hypertrophy and the elderly.

**Intra-articular corticosteroids**
Consider only in cases where a few joints are very actively inflamed.
To be prescribed and administered by a specialist only.
Not more than 2–3 injections per year per joint are recommended.
Intra-articular corticosteroid, e.g.:
· Methylprednisolone acetate, 20–80 mg depending on joint size.

**REFERRAL**
» For joint replacement.

**Urgent**
» Rupture of extensor tendons.
» Scleritis.
» Unstable upper cervical spine.