

The past 20 years have witnessed a remarkable improvement in the outcomes of RA. The crippling arthritis of years past is encountered much less frequently today. Much of this progress can be traced to the expanded therapeutic armamentarium and the adoption of early treatment intervention. The shift in treatment strategy dictates a new mindset for primary care practitioners—namely, one that demands early referral of patients with inflammatory arthritis to a rheumatologist for prompt diagnosis and initiation of therapy. Only then will patients achieve their best outcomes.

CLINICAL FEATURES

The incidence of RA increases between 25 and 55 years of age, after which it plateaus until the age of 75 and then decreases. The presenting symptoms of RA typically result from inflammation of the joints, tendons, and bursae. Patients often complain of early morning joint stiffness lasting >1 hour that eases with physical activity. The earliest involved joints are typically the small joints of the hands and feet. The initial pattern of joint involvement may be monoarticular, oligoarticular (≤ 4 joints), or polyarticular (>5 joints), usually in a symmetric distribution. Some patients with inflammatory arthritis will present with too few affected joints to be classified as having RA—so-called undifferentiated inflammatory arthritis. Those with an undifferentiated arthritis who are most likely to be diagnosed later with RA have a higher number of tender and swollen joints, test positive for serum rheumatoid factor (RF) or ACPA, and have higher scores for physical disability.

Once the disease process of RA is established, the wrists and metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints stand out as the most frequently involved joints (**Fig. 358-1**). Distal interphalangeal (DIP) joint involvement may occur in RA, but it usually is a manifestation of coexistent osteoarthritis. Flexor tendon tenosynovitis is a frequent hallmark of RA and leads to decreased range of motion, reduced grip strength, and “trigger” fingers. Flexor tendon involvement may also lead to tendon rupture, with the flexor pollicis longus the most common flexor tendon to be affected by RA.