Seronegative Arthritis

Dr Mary Gayed

25th April 2018

Overview

- Description of the conditions
- Discussion of symptoms & investigations that may be required
- Discussion of management and treatment
- Questions
- Please ask if anything is unclear

Rheumatologist

CNS

OT

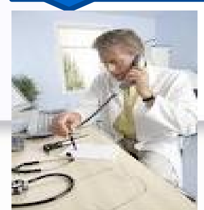
Orthotics

MDT

Physiotherapists

Podiatrists

GP



Rheumatology

Seronegative Arthritis

- Inflammatory arthritis spine and/or joints without the presence of rheumatoid factor or CCP antibodies

- Approximately 3/10 cases RA are seronegative

Psoriatic

AS

Reactive

Sero-negative arthritis

Enteropathic

RA

Inflammatory Vs Mechanical Pain

	Inflammatory Eg RA	Mechanical Eg OA
Early Morning Stiffness	Prolonged	Brief
Peak Period Discomfort	After Prolonged Inactivity	After Prolonged Activity
Warmth	+	+/-
Effusions	+	+/-
Coarse Crepitus	-	+++

2011 Public Awareness Scheme

Have you got... The S Factor?

Stiffness
Early morning joint stiffness lasting over 30 minutes

Swelling
Persistent swelling of one joint or more, especially hand joints

Squeezing
Squeezing the joints is painful in inflammatory arthritis

This could be inflammatory arthritis
See your doctor now! Delay can cause long term disability

For further information, please contact:

nras
National Rheumatoid Arthritis Society

The National Rheumatoid Arthritis Society
Unit B4 Westacott Business Centre
Westacott Way, Littlewick Green
Maidenhead, SL6 3RT

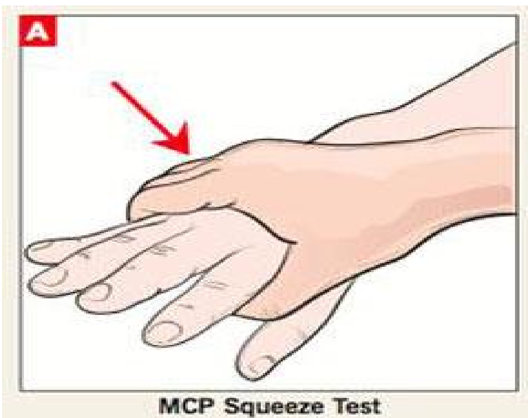
Phone: 0845 458 3969
Free Helpline: 0800 298 7650
Email: enquiries@nras.org.uk
Web: www.nras.org.uk

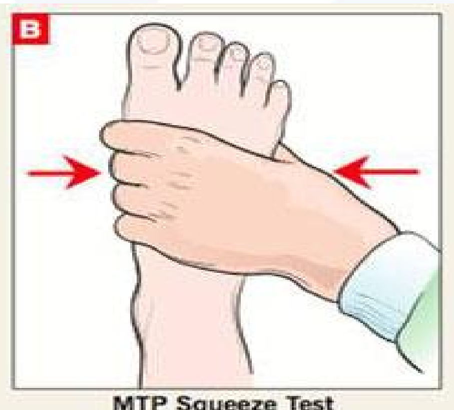
Endorsed by
PCR Primary Care Rheumatology Society
RCGP Royal College of General Practitioners

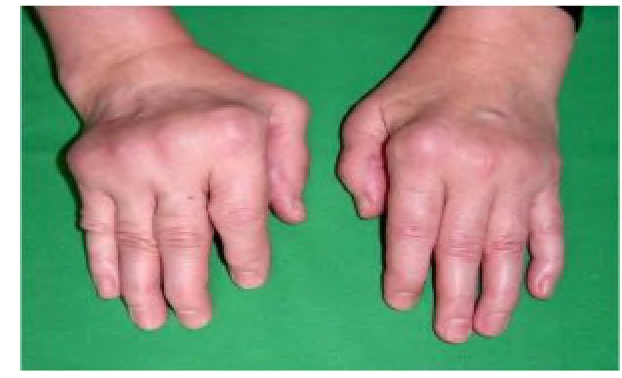
Rheumatoid Arthritis

- Autoimmune disease
  - characterised by inflamed joints
- Approximately 1% UK
  - >400,000 people in the UK
  - 2-3 commoner in women then men
- Can affect any age group:
  - peak around age 45-60

Examination







Tests

- Bloods
- Xrays
- In some cases USS

New RA criteria, 2010

	Score
Target population (Who should be tested?): Patients who have at least 1 joint with definite clinical synovitis (swelling) * with the synovitis not better explained by another disease	
Classification criteria for RA (score-based algorithm: add score of categories A–D; a score of ≥6/10 is needed for classification of a patient as having definite RA) ‡	
A. Joint involvement §	
1 large joint ¶	0
2-10 large joints	1
1-3 small joints (with or without involvement of large joints) #	2
4-10 small joints (with or without involvement of large joints)	3
>10 joints (at least 1 small joint)**	5
B. Serology (at least 1 test result is needed for classification) ††	
Negative RF and negative ACPA	0
Low-positive RF or low-positive ACPA	2
High-positive RF or high-positive ACPA	3
C. Acute-phase reactants (at least 1 test result is needed for classification)‡‡	
Normal CRP and normal ESR	0
Abnormal CRP or abnormal ESR	1
D. Duration of symptoms §§	
<6 weeks	0
≥6 weeks	1

Treatment

- Patient Education

- Lifestyle changes
  - Include stopping smoking
  - Healthy weight

- Physiotherapy

- Occupational therapy

- Keeping up to date with vaccinations

- Drugs
  - Symptom control
  - Disease control

Symptom Treatment

Drug type	Examples	Purpose
Analgesics, also known as painkillers	paracetamol, co-dydramol, co-codamol	Help to control pain
Non steroidal anti-inflammatory drugs	aspirin, ibuprofen, meloxicam	Ease pain and stiffness by reducing inflammation, BUT do not prevent future damage
Corticosteroids, also known as steroids	prednisolone, depo-medrone	Reduce inflammation. Multiple routes of administration Often used as “rescue” therapy during severe episodes of RA.

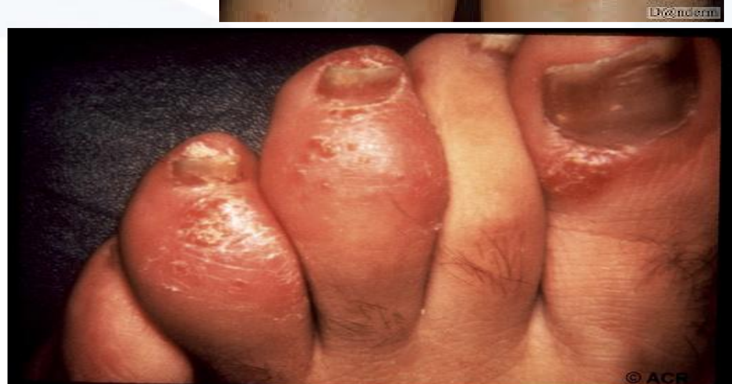
Disease Management

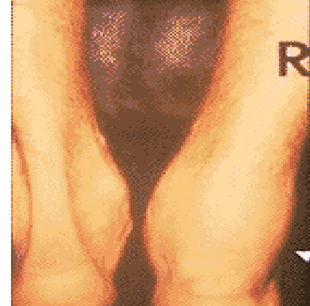
Control the disease over the long term and reduce/prevent damage

Standard DMARDs Disease Modifying Anti-Rheumatic Drugs	Methotrexate Sulfasalazine Leflunomide Hydroxychloroquine	Reduce the immune system ‘attack’. They take time to work (weeks, even months)
Biologic drugs	Infliximab, etanercept, adalimumab, certolizumab pegol, golimumab, tocilizumab, rituximab, abatacept	Reduce the immune system ‘attack’ targeting particular chemicals /cells in the body’s immune system

Psoriatic arthritis

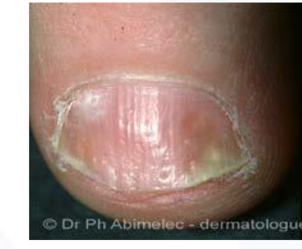
- Arthritis in association with psoriasis
  - may precede skin rash by 20 years!
  - Affects approx 1 in 10 people with skin psoriasis
- M=F
- Other symptoms
  - Dactylitis
  - Enthesitis
  - Red, inflamed eyes
  - Inflammatory back pain

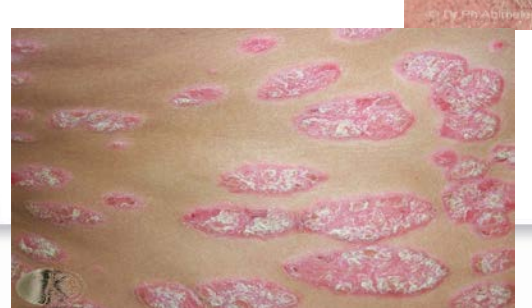




Where can you get Psoriasis

- Nail psoriasis
  - pitting, onycholysis, yellowing and ridging
- Scalp
- Extensor Surfaces (elbows, knees)
- Umbillicus
- Natal Cleft
- Palms and Soles
- Back





Tests

- Bloods
- X-rays
- Sometimes
  - USS/MRI

CASPER Diagnostic Criteria

- **Inflammatory joint and/or back pain**
- **Minimum score 3 points from criteria below:**
- Skin psoriasis that is:
  - Present – 2 points
  - OR Previously present by history – 1 point
  - OR family history of psoriasis, if the patient is not affected – 1 point
- Nail lesions (onycholysis, pitting) – 1 point
- Dactylitis (present or past, documented by a rheumatologist) – 1 point
- Negative rheumatoid factor (RF) – 1 point
- Juxta-articular bone formation on radiographs (distinct from osteophytes) – 1 point

Treatment

- Patient Education
- Lifestyle changes
  - Include stopping smoking
  - Healthy weight
- Physiotherapy
- Occupational therapy
- Keeping up to date with vaccinations
- Drugs
  - Symptom control
  - Disease control

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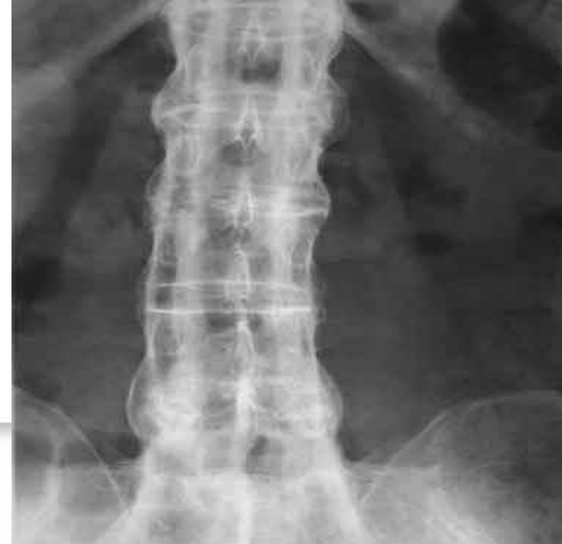
Ankylosing Spondylitis

- Prevalence AS 0.05-0.23%
- 3-4X male
- Episodic inflammation of spine and sacroiliac joints
- Asymmetrical large joint involvement



Tests

- Bloods

- Xray

- In some cases
- MRI scans

ASAS classification criteria for axial spondyloarthritis (SpA)

In patients with ≥3 months back pain and age at onset <45 years

Sacroiliitis on imaging* plus ≥1 SpA feature#	or	HLA-B27 plus ≥2 other SpA features#

#SpA features

- inflammatory back pain
- arthritis
- enthesitis (heel)
- uveitis
- dactylitis
- psoriasis
- Crohn's/colitis
- good response to NSAIDs
- family history for SpA
- HLA-B27
- elevated CRP

*Sacroiliitis on imaging

- active (acute) inflammation on MRI highly suggestive of sacroiliitis associated with SpA
- definite radiographic sacroiliitis according to mod NY criteria

Treatment

- Patient Education
- Lifestyle changes
  - Include stopping smoking
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- **Physiotherapy**
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Reactive arthritis

- Arthritis following infection
- Normally Gastrointestinal/STIs
- M=F
- Normally self limiting
- Requiring symptomatic treatment
  - Painkillers/NSAIDs/Steroids

Enteropathic Spondyloarthritis

- Joints and/or spine inflammation
- linked to Crohns and UC
  - 5-10% UC, 10-20% Crohns
- M=F
- Treatment of underlying IBD usually helps

Summary

- Sero-negative arthritis will have negative RhF and may have normal inflammatory markers, so need high degree of clinical suspicion to make diagnosis
- Early treatment reduces the risk of long-term damage

Thank you for Listening

Any Questions

Further Information

- Arthritis Research UK
- NRAS- National Rheumatoid Arthritis Society
- National Ankylosing Spondylitis Society (NASS)