

## March 03/07: EULAR recommendations for early arthritis

The definition of rheumatoid arthritis is sometimes imprecise and in practice, early inflammatory arthritis is often undifferentiated. An early diagnosis is complicated by the absence of specific tests and diagnostic criteria. In the past few years the development of effective new treatments and the validation of new concepts have highlighted the need to develop guidelines for the management of early arthritis. The objective of the the European League Against Rheumatism (EULAR) was to formulate, and obtain consensus on a set of recommendations aiming at improving the management of early arthritis:

Combe B, Landewe R, Lukas C, et al (2007)

**EULAR recommendations for the management of early arthritis: report of a task force of the European Standing Committee for International Clinical Studies Including Therapeutics (ESCISIT)**

*Ann Rheum Dis 66, 34-45*

**Recommendation 1:** Arthritis is characterised by the presence of joint swelling, associated with pain or stiffness. Patients presenting with arthritis of more than one joint should be referred to and seen by a rheumatologist, ideally within six weeks after the onset of symptoms.

**Recommendation 2:** Clinical examination is the method of choice for detecting arthritis. In doubtful cases, ultrasound, power Doppler, and MRI may be helpful in detecting synovitis.

**Recommendation 3:** Exclusion of other diseases than rheumatoid arthritis requires careful history taking and clinical examination, and ought to include at least the following laboratory tests: complete blood cell count, urinary analysis, transaminases, and antinuclear antibodies.

**Recommendation 4:** In every patient presenting with early arthritis to the rheumatologist, the following factors predicting persistent and erosive disease should be measured: number of swollen and tender joints, ESR or CRP, level of rheumatoid factor and anti-CCP antibodies, and radiographic erosions.

**Recommendation 5:** Patients of risk of developing persistent and/or erosive arthritis should be started with DMARDs as early as possible even if they do not yet fulfil established classification criteria for inflammatory rheumatological diseases.

**Recommendation 6:** Patient information concerning the disease and its treatment and outcome is important. Education programmes aimed at coping with pain disability and the maintenance of work ability may be employed as adjunct interventions.

**Recommendation 7:** NSAIDs have to be considered in symptomatic patients after evaluation of gastrointestinal, renal, and cardiovascular status.

**Recommendation 8:** Systemic glucocorticoids reduce pain and swelling and should be considered as a (mainly temporary) adjunct to the DMARD strategy. Intra-articular glucocorticoid injections should be considered for the relief of local symptoms of inflammation.

**Recommendation 9:** Among the DMARDs, methotrexate is considered the anchor drug and should be used first in patients at risk of developing persistent disease.

**Recommendation 10:** The main goal of DMARD treatment is to achieve remission. Regular monitoring of disease activity and adverse events should guide decisions on choice and changes in treatment strategies (DMARDs including biological agents)

**Recommendation 11:** Non-pharmaceutical interventions such as dynamic exercises, occupational therapy, and hydrotherapy can be applied as treatment adjunct to pharmaceutical interventions in patients with early arthritis.

**Recommendation 12:** Monitoring of disease activity should include tender and swollen joint count, patient's and physician's global assessments, ESR, and CRP. Arthritis activity should be assessed at one to three month intervals, for as long as remission is not achieved. Structural damage should be assessed by x rays every 6 to 12 months during the first few years. Functional assessment (for example, HAQ) can be used to complement the disease activity and structural damage monitoring.

