Rheumatology in Primary Care

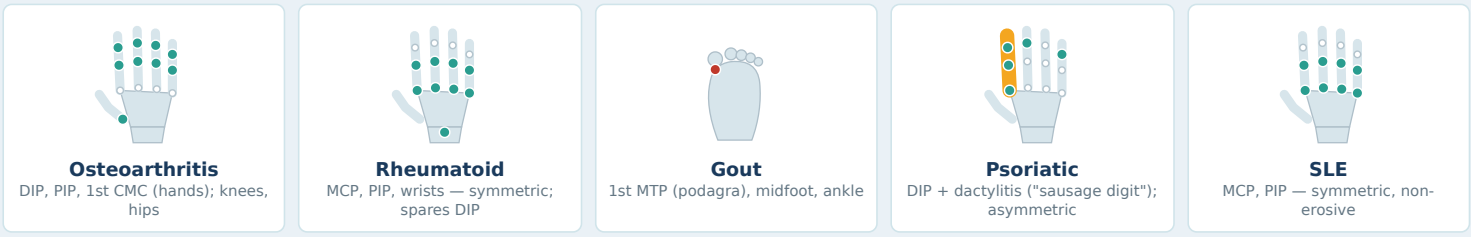
RECOGNIZE · WORK UP · REFER

OA · RA · GOUT
PsA · SLE

1 PATTERN RECOGNITION & INITIAL WORK-UP

CONDITION	HALLMARK JOINT PATTERN	KEY CLINICAL CLUES	FIRST-LINE LABS / IMAGING
Osteoarthritis MECHANICAL	Asymmetric; weight-bearing & hands — DIP/PIP, 1st CMC, knee, hip, spine. Gradual.	Age >45, activity-related pain, stiffness <30 min, bony enlargement (Heberden/Bouchard), crepitus, **no** systemic features.	Clinical diagnosis. ESR/CRP normal. X-ray (osteophytes, joint-space narrowing) confirms but not required. **No serologies.**
Rheumatoid INFLAMMATORY	Symmetric polyarthritis of small joints — MCP, PIP, wrists, MTP. **Spares DIP.**	Morning stiffness >30–60 min, boggy synovitis/swelling, fatigue, symptoms ≥6 wk.	RF, anti-CCP, ESR/CRP, CBC. X-ray hands/feet (erosions). **Refer early** — window of opportunity.
Gout CRYSTAL	Acute mono/oligoarthritis — 1st MTP (podagra), midfoot, ankle, knee. Recurrent.	Rapid onset (peak <24 h), red/hot/exquisitely tender, tophi. Hyperuricemia (may be normal during flare).	Synovial fluid → MSU crystals (gold std; needle-shaped, negatively birefringent). Serum urate — recheck ≥2 wk post-flare. Renal fn.
Psoriatic SERONEG SpA	Variable — asymmetric oligoarthritis, DIP, dactylitis, enthesitis, axial.	Psoriasis (skin/nails — pitting, onycholysis), "sausage digit," enthesitis (Achilles/plantar), inflammatory back pain. Usually RF−.	Clinical + full skin/nail exam. ESR/CRP (often normal). RF/anti-CCP to exclude RA. X-ray ("pencil-in-cup"). **Screen all psoriasis pts.**
SLE AUTOIMMUNE	Multisystem; non-erosive symmetric arthritis/arthralgia + organ involvement.	Young woman; malar/photosensitive rash, oral ulcers, alopecia, Raynaud, serositis, cytopenias, nephritis.	ANA (entry test, ≥1:80). If + → anti-dsDNA, anti-Sm, C3/C4, CBC, Cr, UA + UPCR. Refer.

2 JOINT DISTRIBUTION AT A GLANCE



3 SEROLOGY — HOW TO INTERPRET

- **ANA** — sensitive, not specific. ≥1:80 = EULAR/ACR entry criterion; positive in ~15–25% of healthy adults (rises with age) → don't order without suspicion.
- **Anti-dsDNA / anti-Sm** — specific for SLE; dsDNA tracks activity & nephritis.
- **Low C3/C4** — active SLE (complement consumption).
- **RF** — RA (also other CTD, infection, ~5% healthy).
- **Anti-CCP** — highly specific for RA; predicts erosive disease.
- **Serum urate** — gout (target <6). Can fall to normal range during a flare → does **not** exclude gout.
- **HLA-B27** — supports axial PsA/SpA (not diagnostic alone).

4 DIAGNOSTIC / CLASSIFICATION PEARLS

- → **OA** — clinical diagnosis (history + exam); imaging confirms, labs only to exclude inflammatory mimics.
- → **RA** — ACR/EULAR 2010: score **≥6/10** (joint count, RF/CCP, ESR/CRP, duration ≥6 wk).
- → **Gout** — MSU crystals = definitive; ACR/EULAR clinical criteria when aspiration not feasible.
- → **PsA** — CASPAR: inflammatory articular disease + ≥3 pts (psoriasis, nail changes, dactylitis, RF−, new bone).
- → **SLE** — EULAR/ACR 2019: **ANA ≥1:80 entry** + weighted criteria; total **≥10** classifies.

⚠ RED FLAGS — REFER / ACT URGENTLY

- ⚠ **Hot, swollen single joint** → aspirate to exclude **septic arthritis** before assuming gout/flare.
- ⚠ **Suspected RA or PsA** → refer promptly; erosions can occur within months ("window of opportunity").
- ⚠ **Lupus nephritis** (proteinuria, ↑Cr, active sediment), cytopenias, serositis, or neuropsychiatric features → urgent rheum.
- ⚠ **New multisystem illness** + constitutional symptoms → broaden CTD work-up.

⚲ SYNOVIAL FLUID — WHEN YOU TAP THE HOT JOINT

Non-inflammatory	Inflammatory	Septic
WBC <2,000/µL · OA, trauma	2,000–50,000/µL · RA, gout, PsA, SLE	>50,000/µL (often >100k) · URGENT

Always send Gram stain, culture & crystal analysis. Crystals can coexist with infection, and counts <50,000/µL do not exclude sepsis — don't anchor on "just a gout flare."

References: ACR/AF 2019 (OA); ACR 2021 / EULAR 2022 (RA); ACR 2020 (Gout); GRAPPA 2021 / EULAR 2023 (PsA); EULAR 2023 (SLE); EULAR-ACR 2019 classification.

For informational use only. Clinical judgment should guide all decisions.

Rheumatology in Primary Care

MANAGE · TREAT-TO-TARGET · CO-MANAGE

Osteoarthritis

PCP-MANAGED

- ✓ **Exercise** (strong) + **weight loss** if knee/hip & overweight (strong) — core of therapy.
- ✓ **Topical NSAIDs** — strong for knee (conditional for hand); preferred in older/comorbid patients.
- ✓ **Oral NSAIDs** lowest effective dose; **IA glucocorticoid** for knee flares.
- → Adjuncts: duloxetine, topical capsaicin (knee), acetaminophen (limited), braces, tai chi.
- ✗ Glucosamine/chondroitin, IA hyaluronic acid (knee), **opioids**, TENS — not recommended.

↗ Refer: orthopedics for joint replacement when refractory + functional limitation.

Rheumatoid Arthritis

REFER + CO-MANAGE

- → **Refer to rheumatology promptly** — start a DMARD within the window. See pathway below.
- ✓ **Methotrexate** = anchor first-line (mod–high activity, DMARD-naïve) + folic acid; minimize glucocorticoids to a short bridge.
- • **PCP role:** MTX labs (CBC, LFTs, Cr), TB/HepB screen before biologics, vaccines first, **CV risk (RA ↑MACE).**

↗ Refer: all suspected RA — early treatment prevents joint damage.

Gout

PCP-MANAGED

- ✓ **Acute flare** — NSAID, colchicine, OR oral glucocorticoid (all first-line; choose by comorbidity). Colchicine 1.2 mg → 0.6 mg 1 h later → 0.6 mg daily–BID. **Don't stop ULT** during a flare.
- ✓ **ULT = allopurinol first-line for all** (incl. CKD) → see Treat-to-Target pathway below.
- ⚠ Consider **HLA-B*58:01** testing (conditional) before allopurinol in higher-risk ancestry — Han Chinese, Korean, Thai, African-American.

↗ Refer: refractory despite ULT, frequent flares/tophi (pegloticase candidates), CKD complexity.

Psoriatic Arthritis

REFER + CO-MANAGE

- ✓ **NSAIDs** for mild peripheral disease — short course only (≤4 wk; don't delay DMARDs).
- ✓ **csDMARD (MTX/SSZ/LEF)** for peripheral arthritis; GRAPPA strongly recommends **TNFi, IL-17i, IL-23i, or JAKi** (± IL-12/23i, apremilast).
- → **TNFi & IL-17i** are the only classes effective across all 6 domains — favor when multiple domains are active. **Treat-to-target.**
- • **PCP role:** screen psoriasis pts for joint symptoms (PEST), refer early; manage CV/metabolic comorbidity; watch for uveitis & IBD.

↗ Refer: rheumatology (± dermatology) for any psoriasis pt with inflammatory joint/spine/entheseal symptoms.

SLE

REFER + CO-MANAGE

- ✓ **Hydroxychloroquine for ALL** patients (≤5 mg/kg/d) — reduces flares, organ damage & mortality. **Annual retinal screen.**
- ⚠ **Glucocorticoids** as a bridge; taper to ≤5 mg/d prednisone.
- → Add immunosuppressive (MMF/AZA/MTX) ± biologic (belimumab, anifrolumab) early if uncontrolled / GC-dependent.
- ⚠ **Lupus nephritis** → urgent biopsy; combination induction per rheum/nephrology.
- • **PCP role:** BP, UA/UPCR, Cr, lipids, CV risk, vaccines (no live on immunosuppression), sun protection, pregnancy planning (continue HCQ).

↗ Refer: all confirmed/suspected SLE; urgent if renal, hematologic, or neuropsychiatric involvement.

★ CROSS-CUTTING PCP PEARLS

- ✓ **Treat-to-target** across RA, gout, PsA & SLE — set an objective goal & reassess on schedule.
- ⚠ **Screen before immunosuppression:** TB, HepB/HepC; update vaccines first (live vaccines then contraindicated).
- ⚠ **Inflammatory rheumatic disease ↑ CV risk** — aggressively manage BP, lipids, smoking, weight.
- → **MTX** across RA/PsA/SLE: contraindicated in pregnancy; monitor CBC/LFTs; co-prescribe folic acid.

→ TREAT-TO-TARGET PATHWAYS

GOUT — URATE-LOWERING THERAPY (ULT)

1. **Confirm gout** — MSU crystals or clinical criteria
2. → **Start allopurinol low** — ≤100 mg/d (≤50 if CKD stage ≥3) + flare prophylaxis ≥3–6 mo
3. → **Titrate q2–4 wk** — recheck urate; uptitrate dose
4. → **Target urate <6** — <5 mg/dL if tophi
5. → **Maintain ULT** — long-term + lifestyle

RHEUMATOID ARTHRITIS — DMARD ESCALATION

1. **Suspect inflammatory arthritis** — symmetric small joints, MS >30 min, +RF/CCP
2. → **Refer + confirm** — treat early — window of opportunity
3. → **Start MTX anchor** — + folic acid; short GC bridge
4. → **Reassess at 3 mo** — target remission / low activity
5. → **Escalate** — add/switch bDMARD (TNFi) or tsDMARD (JAKi)

★ FAST (2020) — gout ULT safety

Febuxostat non-inferior to allopurinol for CV events & mortality, easing prior CARES concerns. Allopurinol stays first-line; febuxostat an acceptable alternative. Mackenzie IS et al. Lancet 2020;396(10264):1745-1757.

★ ORAL Surveillance (2022) — JAKi safety

Tofacitinib showed higher MACE & cancer vs TNFi in RA pts ≥50 yr with ≥1 CV risk factor → class boxed warning. Weigh JAKi risk in older/CV-risk patients. Ytterberg SR et al. NEJM 2022;386(4):316-326.

References: ACR/AF 2019; ACR 2021 & EULAR 2022 (RA); ACR 2020 (Gout); GRAPPA 2021 & EULAR 2023 (PsA); EULAR 2023 (SLE). Verify dosing per current labeling.

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