10-minute consultation
Polyarthralgia

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A 45 year old woman says she has had joint pains in her hands, knees, and hips for three months. Her symptoms have progressively worsened.

What issues you should cover

Assessment—Is her joint pain simple arthralgia, degenerative joint disease, or an inflammatory arthropathy, or is it secondary to some other cause?

History—Ask whether she has had any swelling around the joints, morning stiffness, nocturnal pain or pain at rest, or recent viral or throat infection. Check for systemic features such as fever, weight loss, or fatigue. She may have bowel or bladder symptoms, and her eyes or skin may be affected. Is there a family history of rheumatoid arthritis? Other features may be prolonged repetitive use of hands; mood changes, altered sleep pattern, or lack of energy; and use of over the counter drugs or complementary treatment.

Examination—Which joints are affected? Check for symmetrical presentation and proximal interphalangeal or metacarpophalangeal joint swelling (absence of groove between knuckles on making a fist); inflammation and range of movement of joints; hand function, assessed by grip strength and ability to hold objects or write; nodules around elbows or shins; nodes at distal (Heberden's nodes) or proximal (Bouchard's nodes) interphalangeal joints; and pitting of nails. Be alert to risk factors such as overweight, sedentary lifestyle, heavy physical work, repetitive work, or previous joint injury, all of which might indicate osteoarthritis.

What you should do

- If there is no active inflammation, consider simple arthralgia. Reassure her and advise her to take simpleanalgesics or non-steroidal anti-inflammatory drugs (NSAIDs). Consider fibromyalgia if she has more generalised pain and signs of depression. Encourage positive lifestyle changes and ask her to return in four weeks.
- If features indicate osteoarthritis, reassure her and explain the nature of the problem (wear and tear). Advise analgesics or NSAIDs (or both), offer lifestyle education, and encourage exercise and weight loss. Refer her for physiotherapy if needed.
- If swelling and features of inflammation are present, consider an inflammatory arthropathy (the commonest cause is rheumatoid arthritis). Consider further investigations such as a full blood count (for anaemia), markers of inflammation (erythrocyte sedimentation rate, plasma viscosity, C reactive protein), rheumatoid factor, and radiography of the hands.
- In the absence of contraindications start treatment with NSAIDS. Long acting preparations usually offer more sustained control. Consider a cyclo-oxygenase-2 selective inhibitor, as long term treatment is likely to be needed. Advise her to rest affected joints when they are inflamed. Consider referring her to occupational therapy for splinting and home aids.

Useful reading

Michael L Snaith, ed. *ABC of rheumatology*. 2nd ed. London: BMJ Books, 1999

Medendium Group. *Guidelines: summarising clinical guidelines for primary care*. www.eguidelines.co.uk (accessed 7 Jan 2003)

- If the diagnosis is rheumatoid arthritis or a seronegative inflammatory arthropathy, explain the nature of the condition and that referral to hospital for specialist assessment, education, and long term support would benefit. Give positive messages: several treatment modalities are available that can slow down disease progression; chronic disability and "ending up in a wheelchair" are now the exception rather than the norm.
- Arrange early referral. Meanwhile consider starting a disease modifying antirheumatic drug—sulfasalazine and methotrexate are the most common first line treatments. (Chest radiography is advisable before methotrexate treatment because of possible pulmonary side effects.) Remember that these drugs require regular haematological and biochemical monitoring. Liaise with local rheumatologists if in doubt.
- Short term use (6-12 weeks) of low dose oral corticosteroid (<7.5 mg prednisolone a day) relieves symptoms and may slow progression.
- Arrange follow up in four to six weeks for clinical assessment, reinforcement of earlier advice, and evaluation of home and social circumstances.

Polyarthralgia: signs and symptoms

Simple arthralgia
Main symptom is pain; no clinical features of inflammation in the joints or morning stiffness; history of intercurrent illness or viral infection

Osteoarthritis
Pain is usually in large, weight bearing joints, carpometacarpal joint of thumb, or distal interphalangeal joints of the fingers; presence of Heberden's nodes, crepitus; lifestyle factors such as overweight, sedentary occupation, repetitive use of joints, and history of trauma to affected joints may be relevant

Seronegative (non-rheumatoid) arthritis
Linked with psoriasis, bowel disease (ulcerative colitis, Crohn's disease), bladder symptoms, and anterior uveitis. May occur after infections (streptococcal throat infection, chlamydial urethritis, or bowel infection with yersinia, salmonella, shigella). Mainly asymmetrical, large joint oligoarticular involvement; possible spinal involvement (sacroiliitis)

Rheumatoid arthritis
At least four of these signs or symptoms for six weeks: pain and swelling in at least three joint areas; symmetrical presentation; early morning joint stiffness for more than one hour; involvement of metacarpophalangeal joints, proximal interphalangeal joints, and wrists; subcutaneous nodules; positive rheumatoid factor; radiological evidence of erosions

This is part of a series of occasional articles on common problems in primary care

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