The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

Canadian Family Medicine Clinical Card

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Kendal JK
Keegan DA

Joint Pain 1: Arthritis

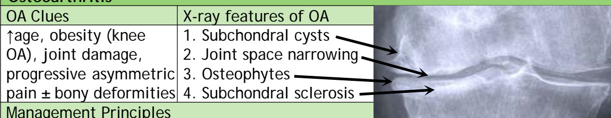
Red Flag: Acute Red Joint – R/O Septic Arthritis

Risk Factors	Presentation	Investigations
Prosthesis, skin infxn, RA, age >80, DM, recent joint surgery or injection, IVDU	Painful joint with erythema, swelling, ↓ROM and ± fever	Clinical suspicion → joint aspiration: WBC + diff, gram stain & culture, blood cultures
R/O gonococcal infxn - ♀>♂, recent menses, age <40, ± tenosynovitis & dermatitis		

Degenerative vs. Inflammatory Arthritis: General Signs & Symptoms

Degenerative	Inflammatory
❑ Pain is relieved by rest	❑ Pain at rest, relieved by motion
❑ <½hr AM stiffness	❑ >1h AM stiffness
❑ Localized, slow onset, progressive pain	❑ warmth, swelling, extra-articular signs

Osteoarthritis



OA Clues	X-ray features of OA
↑age, obesity (knee OA), joint damage, progressive asymmetric pain ± bony deformities	1. Subchondral cysts 2. Joint space narrowing 3. Osteophytes 4. Subchondral sclerosis

Management Principles

Non-pharmacological: Patient education, weight loss, regular low-impact exercise, PT (e.g. flexibility & strength, TENS) & OT (e.g. walking aids).
Medical: Analgesics/NSAIDs (oral &/or topical), corticosteroid injection, topical capsaicin, hyaluronic acid knee injection (controversial). No high quality studies for glucosamine or chondroitin supplements. *If refractory: surgical assessment.*

		Disease	Diagnostic Clues	Investigations & MGMT
Inflammatory Arthropathies	Seropositive	Rheumatoid Arthritis	Symmetric, >3 joints & in hands, >6 weeks. Rheumatoid nodules (e.g. over extensor surfaces), ±↑RF & x-ray changes. ♀>♂ age ~40-50's.	If suspicion: ESR±CRP, RF, anti-CCP & radiographs. **Early intervention with DMARDs*!**
Inflammatory Arthropathies	Seropositive	Lupus (SLE)	Multi-organ involvement, diverse presentation, ♀>♂. Symmetrical, small & large joints. FHx.	ANA (Anti-nuclear antibody) (if -ve virtually R/O SLE), NSAIDs/analgesics for pain
Inflammatory Arthropathies	Seronegative	Reactive Arthritis	Asymmetric 1-4 joints, lower extremity. Usually GI or GU infection 1-4 weeks before joint pain.	NSAIDs & treat infxn. If resistant: steroids (oral & injection) → DMARDs*.
Inflammatory Arthropathies	Seronegative	Psoriatic Arthritis	FHx &/or presence of psoriasis, DIP involvement, enthesitis, bursitis, nail changes. Asymmetric, 1-4 joints.	Most cases controlled with NSAIDs. May require DMARDs or biologics.
Inflammatory Arthropathies	Seronegative	Anklylosing spondylitis	Low back pain &↓ ROM, ♂>♀, asymmetric, enthesitis, younger age	See low back pain card
Inflammatory Arthropathies		Juvenile Idiopathic Arthritis	**<16 years old, ≥1 joint, ≥6 weeks,** other causes excluded (e.g. sepsis). Minimal systemic complaints. ♀>♂.	Many subtypes. Exercise, multi-discipl. team, NSAIDs, steroid inject. = 1st line.
Crystal		Gout	**1st MTP**, ankle, knee, ♂ & post-meno ♀. Risks: Diuretic use, renal disease, EtOH. May mimic cellulitis.	Joint aspiration, NSAIDs, intra-articular steroids. ±Colchicine in acute gout. Lifestyle Δ & ± allopurinol in chronic gout.
Crystal		Pseudogout	Age >60, knee joint most frequent, may resemble gout	

*Disease Modifying Anti-Rheumatic Drugs (e.g. hydroxychloriquine, methotrexate)

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