SPECIALTY

Rheumatology

Arista|MD

Response from eConsult Specialist

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NPI: 1000000006

CHIEF COMPLAINT

Rheumatoid Arthritis

COMMENTS TO SPECIALIST

53-year-old male presents with joint pain for >6 weeks. The joint pain does affect both small and large joints. The patient has a history of obesity, s/p spinal fusion, reported fibromyalgia, and rheumatoid arthritis (RA) since the age of 15. Recently diagnosed type 2 diabetes. Previously ambulatory without assistance; now using wheelchair.

Physical exam is normal except:

- Shoulder shrug is equal, but weak.
- Right hand grasp is weak and tremoring during purposeful grasping of my hand.
- Left hand grasp is moderate.
- There is a very mild swan neck deformity noted.
- Pedal pushes and pulls are equal and weak.
- Limited range of motion in all the joints.

The patient was unable to tolerate me moving his extremities through complete range of motion due to subjective pain and muscle spasticity.

There is inflammation noted in the shoulders, hands, and feet joints.

- No erythematous joints noted.
- There are no ictal signs.
- Deep tendon reflex (DTR) intact.

Patient was started on steroids.

MAIN QUESTION

Please provide expert treatment recommendations, as necessary.

Contact us at info@aristamd.com or visit www.aristamd.com

SUMMARY

In-person visit with specialist recommended, visit urgency ROUTINE.

DETAILS

The patient may be having an RA flare as evidenced by pain, limited mobility, and elevated inflammatory markers. Using a disease activity scoring system such as these can be helpful to quantify severity of the disease:

- RAPID3: https://www.ra.com/rheumatoid-arthritis-resources/rapid3-survey
- COAi: https://www.mdcalc.com/clinical-disease-activity-index-cdai-rheumatoid-arthritis

As there may be concomitant degenerative changes or musculotendinous injury in addition to the inflammatory arthritis flare, assessing the amount of morning stiffness as well as assessing X-rays of affected joints would be helpful.

Monotherapy with methotrexate is likely not sufficient, especially if he has other factors such as being anti-cyclic citrullinated peptide (CCP) positive or extra-articular manifestations. While some patients benefit from switching from oral to parenteral methotrexate when at higher dosages (since this would bypass first-pass metabolism), this may not be feasible or sufficient.

After the completion of the steroid taper, the patient should discuss the addition of conventional or biologic disease-modifying anti-rheumatic drugs (DMARDs) with a rheumatologist.

Because of the complexity and potential for side effects, it is challenging to recommend specific step-up therapies without an in-person consultation. Keep in mind that vaccination timing may factor in with when to implement additional treatments.

Resources for further study:
https://www.rheumatology.org/Portals/0/Files/COVID-19-Vaccine-clinical-guidance-rheumatic-diseases-summary.pdf
https://ard.bmj.com/content/79/1/39

Finally, the patient should be engaged in occupational/physical therapy. Aqua therapy can be beneficial for those with limited mobility as well.

Recommended Visit Urgency: Routine – The patient can be scheduled accordingly.

Jacob Rodgers

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