Pennine MSK Rheumatoid Arthritis Care Pathway

Refer to Pennine MSK Partnership using Early Inflammatory Arthritis Clinical Referral Form for urgent specialist review via ERS
if persistent synovitis of undetermined cause involving small joints of the hands or feet/ more than one joint is affected or there has been a delay from onset of symptoms => 3 months https://www.nice.org.uk/guidance/ng100/chapter/Recommendations#referral-from-primary-care

Review by rheumatologist within 3/52 if RA suspected.
Musculoskeletal examination & any outstanding investigations:
(FBC, ESR, U&Es, LFTs, RF, ANA (consider anti-CCP if RF-ve)
XRAY hands & feet, USS only if synovitis =<1 joint & sub-clinical disease suspected)
Review analgesia/ use of NSAIDs
Baseline disease activity assessment (DAS28)
IM/ IAJ/ oral corticosteroids according to PGDs
Information regarding diagnosis & treatment route
Commence DMARD as soon as possible unless contraindicated
Invite to NEIAA

Ref by MSK GPwSI
Musculoskeletal examination
If suspected IA
FBC, ESR, U&Es, LFTs, RF, ANA
(consider anti-CCP if RF-ve)
XRAY hands & feet; USS only if synovitis =<1 joint & sub-clinical disease suspected
Review analgesia/ use of NSAIDs
IM/ IAJ/ oral corticosteroids as appropriate
Urgent ref to Rheumatology Consultant

Not all patients will be suitable for Nurse led care eg those with complex RA, severe comorbidities such as ILD and overlapping disease. These patients may require Consultant led care.

Nurse led care if RA confirmed
Patient education
Shared clinical decision-making
Shared care monitoring with GP according to DMARD protocols
DMARD initiations as recommended by a prescriber
Dose titration according to nurse led dose titration protocols
IM/ IAJ/ oral corticosteroids according to PGDs
Offer review 4-6 weekly until DAS28<3.2 or disease well controlled (< 3 swollen joints)
If DAS28 < 3.2, review 3-6 monthly.
If disease stable for 12 months, annual review as per NICE guidance https://www.nice.org.uk/guidance/ng100/chapter/Recommendations
Including assessment of disease progression (DAS28, x-rays hands & feet for progression or ultrasound if indicated), MSKHQ, cardiovascular risk (Eular guidelines); osteoporosis screen (FRAX); identify depression.

Ongoing support for self-care
Advice line access
Social prescribing referrals e.g. Early Help; New to RA; Working Well programme; OCL; Smoking cessation service; Mind

MDT referrals as appropriate
e.g., OT; physiotherapy; podiatry; psychology; social work; dietician

Referral to orthopaedic surgeon
if irreversible damage unresponsive to conservative treatment

Consultant or Independent nurse prescriber review
if DAS28 > 3.2 despite optimal treatment or if side effects / intolerance or extra-articular disease/co-morbidities detected

Undertake biologic screening & refer virtual biologics clinic
if disease resistant and failed 2 DMARDS

Consider dose tapering or stopping drugs in a step-down strategy for patients in remission or low disease activity according to protocols.

RA Care Pathway
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