ACUTE FLARE OF RHEUMATOID ARTHRITIS

Rheumatoid arthritis is a relapsing/remitting condition. The aim of treatment is to prevent relapses after achieving remission and to prevent joint damage. Despite this patients occasionally have a flare up, defined as a deterioration in joint symptoms lasting more than five days usually manifesting itself as generalised early morning stiffness. Multiple such episodes are an indication of failed second line drug treatment, but occasionally patients may have an isolated flare for what ever reason. These guidelines are for such occasions.

Monarticular flare.

The worry with monarticular flares is that there is infection in the joint particularly for patients on steroids and other immunosuppressants that may mask the classical signs of infection. The maxim is: IF IN DOUBT ASPIRATE. If skills for aspiration are not present then please discuss aspiration with rheumatology secretaries.

Polyarticular flare. For polyarticular flares we often use a single deep intramuscular dose of Methylprednisolone 120-160mg in the buttock in the usual way. This could be administered in Primary Care on a single prescription. For the reason stated above if this is happening frequently then alternative secondline drugs should be reviewed at a clinic appointment. There is no theoretical maximum for this therapy although clearly over frequent administration not only reflects inadequate disease control but also would lead to significant steroid side effects. As a guide we would normally try to restrict this treatment to no more than 3 monthly.

The main contraindication to an IM steroid injection is the presence of infection (viral or bacterial), so this must be checked by direct questioning. We are finding more and more that patients are asking their General Practitioners to sanction the Depomedrone injection.

INTRAMUSCULAR STEOIDS AS MAINTENANCE TREATMENT

We occasionally use intermittent or regular intramuscular Methylprednisolone as maintenance treatment in such conditions as polymyalgia rheumatica and rheumatoid arthritis. This option, rather than continuous daily oral steroids, is used in the belief that there is less suppression of the hypothalalamo-pituitary axis and thus less chance of secondary adrenal failure when steroids are withdrawn. This option is sometimes used to avoid problems with poor compliance.