Chapter 2

General treatment aspects

Goals of treatment
Rheumatoid arthritis (RA) is almost invariably associated with significant symptomatology. In the early stages of the disease, joint pain and stiffness are the dominant symptoms, but patients also frequently experience general symptoms due to the systemic inflammatory state. Extreme fatigue and lassitude, and even slight fever and profound weight loss are not unusual at this stage. The musculoskeletal symptoms may already in the earlier phase engender significant functional impairment and restriction of activities which are, however, still reversible. At later stages of the disease, inflammatory symptoms may continue to be severe but in contrast to more benign musculoskeletal conditions RA has the potential to cause severe and irreversible damage to the anatomical structures of the joints as well. Thus, erosions and other damage to the bony surfaces of the joints, and cartilage break-down are hallmarks of the disease that when advanced are easily recognized on plain radiographs, but that may at even earlier stages be detected through more sensitive imaging techniques such as magnetic resonance imaging (MRI) and ultrasound (Figure 2.1).

Importantly, these irreversible structural changes do not start late during the disease process, even though they are often only detected after months or years. Several lines of investigation strongly suggest that the destructive process starts around the same time as the onset of inflammatory symptoms [1–3]. A small subset of patients with RA have a disease phenotype that is striking for its limited symptoms despite very obvious
signs of inflammation (synovial swelling of the joints) and destructive potential seen on radiographs. This disease phenotype is referred to as the ‘robustus’ type and patients in this situation may be undertreated as a result of the limited subjective symptoms [4].

From the above follow the treatment goals for RA. First, the patient’s symptomatic burden must be alleviated. Patients generally see this as the most obvious and clearest goal of the treatment and will seek medical care primarily to obtain such relief. However, the important second goal must be to prevent, as much as possible, the destruction of joint structures as a result of the disease; these two goals are not always aligned. Simple analgesics and non-steroidal anti-inflammatory drugs (NSAIDs) may provide some symptomatic relief but there is no evidence that they prevent joint damage. Even glucocorticoids (GCs) may, despite their strong anti-inflammatory and symptom-relieving properties, not prevent damage if used at moderate or high doses as monotherapy for RA (however, adding low-dose GCs to conventional antirheumatic treatments can provide some additional protection from damage, as will be discussed). Thus, the approach to RA must always be based on the dual goals of relieving symptoms and preventing long-term damage and resulting disability. These goals can be regarded as part of the more

Figure 2.1 Ultrasound image of the joint, demonstrating the inflammatory process in the synovium as well as an early erosive change. Photo courtesy of Y Kisten.