# Module 3: The chronic stage of rheumatoid arthritis (RA) (> 2 years post diagnosis)

## Key concepts

- There are a range of clinical presentations during the chronic stage.
- With appropriate medical management a person may present in remission, with little disease activity and disability. Without appropriate medical and pharmacological management, people are more likely to experience substantial disability and increased mortality.
- Physiotherapists have long-term involvement in managing persons with RA.
- Assessment and treatment need to be adapted over time, taking into account changing needs, wants and priorities.
- There are important treatment contraindications and safety issues relevant to physiotherapy practice.
- Communication and timely on-referral to other care team members is critical - know who these people are and how to contact them.

## Physiotherapy in the chronic stage of RA

- The physiotherapist's role is to is to continue to co-manage the person with RA.
- As the disease progresses, clinical features may change or develop. It is important to monitor, and be prepared to respond to these changes.
- Assessment and management must continue to take into account the relevant biological, psychological and social factors affecting the person's function and quality of life.
- The assessment and management principles outlined in Module 2 remain relevant.

## Safety issues NOT to miss… (including red flags)

| | |
|---|---|
| **Joint instability** (see Cervical Spine Instability below) | Recognising **upper cervical spine** instability is critical – instability can lead to sudden, unexpected death or quadriplegia.<br>The most frequent instability in the cervical spine is atlanto-axial subluxation (**AAS**) occurring in up to 50% of cases<br>NOTE –AAS can be asymptomatic so clinical vigilance is critical: manual examination and treatment techniques are contraindicated in this case<br>**Look for**: clunking or clanking on neck movements; paraesthesia of the lips and tongue, global restriction of range (which may alternate with increased ROM), cord signs, vertebrobasilar signs, facial sensory alterations, dysphagia<br>**IMMEDIATELY** on-refer to the GP or rheumatologist if you suspect AAS |
| **Vasculitis driven dysfunction in other body systems** | **IMMEDIATELY** on-refer to GP or rheumatologist if changes in **visual**, **neurological**, and **cardiopulmonary** conditions |
| **Treatment-mediated conditions** | **Osteoporosis** secondary to treatment must be considered in your management plan and treatment selection: this is a safety issue |

| | |
|---|---|
| **Disease flares** | Symptoms include pain, inflammation, fatigue, malaise and impaired function. Flares require:<br>**Responsive** and **timely physiotherapy** to ameliorate acute symptoms<br>**Communication** with other care team members including updating interdisciplinary team care plans during/following a disease flare |

**Cervical spine instability**

- If you suspect RA, or know it is RA, **specific screening** is required prior to any manual assessment or management
- If suspected AAS **NO** manual treatment of the cervical spine until the patient is reviewed by a medical professional and the status of upper cervical stability established
- Cervical Spine Instability can be viewed on plain film radiographs of the cervical spine (flexion/extension views). The anterior atlanto-dens interval (AADI) is abnormally increased on flexion and is reduced with cervical extension
- For more detailed information see Slater et al (2013)