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Rheumatoid factor and rheumatoid arthritis

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Box 1:
Key points about Diagnosis of Rheumatoid Arthritis

- Rheumatoid Arthritis (RA) is predominantly a clinical diagnosis
- Classification criteria are different from diagnostic criteria.
- A diagnosis of RA can confidently be made on the bedside even in absence of rheumatoid factor (RF). In fact, only 75–80% of the individuals are seropositive (that is, +ve for rheumatoid factor).
- RA is typically bilaterally symmetrical. Asymmetrical or unilateral involvement should arouse suspicion of other arthritides like psoriasis or spondarthritides.
- RA is a polyarthritis. One should be reluctant to entertain a diagnosis of RA in a patient with monoarthritis.
- Do not diagnose RA unless hands are involved.
- Distal interphalangeal joint (DIP) involvement is exceedingly uncommon in RA. If DIP joints are involved, suspect psoriatic arthropathy or osteoarthritis.
- Lumbar spine is not involved in RA. The presence of inflammatory low back ache with mono or oligoarticular involvement, especially of large joints of lower limbs, should arouse suspicion of spondyloarthropathy
- Mere presence of rheumatoid factor does not translate into a diagnosis of RA.
- Once RF is positive in a given patient, it need not be repeated since it correlates poorly with clinical response to treatment. Titers of RF do not help in monitoring treatment efficacy.
- Patients with high titres of RF, in general, tend to have a poor prognosis
- Anti citrullinated peptide antibodies (ACPA) are more specific than RF but sensitivity remains nearly the same as RF
- Patients with RA may exhibit dual RF & ACPA positivity, either autoantibody may be positive or both may be negative

Box 2:
Key points in management of RA

- Early treatment produces better results

(Caveat: It is never too late to treat RA. There is nothing like burnt out RA. The fire continues to smoulder inside. Do not deny treatment to patients who present late)

- Tight control of disease activity is the goal of treatment
- Disease modifying anti rheumatic drugs (DMARDs) should be offered to all patients with RA. Currently used DMARDs include Methotrexate (MTX), Hydroxychloroquine (HCQ), Leflunomide (LEF) and Sulfasalazine (SSZ) (Table 1)
- Methotrexate (MTX) is the anchor drug for treatment of RA (initial dose 7.5 mg weekly, escalated rapidly to 25 mg weekly according to clinical response). Folic acid should be given to all patients on methotrexate
- In patients with suboptimal relief to oral MTX, subcutaneous MTX may be used at it offers better bioavailability

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- DMARD combinations (MTX + HCQ, MTX + LEF, MTX + HCQ + SSZ) can be used in patients not responding to single agent DMARD
- Corticosteroids are very useful adjuncts in the management of RA. Should not be used as the sole agents. Use minimum possible dose for the shortest possible time.
- Biologics represent a major advance, especially in refractory, aggressive RA
- Switching of biologic agents may help in patients not responding to one agent
- Extra-articular problems in RA like osteoporosis, premature coronary artery disease need appropriate treatment
- Seronegative RA is treated no differently from seropositive RA

Table 1
The current nomenclature for DMARDs.

Synthetic DMARDs	
Conventional- cs DMARDs	Methotrexate, Leflunomide, Hydroxychloroquine, Sulfasalazine
Targeted- ts DMARDs	Tofacitinib, Baricitinib
Biological DMARDs	
Biological Originator- bo DMARDs	Infliximab, Etanercept, Tocilizumab, Abatacept*, Rituximab, Golimumab, Certolizumab*, Adalimumab*, Anakinra*, Sarilumab*
Biosimilar DMARDS- bs DMARDs	Etanercept, Rituximab, Adalimumab, Infliximab

*Not available in India

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jcot.2019.03.007.