Rheumatoid Arthritis Clinical Playbook

An operational guide to the 2026 Australian Guidelines, from early detection to treat-to-target execution.

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Australian Epidemiology

Prevalence

~0.5–1% of adults.

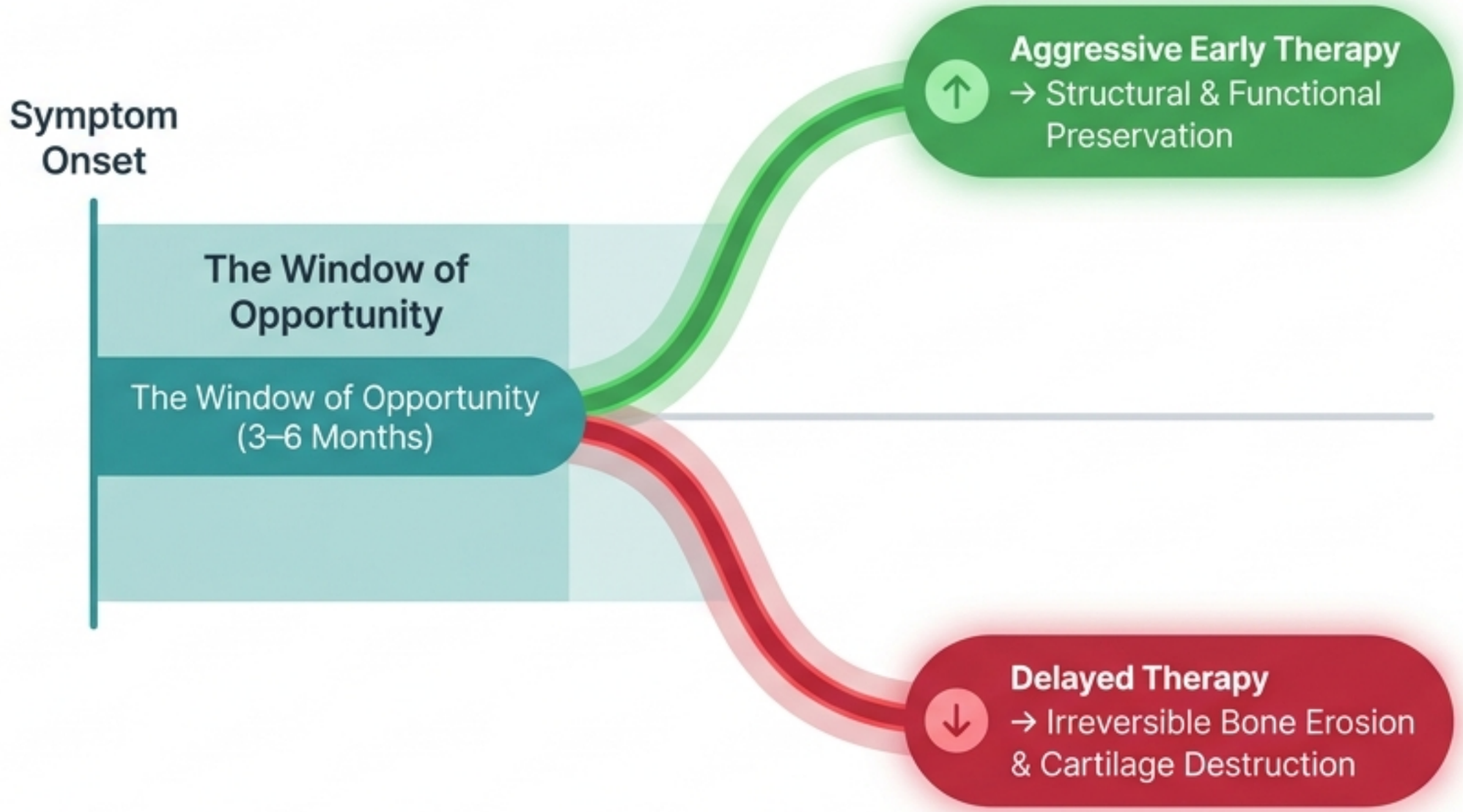
Demographics

Female to male ratio of 3:1.
Typical onset 35–60 years.

⚠ High Risk

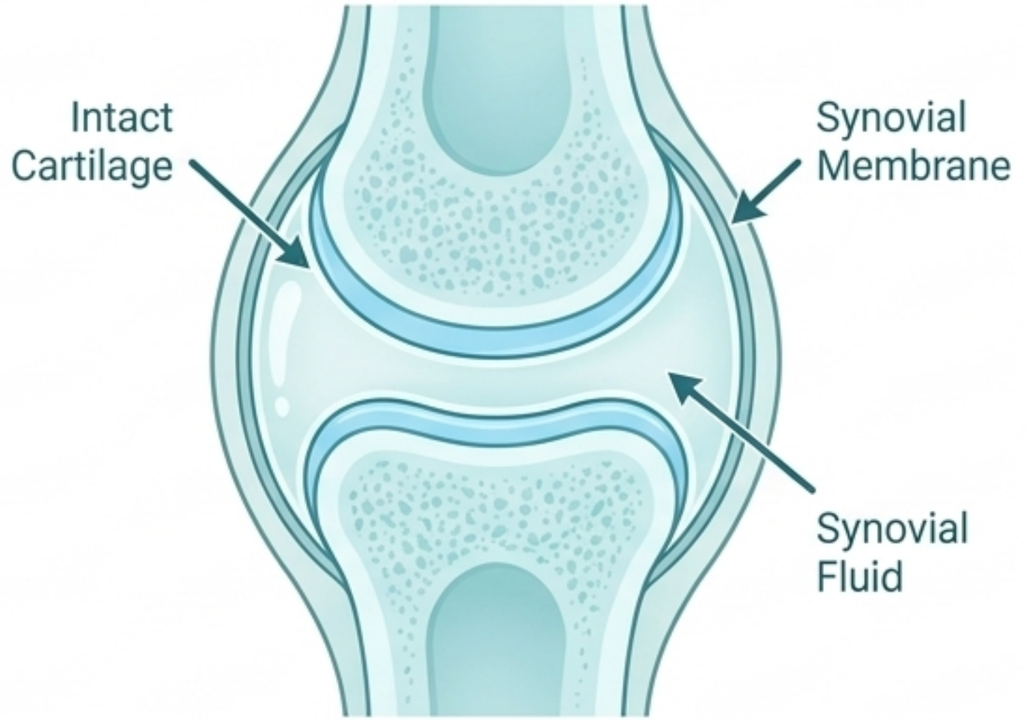
Elevated rates in Aboriginal and Torres Strait Islander communities.

The Trajectory of Disease

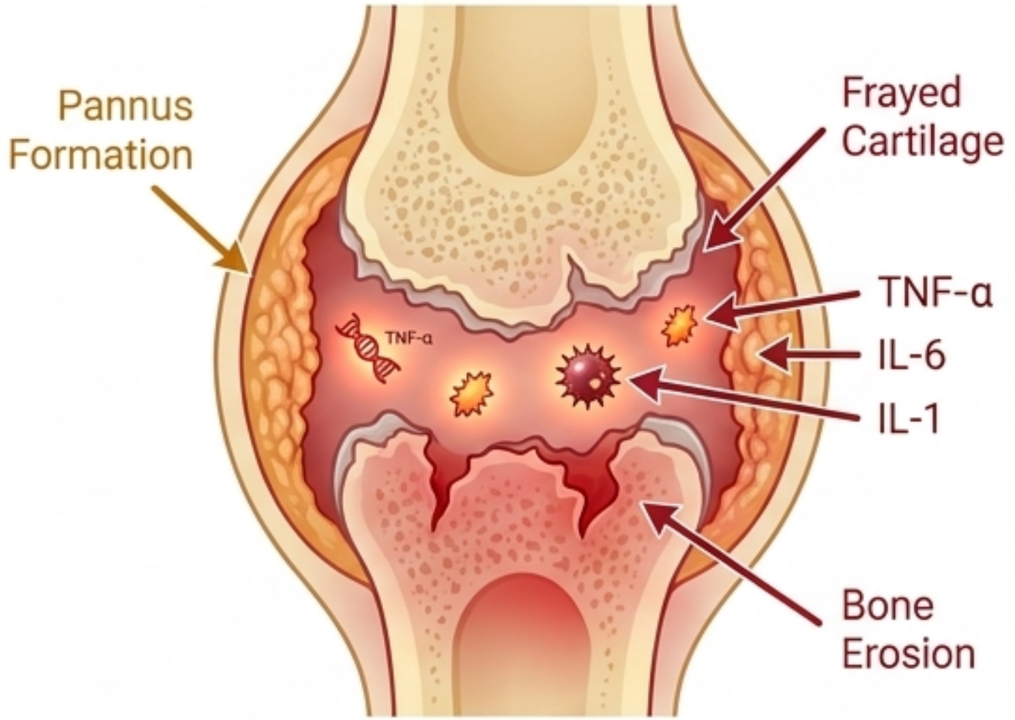


Joint Pathology Comparison

Healthy Joint



Autoimmune Synovitis



Mechanism:

Genetic predisposition (HLA-DRB1 shared epitope) + Environmental triggers (Smoking, Periodontitis, Silica) → Autoimmune-driven synovitis.

2010 ACR/EULAR Classification Criteria: Scoring Interface

Joint Involvement (0-5 pts)

1 large (0) | 2-10 large (1) | 1-3 small (2) | 4-10 small (3) | >10 with ≥1 small (5)

20% | 40% | 60%

Serology (0-3 pts)

Negative (0) | Low-positive RF/ACPA (2) | High-positive RF/ACPA (3)

66%

Acute Phase Reactants (0-1 pt)

Normal CRP/ESR (0) | Abnormal CRP/ESR (1)

Symptom Duration (0-1 pt)

<6 weeks (0) | ≥6 weeks (1)

6 /10

Definite RA Diagnosis: Score ≥6/10

Key Investigations

Essential

RF & Anti-CCP (>95% specific, predicts erosive disease. MBS 69480).

Baseline

X-rays (hands/feet), ESR, CRP, FBC.

DAS28 Gauge Dashboard

Module 1

28 Tender/Swollen Joint Count

⚠ Limitation: Does not assess feet, ankles, or spine

Module 2

ESR or CRP

Module 3

Patient Global Assessment (0–100 mm VAS)

Remission

Target state. Consider cautious DMARD tapering.

Low Activity

Alternative target. Optimise current therapy.

High Activity

Active disease. Intensify DMARD or escalate to biologic.

The csDMARD Arsenal Matrix

Methotrexate (The Anchor)

- **Highlight**: First-line antifolate.
- **Dose**: 7.5–25 mg PO/SC weekly. Start 7.5-10mg, +2.5mg every 4 weeks. **Folic acid** 5mg weekly (not on MTX day).
- **Monitor**: FBC, LFTs, Cr every 2-4 weeks initially, then 2-3 months.

Sulfasalazine

- **Highlight**: Pyrimidine DMARD.
- **Dose**: Start 500mg daily, increase by 500mg weekly to 1-2g/day divided.

Hydroxychloroquine

- **Highlight**: Antimalarial DMARD.
- **Dose**: 200–400 mg daily (≤5 mg/kg actual body weight).
- **Monitor**: Baseline & annual eye exam (maculopathy risk).

Triple Therapy Strategy: MTX + Sulfasalazine + Hydroxychloroquine is an effective, affordable alternative to biologics for moderate disease. (All general benefit PBS)

The Biologics & tsDMARDs Escalation Matrix

Indicated post-failure of ≥2 csDMARDs. PBS Authority Required for severe active RA (DAS28 >5.1).

Class & Drugs	Delivery	Key Clinical Alert
TNF inhibitors (TNFi) Adalimumab, Etanercept.	SC injection (First-line biologic).	⚠ Risk of infection, demyelination.
IL-6 receptor inhibitors Tocilizumab.	IV or SC.	⚠ Can completely mask CRP rise. Monitor lipids & neutrophils.
JAK inhibitors (JAKi) Tofacitinib, Baricitinib.	Oral.	FDA ALERT Increased VTE, MACE, and malignancy risk in patients >50y with CV risk factors.

MANDATORY SCREENING: Live vaccines are strictly contraindicated on biologics/tsDMARDs.

System Diagrostics Pre-screening

Tuberculosis

QuantiFERON Gold screening for latent TB.

Viral Hepatitis

Hepatitis B and C serology.

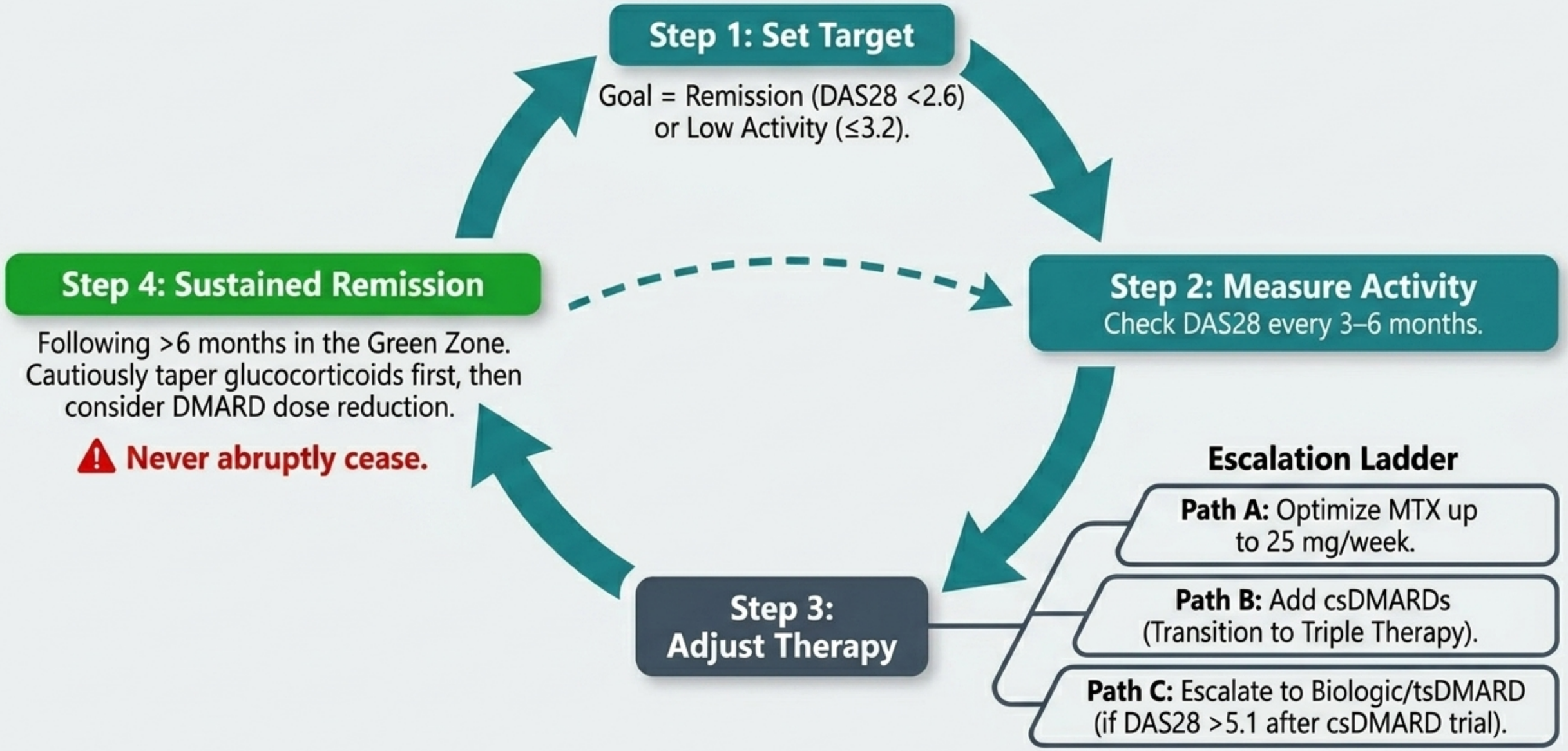
HIV

Baseline retroviral status.

Varicella

Confirm immunity or vaccinate prior to initiation.

The Treat-to-Target Execution Engine



The Anatomical Map

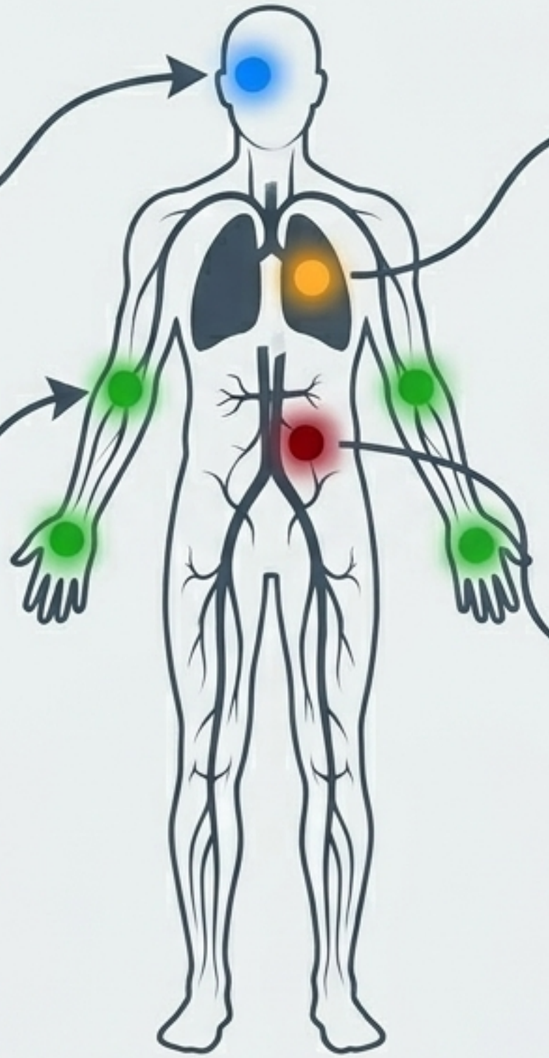
Eyes

Scleritis/Episcleritis.
Requires urgent ophthalmology referral.

Lungs

Interstitial Lung Disease (ILD).
Screen with HRCT if symptomatic.

⚠ **Alert:** Avoid Methotrexate.



Skin/Joints

Rheumatoid Nodules.
Most common. Occur on pressure points. Monitor for infection/ulceration.

Vascular system

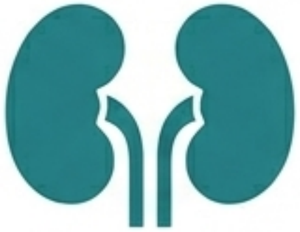
Rheumatoid Vasculitis.
Rare but severe. Requires high-dose corticosteroids + cyclophosphamide/rituximab.

Occurs in ~20% of patients, highly correlated with high-titre RF/anti-CCP. Requires specialist co-management.

Special Populations Navigator

Pregnancy & Conception

- **Red/Stop:** MTX, leflunomide, JAKi (cease ≥3 months pre-conception).
- **Green/Safe:** Hydroxychloroquine, sulfasalazine, low-dose prednisolone, certolizumab (TNFi without Fc region).



Renal Impairment

- **Red/Stop:** NSAIDs if eGFR <60. MTX absolutely contraindicated if eGFR <30 mL/min.
- **Amber/Caution:** Use MTX with extreme caution if eGFR 30–50.

Immunocompromised

- Screen and treat latent infections pre-immunosuppression.
- Ensure pneumococcal and influenza vaccination prior to biologic initiation.

Aboriginal and Torres Strait Islander Health Considerations

Risk Profile	Higher overall prevalence, earlier age of onset, and significantly more aggressive, erosive disease compared to non-Indigenous populations.
Systemic Barriers	Geographic isolation, limited access to specialist rheumatology in remote areas, and the compounding factor of PBS co-payments.
Clinical Solutions	• Establish cultural safety and build trust. • Utilize 'Closing the Gap' (CTG) PBS scripts to eliminate co-payment barriers for DMARDs. • Leverage specialist telehealth for continuous remote monitoring.

The Three Pillars of Modern RA Care

Pillar 1: The Window of Opportunity

Identify early. Time is cartilage. Initiate MTX within the 3–6 month window.

Pillar 2: Relentless Measurement

Do not treat blindly. Use DAS28 every 3-6 months to continuously drive therapy into the remission zone (<2.6).

Pillar 3: Multidisciplinary Integration

RA cannot be managed by a GP or Rheumatologist in isolation. It requires a synchronized team including physiotherapy and podiatry to protect functional outcomes.

Aligned with 2026 RACGP & ARA Guidelines.