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An update on lower limb joint replacement in rheumatoid arthritis

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More than 2/3rd of patients of Rheumatoid arthritis (RA) become disabled 20 years from primary diagnosis. RA is one of the most common indications for lower limb joint replacement in Northern Europe and North America. Though improved medical treatment of RA over last 2 decades have decreased the rate of hip and knee surgery, over a third of patients will need a major joint replacement, of which the majority will receive a total hip or knee replacement (THR and TKR). This paper summarizes an update on the major lower limb arthroplasty surgery for patients with RA. A multidisciplinary approach is needed for preoperative optimization. RA patients may need joint replacement at relatively younger age when compared to the patients with osteoarthritis and may need multiple revision surgeries over their lifespan. Patients should be made aware of this and increased risk of infection and peri-prosthetic fracture rates associated with their disease. Biologic agents should be stopped pre-operatively due the increased infection rate. However, continued use of methotrexate does not increase infection risk, and may infact be helpful in recovery. The surgical sequence is commonly hip, knee and then ankle. Cemented total hip replacement (THR) and total knee replacement (TKR) have superior survival rates over uncemented components. Achieving ligamentous balance may be challenging in knee replacements in these patients and more constrained implants may be needed in patients with poor ligaments and severe deformities. The evidence is not clear regarding a cruciate sacrificing versus retaining in TKR, but a cruciate sacrificing component limits the risk early instability and potential revision. The results of total ankle replacement remain inferior to THR and TKR though the science of ankle replacement continues to evolve. RA patients achieve equivalent pain relief after joint replacement, but their rehabilitation is slower and their functional outcome may not be optimum due to continued presence or worsening of the disease. Again, the key to managing these complicated patients is to work as part of a multidisciplinary team to optimize their outcome.

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Diagnostic tools and techniques for rheumatic diseases

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Autoimmune rheumatic diseases presents in many ways. A good history and detailed clinical examination of patient are extremely important for proper diagnosis of over 100 types of arthritis. Recognition of patterns of joint involvement (topography) as well as those of disease presentation and progression is essential for correct clinical diagnosis. In Rheumatology practice, a working diagnosis can usually be made on proper clinical examination of the patient. Routine laboratory & immunologic laboratory tests as well as imaging modalities, serves critical role in care of patients with rheumatic disease to diagnose, look for disease activity, end organ involvement, prognosis and response to treatment. But scope of misuse of tests is also large for misdiagnosis, inappropriate therapy and unnecessary health care expenditure. Increasing emphasis on primary care medicine leads to greater primary care ordering and analysis of such tests. Aim should be to focus on utility and interpretation of most frequently used tests. .

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