CASE REPORT

The Atypical Presentation of Rheumatoid Arthritis in an Elderly Woman: A Case Report

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ABSTRACT

The diagnosis of rheumatologic problem can be difficult, especially if not all the diagnostic criteria or typical clinical features are seen. This includes conditions such as rheumatoid arthritis which needs early diagnosis to start disease modifying drugs (DMARDs) which can improve the prognosis and prevent further joint erosion and organ damage.

This case report focused on a similar scenario in an elderly woman initially thought to have osteoarthritis but was diagnosed later with rheumatoid arthritis which brought much relief to her current predicament.

KEYWORDS: Atypical, rheumatoid arthritis, DMARDs, quality of life

INRODUCTION

Rheumatoid arthritis is a life changing disorder that can cause immense suffering and effect on quality of life. It is a systemic chronic inflammatory disorder that is triggered by auto-antibodies against various parts of the body, especially the small joints and organs (1).

It becomes important to diagnose this condition early as delay in diagnosis may worsen prognosis which may lead to further damage to the joints and organs such as the lungs and the heart and even to death. However, diagnosis can be elusive especially if the typical diagnostic criteria are not meet or there is absence of typical clinical features (2).

This case report will focus on an elderly woman with a long history of bilateral knee joint pain which was later diagnosed as rheumatoid arthritis and subsequently started on disease modifying drugs (DMARDs).

CASE REPORT

A 71 years old woman, with underlying hypertension and diabetes mellitus, came for her usual follow-up at a government primary care clinic. At this visit, which was her second visit with the same doctor she saw the last time, she complained of on and off bilateral knee pain for the past five years. She had seen various private general practitioners who had diagnosed her as bilateral knee osteoarthritis and prescribed her with analgesics as well glucosamine and

physiotherapy. However, this did not relieve her of the pain that caused her obvious difficulty in walking.

She described her pain score ranging from 6-8/10 with worse pain at the start of the day and slight improvement as the day wears off. There was occasional blateral knee joint stiffness but no obvious swelling. On examination, her vital signs were stable. Examination of both knees showed normal range of movement with tenderness at joint line. There was no effusion, and both tendon and ligaments stability tests were normal.

Looking at the chronicity of her problem especially with just minimal improvement with the current treatment plan, she was subjected to X-ray of both knees along with connective tissue screening profile that included erythrocyte sedimentation rate, C-reactive protein (CRP), anti-cyclic citrullinated peptide (anti-CCP), anti-neutrophil cytoplasmic antibody (ANCA) plus anti-double stranded DNA antibody (anti-dsDNA) and rheumatoid factor (RF). She was given an appointment of two weeks.

At two weeks, she returned with all her investigations ready. Her RF was high at 67 IU/mL while her ESR and anti-CCP were also elevated at levels of 78 mm/hr and 47 u/ml. Her knee X-rays showed typical features of rheumatoid arthritis such as joint space narrowing, soft tissue swelling and periarticular erosions. Other investigations were normal.

She was treated as rheumatoid arthritis and started on a low dose prednisolone as bridging therapy concurrently with methotrexate, taking into account that her liver function test so far was normal. She was given an appointment of another 2 weeks where an improvement in pain scoreed from 6-8/10 to a current score of 1-3/10 was noted. She was continued on methotrexate and her prednisone was stopped. She was advised to return every 3 months to monitor her liver function test as hepatotoxicity since liver fibrosis are known side effects of methotrexate.

DISCUSSION

Rheumatoid arthritis is usually diagnosed based on 2010 American College of Rheumatology-European League Against Rheumatism (ACR-EULAR) Classification (3). In this classification, a score of 6 or more usually indicates a definite rheumatoid arthritis (RA) while a lower score indicates a lower likelihood of that condition being RA. This classification includes features such as duration, involved joint type, i.e., large or small joints and raised serology markers such as anti-CCP,RF, ESR and CRP.

Based on this classification, this patient would rank in a score of only 4 which then was needed to be correlated with other features such as classical X-ray findings as noted to be present in this patient to diagnose the presence of RA. Therefore, diagnosis of RA can be a challenge, especially when scores of less than 6 are obtained on the gold standard ARC-EULAR classification.

As stated before, DMARDs such as methotrexate or azathioprine should be started as soon as possible to prevent further harm to the joints and organs (4). Therefore, both early diagnosis and subsequent commencement with DMARDs will help improve prognosis of RA.

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