

Client Situation and Presentation

Chara Gutierrez, a 58-year-old female, presents to the clinic with complaints of fatigue, pain, swelling, and stiffness in her hands, fingers, toes, and feet for the past month. Her symptoms are exacerbated after periods of immobility. Laboratory tests and imaging were ordered, confirming a diagnosis of rheumatoid arthritis (RA). Her physical examination is normal aside from joint pain and swelling. Her medical history includes hypertension and type 2 diabetes, and her BMI of 36.6 classifies her as obese, which may exacerbate inflammatory responses. Her current medications include captopril 25 mg PO q12hr for hypertension and metformin 500 mg PO BID for type 2 diabetes.

The American College of Rheumatology (ACR) 2021 guidelines for the management of RA emphasize early initiation of disease-modifying antirheumatic drugs (DMARDs), specifically methotrexate as a first-line treatment (Fraenkel et al., 2021). For patients with moderate to severe RA symptoms, additional therapies, including biologic agents or Janus kinase (JAK) inhibitors, may be considered if there is an inadequate response to initial DMARD therapy. Nonsteroidal anti-inflammatory drugs (NSAIDs) and corticosteroids may be used to manage acute inflammation and pain while waiting for the DMARDs to take effect.

Given Chara's comorbidities, close monitoring is required, as some pharmacological treatments for RA may affect blood pressure and glycemic control. Methotrexate is appropriate unless contraindicated. Low-dose corticosteroids might also be prescribed temporarily to alleviate her severe symptoms.

In Chara's case, the initiation of methotrexate, 15 mg per week orally or subcutaneously, is recommended as the first-line therapy to control RA progression. Folic acid supplementation should also be prescribed to minimize methotrexate-associated toxicity (Fraenkel et al., 2021). If symptoms persist or side effects occur, alternative options such as leflunomide or hydroxychloroquine may be considered. NSAIDs like naproxen or ibuprofen may provide immediate symptom relief, but these should be used cautiously due to potential cardiovascular risks in patients with hypertension. Short-term low-dose prednisone (≤ 10 mg/day) can manage acute inflammation while waiting for methotrexate's therapeutic effect. However, prolonged use should be avoided due to risks of hyperglycemia and weight gain, which are particularly relevant for Chara (Kay & Singh, 2022).

Additional Considerations and Follow-Up

Further information is needed to optimize treatment:

Hepatic and Renal Function: Baseline liver and kidney function tests are crucial before initiating methotrexate, as it can be hepatotoxic and nephrotoxic.

Infection Screening: Screen for latent tuberculosis and hepatitis B/C due to immunosuppressive therapy risks (Fraenkel et al., 2021).