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Review on Rheumatoid Arthritis

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Abstract: ***A chronic, systemic inflammatory disease that mostly affects synovial joints, rheumatoid arthritis (RA) causes gradual joint degeneration, deformity, and disability. Systemic symptoms, autoantibody production, and chronic synovial inflammation are its defining characteristics. Its development and progression are influenced by immunological, environmental, and genetic variables, albeit the precise aetiology is yet unclear. Millions of people are impacted by the illness globally, particularly women, and it has a major negative influence on quality of life. Results have improved with early diagnosis and vigorous therapy with biologics and disease-modifying anti rheumatic medications (DMARDs). However, there are still issues with managing extra-articular problems, personalised therapy, and illness prognosis. Future improvements in illness management and perhaps remission are possible with ongoing research into immunological mechanisms and targeted medicines.***
Keywords: ***Rheumatoid arthritis, autoimmune disease, synovial inflammation, DMARDs, TNF inhibitors, diagnosis, joint deformity, immunopathology, anti-CCP antibodies, biologics, pathophysiology, chronic inflammation.***

I. INTRODUCTION

The inflammatory, systemic, chronic autoimmune disease known as rheumatoid arthritis (RA) mostly affects the synovial joints. Prolonged synovitis, systemic inflammation, and the development of autoantibodies, such as anti-citrullinated protein antibodies (ACPAs) and rheumatoid factor (RF), are its defining features. Women are two to three times more likely than males to acquire RA, which affects between 0.5% and 1% of the world's population [1]-[2].

Although it can happen at any age, RA usually shows up between the ages of 30 and 60. In contrast to osteoarthritis, which is more localized and degenerative, RA is an autoimmune disease that affects many different organs and systems, including the skin, eyes, lungs, and cardiovascular system [3]-[4].

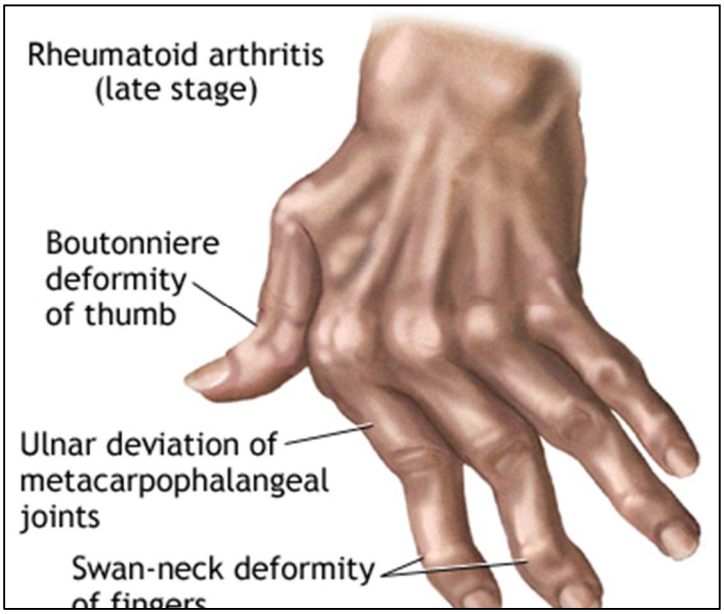


FIG.1: RHEUMATOID ARTHRITIS [1]

Environmental variables, immune system dysregulation, and genetic predisposition interact intricately in the pathophysiology of RA. Increased vulnerability to RA has been linked to genetic markers, specifically the HLA-DR4 and HLA-DR1 alleles. It is believed that immunological responses in genetically vulnerable people are triggered by environmental factors including smoking, infections, and microbiome abnormalities [5].

Joint inflammation and injury are caused by pro-inflammatory cytokines such tumor necrosis factor-alpha (TNF-α), interleukin-1 (IL-1), and interleukin-6 (IL-6) that are produced as a result of these immunological responses, which entail the activation of T-cells, B-cells, and macrophages [6]-[7].

Symmetric joint pain, stiffness (particularly in the morning), oedema, and functional impairment are the usual clinical manifestations of RA. Although the illness can spread to bigger joints, the tiny joints of the hands and feet are more frequently impacted. One of the basic signs of RA is morning stiffness that lasts more than half an hour. Prolonged inflammation causes deformity, incapacity, and joint damage over time [8]-[9].

The illness is made more difficult by extra-articular symptoms as eye inflammation, vasculitis, interstitial lung disease, and rheumatoid nodules.

In order to avoid irreparable joint injury and systemic consequences, early diagnosis and treatments are essential. Clinical characteristics, serological markers, acute-phase reactants, and symptom duration are all included in the 2010 American College of Rheumatology (ACR)/European League against Rheumatism (EULAR) classification criteria, which offer a standardized method for diagnosing RA. Diagnostic procedures include magnetic resonance imaging (MRI), ultrasound, and X-rays aid in determining the extent of joint damage and the course of a disease [10]-[11].

Over the past few decades, there has been a major evolution in the management of RA. The mainstay of treatment consists of disease-modifying anti-rheumatic medications (DMARDs), such as leflunomide, sulfasalazine, and methotrexate.

The therapy landscape has been completely transformed by biologic medicines that target certain cytokines or immune cells, such as TNF inhibitors (e.g., etanercept, infliximab), IL-6 inhibitors (e.g., tocilizumab), and B-cell depleting therapies (e.g., rituximab). Patients with moderate to severe illness now have more options thanks to the recent development of oral Janus kinase (JAK) inhibitors as biologic substitutes. Non-steroidal anti-inflammatory medications (NSAIDs) and corticosteroids are used to treat symptoms, however they are insufficient when taken alone [12]-[13].

In order to achieve remission or low disease activity, a "treat-to-target" approach that involves routinely assessing disease activity and modifying medication has become the accepted standard of care. For people with RA, this strategy greatly enhances results and quality of life when combined with patient education, physical therapy, and lifestyle changes [14]-[15].

Treatment has advanced, but there are still numerous obstacles to overcome. Long-term usage of immunosuppressive drugs can have negative consequences, and not all patients react well to current treatments.

Furthermore, RA is linked to a higher incidence of comorbid conditions like depression, osteoporosis, and cardiovascular disease.

With current efforts concentrated on finding novel biomarkers for early diagnosis and predicting therapy response, research into the underlying processes of RA is still growing. Future RA treatment may benefit from precision medicine, which attempts to customize treatment according to each patient's unique genetic, molecular, and clinical characteristics. Potential routes for prevention and novel treatments are presented by current research into the roles of environmental exposures, the gut microbiota, and epigenetic alterations [16]-[17].

Alternative and complementary therapies, such as herbal remedies, acupuncture, omega-3 fatty acid supplements, and dietary changes, are being investigated as supplements to traditional medical care. Although there is some evidence to support their usage, thorough clinical trials are required to determine their efficacy and safety.

In order to manage the worldwide burden of RA, public health measures that focus on raising awareness, early diagnosis, and access to care are essential. Addressing the multifaceted requirements of RA patients requires patient-centered care models that involve multidisciplinary teams of rheumatologists, primary care doctors, physical therapists, psychologists, and social workers.

Rheumatoid arthritis is a complex autoimmune disease that has a big influence on people's lives and society. Improving patient outcomes and lowering the burden of disease need ongoing research, early intervention, and customized treatment plans. Future research into RA might lead to safer, more effective, and more focused treatments, giving millions of people living with this crippling illness hope [18]-[20].

II. ETIOLOGY

The exact aetiology of rheumatoid arthritis (RA), an inflammatory illness, is unclear, however several variables may play a role in its development. With close ties to the HLA-DR1 and HLA-DR4 alleles, genetic predisposition is important.

In those who are genetically predisposed, environmental triggers such as smoking, periodontal diseases, and abnormalities in the gut microbiota can start immunological reactions.

Given that RA is more common in women, hormonal factors could potentially play a role. Through molecular mimicry, bacterial or viral infections can serve as initiators. Prolonged stress and epigenetic changes have also been linked.

RA is therefore seen as complex, including the interaction of immune-mediated, environmental, and genetic processes [21]-[22].

III. PATHOPHYSIOLOGY

An abnormal immune response that targets synovial joints is a hallmark of RA. First, CD4+ T-cells are activated by antigen-presenting cells, which in turn activates B-cells and produces autoantibodies (such as RF and anti-CCP).

Chronic synovial inflammation is caused by these immune complexes, which encourage the production of pro-inflammatory cytokines such as TNF-α, IL-1, and IL-6. Pannus, an invasive tissue that erodes bone and cartilage, is created when activated synovial fibroblasts multiply. Tissue injury is exacerbated when neutrophils and macrophages enter the joint area.

Angiogenesis improves the flow of blood to inflammatory joints. This immunological cascade eventually leads to systemic symptoms, abnormalities, and joint degeneration [23]-[24].

IV. SYMPTOMS

Symmetric joint pain, stiffness, and oedema are common early symptoms of RA, especially in tiny joints like the hands and feet. One of the defining symptoms is morning stiffness that lasts longer than half an hour. Joint problems are frequently accompanied by fatigue, low-grade fever, and overall malaise. Larger joints including the knees, shoulders, and hips may become affected as the illness worsens. It is possible for nodules to form beneath the skin, especially at pressure sites. Anemia, ocular inflammation, lung involvement, and vasculitis are examples of extra-articular symptoms. Joint abnormalities and functional impairment may develop in long-term situations. Although the course of the disease varies, flare-ups and remissions are common [25]-[26].

V. DIAGNOSIS

Imaging, laboratory testing, and clinical presentation are used to diagnose RA. Acute-phase reactants (CRP and ESR), serology (RF and anti-CCP antibodies), joint involvement, and symptom duration are all taken into account by the widely used 2010 ACR/EULAR criteria. The diagnosis is supported by elevated RF and anti-CCP levels. Imaging tests such as MRIs, ultrasounds, and X-rays show inflammation, synovial thickness, and joint erosion. In order to prevent joint injury, early diagnosis is essential for starting therapy right away. It is necessary to rule out differential diagnoses such osteoarthritis, psoriatic arthritis, and lupus. Inflammatory indicators aid in evaluating the severity of the disease and tracking the effectiveness of therapy over time [27]-[28].

VI. TREATMENT

Controlling inflammation, reducing discomfort, avoiding joint deterioration, and preserving function are the goals of RA therapy. Conventional synthetic DMARDs, such as methotrexate, are part of first-line treatment.

In moderate to severe instances, biologic DMARDs are employed, such as B-cell treatments, IL-6 inhibitors, and TNF-α inhibitors. JAK inhibitors offer a specific oral alternative. Although they do not alter the course of the disease, NSAIDs and corticosteroids aid in symptom management.

It is common practice to use a "treat-to-target" strategy, which involves changing medication to produce remission or low disease activity. Long-term treatment is supported by patient education, physical therapy, and lifestyle changes.

To maximize treatment, reduce side effects, and enhance patient outcomes, routine monitoring is crucial [29]-[30].

VII. RISK FACTORS

The chance of having RA is increased by a number of variables. A significant risk factor is genetic predisposition, particularly HLA-DR4 and HLA-DR1 alleles. Especially during the reproductive years, women are more likely than males to be impacted.

Disease onset can be triggered by environmental factors including smoking cigarettes, air pollution, and exposure to asbestos or silica. Epstein-Barr virus is one infection that can trigger autoimmunity. Low vitamin D levels and hormonal abnormalities have also been linked to an increased risk.

Sedentary lifestyles and obesity can exacerbate RA symptoms by causing systemic inflammation. Susceptibility to RA is further increased by autoimmune co-morbidities and family history [31]-[32].

VIII. FUTURE SCOPE OF STUDY

The goal of future RA research is to create precision medicine strategies that tailor treatment by using genetic, epigenetic, and biomarker profiles. Knowing how the gut microbiota contributes to the development and course of RA opens up exciting new treatment and prevention options. Digital monitoring techniques and advanced imaging can improve illness tracking and early detection. Immunotherapies and gene-editing technologies could have therapeutic potential.

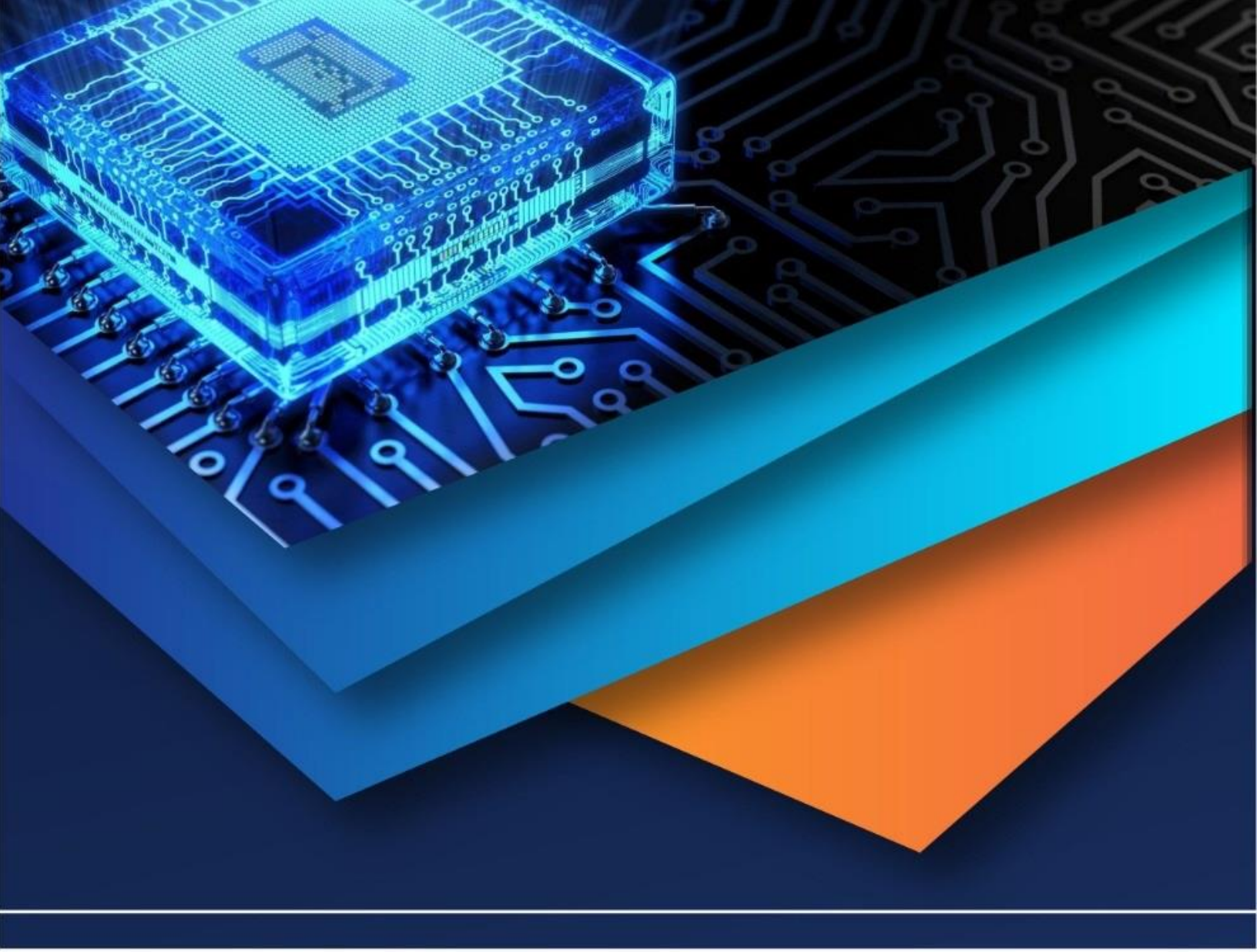
Research is still being done on less immunosuppressive medications with fewer adverse effects. Additionally, combining diet-based therapy with complementary therapies may enhance quality of life. To further understand RA heterogeneity and improve therapy recommendations worldwide, extensive, multiethnic research is required [33]-[35].

IX. CONCLUSION

Rheumatoid arthritis is still a crippling and complicated autoimmune disease that has a significant impact on joint integrity and general health. Prognosis and patient care have been greatly improved by developments in immunology and treatment approaches. Even with these advancements, better results still depend on early diagnosis, tailored therapy, and a deeper comprehension of disease causes. Effective illness management requires a multidisciplinary strategy that includes medication, lifestyle changes, and rehabilitation. Predictive biomarkers, less immunosuppressive therapies, and possible curative measures should be the main topics of future study. The burden of RA can be lessened with ongoing innovation and clinical attention, providing hope for a longer-lasting remission and an enhanced quality of life.

REFERENCES

[1] Smolen JS, Aletaha D, McInnes IB. Rheumatoid arthritis. The Lancet. 2016;388(10055):2023-2038.
[2] Firestein GS. Evolving concepts of rheumatoid arthritis. Nature. 2003;423(6937):356-361.
[3] McInnes IB, Schett G. Pathogenetic insights from the treatment of rheumatoid arthritis. The Lancet. 2017;389(10086):2328-2337.
[4] Aletaha D, Neogi T, Silman AJ, et al. 2010 Rheumatoid Arthritis classification criteria. Arthritis Rheum. 2010;62(9):2569-2581.
[5] Cojocaru M, Cojocaru IM, Silosi I, Vrabie CD. Manifestations of systemic diseases on the oral mucosa. J Med Life. 2010;3(4):386–390.
[6] Scott DL, Wolfe F, Huizinga TW. Rheumatoid arthritis. The Lancet. 2010;376(9746):1094-1108.
[7] Klareskog L, Padyukov L, Lorentzen J, Alfredsson L. Mechanisms of disease: Genetic susceptibility and environmental triggers in the development of rheumatoid arthritis. Nat Clin Pract Rheumatol. 2006;2(8):425-433.
[8] van der Heijde D. How to read radiographs according to the Sharp/van der Heijde method. J Rheumatol. 1999;26(3):743-745.
[9] Gabriel SE. The epidemiology of rheumatoid arthritis. Rheum Dis Clin North Am. 2001;27(2):269-281.
[10] Rindfleisch JA, Muller D. Diagnosis and management of rheumatoid arthritis. Am Fam Physician. 2005;72(6):1037-1047.
[11] Arend WP, Dayer JM. Inhibition of the production and effects of interleukin-1 and tumor necrosis factor alpha in rheumatoid arthritis. Arthritis Rheum. 1995;38(2):151-160.
[12] Moreland LW, O'Dell JR. Glucocorticoids and disease-modifying anti-rheumatic drugs. Arthritis Res Ther. 2002;4(Suppl 2):S21–S23.
[13] Taylor PC. Biologic therapies and the future of the targeted approach for rheumatoid arthritis. Curr Opin Rheumatol. 2012;24(3):327-334.
[14] Weinblatt ME. Methotrexate in rheumatoid arthritis: A quarter century of development. Trans Am Clin Climatol Assoc. 2013;124:16–25.
[15] Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. Arthritis Rheumatol. 2016;68(1):1-26.
[16] Feldmann M, Maini RN. Anti-TNF alpha therapy of rheumatoid arthritis: What have we learned? Annu Rev Immunol. 2001;19:163-196.
[17] Smolen JS, Landewé R, Bijlsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological DMARDs: 2019 update. Ann Rheum Dis. 2020;79(6):685-699.
[18] Emery P. Treatment of rheumatoid arthritis. BMJ. 2006;332(7534):152-155.
[19] Gravallese EM. Bone destruction in arthritis. Ann Rheum Dis. 2002;61(suppl 2):ii84–ii86.
[20] Kavanaugh A, Cush JJ. The evolving use of biologic agents in rheumatoid arthritis. J Rheumatol Suppl. 2004;71:13-22.
[21] van der Heijde D, et al. Comparison of the 1987 ACR and 2010 ACR/EULAR classification criteria. Ann Rheum Dis. 2011;70(9):1478-1484.
[22] Choy EH, Panayi GS. Cytokine pathways and joint inflammation in rheumatoid arthritis. N Engl J Med. 2001;344(12):907-916.
[23] Brennan FM, McInnes IB. Evidence that cytokines play a role in rheumatoid arthritis. J Clin Invest. 2008;118(11):3537–3545.
[24] Yelin E, et al. Medical care expenditures and earnings losses among persons with arthritis and other rheumatic conditions. Arthritis Rheum. 2007;56(5):1397-1407.
[25] Sokka T, et al. Radiographic progression in rheumatoid arthritis: Evolving insights. Clin Exp Rheumatol. 2012;30(5 Suppl 73):S10–S14.
[26] van Vollenhoven RF. Treat-to-target in rheumatoid arthritis – are we there yet? Nat Rev Rheumatol. 2019;15(3):180-186.
[27] van der Helm-van Mil AH, et al. Prediction of progression to RA. Arthritis Res Ther. 2005;7(3):R703–R715.
[28] Bombardier C, et al. Adalimumab efficacy and safety in early RA. Ann Intern Med. 2007;146(12):829-838.
[29] Lard LR, et al. Early versus delayed treatment in patients with recent-onset RA: Comparison of two cohorts. Arthritis Rheum. 2001;44(5):1037-1046.
[30] Tarp S, et al. Systematic review: Biologic vs conventional DMARDs in RA. Ann Intern Med. 2012;157(7):498-510.
[31] Keystone EC. Targeting cytokines in rheumatoid arthritis. Clin Exp Rheumatol. 2015;33(4 Suppl 92):S4-S6.
[32] Huizinga TWJ, et al. Clinical and radiographic outcomes with combination therapy in early RA. Lancet. 2008;372(9636):979-989.
[33] Dougados M, et al. TNF inhibition and radiographic damage progression. Ann Rheum Dis. 2003;62(7):611-614.
[34] Genovese MC, et al. Tofacitinib, an oral JAK inhibitor, in RA treatment. N Engl J Med. 2012;367(6):495-507.
[35] Burmester GR, et al. Emerging cell-based therapies in RA. Nat Rev Rheumatol. 2020;16(1):13-25.



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