Rheumatoid arthritis

1 Rheumatoid arthritis (RA):
   a) Is an acute and local disorder of the synovial joints
   b) Can lead to joint destruction, deformity and disability
   c) Has an annual incidence in the UK of 3%
   d) Is rare in rural China and Indonesia
   e) Has increased in incidence over recent decades

2 Regarding RA causes and trends:
   a) Women who have taken oral contraceptives are twice as likely to develop the condition
   b) Genetic clustering in families has been confirmed through observations in twin studies
   c) Fewer men develop RA than women
   d) Inflammatory arthropathy caused by parvovirus often progresses to RA
   e) There is no link between smoking and RA

3 Patients with RA have an increased risk of:
   a) Some types of cancer
   b) Ischaemic heart disease
   c) Pregnancy
   d) Developing infections
   e) Alcohol misuse

4 Concerning RA pathophysiology:
   a) T cells are believed to activate macrophages and fibroblasts, resulting in tissue destruction
   b) T cells stimulate the production of autoantibodies such as rheumatoid factor
   c) Proinflammatory cytokines such as tumour necrosis factor (TNF) prevent osteoclastogenesis
   d) The disease can affect any joint lined by synovial membrane containing synovial fluid
   e) Joint damage results from active remodelling processes that occur in the synovium in response to inflammation

5 Regarding treatment with methotrexate:
   a) It should only be prescribed as monotherapy for patients with RA
   b) Folic acid should be co-administered on the day of methotrexate dosing
   c) Kidney function should be monitored since methotrexate is renally excreted
   d) The drug should be withheld if the patient develops a severe infection
   e) Subcutaneous injection can reduce gastrointestinal intolerance

6 Regarding side effects of RA treatments:
   a) Rituximab has been associated with fatal cases of multifocal leukoencephalopathy
   b) Hydroxychloroquine has the potential to cause retinal toxicity
   c) Infection is a particular risk for patients receiving non-TNF-inhibitor biologics
   d) In the case of serious infection, leflunomide must be “washed out” using colestyramine
   e) Methotrexate and leflunomide are associated with interstitial pneumonitis

7 Concerning corticosteroid use for patients with RA:
   a) Regular oral treatment is preferred
   b) Patients should be counselled regarding potential risks of psychotic reactions following higher intramuscular (IM) doses
   c) Intermittent use of IM or intra-articular (IA) injections can increase joint erosion
   d) They have an important place in controlling “flares” of disease
   e) Licensed loading doses can cause severe diarrhoea and abdominal pain

8 The following biologics are administered subcutaneously:
   a) Certolizumab pegol
   b) Infliximab
   c) Abatacept
   d) Adalimumab
   e) Anakinra

9 In the care of patients with RA:
   a) Some specialist rheumatology pharmacists are trained to administer IA injections
   b) Community pharmacists should ensure those taking methotrexate have their dose recorded in monitoring booklets
   c) Surgery should always be viewed as a last resort
   d) Occupational therapists undertake home assessments and provide splints and supports for joints
   e) American College of Rheumatology criteria are used to determine an individual’s disease activity score (DAS)

10 Regarding RA treatment and monitoring:
    a) DAS-28 is based on assessment of symptoms at 28 separate clinic visits
    b) Biologic treatment should be stopped if a patient achieves a decrease in DAS-28 score of at least 1.2 after six months of therapy
    c) Early use of disease-modifying antirheumatic drugs (DMARDs) is crucial in preventing joint damage
    d) Various baseline tests should be conducted before starting DMARD treatment to aid assessment of drug toxicity
    e) The introduction of biologics has reduced the need to offer lifestyle advice