Clinical Report

Patient Information

- **Name:** Eleanor Vance
- **Date of Birth:** 08/15/1979
- **Age:** 45
- **Gender:** Female
- **Contact Information:** (555) 123-4567, eleanor.vance@email.com
- **Address:** 456 Oak Avenue, Anytown, USA

Referring Physician

- Dr. Sarah Jenkins, MD
- General Practitioner
- Anytown General Hospital

Medical Institution

- Rheumatology Associates of Anytown
- **Report Date:** 07/18/2025

Clinical History and Background

Eleanor Vance is a 45-year-old high school art teacher who was referred to our clinic by her primary care physician, Dr. Sarah Jenkins, for evaluation of persistent and worsening joint pain. Mrs. Vance has a past medical history significant for hypothyroidism, well-controlled with levothyroxine. She has no prior history of autoimmune diseases. Her family history is notable for a mother with rheumatoid arthritis (RA) and a maternal aunt with Sjögren's syndrome. Socially, Mrs. Vance is a non-smoker and consumes alcohol occasionally. She is married with two teenage children and reports a supportive home environment. She denies any recent travel or known exposures to infectious agents.

The onset of her symptoms was insidious, beginning approximately nine months ago.[1] Initially, she experienced intermittent stiffness in her hands, which she attributed to her work as an art teacher.[1] Over the past four months, the symptoms have progressed significantly, now involving multiple joints with increased intensity and duration.

Current Symptoms & Patient-Reported Outcomes (PROs)

- **Joint Pain:**
    - **Patient's Description:** "A deep, aching pain" primarily in her hands, wrists, and knees, but also affecting her shoulders and feet.[2] The pain is symmetrical, affecting both sides of her body.[2][3]
    - **Severity:** Rates the pain as a 7/10 on average, with morning pain reaching 9/10.

    - **Duration:** The pain is constant but fluctuates in intensity throughout the day.
    - **Clinical Note:** The patient's description of symmetrical polyarthritis is a hallmark of RA.[4]
- **Morning Stiffness:**
    - **Patient's Description:** "I feel like the Tin Man in the morning. It takes me a good hour or two to loosen up." The stiffness is most profound in her hands and knees.[3][5]
    - **Severity:** Describes the stiffness as "severe," significantly impacting her ability to perform morning routines.
    - **Duration:** Lasts for approximately 1-2 hours after waking.
    - **Clinical Note:** Morning stiffness lasting longer than 30 minutes is a key diagnostic criterion for RA.[3]
- **Fatigue:**
    - **Patient's Description:** "An overwhelming exhaustion that isn't relieved by sleep." She reports feeling tired most days, which affects her energy levels for teaching and family activities.[1][2]
    - **Severity:** Describes her fatigue as moderate to severe.
    - **Duration:** Persistent for the last few months.
    - **Clinical Note:** Systemic symptoms like fatigue are common in RA and can be as debilitating as the joint pain.[1]
- **Swelling:**
    - **Patient's Description:** "My knuckles and wrists are puffy, especially in the morning." She has also noticed swelling in her knees.[6]
    - **Severity:** Mild to moderate swelling.
    - **Duration:** The swelling is persistent but can worsen during flares.
    - **Clinical Note:** The patient's report of swelling is consistent with synovitis, the inflammation of the joint lining that is characteristic of RA.[2]

Clinical Findings

- **Vital Signs:**
    - **Blood Pressure:** 128/76 mmHg
    - **Heart Rate:** 78 bpm
    - **Respiratory Rate:** 16 breaths/min
    - **Temperature:** 99.1°F (37.3°C) (low-grade fever)[2]

- **Physical Examination:**
    - **General:** The patient appears well-nourished but fatigued.
    - **Musculoskeletal:** Examination of the joints reveals swelling, warmth, and tenderness to palpation in the metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints of both hands, as well as both wrists and knees.[4]

There is a "boggy" or "spongy" feel to the affected joints, consistent with synovitis.[1][7] A decreased range of motion is noted in the wrists and knees. No rheumatoid nodules were palpated.[6] There is evidence of symmetrical joint involvement.[1][3]

- **Laboratory Results:**
    - **Rheumatoid Factor (RF):** 125 IU/mL (Normal < 15 IU/mL) - *Positive*.[8]
    - **Anti-citrullinated protein antibodies (anti-CCP):** 150 U/mL (Normal < 20 U/mL) - *Positive*.[8]
    - **Erythrocyte Sedimentation Rate (ESR):** 45 mm/hr (Normal 0-20 mm/hr) - *Elevated, indicating inflammation*.[9][10]
    - **C-reactive Protein (CRP):** 3.2 mg/dL (Normal < 1.0 mg/dL) - *Elevated, indicating inflammation*.[9][10]
    - **Complete Blood Count (CBC):** Revealed mild normocytic anemia (Hemoglobin 11.5 g/dL), which can be associated with chronic inflammation in RA.[10][11]
    - **Liver and Kidney Function Tests:** Within normal limits.[11]
- **Imaging:**
    - **Hand and Wrist X-rays:** Show soft tissue swelling and periarticular osteopenia (thinning of the bone around the joints). No significant erosions are noted at this time, suggesting an early stage of the disease.[12]

Diagnosis

Based on the American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) 2010 classification criteria for Rheumatoid Arthritis, Mrs. Vance scores a 7 out of 10, confirming a diagnosis of definite RA.[13][14] The score is calculated as follows:

- Joint Involvement (2 large joints, 10 small joints): 5 points
- Serology (High positive RF and anti-CCP): 3 points
- Acute Phase Reactants (Elevated ESR and CRP): 1 point
- Duration of Symptoms (Greater than 6 weeks): 1 point

Treatment Strategy

The primary goal of treatment is to achieve remission or low disease activity to prevent joint damage, preserve function, and improve quality of life.[9][15]

1. **Pharmacological Treatment:**
    - **Disease-Modifying Antirheumatic Drug (DMARD):** The cornerstone of treatment will be Methotrexate, initiated at a low dose and titrated up as needed.[16][17] Methotrexate is the recommended first-line treatment for moderate to high disease activity in RA.[16][18] Folic acid supplementation will be prescribed to minimize potential side effects.
    - **Bridging Therapy:** A short course of a low-dose oral corticosteroid (e.g., prednisone) will be considered to rapidly reduce inflammation and symptoms

while the Methotrexate takes effect.[7][15] The goal is to taper and discontinue the steroid as quickly as possible.[9]

2. **Non-Pharmacological Treatment:**
    - **Physical and Occupational Therapy:** A referral will be made for a comprehensive evaluation. Physical therapy will focus on exercises to maintain joint flexibility and muscle strength.[9] Occupational therapy will provide strategies and adaptive equipment to protect joints and manage daily activities.
    - **Patient Education:** Comprehensive education on RA, its chronic nature, and the importance of treatment adherence will be provided.
    - **Lifestyle Modifications:** Guidance on the importance of regular, gentle exercise like walking or swimming, and stress management techniques will be offered.[9]

Summary and Plan

Mrs. Eleanor Vance is a 45-year-old female who presents with classic signs and symptoms of rheumatoid arthritis, supported by physical examination and laboratory findings. Her diagnosis of seropositive rheumatoid arthritis is confirmed. We will initiate a comprehensive treatment plan including a DMARD and patient education to manage her disease activity and improve her overall well-being. The importance of early and aggressive treatment to prevent long-term joint damage has been discussed with her.[9]

Follow-up

A follow-up appointment is scheduled in 4 weeks to assess her response to treatment, monitor for any side effects of the medication, and review the results of her physical and occupational therapy evaluations. Regular follow-up appointments will be scheduled every 3 months to monitor disease activity and adjust the treatment plan as needed.

Sources help

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