Concise Management of the

Common Rheumatic Disorders

Edited by
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PREFACE

Convinced of the need for a short rheumatology text devoted to treatment, I embarked upon this book with the aim of 'doing it myself', perhaps with an orthopaedic surgeon to comment helpfully at relevant moments. It soon became clear that the book would be enhanced by contributions by others specialists and I succeeded in persuading eight physicians and surgeons and a physiotherapist to help me with the various chapters. I am nevertheless responsible for ruthlessly editing all contributions in an effort to weld the subject into a consistent and readable 'whole'.

Much information that seems well-established at the time of writing is incorrect by the time of publication: this is a problem common to all medical texts, and there is not a great deal one can do about it. It is nevertheless hoped that the principal subject matter will stand the test of time and that the book will therefore prove useful as a practical guide to the treatment of the common rheumatic disorders for the readership intended, namely general practitioners, junior medical staff (particularly those training in rheumatology), clinical assistants and perhaps orthopaedic surgeons wishing to have a broad-based account of the subject.

I wish to thank Mrs. Pauline Harris for patiently typing the manuscript.

1979 D.N.G.

FOREWORD

The rheumatic disorders cover so much of medicine that to know and understand them is to know and understand a great deal of general medicine. Few specialties cover so many different disorders as does rheumatology, ranging as it does from tennis elbow to Wegener's granulomatosus, from systemic lupus erythematosus to the frozen shoulder. The treatment of these disorders is therefore a gigantic subject and a major headache to the general practitioner faced with a large number of persistent disorders, for most of which there is no specific simple therapy.

The editor of this book (who is also the author of a great deal of it) is an experienced clinician with a wide practical knowledge of his subject and he has wisely concentrated on the treatment of the more common rheumatic disorders. In a subject so large and complicated he has done extraordinarily well to have compressed so much practical therapeutic advice into such a relatively small compass. The book should prove a practical and useful guide for all those concerned with the treatment of this large group of unfortunate sufferers.

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CONTENTS

CHAPTER 1

INTRODUCTION

It is first necessary to justify the need for a rheumatology textbook devoted to management. In standard texts treatment does not usually receive such detailed coverage as diagnosis and investigation, particularly in the smaller books, and is rarely described with a down-to-earth, practical approach. It can be advantageous to view the subject from a different angle by looking at the whole spectrum of rheumatic diseases with regard to general management rather than treat them individually from the descriptive aspect. For example, it is helpful to discuss antirheumatic drugs as a whole in their role of treatment of all forms of inflammatory arthritis; to make suggestions for the planning and running of a rheumatology ward; to observe patients as they arrive at the Outpatient Clinic and the Ward, as they are nursed and treated during their stay in hospital and as they leave hospital to return home. We can appraise the follow-up of the patient from the general practitioner's point of view as well as that of the specialist, and we should be able to have a 'longitudinal' view of the patient coping with his disease at home after he leaves hospital.

Nevertheless, it is axiomatic that diagnosis, differential diagnosis and treatment are closely inter-related and it is difficult to decide how much information about clinical features, aetiology and pathology should be included in a book on treatment. This has been largely influenced by the immediate bearing of such matters on management: for example, backache due to sacro-iliitis is sometimes related to 'silent' ulcerative colitis, so barium studies and sigmoidoscopy may be considered as part of the total management of this condition.

This book sets out to describe the treatment of only the *common* rheumatic disorders and no attempt is made to include the rare (or even the less common) conditions. Polymyalgia rheumatica, backache and the various forms of soft-tissue rheumatism keep cropping up in the busy clinic and such disorders are described in detail, mainly from the viewpoints of the general practitioner, the junior hospital doctor and the clinical assistant. On the other hand, important as they are, other systemic connective-tissue disorders receive brief or no mention as they are not common in everyday practice.

The first six chapters relate to principles of management. This leads on to the common varieties of arthritis and rheumatism and then to painful syndromes affecting the limbs and spine. The book begins with

a general description of the rheumatic disorders as seen by the house officer and the family doctor. Then follows a discussion of the principles of alleviation of pain, including the determination and eradication of aggravating factors, followed by a general description of analgesic and antirheumatic drugs used in all inflammatory rheumatic conditions, then the alleviation of inflammation in joints by methods such as splinting, intra-articular steroid injections and removal of the inflamed synovial membrane, and the improvement in mobility and function of joints by such techniques as physiotherapy, remedial occupational therapy and surgery. This leads to a general consideration of the rehabilitation of the chronic arthritic and the special problems posed by the elderly patient. The next chapters cover various common and important types of rheumatic disease—soft-tissue rheumatism, degenerative joint disease, rheumatoid arthritis, gout and crystal deposition disease, seronegative spondarthritis and rheumatism of psychogenic origin. Finally, the spine, the upper limb and the lower limb are considered topographically.

The alphabetic 'Glossary of the Rheumatic Diseases' at the end of the book is intended to be used as a ready-reference, to help fill the gaps left in the main body of the text and supply a summary of the salient features and principles of treatment of these conditions.

CHAPTER 2

RHEUMATOLOGY IN HOSPITAL AND FAMILY PRACTICE

What sort of clinical material passes through the hospital rheumatology clinic? Some rheumatism departments are biased towards the various types of arthritis, others deal with a large intake of 'medical orthopaedics'—backache, neckache, soft-tissue lesions and injuries, with a smaller proportion of patients with 'arthritis'. A few years ago I recorded the presenting symptoms, investigations, diagnosis and other information in every newly-referred patient over a period of three months. The most frequent referrals were low back pain syndromes, osteoarthritis of peripheral joints, neck and shoulder pain syndromes. There were relatively few new patients with rheumatoid arthritis but these occupied a relatively large time for full history-taking, physical examination, organization of investigations and initial treatment.

A reasonably firm diagnosis can often be made at the first consultation in the majority of patients presenting with 'rheumatism' or 'arthritis', an initial diagnosis being possible in about three-quarters of the patients in this survey. X-rays and other investigations were needed in about half. Only a handful required immediate admission to hospital, the great majority being adequately treated as outpatients.

It must be carefully noted that the patients in this survey comprised a selected group, because they were referred for specialist advice. In the United Kingdom, patients complaining of 'rheumatism' or 'arthritis' almost invariably attend their own family doctor in the first instance. Examples of conditions that seldom reach the hospital specialist are early osteoarthritis, all but the most severe cases of tennis elbow, and self-limiting disorders such as 'benign' (virus) polyarthritis.

When should a patient with a rheumatic disorder be referred for specialist advice? It is probably wise for the general practitioner to refer progressive cases of polyarthritis, which should receive hospital assessment and treatment preferably at an early stage. It is perhaps arguable whether such patients should be routinely followed up at the hospital. Certainly, this allows a patient to be regularly assessed and to be in contact with new forms of treatment. On the other hand, it is a regrettable fact that the 'follow-up' patient's visit is often cursory—he has just a few words with a junior house officer, hardly justifying the trip to hospital which can be both arduous and painful. In general,

when a patient with rheumatoid disease has been 'stabilized' (rheumatoid activity has been controlled and best possible function gained), regular assessments by the family doctor should take the place of frequent hospital visits, which should now be reduced to the minimum—perhaps once yearly. 'Extra' or urgent visits to the rheumatology clinic can always be arranged, whenever considered advisable by the family doctor. On some occasions a home visit will serve to focus the rheumatologist's attention on the home environment and social circumstances, or may be justified when there is an acute flare-up of disease activity or an unexpected complication develops. Under these circumstances, a period of hospital treatment is often best.

THE CONSULTANT RHEUMATOLOGIST'S OPINION

Let us now consider more precisely the indications for specialist consultation. Needless to say, a general practitioner who, because of inadequate training or experience in the specialty, lacks confidence in the diagnosis and treatment of rheumatic disorders will not lose time in seeking advice. Until quite recently the teaching of rheumatology in medical schools was quite inadequate and (unless one was going to specialize in the subject) there was little opportunity for postgraduate study. While undergraduate education in rheumatology is still very patchy from one medical school to the next the younger generation of practitioners are on the whole more informed than were their predecessors. Specialist advice may be required under the following circumstances:

a. There is doubt about the diagnosis. Although, as already mentioned, a fairly firm diagnosis can usually be made at an early stage, sometimes there is failure to reach a diagnosis or confirmation of the diagnosis is required. For example, the experience of a rheumatologist may be valuable in deciding whether or not a patient with backache has early sacro-iliitis—it is difficult to miss a developed case of ankylosing spondylitis, but the clinical and radiological recognition of early cases is often more difficult.

b. Certain special investigations are required. The majority of standard laboratory investigations useful in the rheumatic diseases should be accessible to the general practitioner (e.g. blood count, ESR, serum uric acid, tests for rheumatoid factor and X-rays), but their interpretation may be found difficult. More specialized procedures, such as examination of synovial fluid using the polarizing microscope and arthroscopy, are in the field of the experienced rheumatologist.

c. Advice on treatment and special facilities are required. The rheumatologist is conversant with the general management of rheumatic disease in the context of internal medicine, as well as special

techniques and procedures. He can offer expertise in the prescription of physiotherapy, occupational therapy and the provision of splints and appliances. Referral provides the opportunity for the patient to contact the range of skills and techniques of paramedical workers such as medical social workers, physiotherapists, occupational therapists and appliance officers. The link between the hospital and the family doctor is provided by specialist consultations, domiciliary visits (the car ride to the patient's home often affords a valuable opportunity for discussion of the case) and, more informally, postgraduate meetings—not forgetting the chat at the bar afterwards!

THE REFERRAL LETTER

It cannot be too strongly stressed that nothing is more valuable than a careful letter of introduction from the family doctor to the consultant—comprehensive, and yet succinct. The letter should always include details of *current and previous therapy*—previous drugs, operations and physical treatment. It should be stated whether or not these treatments have been beneficial and whether there has been any drug intolerance. The clinical presentation, previous history, family history, positive physical signs and results of any recent X-rays and laboratory investigations should be given. Mention of the *social and psychological background* provides what might be the only opportunity for the consultant to familiarize himself with this important aspect.

THE CONSULTANT'S LETTER

That letter-writing is an art developed only after some experience became clear to me a few years after I had been appointed, when I was duly informed by a respected general practitioner that 'my letters were improving'! Without any shilly-shallying, the practitioner wants to know the *diagnosis*, the *prognosis* (and possible *complications*) and the proposed *treatment*. In the case of less well-understood conditions, a brief mention of the facts known about the disease are appreciated. For example, in a case of palindromic rheumatism it is explained that this condition often heralds the development of rheumatoid arthritis in later years.

The following is a representative consultant's letter about a patient with arthritis and psoriasis. 'The man has one form of psoriatic arthritis, as shown by atypical, asymmetrical seronegative arthritis, sacro-iliitis, and psoriasis including nail involvement. The X-rays of the hands show terminal interphalangeal erosions, but clinically there is little deformity or loss of function. The patient has already found phenylbutazone effective and I have encouraged him to continue this drug in as low dosage as possible—there will be little chance of blood

dyscrasia, even over a long period, if he limits the dose to 100 mg once or twice daily. Nevertheless, I would advise monthly blood counts, and you may care to try him on other non-steroidal anti-inflammatory drugs instead. I am prescribing physiotherapy for his neck and shoulders which are very stiff and painful. The painful wrists might be helped by steroid injections and short polythene splints, but synovectomy may eventually be required, especially on the left side, where there is a good deal of pain but little erosive change on the X-ray. There is no reason why this man should not be able to continue his present job as a long-distance lorry driver, at least in the foreseeable future. Finally, the psoriatic lesions have always worried him and I suggest a dermatological consultation if they fail to clear up adequately with the ointment and shampoo that you have prescribed.'

Another illustrative example is this letter about a stubborn tennis elbow: 'This man's tennis elbow has responded only temporarily to local steroid injections to the common extensor origin. It is clear that unless he adquately rests the elbow for a few weeks the lesion has no chance of resolving, so I have persuaded him to go off work till he is seen next in a month's time. During this period we shall try the effect of ultrasound applied to the area. Should this régime fail to alleviate his symptoms, we shall try manipulation under anaesthetic prior to suggesting that he sees an orthopaedic surgeon with a view to operation on the common extensor origin.'

THE RHEUMATOLOGY DEPARTMENT

The Rheumatology Department comprises outpatient consultative clinics, a specified number of beds (often known as the 'Rheumatology Unit') and facilities for research. Its principal function is the investigation and management of arthritis and other medical disorders of the locomotor system. It has strong liaisons with the orthopaedic department and with the paramedical disciplines of physiotherapy and occupational therapy.

The Outpatient Clinic

Here patients are seen by the Consultant, Registrar, House Physician or Clinical Assistant in Rheumatology. The following remarks are primarily addressed to junior staff who, being new to the specialty, may find themselves responsible for outpatient clinics.

Ideally, the Consultant should see all 'new' cases. However, owing to the large volume of work inevitably some patients are initially seen by a junior doctor. When this is the case I believe the Consultant should make it his job to 'drop in' (even briefly) to see each patient and discuss the problem. The junior doctor can then write to the family doctor in the following terms: 'Thank you for referring Mrs. X, whom

I saw together with Dr Y (the Consultant)'. Where this is not a practical possibility, the Consultant should make every effort to see the patient at the next attendance. To facilitate this I always sort out the case notes required at each follow-up clinic ahead, to make sure I shall have seen all new patients at least once and also to select those follow-up patients whom I personally wish to see at the next visit.

The referral letter (or request for consultation) should be read carefully. In order to get a balanced view of the case, *all previous letters and discharge summaries should be consulted*—this can provide information leading to the diagnosis and also about previous treatment. A detailed history is taken and, although full general examination is advisable, in practice most of the examination is devoted to a detailed survey of the joints and other musculoskeletal structures. Then follows an explanation to the patient of the presumed diagnosis and the proposed course of action. The plan for investigation and treatment is outlined. Immediate treatment (such as intra-articular steroid injections) is carried out and drugs, physiotherapy and so on are prescribed. When it is proposed to admit a patient to hospital it is a good idea to plan '*admission instructions*', which will be discussed later.

Whereas sometimes the second visit to rheumatology outpatients is fairly prolonged (owing to the time required for noting and assessing investigations, examining X-rays and generally sorting out the problem), subsequent visits need only be relatively short, unless there has been considerable worsening of the clinical situation since the patient was last seen. The salient features at the follow-up visit are: the general clinical progress, any new symptoms or specific joints affected, the degree of generalized rheumatoid activity, results of investigations and the effects of current therapy. Gain or loss of weight, any abnormality in the urine, deterioration in the general health or mental stage, state of the ADL (activities of daily living) and work situation should be noted. A blood count and ESR are arranged a day or so *before* the visit so that the current status of these parameters can be evaluated. The outpatient visit gives opportunity for reference to social services, as well as consultation with other specialists where indicated. Clinical photographs, plans for drug trials and other research projects complete the session.

The Arthritis Clinic

While patients with arthritis are usually seen in general outpatient rheumatology clinics, there is a case for having a special 'Arthritis Clinic' at which difficult cases can be reviewed so that comprehensive diagnostic and therapeutic facilities are facilitated in every case. This can be achieved by having a case record in which all aspects of the disease are reviewed at each attendance (*Table* 1).

Table 1. The arthritis clinic Arthritic Case Record

Name	Age	Hospital No.	
Date			
Onset			
Complications			
Principal joints involved			
Principal deformities			
Functional status			
Mental status			
Other conditions			
X-ray features			
Blood count/ESR			
Urine			
Immunology			
Synovial fluid			
Occupational therapy assessment			
Social factors			
Photographs			
Case conference			
Hospitalization			
Drugs			
Surgery			
Rehabilitation			

The 'Emergency Clinic'

This clinic is devoted to the diagnosis and urgent treatment of acute pain syndromes (such as tennis elbow, acute polyarthritis, low back pain) of recent onset. The Emergency Clinic can be held by a member of the junior medical staff assisted by a physiotherapist, patients being referred for a consultant opinion where thought advisable. We have made it a rule that patients attending the Emergency Clinic must have symptoms of less than two weeks' duration—or this tends to become another 'chronic rheumatism clinic' rather than an emergency one.

The Back Pain Clinic

This clinic is devoted to the more knotty problems of low back pain and sciatica where treatment has been found difficult. At the first attendance, a special proforma giving details of diagnosis, investigations, previous treatments and so forth is completed (*Table* 2). At this clinic patients are seen by more than one clinician, including one with special experience of back pain and manipulative techniques; and also by a physiotherapist, a medical social worker and (where relevant) a clinical psychologist. The clinic also provides an opportunity to try certain 'fringe' methods of pain relief, such as acupuncture (*see* Chapter 3).

Table 2. The back pain clinic

Name	
Diagnosis	
Occupation	
Principal Symptoms	
Principal Signs (Spinal and Neurological)	
Causative Factors: Trauma, Occupation, Postural Defects, Congenital Defects, Psychogenic, Arthritis, Bone Disease, Hypermobility	
Investigations: Spine X-ray, Urine, ESR	
Myelogram	
Consultations	
	Management
Drugs	
Home Exercise/Back Discipline	
Physiotherapy: Heat/Exercises	
Traction	
Manipulation	
Corset	
Epidural Injection	
Acupuncture	
Hospital	
Rehabilitation	
Surgery	
Other	

The Surgical Combined Clinic

The value of liaison between orthopaedic surgeons and rheumatologists at Combined Clinics is well established. These clinics must be held as often and as regularly as possible (at least monthly), or else patients with problems that would benefit from discussion tend to be referred elsewhere owing to the urgency factor.

Where one of the orthopaedic surgeons has a special interest in rheumatoid hand surgery, a special Combined Hand Clinic can be usefully set aside.

HOME VISITING

It is customary for medical social workers and occupational therapists to visit disabled patients at home after their discharge from hospital. More comprehensive home visiting, where many members of the rehabilitation team visit the patient, can be extra valuable and ideally is advisable for all cases of severe arthritis where there is consequent disability. Members of this team include the rheumatologist and/or his junior staff and trainees, a physiotherapist, occupational therapist and medical social worker. Medical students should also be encouraged to see patients in their home environment. Matters arising from the home visit could for example include future needs for medical treatment at

home and at the hospital clinic, advice on self-help devices, the need for future physiotherapy, and education of the patient.

THE RHEUMATOLOGY WARD

Rheumatology beds are probably best located in the vicinity of the orthopaedic ward. This facilitates cross-consultation between the two disciplines, each of which is of prime importance in the management of rheumatic disease. Moreover, the nursing staff become familiar with both medical and surgical aspects. There can be an extra bonus in that a patient needing surgery may be lucky enough to have his operation without delay and, conversely, arthritis patients admitted for orthopaedic surgery can easily be assessed and treated by the rheumatologist.

The following remarks are directed towards the junior doctor on a rheumatology unit who (as is often the case) has recently been house officer in a general medical or surgical unit. Medical students often come to regard the patient in hospital as a sort of 'package' with a 'hospital life'—an existence which 'begins' on admission and 'ends' on discharge from hospital! This, of course, is far from the truth and it is important to try to 'see' the patient's life before and after admission. Before even taking the history it is wise to look at previous notes, read the general practitioner's referral letter and the previous outpatient consultation (or domiciliary visit) and note any previous treatments. The '*Admission Instructions*' are a transitional bridge to the hospital admission. After discharge, continuity must be obtained: for example, the patient is not just given a week's supply of drugs, he is instructed to continue these by obtaining further supplies from his own family doctor (a concise list of drugs must be included in the discharge note). As the full *discharge summary* will inevitably be delayed for at least a few days (often much longer), an immediate *discharge note* to the practitioner is mandatory. This should contain the following minimum information: principal diagnosis, other diagnoses, current drugs, plans for continuation of physiotherapy or occupational therapy, proposed home visits and the date and venue of the next outpatient appointment.

When the full discharge summary arrives, it is a rather sad fact that many general practitioners read only the last paragraph which is headed 'Treatment and Progress'. It is therefore incumbent on the house officer to regard this section as the most important and make it complete and accurate. Only a brief account of the history and examination on admission is required (this is probably already known to the general practitioner). However, a full statement of the results of investigations should be given, because this serves as a valuable documentary summary which can be found on looking through the