Key issues in rheumatology for general practice

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The management of many disorders in rheumatology can be optimised by collaboration between the GP and the specialist

RHEUMATOLOGICAL OR MUSCULOSKELETAL disorders are common, accounting for 15-20% of GP consultations, and cause a significant amount of morbidity and disability. Most musculoskeletal disorders are chronic conditions and their management presents a number of challenges to GPs. The GP frequently has to manage problems arising either due to the condition itself or due to complications of therapy. Common conditions encountered in general practice include osteoarthritis, gout and fibromyalgia. While inflammatory arthropathies are less prevalent, the GP needs to be familiar with them also.

Rheumatoid arthritis

The development of newer, improved therapies has been of benefit to patients, particularly in the case of inflammatory arthropathies such as rheumatoid arthritis (RA). Clinical trials have shown that aggressive treatment in early RA leads to positive outcomes. Initial aggressive treatment with a combination of disease-modifying anti-rheumatic drugs (DMARD) relative to therapy with a single DMARD improves outcomes. Methotrexate remains the firstline DMARD for RA and results in symptomatic and functional improvement, slowing of joint damage and reduced mortality. Patients with RA are at increased risk of cardiovascular disease and stroke and therefore tight control of conventional cardiovascular risk factors, such as hypertension and hypercholesterolaemia, is indicated in these patients.

The use of biological therapies such as anti-TNF agents (etanercept, infliximab, adalimumab, golimumb and certolizumab) has revolutionised our management of these patients and can induce disease remission, although patients typically relapse if treatment is discontinued. These drugs are generally safe and well-tolerated and there is evidence that they result in reduction in inflammation-associated co-morbidities such as myocardial infarction (MI) and stroke. Anti-TNF therapies are also effective in patients with spondyloarthritis, psoriatic arthritis and sero-negative inflammatory arthritis, as well as a number of other conditions.

The main issue associated with these agents is the potential for serious infection, including tuberculosis and opportunistic infections. Therefore, the threshold in general practice for suspicion of infection in these patients needs to be relatively low. These drugs are not generally prescribed for patients with a history of malignancy, moderate to severe congestive heart failure or demyelination.

Other biologic drugs currently available include: anakinra (anti-interleukin(IL)-1), tocilizumab (anti-IL-6), rituximab (targets B cells) and abatacept (targets T cells). Currently, tocilizumab and abatacept are available only by infusion but in the near future will be available for subcutaneous injection allowing more independence for the patient.

Gout

Gout is the most common inflammatory arthritis in men and older women. Audit shows that the management of patients with gout is far from optimal. Only one third to one half of patients with gout receive urate lowering therapy (ULT) and even when given, ULT is often prescribed at a single fixed dose (usually allopurinol 300mg daily) that is insufficient for many patients. The majority continue to experience acute attacks. Few patients receive a clear explanation for their gout or appropriate lifestyle advice to reduce predisposing risk factors. Asymptomatic hyperuricaemia is not currently treated with ULT.

However, associated factors such as hypertension, obesity, excess alcohol consumption and hyperlipidaemia need to be addressed. Therapy for acute gouty arthritis should be administered rapidly. The sooner the attack is treated, the shorter its duration will be. Drug treatments include low-dose colchicine (0.5mg BID or TID), non-steroidal inflammatory agents (NSAIDs) or corticosteroids. NSAIDs should be used cautiously, particularly in individuals at risk of thrombosis predisposing them to MI or stroke.

There is no consensus on when to start ULT but, when started, it is normally continued indefinitely. It is important to treat to a target serum urate level. European League Against Rheumatism (EULAR) guidelines recommend a target of <360umol/L and British Society for Rheumatology (BSR) guidelines recommend < 300umol/L.1,2 Once a patient is receiving ULT, it should not be stopped during an acute attack. It should be continued while the acute attack is being treated and thereafter.

The ultimate aim of ULT is reduction of total body urate stores, reduction and disappearance of tophi, reduction of the frequency of gout flares and decreasing risk of ongoing precipitation of supersaturated urate into monosodium urate crystals. There will be resultant reduction in joint damage.

Since patients are at increased risk of acute gouty attacks during the initial period of ULT, prophylaxis against acute attacks will enhance compliance. The duration of prophylaxis will depend on the estimated burden of urate crystals. Therefore, this could vary from three months to greater than a year. Colchicine 0.5mg BID...
is a safe and effective agent to use and recent evidence suggests a potential cardiovascular benefit.\(^3\)

**Osteoarthritis**

Osteoarthritis is the most common cause of disability in individuals over 65 years of age. There has been a paucity of new therapeutic approaches and a relative lack of interest from the pharmaceutical industry. Also, there can be poor correlation between structural alterations and symptoms. No known drug significantly alters or reverses the pathogenic process. OA is not a homogenous disorder and pathogenic mechanisms may differ between individuals. Synovial inflammation contributes to symptoms and signs. Obesity is consistently associated with progression of OA, therefore appropriate weight reduction should be pursued vigorously. NSAIDs remain useful for the reduction in symptoms but have many potential adverse effects. Some individuals note symptomatic relief from glucosamine or chondroitin sulphate. Intra-articular steroid injection can be very effective in the short term and can be repeated. Topical NSAID or capsaicin cream is an additional approach. Conservative management should be undertaken prior to consideration of joint replacement.

**Fibromyalgia**

Finally, fibromyalgia is a common cause of chronic musculoskeletal pain and is associated with other multisystem symptoms. Non-restorative sleep is almost universal in these individuals. The ultimate aim of treatment is to facilitate the patient to become aerobically conditioned. This can be promoted by a multifaceted approach to include drug therapy and a variety of physiotherapy modalities. We have found particular benefit from use of neurostructural integration technique (NST). More recently, the contribution of obesity to the aggravation of symptoms in fibromyalgia has been recognised and therefore weight loss may play an important role in improving the symptoms. Finally, patient education is essential for successful management.

Ultimately, the management of many disorders in rheumatology can be optimised by collaboration between the GP and the specialist.

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References