Family physicians and arthritis

Conspiracy of neglect

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There is a health condition that family doctors see every day, especially in women and seniors. It varies in severity, location in the body, degree of pain, and effect on people's lives. It is the leading cause of disability among Canadians and takes, on average, a year of healthy life expectancy from each of us. The number of Canadians affected will increase 50% in the next 20 years. Compared with other chronic conditions, the condition causes more pain, more restrictions on activity, more long-term disability, worse self-rated health, more disrupted sleep and depression, and more health care visits.[1] It accounts for 10% of the economic burden of all illnesses. Family doctors provide more than 80% of care for this condition: arthritis.

Despite its effect on our practices, on our patients, and increasingly on us as we age, we conspire with our patients to ignore arthritis. How often have you heard patients say they hurt a lot, but it must be the weather? How often have you let that comment go? How often has a patient limped into your examining room but then failed to mention arthritis pain or limited function as a problem?

As a society, we tend to see arthritis as a problem of aches and pains, which are mostly transitory, inevitable, poorly responsive to treatment, and affecting seniors. Perhaps societal neglect is responsible for health research spending of only 1% on arthritis,[1] for underuse of effective therapies,[2] for delayed diagnosis,[3] and for serious sex and socioeconomic disparities in use of surgical interventions.[4,5] Family physicians have less confidence in doing a joint examination than a cardiovascular examination,[6] likely due to lack of attention to the musculoskeletal system in medical training. Most of us are not even aware of this problem. Some years ago, a rheumatology colleague loaned me a video on joint examination, and for the first time I realized that my own clinical skills were sorely deficient.

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More than aches and pains

Arthritis is not due to the weather,[7] is not transitory, is not inevitable or untreatable, has a disproportionate effect on working-age people, and has enormous personal and societal effects that go well beyond a few aches and pains.[8] Did you know that there is strong randomized trial evidence for the effectiveness of exercise[9] and for groups, such as the Arthritis Self-Management Program (ASMP)?[10] Did you know that 12 of 13 randomized trials of glucosamine versus placebo showed benefit?[11] Did you know that musculoskeletal pain is so widespread that the best-selling new drugs in history were not for erectile dysfunction but for arthritis (the cyclooxygenase-2 inhibitors)? Did you know that the Arthritis Society website has detailed sections on "Tips for Living Well," "Programs and Resources," and "Local Programs and Information"? (**www.arthritis.ca**) Did you know that arthritis programs are available now or can be made available in most communities?

Three articles in this issue of *Canadian Family Physician* examine issues related to arthritis management. Godwin and Dawes (**page 241**) take a systematic look at the evidence for corticosteroid injections for knee arthritis. Surprisingly, they found only a handful of trials that examined such a common therapy. The trials showed good evidence of short-term effectiveness and few serious long-term adverse effects.

The systematic review of viscosupplementation by Aggarwal and Sempowski (**page 249**) ventured farther from common family practice but found evidence of both effectiveness and safety. Another systematic review supports their findings but raises caveats of small effect sizes and publication bias.[12] Finally, Maksymowych (**page 257**) describes serious diagnostic delays with ankylosing spondylitis and new approaches to diagnosis and treatment. All three articles describe effective therapies that add to a long list of what family doctors can do to make an early diagnosis and manage patients with arthritis effectively.

Appropriate diagnosis and treatment

The first barrier to effective care is joint examination. I have been exposed to the Patient Partners in Arthritis Program, a joint examination program presented by trained patients with more than 150 trainers across Canada (found through your local Arthritis Society). With good examination skills, family doctors can differentiate arthritis from other painful conditions, such as fibromyalgia; understand functional limitations due to joint problems; identify and refer patients with inflammatory arthritis or arthritis unresponsive to treatment; order appropriate diagnostic tests; and monitor response to therapy. Pharmacotherapy is a mainstay of treatment, typically with nonsteroidal anti-inflammatory drugs (NSAIDs) and analgesics. Up to 4 g per day of acetaminophen is safe and is an excellent choice for mild to moderate osteoarthritis (OA). Although its long-term effectiveness and toxicity are not well understood, glucosamine appears to be both effective and safe. Canadian physicians are using cyclooxygenase-2 inhibitors for higher risk patients than was the case for non-selective agents.[13] While this practice might offer pain relief and improve function, caution is warranted due to serious gastrointestinal and other side effects. Although selective agents might be safer, the much broader current use of NSAIDs is likely to increase rather than decrease serious complications.

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Recommending exercise or referring patients to organized exercise programs or physiotherapy is highly appropriate for people with OA and might also contribute to improved lipid levels, blood pressure, mood, and weight reduction. Activity and dietary recommendations for weight loss might be helpful for obese patients with OA.

Joint injection is safe and effective for moderate or severe OA. This skill is easy to learn and gratifying to use in the office. If you are uncomfortable doing joint injections or even learning about them, find a family medicine colleague who will do them. Many patients appreciate support from family physicians to cope with their arthritis. For those who need formal education or support, I highly recommend the ASMP program.

Referral for medical or surgical opinion and therapy should be made when usual therapy is not working. Joint replacement is highly effective in reducing pain and improving function, but many patients are unwilling to consider surgery.[14] Family physicians must educate patients and clear up misinformation about the procedure.

Arthritis advocates

Can family physicians address the population burden of arthritis pain and disability by themselves?

Physicians know the answer to this question every time they try to refer a low-income patient for physiotherapy or learn their patients are on long waiting lists for surgery. Insufficient health care resources are being directed to musculoskeletal problems now, yet many more resources will be needed in the future as our population ages. Family physicians must advocate for better musculoskeletal training in medical school and residency programs, more community exercise programs, more publicly funded physiotherapy, and greater availability of joint replacement surgery. Now is the time to conspire with your family medicine and specialist colleagues, your patients, the public, and policy makers to do something about the growing consequences of arthritis.

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