UPDATES IN RHEUMATOLOGY

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Have your patients ever said, "Doctor, my knee joints hurt whenever I stand and walk!" or "Doctor, I have stiffness and pain all over my body the moment I wake up!"? It is truly an understatement to say that we see many patients with similar complaints. Some physicians may regard such patients as difficult to manage simply because they approach us with multiple complaints of pain and it tests our medical skills to the extreme. Common as it may be, such conditions are not to be trivialised as they cause great distress and suffering. Disease progression will mean complications setting in for our patients if we do not manage the conditions well. Patients trust and see family physicians as the first line for their rheumatologic complaints, and there is a lot that we can do to evaluate, diagnose, and provide initial treatment for this group of patients. Even for those whom we are unable to manage in our own practice due to red flags or intractable symptoms, we can make the effort to refer appropriately to our rheumatology colleagues and co-manage such patients with them, allowing patients to be cared for in the community as far as possible, while guided by our rheumatology colleagues. This issue is crafted with this purpose in mind — to empower our family physicians in this discipline.

In unit 1, A/Prof Lau Tang Ching shares his professional insights on the approach to symmetrical polyarthritis with a focus on rheumatoid arthritis, applying the "RIME model" (Reporter, Interpreter, Manager, Educator) framework in the clinical approach to joint pain. He integrates clinical reasoning with evidence-based medicine in the various diagnoses of symmetrical polyarthritis, and shows how we as family physicians can perform shared care of patients with rheumatoid arthritis with a rheumatologist.

In unit 2, Dr Anindita describes some of the recent advances in gout, giving us a better understanding of the morbidity associated with untreated gout. Given the rising prevalence, it is indeed important information for all family physicians to know.

Patients with seronegative spondyloarthropathies remain a constant diagnostic and therapeutic challenge for family physicians due to their multiple symptoms that span across organs. In unit 3, Dr Koh Li-Wearn sheds light on how seronegative spondyloarthropathies are a heterogeneous group with certain characteristic clinical features in common, especially inflammatory back pain, sacroiliitis, arthritis, and extra-articular features. She highlights the crucial need to recognise the features of inflammatory back pain as well as the features pointing to the pattern of different subtypes of seronegative spondyloarthropathies. To better treat these patients, we should adopt a holistic multidisciplinary approach.

This issue features 3 PRISM articles discussing conditions and dilemmas commonly faced by family physicians. The first PRISM article by Dr Tang Jessica Hay, a family medicine resident, shares a familiar patient journey through the complications of aspirin use. It focuses on the question of whether gastric protection is required in aspirin use. Her article allows us to revisit the potential gastrointestinal complications, risks factors for these complications, and approaches to prevent them. The second PRISM article co-authored by Dr Julia Ong, a family medicine resident, and Prof Goh Lee Gan, professorial fellow in the division of family medicine, provides insights on the management of recurrent urinary tract infections (UTIs) in primary care through a case study. UTIs are a commonly treated condition in primary care but when do we suspect it is something more? Bladder cancer can present as recurrent UTIs in some patients and a high index of suspicion and prompt referrals to our Urology colleagues will assist with early detection. This article takes us through understanding recurrent UTIs, gaps in management, incidence, and prognostication of bladder tumours that present as UTIs. The final PRISM article by Dr Xu Bang Yu, family physician, shares the journey of a patient presenting with falls, a common geriatric syndrome that is often multifactorial and requires a bio-psycho-social approach in evaluation and management. He takes us through the learning points of the case which include using the SBAR4 Complex care model, the impact of frailty on outcomes, the importance of good communication, and the need for a comprehensive bio-psycho-social approach in the evaluation of patients presenting with falls.

Prof Goh has also kindly shared 10 readings on rheumatology. Treatment for autoimmune inflammatory rheumatic diseases (AIIRD) has evolved over the years, and with the advent of newer disease-modifying anti-rheumatic drugs (DMARDS), such patients are now subjected to a higher degree of immunosuppression, thus exposing them to other types of vaccinations. Reading 1 advises the vaccinations that should be considered for these AIIRD patients before initiation of immunosuppressive therapy. Patients with chronic inflammatory rheumatic diseases (CIRDs) also suffer from co-morbidities that are sub-optimally managed.

Reading 2 is an initiative that defines comorbidities such as ischaemic cardiovascular diseases, malignancies, infections, diverticulitis, osteoporosis, and depression that are potentially within the remit of the rheumatologist, thus facilitating the systematic management of such patients with CIRDs. The strong causative association between elevated serum uric acid (sUA) levels and gout attacks has long been proven, and reading 3 strongly reinforces the need to reduce sUA levels in order to better manage gout. Some of the factors that result in poorly managed gout include non-compliance to treatment guidelines by healthcare providers, patients' poor adherence to therapy, and differences in perspectives between providers and patients. Many rheumatologists base their management strategies on EULAR guidelines and reading 4 provides that. The guidelines aim to inform physicians and patients about the non-pharmacological and pharmacological treatments for gout to achieve the predefined urate target, and recommend the use of colchicine, NSAIDs, oral or intra-articular steroids, or a

combination.

Ultrasound (US) utilisation has become a very common bedside investigation, with advantages of being fairly portable and affordable compared to other forms of imaging modalities. Reading 5 provides guidance on how US can support clinicians in their daily rheumatology work, to aid diagnosis, to inform assessment of treatment response/disease monitoring, and to evaluate stable disease state or remission in patients with suspected or established RA.

In a time of increased patient engagement and activation, approximately 300 patients with Rheumatoid Arthritis in the UK were introduced to a patient-initiated review appointment system. Reading 6 documents how, instead of regular reviews where patients were usually well, they were given access to a nurse-led telephone advice line where appointments could be accessed within 2 weeks. Patient satisfaction favoured this initiative.

RA is a chronic condition and often management varies depending on severity, stage of disease, and the age of the patient. Reading 7 shows that in the elderly, there is interplay between RA and existing co-morbidities. As such there may be a need for a paradigm shift from a disease-centred to a goal-oriented approach for these patients. The Asia Pacific League of Associations for Rheumatology 2015 has also created best practice guidelines for the management of RA which serve as a reference for physicians in the Asia-Pacific. Reading 8 records how the guidelines focus on local issues to ensure the delivery of basic care for these patients and to improve their outcomes.

Reading 9 highlights the fact that psoriatic arthritis and ankylosing spondylitis are less commonly seen but are nevertheless important conditions that require early and appropriate intervention. In psoriatic arthritis, a tight control with early reviews and escalation of treatment to target significantly improves joint outcomes for newly diagnosed patients. Thus, early recognition and treatment is key.

Reading 10 notes that acute anterior uveitis occurs in approximately 40% of patients with ankylosing spondylitis. In most instances, the eye inflammation responds well to corticosteroid and mydriatic eye drops, without the need for additional therapy. However oral corticosteroids and potential novel therapies such as tumour necrosis factor blockers may be required in more severe or refractory cases.

For this issue, we are also fortunate to have article contributions from the Department of Gastroenterology and Hepatology, Singapore General Hospital. Their department organised a symposium for general practitioners and family physicians on 11 February 2017 and contributed original articles to help with continuing education for our doctors. The first paper by Dr Vikneswaran describes a practical approach to reflux symptoms. This useful approach allows family physicians to efficiently segregate patients with typical reflux symptoms that can be treated safely in their own practice, from those with red flags, or those who do not respond to initial therapy and will require further evaluation. The second paper by Dr Li Weiquan James outlines testing and treatment strategies for Helicobacter pylori, which causes peptic ulcer disease and increases risk of gastric carcinoma. Some of these tests, such as the stool antigen assay, can be done at a primary care setting, while other more invasive and specialised tests will require evaluation in a hospital. Treatment strategies such as triple therapy are also described.

We hope that these articles will immensely enhance our family physicians' knowledge and understanding of rheumatology conditions and empower them to develop their own practical approaches when consulting such patients.