Musculoskeletal conditions in Primary Care

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Musculoskeletal conditions

- Very common
- Affect all ages
- Enormous burden
- Timely management essential

What healthcare services do people with Musculoskeletal conditions need? The role of Rheumatology. Anthony D Woolf Annals of the Rheumatic Diseases 2007; 66:281-282;doi:10.1136/ard.2007.069443

Role of a Rheumatologist

Work closely with primary care and within an integrated coordinated multidisciplinary, multiprofessional team with close working relationships with other relevant specialties and professions

The Musculoskeletal Services Framework DOH 2006

Initial presentation

- Joint pain
- Joint stiffness
- Joint swelling

Dilemmas

- Diagnosis
- Management
- When to refer
- Who to refer to
- Urgent/ routine referral
- How to refer

Osteoarthritis

- Most common arthritis
- Incidence and prevalence increase with age
- Morbidity

Each year 2 million adults visit their GP because of Osteoarthritis

Arthritis Research Campaign 2002

Risk factors

- Age
- Gender
- Genetics
- Joint Injury
- Joint malalignment
- Obesity
- Occupation

Diagnosis of OA

History

- 45 yrs or older **AND**
- activity-related joint pain **AND**
- no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes

Examination

Crepitus, bony swelling

NICE CG177 Feb 2014

Effect of arthritis on patient

- Function
- Quality of life
- Occupation
- Mood
- Relationships
- Leisure activities

Management of OA

- Assess the effect of OA on the individual's function, quality of life, mood, relationships and leisure activities
- Tailor management to individual needs
- Formulate a management plan with patient taking into consideration their comorbidities
- Patient education

Non-pharmacological

- Self management strategies
- Thermotherapy
- Exercise – local muscle strengthening and general aerobic fitness
- Consider manipulation and stretching – hip OA
- Weight loss if obese or overweight
- TENS
- Appropriate footwear
- Consider bracing, joint supports or insoles
- Assistive devices – walking stick, tap turners

Invasive treatments

Do not refer for arthroscopic lavage and debridement unless clear evidence of mechanical locking

Joint Surgery

- Joint pain, stiffness and reduced function – substantial impact on quality of life and refractory to non surgical treatment
- Refer before there is prolonged and established functional limitation and severe pain

Follow up and review

- All people with symptomatic arthritis

Fibromyalgia

- Abnormal pain processing and other secondary features
- Pain
- Function
- Psychosocial context

Diagnosis

2016 Revision to the 2010/2011Fibromyalgia diagnostic criteria. Wolfe F Claus DJ et al Semin Arthritis rheum 2016 Dec:46(3):319-329

A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses

EULAR recommendations 2016

- Prompt diagnosis
- Management – graduated approach to improve health related QOL
- Balance benefits and risks of treatments
- MDT approach
- Initial management non pharmacological methods
- Individualised treatment tailored according to pain intensity, function, associated features such as depression, fatigue, sleep disturbance, patient preferences and comorbidities
- Shared decision making with the patient

Non pharmacological management

- Patient education
- Aerobic and strengthening exercise
- Graded physical exercise regime
- Cognitive behavioural therapies
- Hydrotherapy
- Acupuncture

Psychological therapies

Pain related depression, anxiety, overly passive or active coping

- Mainly CBT
- Psychopharmacological treatment – if more severe depression or anxiety

Pharmacotherapy

- If severe pain

  Duloxetine, Pregabalin, Tramadol or in combination with paracetamol

- If severe sleep problems

  low dose Amitryptilline or Pregabalin nocte

Severe disability or sick leave

Multimodal rehabilitation programs

Factors that influence outcome

- Physical health comorbidities
- Psychological issues
- Social issues

Gout

Incidence, prevalence and severity of gout have increased despite availability of safe, effective and potentially curative treatment

Kuo CF, Grainge MJ, Mallen C, Zhang W, Doherty M. Rising burden of gout in the UK but continuing suboptimal management: a nationwide population study. Ann Rheum Dis
2015;74:661–7.

BSR guidelines Gout

The British Society for Rheumatology Guideline for the management of Gout. Michelle Hui et al. Rheumatology, Volume 56, Issue 7, 1 July 2017, Pages e1–e20, https://doi.org/10.1093/rheumatology/kex156

Acute attacks

- Patient education – treat as soon as an attack occurs and continue ULT during attack
- Rest and elevate affected joint and expose in a cool environment
- NSAID maximum dose with gastroprotective agent or Colchicine 500mcg bd –qds
- Joint aspiration and intraarticular steroid injection
- Short course oral steroids or an IM steroids

Modify Lifestyle and risk factors

- Diuretics as antihypertensive – consider alternative
- Dietary modifications if overweight
- Discuss diet and exercise with all gout patients
- Drink 2l water daily and avoid dehydration if history of urolithiasis
- Cardiovascular risk factors and comorbidities - review and address – cigarette smoking, hypertension, diabetes, dyslipidaemia, obesity and renal disease

Urate lowering therapies

- After acute flare settled
- Offer to all patients, particularly if 2 or more attacks in 12 months, gouty tophi, chronic gouty arthritis, joint damage, renal impairment, history urolithiasis, diuretic use, primary gout starting at a young age
- Aim to maintain serum uric acid at or below 300micromol/L

Allopurinol

- Start at 50-100mg daily
- Increase in 100mg increments every 4 weeks until serum uric acid target achieved (max 900mg). If renal impairment, 50mg increments and lower maximum dose but uric acid target same

Febuxostat

- If Allopurinol not tolerated or
- Renal impairment prevents sufficient allopurinol dose escalation
- Start with 80mg daily

Uricosuric agents

- Sulphinpyrazone or Probenecid - normal or mildly impaired renal function
- Benzbromarone – mild to moderate renal insufficiency

Flare prevention on starting uric acid lowering treatment

- Colchicine 500microgram bd or daily for 6 months
- low dose NSAID or Coxib with gastroprotection if colchicine contraindicated

Thank you