Although physicians tend to concentrate on pain when treating RA, most patients are concerned with mobility, and in particular, their ability to undertake domestic duties outside the house [1]. Despite the functional problems of arthritis, there is a surprisingly small literature on the problems patients face and how these may be overcome, with the bulk of the published work being on the aetiology, and the drug and surgical treatment of the disease. In the standard texts on RA the disease is described as a disease of middle age, affecting mainly women [2, 3], but it is a disease of low incidence but, because of the low mortality, high prevalence [4]. This means that many patients will experience increasing problems with mobility, not only because of disease progression, but because of ageing and the occurrence of intercurrent disease. Lachmann describes in this issue 11 patients with RA who have had amputation of the lower limb. She points out that compared to a control group, matched for age, sex, and time of amputation, the outcome for the RA patients is much worse, not only because they are less mobile, but because the arthritis flared during walking training. Because RA is a potentially disabling disease it can adversely affect the outcome of other medical episodes and have profound effects on the life of the sufferer.

If we consider the joints firstly, then there are a number of major considerations. Involvement of the weight-bearing joints means that the patient will, for instance, have difficulty getting to the lavatory. Frusemide is a very effective diuretic for the management of heart failure, but it has a very brisk action. Subsequently it is a major cause of incontinence in patients with arthritis and many patients do not take it if they are going out for the day. Although weight loss is a feature of active RA [5] in controlled disease lack of activity because of secondary OA may encourage obesity. Hip or knee problems will considerably inhibit active RA can be complicated by osteoporosis, even in the absence of steroid therapy and pathological fracture, particularly in and around the pelvis, can cause a sudden loss of mobility.

Doctors sometimes forget the handicapping effects of the drugs and other interventions for which they are responsible. Steroids may lead to myopathy [15] or osteoporosis, which in turn can lead to spinal collapse or failure of long bones. Indomethacin and the other NSAIDs can cause marked dizziness [16], a particular hazard for the driver. The problems of frusemide and brisk diuresis has already been mentioned. In a wider philosophical way the too frequent outpatient appointments and badly organized clinics can seriously hamper the way the patient can order his or her life.

Society at large can be handicapping for the person with late RA. Architectural barriers, such as steep steps, are obvious problems for the patient with arthritis-related mobility problems. Some things are more subtle. A national obsession with fire safety has obscured by destructive changes in the forefoot.
fire doors. In our own experience in Bath we have actually had patients trapped in rooms by door closures, while wheelchair users cannot open fire doors. Because RA is a variable disease patients workmates or partners do not always understand why the patient can be fine on one day and then debilitated on the next. Because of the perception by the public that RA is a progressive disabling condition, patients may be prevented from having proper job promotion (or mobility) because the seriousness of their disease is overestimated.

What are the implications for the patient, the doctor, and society? Firstly it must be that each patient is an individual whose particular needs must be considered. Secondly the doctor must consider more than just the problems of pain and the results of laboratory tests. Next we need to encourage the introduction of comprehensive, specialist rheumatology services throughout the country. One advantage of such a service is that it can work closely with other medical colleagues to reduce as far as possible the secondary handicap of intercurrent disease. Lastly we need to get society at large to understand the problems of the arthritic patient and thus ensure that the impairment and disability that ensues from arthritis does not lead to significant handicap. RA is one of the commonest causes of disability in the Western industrialized countries, far exceeding the prevalence of, for instance, spinal injury [17]. We need to recognize the burden of handicap that this represents and take positive action to overcome it.

A comprehensive rehabilitation service, based on a patient and thus ensure that the impairment and disability that ensues from arthritis does not lead to significant handicap. RA is one of the commonest causes of disability in the Western industrialized countries, far exceeding the prevalence of, for instance, spinal injury [17]. We need to recognize the burden of handicap that this represents and take positive action to overcome it. A comprehensive rehabilitation service, based on a natural population of, say, 500,000 may be the best way of tackling this.

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REFERENCES

ANNOUNCEMENTS AND CALENDAR FOR 1994

April 20–22 XIth AGM. BRIGHTON.
May 23–27 BSR Travelling Fellowship. EDINBURGH and GLASGOW.
September 22–23 BSR Heberden Round. BATH (Prof. P. Maddison).
October 12–13 British Health Professionals in Rheumatology/BSR combined meeting. STAFFORD.

Further information about these events from Ms. Anne Mansfield, British Society for Rheumatology, 3 St Andrew's Place, Regent's Park, London NW1 4LB.