RHEUMATOLOGY IN GENERAL PRACTICE

RHEUMATIC symptoms are the most common problem seen by most general practitioners (GPs). Surveys of the workload of GPs have shown that between 15 and 20% of all consultations are for disorders of the musculoskeletal system [1].

Most patients will recover without treatment, some will develop persistent or progressive disease including systemic diseases. In The Netherlands an estimated 3 000 000 people, 20% of the population, have rheumatic complaints. It is clear that rheumatism is a major health problem and much of its management will be done in general practice.

About 500 000 people (3.3%) are under the care of his or her GP and about 300 000 people (2%) require specialist care, 100 000 of these are under the, often permanent, care of a rheumatologist.

Of the new cases the family practitioners handle 85% themselves, sometimes additional laboratory investigations or radiography are performed. During a follow-up period of 4 yr in the Netherlands, some 35% are referred to a physiotherapist; about 15% are referred to a specialist, primarily an orthopaedic surgeon (8.2%), a neurologist (4%) or a general surgeon (1.8%); only 1.2% of the new cases are seen by a
rheumatologist [3]. It is clear that for the chronic forms of arthritis and multisystem diseases, these figures are very different.

One of the main functions of the GP as 'gatekeeper' is the selection of patients who will receive the right care in the right place. He or she also has the continuous responsibility for the medical record, providing an integrated as well as an easily accessible health care. A better term than 'gatekeeper' would thus be 'manager' of the health care of the patient [4].

A GP will see about 400 different ailments (from sore throat to appendicitis), sufficiently frequently (globally more than five times each year) to be able to handle them him or herself or send them on to a specialist [5].

In the UK this difficult gatekeeper's task is connected with the care for the budget [6]. In the USA the situation is different, as the rheumatologist often provides primary care, in the fee-for-service environment he or she sometimes is a gatekeeper. In the USA, however, the accountability for the patient is a problem, nobody appears responsible for the integrated care of the patient and his or her family [7, 8].

A GATEKEEPER NEEDS GOOD EYES

Rheumatologists are scarce in The Netherlands as well as in the UK (100 and 350 vs about 7000 and 45 000 GPs in populations of respectively 16 and 55 million [1]). Also from this point of view rheumatologists are only able to see a selection of patients with rheumatic complaints. Which of them will be cared for by the GP and which will benefit from or even need the care of a rheumatologist? This depends as much on the knowledge and clinical experience of the GPs as on the severity of the disease of the patients and the wishes of the patient. For this reason studies giving insight into these aspects are important.

The study of Blaauw et al. [9] refers to the diagnostic ability of the GP. It does not regard abilities of history taking, physical examination and knowledge of therapeutic possibilities and prognosis. For example, the fact that many GPs are able to diagnose rheumatoid arthritis (RA) does not mean that they are competent to manage patients with this disease. Physical therapy, non-steroidal anti-inflammatory drugs, sulphasalazine, methotrexate, gold, hydroxychloroquine are all ingredients of a programme. A great chef can make something very tasty which I would make into a very ordinary and awful dish. So most GPs cannot use the ingredients, as can rheumatologists. RA may follow different courses, but in general has a bad prognosis with many complications due to the disease or its treatment [10]. One-third of the patients under the care of a rheumatologist will end up dependent on others and one-third wheelchair-bound or bed-ridden [11]. Of the more severe cases prognosis is as bad as that of Morbus Hodgkin stage 4 before radiotherapy was introduced [12]. To treat such a disease a great deal of experience is required; however, most GPs will see only a few cases of RA in their consulting rooms, and about one new case each year. Competence is related to prevalence. One can never become an expert in something one never or hardly ever sees. For example, when a GP sees one new case of ankylosing spondylitis in 10 yr, his or her task will be to recognize the early cases (and not only the established ones) by careful family history, low back complaints, morning stiffness and so on.

It is clear that many musculoskeletal disorders are benign and self-limiting or easily treated, but there are also complex multisystem and sometimes life-threatening diseases and some uncommon but important conditions which need to be recognized and treated urgently. The management of many of the chronic rheumatic conditions is complex and difficult, requiring considerable knowledge, experience and skills.

SHARED CARE

It is important that a GP is able to recognize which patients with musculoskeletal problems should be referred to the specialist. The GP can make use of simple diagnostic procedures if relevant. This will depend on the experience of the practitioner [1]. Ideally GPs should be able to develop a rapport with the local rheumatologist: 'shared care' of patients as well as dialogue about problems is then possible [1]. By regular dialogue with a specialist, the number of anxious patients can be reduced as well as the number of referrals to a specialist [13]. But still in many cases 'one shot' referrals will be requested by patients.

As the GP will never see sufficient cases of rare forms of arthritis all patients with active arthritis (swelling, pain, heat of joints) should be presented at least once to a rheumatologist, preferably in an early phase; also many patients with vasculitis, aches and pains in muscles and joints with or without fever and other general symptoms, will benefit from his or her expertise. So expert history taking will be possible and when this is combined with synovial fluid analysis for microorganisms and crystals, and additional (immunological) laboratory tests and further imaging or invasive techniques early diagnosis can be made and early adequate treatment initiated to prevent unnecessary damage. GPs could probably be taught to manage patients with osteoarthrosis as they will see many more of these cases.

ALTERNATIVE TREATMENTS

Many patients with rheumatic complaints are seen by chiropractors, osteopaths and more than half of those with chronic rheumatic diseases will be treated by at least one alternative healer [14]. Many doctors lack knowledge in these fields and cannot give their patients balanced advice; although the patients expect this. General information about alternative treatments should be part of the education of medical students [15].

EDUCATION OF STUDENTS AND GPs IN RHEUMATOLOGY

The education of medical students in rheumatic diseases is often insufficient. In The Netherlands three medical schools still do not have a rheumatology
department. In the other medical schools rheumatological education is limited, moreover the rheumatological education for the GP has yet to be developed. In the USA reports suggest that the education of medical students in the musculoskeletal diseases is inadequate and warrants careful reconsideration [16–18].

The often negative attitude of medical students to people with disability deserves attention; students should frequently meet these patients themselves as they are the best teachers [19].

In order to be able to improve the education of students and GPs further studies are needed about their knowledge regarding differential diagnosis of rheumatic disorders, but also in physical examination and therapeutic possibilities. The ideas about diagnosis and treatment of relatively common conditions like polymyalgia rheumatica and giant cell arteritis may vary considerably among GPs, but also among rheumatologists [20]. Clear guidelines for more uniform and effective treatment are needed.

We may conclude that:

- A GP should learn to recognize active arthritis.
- Further studies are needed to investigate the knowledge of GPs in history taking, physical examination, diagnosis and treatment regarding rheumatic diseases, in order to be able to improve this situation.
- Shared care and low-threshold interaction between GPs and specialists may be of great value for the patients.
- Patients with active arthritis should be presented early to a rheumatologist, as well as those with vasculitis and general symptoms; this may prevent unnecessary operative investigations and/or treatment.
- The current method of medical school and postgraduate training appears to be insufficient in the field of rheumatology, including information about alternative treatments.
- The fact that 'the rheumatologist makes the difference' should be explained to the GPs by publications and journals read by GPs.
- The best and most brilliant young doctors should join the fascinating speciality called rheumatology.
- Modesty is needed by rheumatologists, as we too may have the wool pulled over our eyes by patient's history.

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J. J. RASKER

Rheumatology, Medisch Spectrum Twente, Postbus 50 000, 7500 KA Enschede, The Netherlands

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