Guidelines causing iatrogenic disease?

Sir, We would like to congratulate Coakley et al. [1] for writing the guidelines for the management of the hot swollen joint in adults in such a way that is useful and relevant to primary care. Commonly, guidelines written from a secondary care perspective may be difficult for primary care doctors to apply to their practice, but the algorithm and the specific section for GPs are particularly helpful.

Unfortunately though, these guidelines do not reflect the level of uncertainty that exists in primary care and that GPs often have to manage. As discussed in a previous editorial, patients do not often fit into a neat diagnostic category on presentation and GPs commonly use time as a management tool [2].

GPs may often see hot swollen joints that they feel are not septic but they may be unable to make a definite alternative diagnosis. If the doctor were to follow these guidelines, the patient would be referred for urgent A&E or specialist assessment, whereas, if they were allowed to follow their intuition and use their clinical judgement, they may check bloods, provide analgesia and review in 24–48 h. The guidelines should reflect this and have a section for ‘no definite alternative diagnosis, but sepsis unlikely’. This would allow concerns regarding guidelines raised in primary care, e.g. ‘they de-personalize the doctor patient relationship, exclude intuitive methods of diagnosis and undervalue the role of experience, to be addressed’ [3]. It is recognized that on reviewing these patients, a diagnosis may become obvious and it could be that an early septic arthritis has been missed, but we believe that this would prevent a significant number of unnecessary referrals, inappropriate investigations and treatment.

These guidelines also do not mirror the changes occurring in the provision of primary care services. Patients may now be initially assessed by nurse practitioners or physiotherapists [Allied Health Professionals (AHPs)], especially when presenting with acute joint problems, as it may be easier to get an appointment with them than with a GP. Guidance should therefore be provided, specifically, for these staff in the management of the acute swollen joint as they may require it more than a GP. It could be that an acute, swollen joint should be recognized as being a ‘red flag’ by AHPs and that these should be discussed with a member of the medical staff urgently.

We conclude that guidelines are beneficial and at times essential, but that, when produced for primary care, they should be modified by primary care health professionals to reflect our working practices and should allow personnel with experience to be able to use this when making a decision. We believe that these changes would address the concerns raised previously, i.e. unnecessary referrals, inappropriate investigations and treatment, all of which have inherent risks.

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Guidelines causing iatrogenic diseases?: reply

Sir, We thank Wise et al. for their interest in and kind comments about the Hot Swollen Joint Guidelines. We do not accept that use of the guidelines will promote iatrogenic disease; we believe that we navigated a reasonable path between the equal risks of over- and under-investigation in this clinical setting.

We would, however, make the following observations:

(i) Experienced clinicians can and should use their clinical judgement to elect not to follow guidelines where they feel they are inappropriate to the case in question.

(ii) Guidelines are of most use to the inexperienced or those without specific expertise relating to the decisions in question. For these, a statement in a guideline allowing a decision of ‘no alternative diagnosis, but sepsis unlikely’ has dangers in leading to missed cases of septic arthritis with potentially fatal consequences. Such practitioners should seek advice from an experienced musculoskeletal clinician if they feel the guideline is leading them to an inappropriate decision, and act accordingly.

(iii) The guidelines were developed for medical practitioners. They are not appropriate for use by nurse practitioners and physiotherapists without local amendment. For practices where patients are seen first by nurses or allied health professionals, a statement that ‘acute hot joint’ should be recognized as a red flag and require discussion with a medical practitioner (as Wise et al. suggest) is entirely appropriate and sensible. This would best be implemented at local level.

(iv) National guidelines can only act as a guide to appropriate local practice, and we recognize that there are some community practitioners (such as Wise et al.) with high levels of skill in rheumatology who may appropriately not follow the guidelines. For this small group, the category ‘no alternative diagnosis, but sepsis unlikely’ may be useful. However, we had to reflect the full range of skills in musculoskeletal medicine within UK primary care, many of whom have insufficient experience with this group of patients to make an informed decision. To reflect the current state of UK primary care, we not only had a general practitioner (A.M) on our panel, but also sent the draft guidelines to the Royal College of General Practitioners for their amendment and approval.

G.K. received grants from Arthritis Research Campaign (arc) to support work on the pathogenesis, outcome and management of inflammatory arthritis.


Queen Elizabeth Hospital, Woolwich, Centre for Rheumatic Diseases, Royal Infirmary, Glasgow, City Hospital, Nottingham, University Hospital Lewisham, Freeman Hospital, Newcastle, King’s College Hospital, Royal Orthopaedic Hospital, Birmingham (representing the British Orthopaedic Association), Hetherington Group Practice, SW4, Arthritis Care and University Hospital NHS Trust, Nottingham, London

SF-36 Scales in the Relaxin study

Sir, Georges et al. [1], in their original publication, report the raw scores for the SF-36 scales and norm-based summary scores in their cohort of subjects with systemic sclerosis (SSc). In Table 5, they refer our article [2], stating that we did not provide data on the SF-36 scales. As the purpose of our original study was to examine the responsiveness to change of the SF-36 summary scores and Health Assessment Questionnaire-Disability Index, we presented the summary scores. Our analysis was conducted on data collected from the Relaxin study that assessed the efficacy of Relaxin in early diffuse SSc [3]. In this letter, we provide both baseline raw and norm-based scores for the SF-36 scales for 196 patients who completed the study (Table 1), so comparisons can be made with present and future SF-36 publications in SSc. Since we used version 1 of the SF-36, we recalculated the scores using the 1998 norms [4]. Therefore, the mean values of the summary scores differ slightly from what was reported in our original article [2]. Our revised analysis is based on the assumption that Georges et al. used SF-36 version 2 (which uses 1998 norms) since their study was conducted from 2001 to 2004.

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<table>
<thead>
<tr>
<th>SF-36*</th>
<th>Norm-based scores Mean ± S.D.</th>
<th>Raw scores Mean ± S.D.</th>
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<tbody>
<tr>
<td>Physical functioning</td>
<td>33.9 ± 11.7</td>
<td>45.0 ± 27.7</td>
</tr>
<tr>
<td>Role physical</td>
<td>34.6 ± 16.2</td>
<td>43.1 ± 41.4</td>
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<tr>
<td>Bodily pain</td>
<td>42.2 ± 9.8</td>
<td>52.8 ± 23.1</td>
</tr>
<tr>
<td>General health</td>
<td>40.3 ± 10.0</td>
<td>50.4 ± 21.0</td>
</tr>
<tr>
<td>Vitality</td>
<td>41.0 ± 10.7</td>
<td>40.3 ± 21.5</td>
</tr>
<tr>
<td>Social functioning</td>
<td>42.3 ± 11.5</td>
<td>66.6 ± 26.3</td>
</tr>
<tr>
<td>Role emotional</td>
<td>42.5 ± 19.2</td>
<td>71.3 ± 41.1</td>
</tr>
<tr>
<td>Mental health</td>
<td>47.9 ± 9.6</td>
<td>71.3 ± 17.0</td>
</tr>
<tr>
<td>Physical component summary score</td>
<td>34.5 ± 11.2</td>
<td>–</td>
</tr>
<tr>
<td>Mental component summary score</td>
<td>48.1 ± 11.9</td>
<td>–</td>
</tr>
</tbody>
</table>

*Based on 1998 US population norms.