WHAT TO EXPECT FROM AN EVALUATION BY A RHEUMATOLOGIST

WHAT IS A RHEUMATOLOGIST?

A rheumatologist is a medical doctor who attends 4 years of medical school, 3 years of internal medicine residency, and 2 years (sometimes longer) of a rheumatology fellowship. A rheumatologist specializes in the diagnosis and management of autoimmune disease and musculoskeletal diseases such as Rheumatoid Arthritis, Sjogren's syndrome, Systemic Lupus Erythematosus (Lupus), Psoriatic Arthritis, Ankylosing Spondylitis, Polymyalgia Rheumatica, Giant Cell Arteritis, and Gout.

Rheumatologists DO NOT specialize in the treatment of all autoimmune diseases. There are many autoimmune diseases that affect organ systems outside the musculoskeletal system (one example is multiple sclerosis AKA MS).

Rheumatologists DO NOT specialize in the treatment of mechanical pain caused by degenerative disease of the joints or spine (such as osteoarthritis). I am happy to refer you to other specialists at Southview or outside of Southview who will be able to help you with these conditions.

WHAT ARE SYMPTOMS THAT ARE PARTICULARLY CONCERNING FOR A RHEUMATOLOGIST?

Joint/muscle/back pain that improves throughout the day, joint/muscle/back pain that occurs mostly at night or early hours of the morning, joint swelling, reduced range of motion of a joint (one example is reduced fist formation), severe muscle weakness, unintentional weight loss, documented fevers (100.4F or higher), drenching night sweats, and headaches in people over the age of 50.

I HAVE LOW BACK PAIN

The majority of patients with low back pain have mechanical back pain, which is not my expertise. What I am looking for in patient with low back pain is inflammatory back pain –characterized by: onset of pain under the age of 40, persists for more than 3 months, worsens with immobility (worse at night or in the morning), improves with physical activity, and is relieved by NSAID medications such as ibuprofen (Advil) 800mg three times a day, naproxen (Aleve) 440mg twice a day, or meloxicam (Mobic) 15mg daily.

I HAVE CHRONIC FATIGUE. I AM TIRED ALL THE TIME.

Fatigue can be a major symptoms in patients with rheumatologic disease. However, the majority of patients who complain of fatigue DO NOT end up having a rheumatologic disease. Common causes of fatigue I rule out with labs include: anemia, liver disease, kidney disease, thyroid disease, vitamin D deficiency. A review of literature indicates that 95% of patients with fatigue DO NOT have any lab abnormalities to explain their fatigue. If I tell you that you don't have a rheumatologic disease , I still want you to find solutions for your fatigue.

Non-rheumatologic causes of fatigue in patients with normal physical exam and labs include: poor sleep hygiene, sleep apnea, depression, anxiety, excessive caffeine intake, medications (for example, beta blockers), obesity, lack of regular exercise, alcohol abuse, tobacco use. Please feel free to ask me about cardiovascular exercise, a sleep medicine referral, referral to a therapist or psychiatrist for management of stress and mental health problems, self-care recommendations, referral to functional medicine, dietary changes such as aiming for a plant-based diet, elimination diet (Whole 30), and eliminating processed foods.

I HAVE LEG CRAMPING

Leg cramps are not a symptom of any rheumatologic disease, but in most patients, there are non-pharmacologic and over-the-counter solutions that we can certainly discuss.

I HAVE SWELLING AND/OR ACHING IN MY LOWER LEGS

Leg swelling, especially when present in only one leg, is concerning to physicians across all medical specialties. We want to rule out blood clots, heart failure, and other serious conditions. Most of the time, leg swelling is secondary to chronic venous stasis (blood pooling in veins in the legs), obesity, heavy sodium intake, amlodipine (Norvasc). I recommend compression stockings, leg elevation, regular cardiovascular exercise, weight loss, and consulting with a vascular specialist.

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ALL OF MY MUSCLES ARE ACHING

Many patients with rheumatologic disease will complain of diffuse muscle aching. I address this complaint similarly to fatigue (as discussed above).

MY JOINTS CRACK AND POP

As long as you do no experience consistent pain or swelling in a cracking/popping joint, you can consider this to be a normal and common occurrence. The older you get, the more noise your joints can make because some of the cartilage has worn away as part of the normal aging process. This causes the surfaces of the joint to be a little rougher so you get more noise as they rub against each other. Knuckles pop when nitrogen bubbles in the joint spaces are compressed and the gas is released into the joint.

I HAVE BEEN DIAGNOSED WITH FIBROMYALGIA BY ANOTHER DOCTOR

Fibromyalgia syndrome (FMS) is a chronic pain syndrome of unknown etiology that is characterized by otherwise unexplained diffuse pain, as well as tender points, fatigues and sleep disturbance. At this point in time, it is not believed to be an autoimmune disease.

Once I have ruled out rheumatologic diseases with a history, exam and labs, I typically refer patients with this diagnosis to sleep medicine to rule out sleep apnea and other sleep disorders. I always recommend low intensity exercise such as yoga and walking. Sometimes, I recommend physical therapy, or aquatic therapy. Other beneficial treatments include massage and acupuncture. Many patients benefit from consulting with psychology or psychiatry for the treatment of anxiety or depression and improved stress management techniques. Sometimes medications is used such as NSAIDs (ibuprofen, naproxen, meloxicam, celecoxib), Tylenol, SSRIs, TCAs, duloxetine (Cymbalta), milnacipran (Savella), gabapentin, pregabalin, topicals (diclofenac/BioMed), cyclobenzaprine.

I choose not to diagnose or chronically follow patients with fibromyalgia in my office.

MY KNUCKLES ARE BECOMING ENLARGED AND/OR CROOKED

Hand osteoarthritis affect about 40% of people by age 60. Unfortunately, we do not have any medication that can slow down the progression of hand osteoarthritis the way we can in diseases such as rheumatoid arthritis and psoriatic arthritis. Treatment of hand osteoarthritis focuses on management of pain and maintenance of function for activities of daily living. The most affected joints in hand osteoarthritis are the DIP joints (closest to each fingernails) and the CMC joint (where your thumb attaches to your wrist). There is an aggressive type of hand osteoarthritis called erosive osteoarthritis, which we can see on X-ray. We sometimes use a medication called hydroxychloroquine to treat it, but not all patients benefit from this.

The options for treatment of hand osteoarthritis include: topical diclofenac, Tylenol 650mg 4 times a day, NSAIDs (Aleve, Celebrex), therapy, paraffin hand baths, injections and surgery.

I HAVE A POSITIVE LAB RESULT (POSITIVE ANA, POSITIVE RHEUMATOID FACTOR, ETC)

Many patients I see have a false positive lab results, meaning the test is positive, but the patient does not have the disease. It is usually easy for me to identify which labs are false positives, but I must first obtain a history and perform a physical exam and look at other labs. About 1/3 healthy people have a positive, low level ANA test and about 5% of healthy people have a positive rheumatoid factor.

I HAVE A RASH

Rash can be associated with some rheumatologic autoimmune conditions. Typically, if the rash is new and persistent, and you have not been evaluated by a dermatologist, I recommend referral to a dermatologist for further work-up including possible biopsy. If after evaluation by a dermatologist, it is found that the rash is due to an underlying rheumatologic autoimmune disease, I will work together with the dermatologist to treat the disease. I do not typically diagnose or treat rash without it being first evaluated by a dermatologist.

Whether or not you are diagnosed with a rheumatologic condition, I hope that together we can figure out the cause of your symptoms, and get you on the path to feeling well again.