

# HEALTH



## JOINT VENTURES

# HOW ADVANCES IN THE FIELD OF RHEUMATOLOGY OFFER A BRIGHTER FUTURE FOR MANY

BY VIEL RICHARDSON

“People often don’t really understand what rheumatologists do,” says Dr Stephanie Barrett, a trained rheumatologist based at the London Clinic and the Lister hospital.

“Rheumatology is essentially dealing with pain in the muscular skeletal systems. So we are interested in bones, joints and muscles in relation to arthritis and osteoporosis.”

There are several categories of arthritis: inflammatory arthritis, which includes rheumatoid arthritis and connective tissue diseases like systemic (erythematosus) lupus; degenerative arthritis, which includes osteoarthritis; and gout, which is a critical arthritis which causes acutely inflamed joints. All forms of arthritis can cause the sufferer debilitating pain.

Osteoporosis relates to thinning of the bones. Patients often show no symptoms at all as their bones lose mass. “The first sign is often what we call a fragility fracture,” explains Dr Barrett. “These happen when the bones get critically thin. Often there’s a sudden collapse of a vertebrae, or the patient has fallen and broken a hip in way that should have caused

minimal trauma, such as a short fall onto a carpeted floor. This is real a warning sign and we definitely have to investigate the patient for osteoporosis.”

The conditions Dr Barrett treats can affect every part of the body from head to toe. “It’s this variety that really appealed to me about rheumatology—it encompasses a very wide field and you have a lot of clinical conundrums to solve,” she says. “You are like a detective trying to find out where the pain is coming from, how it originated and how to treat it.”

Challenging as the clinical side of rheumatology can be, one of the greatest issues Dr Barrett faces is a general lack of awareness: people often do not know just how much rheumatologists can do to help them. There are a lot of people, including some in the medical world, who think that any joint pain should be referred to an orthopaedic surgeon.

This leads to people with joint pain being sent to orthopaedics specialists by their GP or hospital admissions teams, and when this is not the appropriate the patient can go

round in circles before finally seeing a rheumatologist.

“If we see patients early we can say if they need to see an orthopaedic surgeon, or whether they can treated with medication by us. If a person with a foot swollen because of gout is initially sent to orthopaedics, it could be a long time before they see a rheumatologist, and for all this time they can be in real pain. It is about increasing awareness at the moment—there are only about two weeks rheumatology training in the whole five year medical course, and that is just not enough for a field that can make such a huge difference to so many people, the number of whom will only increase as the population ages.”

This is particularly frustrating considering the vast progress that has been made in the field in recent years, which has transformed treatment for rheumatoid arthritis. Treatments that have been around for 50 years have been supplanted by new drugs called biological agents or anti-TNS drugs. “These are injectable treatments which put the condition into

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remission. We no longer have to tell young people that they will eventually have to take a cocktail of miserable drugs for years, which will not actually be all that effective," says Dr Barrett. "We can now give them a good chance of getting back to work and forgetting about their disease—other than occasional check-ups, and injections that they can self-administer—allowing them to live a normal life. And the great thing is the drugs are getting better all the time. They're becoming easier to administer, more effective and longer lasting. Things in the field are moving very fast—faster than most other specialties, which makes it very exciting."

Osteoporosis is another area in which huge strides have been made—it is now possible to diagnose and treat people before they suffer a fracture, but it requires the patient to be proactive. "A lot of people think we can't treat osteoporosis," Dr Barrett

explains, "but we have drugs designed to prevent fractures and increase bone density. It's a myth that it is static. You can build up your bone density and track it on graphs using scans."

Dr Barrett sees many young women who have developed bone density issues due to eating disorders. "It is possible to help them and prevent real health issues developing later on," she says. "The scans can tell you where you are on the scale for osteopenia—low bone density which has not yet developed into full blown osteoporosis. They can tell us whether a person can improve things by taking preventative action or whether they will need to undergo treatment. It is vital to do this pre-emptively because it can make a real difference to the patient's future quality of life. I have seen a lot of people in this position improve their diets based on the fact they don't want to lose height, end up with a stoop or suffer fractures. They don't want to be the old lady with the stooped back. Their diagnosis has motivated these young women to eat, which has then switched on their oestrogen and ovaries and got their whole system moving again. The results can be wonderful to see."

Another common condition is gout. This occurs when a normally harmless chemical called urate builds up in the system and forms tiny crystals in joints, causing inflammation and severe pain. Dr Barrett is very keen to stress the fact that gout is not an amusing, old fashioned ailment based on drinking too much port, but an inherited condition which can be very serious.

While patients can modify their behaviour to avoid it, certain genes do increase the likelihood of developing the condition. "Getting gout is easily

treatable and is not the patient's fault," Dr Barrett says. "Unfortunately there is a stigma attached to the condition so people can feel embarrassed about seeking help, and continue to suffer unnecessarily—which is tragic because the treatments we now have are fantastic. But there is another reason you need to seek treatment: there is a clear link between gout and cardiovascular disease if the gout is left untreated for a long time, so it really pays to get it looked at."

While there is a lot of progress being made in the world of rheumatology, there are still challenges that need to be faced. At the moment, the battle is to find something that will arrest osteoarthritis. Some joints will inevitably suffer wear and tear through use over time, but the hands can get a form of osteoarthritis which isn't related to overuse, and it can lead to a level of deformity which severely compromises a patient's ability to perform everyday functions.

"Unfortunately, we still don't know what causes osteoarthritis, but we are actively researching it at the moment—and I think it's going to be the next breakthrough area. We know that there appears to be an immune reaction that degrades the cartilage—the surface of the joint—but we don't know what triggers this reaction. I still find it very disappointing when I have to tell a patient that there is not a lot we can do. If I had a silver bullet, that's where I'd be aiming it."

Overall, though, Dr Barrett feels very positive about her field. "One of my favourite moments is when I can tell a newly diagnosed patient, who may have been suffering for quite some time just how much we can do to help them," she reveals. "When I first qualified I would hear consultants tell patients that there was very little that could be done, and that there was a chance they could end up in a wheel chair. Now I can send patients on their way with treatments that mean they can lead a normal, pain-free life for the foreseeable future."

## LINKS

**Dr Stephanie Barrett**

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