INSIDE RHEUM

Delicate Negotiations

BY LARRY GREENBAUM, M.D.

On a recent visit, one of my patients complained about foot pain. Using her electronic medical record, I opened her foot x-rays, and using the magnifying and panning features I was able to zoom in on an erosion of her left fifth metatarsophalangeal joint. Metatarsalgia was one of her big complaints, and she and her husband were interested to see the ghostly radiographic image of her magnified toe joint. After this little bit of electronically facilitated show-and-tell, she complained about a "dip" of the proximal interphalangeal joint of her left pinky. She explained that she could not flex her left middle, ring, or small fingers unless she used her right hand to bend these fingers into shape. I explained that the "dip" she had noticed in her pinky was called a "swan-neck" deformity.

I went on to point out the obvious: "Your rheumatoid arthritis is getting worse. You are developing deformities of your fingers and worsening hand function. Walking is becoming more painful and limited for you, even though you are taking a reasonable dose of methotrexate."

The patient had been approved for adalimumab, but it had languished in her refrigerator for about a year since she remained terrified of giving herself her first injection. Some patients are afraid of the list of possible side effects they hear about in TV commercials, and others are turned off by the drug information sheets the pharmacy gives them. In the face of clear evidence that she was surely getting worse, my patient was finally ready to start her medication, although she asked me one last question – "my face won't turn purple, will it?"

All current guidelines for the treatment of RA urge early treatment to control the disease, although things don't always go so smoothly. The usual flavors of procrastination are patient reluctance, physician delay, or insurance company stonewalling, especially when expensive treatments are involved. Despite this generalization, some stalling tactics are truly unique.

Consider a 67-year-old woman whom I have been seeing for 5 years. She developed RA in 1994. She was concerned that her treatment was unsafe, so she left her first doctor and found a family physician that treated her with a combination of intravenous clindamycin and oral minocycline. She found this treatment less threatening and she did well for 6 years, until it seemed to quit working in 2002. A rheumatologist put her on methotrexate and gradually increased the dose to 25 mg a week. This didn't work well. She went off the methotrexate, and she came to see me, hoping I would resume her antibiotics.

As I mentioned in another column, my usual approach to patient requests can be summed up as "No reasonable request is refused." Unfortunately, IV clindamycin didn't fall into what I would call a reasonable request for the treatment of her RA. She probably thought I was being narrow minded, but I pointed out to her on several occasions that I didn't know any other rheumatologists who were using this treatment. I also argued that, if she had to drive hundreds of miles to find a physician offering this treatment, it had to be an unusual practice. Even if this treatment were harmless, she also ran the clear risk that her disease would progress while she wasted time on an ineffective remedy. I wouldn't prescribe intravenous antibiotics for her arthritis, but after some negotiations, I refilled her oral minocycline and low-dose prednisone. She did well again for awhile, but I remained suspicious that her improvement had much more to do with the prednisone than the minocycline, although I have seen occasional patients have nice responses to minocycline.

Her improvement didn't last long. Her RA got worse, and I had her resume methotrexate in November 2006. In June 2007 she was still doing poorly and I suggested she start on etanercept. Instead of starting etanercept, she contacted the out-of-state physician who had originally treated her with IV antibiotics. She resumed oral minocycline.

She did well from 2007 to 2009, and she disappeared from my practice for more than a year. She later went off minocycline in part because I had expressed skepticism that it was helping and also because a dermatologist told her the medication was turning her nail beds blue! I injected a painful wrist joint in April 2009 and preached the value of biologics, but she chose again to return to the out-of-state physician for IV antibiotics. She came back and told me that she felt the treatment had helped her, but she described the trip as the "drive from hell" and that offset much of her benefit. The trip was hard on her because her husband was becoming demented, and she had to do the entire long drive with painful hands while at the same time keeping an eye on her husband.

In August 2009, I ordered hand x-rays. She delayed for 7 months before she finally got these done. The x-rays showed erosions. Well, duh?! She never started the etanercept because she was afraid of it. After her Multi-Dimensional Health Assessment Questionnaire (MDHAQ) Rapid 3 score rose to an amazingly bad 26.3, she reluctantly agreed to try certolizumab. She did well on this medication for about 6 months, and then she had a big flare-up of her arthritis. I switched her to abatacept, and so far she has done well, and she has even tapered off prednisone after many years of treatment. She was left with painful foot and toe deformities. A very good podiatrist told her to postpone reconstructive surgery as long as she could because the foot doctor predicted a long and painful postoperative course. I suspected her outcome would have been better if she hadn't procrastinated starting effective therapy for so many years, but there isn't any room in my practice for saying "I told you so." ■

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A Young Rheumatologist Plans to Kayak for Charity

BY SALLY KOCH KUBETIN

The circumference of Great Britain is 2,600 miles, according to Dr. Martin Lee. The newly qualified consultant rheumatologist should know, given that he intends to kayak every inch of it to raise £100,000 in pledges for the National Rheumatoid Arthritis Society.

With a launch date of April 1, 2012, Dr. Lee, who has been granted a sabbatical by the Royal National Hospital of Rheumatic Diseases in Bath, has been inspired to undertake this endeavor by his beloved aunt, who has rheumatoid arthritis. Also on his mind are the many other people with RA whom he has met during his training, first at the University of Wales College of Medicine and then during his rheumatology training in southwest England

Planning to structure the trip as 100 marathons in 100 days, 32-year-old Dr. Lee said in an interview that he will launch from the a public boating club in Greenwich called the Ahoy Centre.

Anyone who attended the 2011 European Congress of Rheumatology in London's Docklands neighborhood was close to being across the Thames from the Ahoy Centre.

The conditions of his voyage will be spartan. Dr. Lee plans to sleep in a sleeping bag on the ground and survive on food stored in the kayak's hatches. "I don't have a spare kayak, so I can't smash my one on rocks!" Friends and relatives will deliver supplies of fresh food at prearranged meeting places along the route.

All the funds Dr. Lee plans to raise are to go to the National Rheumatoid Arthritis Society, a charity that provides support and advice for people with rheumatoid arthritis. Dr. Lee's own clinical area of interest is early inflammatory arthritis and rheumatoid arthritis, he said.

COURTESY DR. MARTIN LEE

Dr. Martin Lee is attempting to raise funds for the National Royal Arthritis Society in a 100-day circumnavigation of Great Britain by kayak.

Dr. Lee has been kayaking since he was a teenager. To date, his greatest kayak adventure was when he was 17 years old and spent the summer exploring North Vancouver Island in Canada. An all-around fierce athlete, Dr. Lee is also a member of the British Medical Football Team (http://www.britishmedicalfootballteam.co.uk/index.php/the-news/62-dr-martin-lees-100-day-round-the-isles-challenge).

For more information about the challenge and to sponsor Dr. Lee, please go to http://www.martinkayaking.co.uk/. ■