

Four Common Rheumatological Consultations Based On Misunderstandings



There are a number of misunderstandings that occur during rheumatological consultations, most of which can be handled quite readily by primary-care physicians.

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Presented at McGill University, Montreal, Quebec, November 1999.

There are a number of reasons for rheumatological consultations. Four of the most common causes, in the author's experience, are due to misunderstandings. These misunderstandings are: (1) the patient's understanding of the term "back," needn't be medically accurate; (2) acute gout shouldn't be treated by correcting the underlying

metabolic abnormality; (3) rheumatic distress needn't be due to musculoskeletal pain; and (4) rheumatic pain, suffering, and disability, needn't be due to a musculoskeletal abnormality. The first three of these are relatively easy to manage. The fourth is a major clinical challenge.

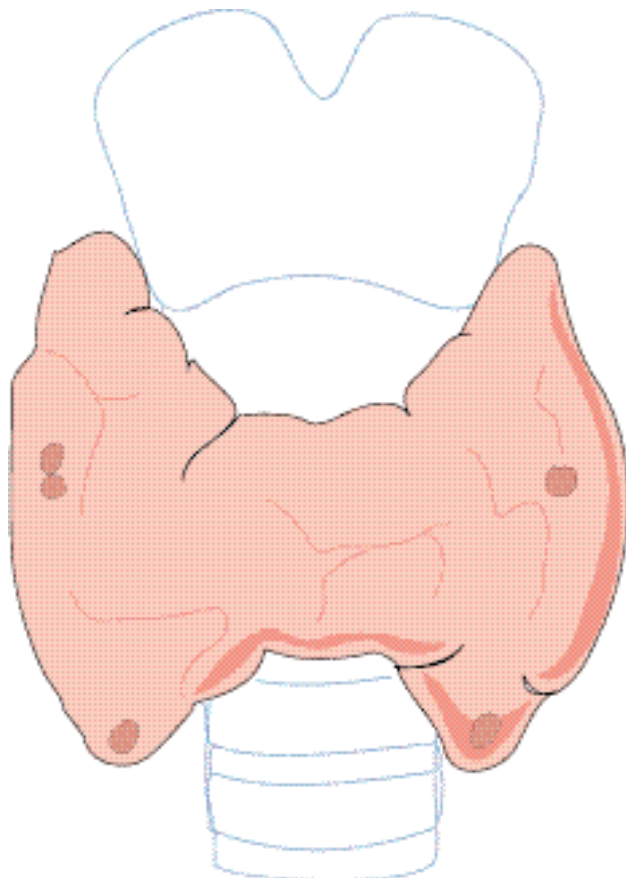
The Patient's Understanding of the Term "Back" Needn't be Medically Accurate

Patients may present with complaints of "back pain" that are difficult to diagnose. One reason for this is that physicians are conditioned to think of the term "back" as referring mainly to the lumbar region. As a first step in diagnosis, it is worthwhile



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Metabolic abnormalities due to dysfunction of either the thyroid or parathyroid gland occasionally may cause diffuse musculoskeletal pain.

to ask the patient to point to the area of his/her “back” discomfort. Patients may actually point either to a buttock, or the region of a shoulder blade. Many patients consider these areas to be part of the back.

Clearly, buttock pain arises from the hip. Occasionally, hip pain may radiate to the knee, resulting in a history that may superficially resemble that of sciatica. Diagnostic clarification is

readily obtained by internally rotating the affected hip, which reproduces the hip and knee pain.

In the case of “back” pain in the scapular region, the author has observed that tenderness over the mid portion of the medial border of the scapula is usually accompanied by limitation of internal rotation of the same shoulder. The other shoulder structures may, or may not, be tender to palpation. Remobilization of the affected shoulder serves to eliminate this form of “back” pain.

Acute Gout Shouldn't be Treated by Correcting the Underlying Metabolic Abnormality

Patients may be referred for treatment of refractory acute gouty arthritis. Further enquiry reveals that therapy (usually allopurinol) has been instituted to correct the hyperuricaemia during the acute attack. Clinical manifestations of metabolic diseases, such as diabetes or azotaemia, may be improved by correcting their underlying biochemical abnormalities. It is common knowledge that lowering serum urate levels may predispose a patient towards developing attacks of acute gouty arthritis, for several months. However, it is not generally appreciated that this same intervention may also prolong, and intensify, an ongoing attack of acute gouty arthritis.¹ Acute gout, then, unlike the clinical manifestations of other metabolic diseases, is not improved by correcting the underlying metabolic abnormality.

Rheumatic Distress Needn't be Due to Musculoskeletal Pain

A patient may be referred for consultation because of distress related to his/her musculoskeletal sys-

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tem, which is poorly responsive to analgesic or anti-inflammatory therapy. This type of diagnostic problem usually involves visible joint abnormalities, such as Heberden's nodes, or osteoarthritic enlargement of a sternoclavicular joint.

Two simple questions will quickly clarify the problem. First, determine whether there is any loss of sleep due to the pain, and then, ask the patient whether the pain causes any disability. If both answers are no, it is clear that the patient's distress is not due to the impact of musculoskeletal pain, *per se*. The source of the patient's distress must be sought elsewhere.

In the case of the Heberden's nodes, the usual cause of the distress is worry about the possibility of disabling arthritis. In the case of the enlargement of the sternoclavicular joint, the worry is usually about malignancy. Both of these needlessly worrisome causes of distress are readily treated by reassurance.

These are simple examples of distress due to illness worry, stemming from a lay individual's misunderstanding of the nature of disease. The next section will present a more complex example of extreme disabling distress due to illness worry, or conviction.

Rheumatic Pain, Suffering and Disability Needn't be Due to Musculoskeletal Abnormality

A rheumatological consultation may be requested for a patient because of diffuse pain of uncertain etiology. The most common cause of this problem in office practice is the fibromyalgia syndrome.

Fibromyalgia is characterized by diffuse musculoskeletal pain, associated with insomnia, fatigue, frequent headaches and dyspeptic symptoms. There are typical tender points to palpation about the pectoral and pelvic girdles, however,

there are no known abnormalities of the musculoskeletal system, *per se*, to explain the presence of pain in fibromyalgia.^{2,3} Nevertheless, the presence of increased substance P, both in the nerve endings of biopsies of tender points,⁴ and in the spinal fluid,⁵ is evidence for the existence of pain. Moreover, there are thalamic changes, suggesting that there is increased pain transmission within the nervous system of patients with fibromyalgia.⁶

Individuals with pain, suffering and disability, in the absence of demonstrable underlying anatomic, physiologic, or psychiatric illness, are classified as having a functional somatic syndrome.⁷ A variety of syndromes are so classified, including chronic fatigue, multiple chemical sensitivity syndrome and fibromyalgia.

The current working hypothesis of symptom generation in functional somatic syndromes, such as fibromyalgia, suggests that various common, benign symptoms are focused upon and magnified by these individuals.^{7,8} In the author's experience, with early cases, this amplification process is often set in motion by various forms of stress. Illness worry, or conviction resulting from misunderstood magnified benign symptoms, causes severe distress, which, in turn, leads to disability.

The distress, and disability in these patients, then may produce secondary anxiety and depression, which not only serve to amplify the previously existing benign symptoms, but also may contribute some unpleasant symptoms of their own.

The difficulties involved in making a diagnosis of fibromyalgia, is the subject of a recent review.⁹ The greatest difficulties are found in patients with symptoms of recent onset. It is extremely important to rule out any early collagen-vascular diseases in all patients with generalized pain. Polymyalgia rheumatica, multiple myeloma and metastatic malignancy are particularly important considerations in the elderly. Somatic symptoms due to psychiatric illnesses, such as depression,

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Symptoms of early rheumatic diseases, or metastatic malignancy, may present before they can be clearly diagnosed with physical, laboratory, or imaging examinations.

schizophrenia, or borderline personality also must be ruled out. Finally, metabolic abnormalities due to dysfunction of either the thyroid or parathyroid gland occasionally may cause diffuse musculoskeletal pain.

Symptoms of early rheumatic diseases, or metastatic malignancy, may present before they can be clearly diagnosed with physical, laboratory, or imaging examinations. This difficult diagnostic situation may take all of the skill of the consultant, together with ongoing, repeated observations in order to achieve a firm diagnosis.

The diagnostic problem in early cases is mainly seen in a primary-care setting. There are two main priorities in this situation. The first of these is to diagnose occult cranial arteritis, associated with polymyalgia rheumatica. Corticosteroid therapy then may be instituted in order to prevent irreversible blindness. The second is to make a firm diagnosis of a fibromyalgia syndrome as soon as possible since, in the author's experience, there is only a limited time frame wherein this problem can be managed. This is because illness worry is characteristic of the early stages of fibromyalgia.⁸ Illness conviction is more typical of long-standing cases seen in tertiary care.¹⁰ Illness worry is amenable to intervention, while conviction is not.

Illness worry usually can be dealt with by reassurance. The author has often found it helpful to use the common expression "up tight," in order to emphasize to fibromyalgic patients that their musculoskeletal pain may be related to emotional tension, rather than to life-threatening, or disabling, illnesses. This admittedly oversimplified explanation may, hopefully, serve to empower the patient to overcome his/her illness worry. Indeed, it is an excellent prognostic sign if the patient smiles with relief upon being reassured. Patients may then vent their stressful problems. Patients with fibromyalgia also may be empowered by encouraging them to undertake a regular exercise program and to use heat, as required, to relieve the pain.

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Since, as previously mentioned, there is evidence of increased pain transmission within the nervous system, in fibromyalgia, a rational adjunct to therapy involves down-regulating the afferent pain synapse in the dorsal horn with small doses of tricyclic antidepressants.

If the diagnosis of fibromyalgia is delayed, the individual will likely have chronic pain, suffering and disability, and will be firmly convinced that he/she has a serious illness. This is particularly true of individuals who believe that their plight is due to having been victimized (e.g., a traffic accident or working conditions). These long-standing convictions are unshakable.^{7,10} Attempts at reassurance are rejected by patients who cite misunderstood false-positive blood test results or irrelevant changes in the imaging studies. It is disheartening to have each attempt at reassurance met with: "Yes doctor but..." At this point, the physician and patient are clearly in a "no win" situation, due to an immutable misunderstanding.

The physician is faced with the sad realization that these individuals have no medically treatable anatomic, physiologic, or psychiatric abnormalities. Moreover, there are no other therapeutic tools, since attempts at reassurance are ineffective. These individuals, therefore, are condemned to prolonged, and untreatable, suffering.⁷

Conclusion

In summary, there are a number of misunderstandings that result in rheumatological consultations. Three of the four misunderstandings can be han-

dled quite readily by the primary-care physician. The fourth (i.e., the early exact diagnosis of a diffuse pain syndrome) is extremely difficult, and may require the assistance of a rheumatologist. [CME](#)

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