How you can empower your patients with arthritis to better manage their health.

Nurses in General Practice Workshop
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What is arthritis?

What are the differences between RA and OA?

How can the Practice Nurse contribute to the management of the patient with arthritis?

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What is self management in chronic disease?

What resources are available to help?

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What is arthritis?

- Arthritis means “inflammation of the joint”
- It derives from the Greek words “arthron” meaning joint and “itis” meaning inflammation
- There are more than 150 different types of arthritis

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Facts

- Arthritis & other MSkD's are Australia's 7th National Health Priority (July 2002)
- Arthritis affects over 3 million or 16% of Australians
- Almost 60% of people with arthritis are of working age (15-64 years)
- Arthritis is the leading cause of disability associated with chronic conditions
- 19.000 hip & 20,000 knee replacements for OA are performed in Australia each year

Sources – 2001 Prevalence & Cost of Disease Burden of Arthritis in Australia. Access Economics.
1998 ABS Survey of Disability, Ageing & Carers
March,L. Epidemiology of OA in Aust. MJA 2004, 180 (5 Supplement, S6-S10

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Osteoarthritis (OA)

- Most common type of arthritis
- Affects approximately twice as many women as men
- Commonly diagnosed between 50 – 65 years
- Caused by degeneration of cartilage
- Almost everyone over 65 years shows some degeneration on X-ray, but may be asymptomatic

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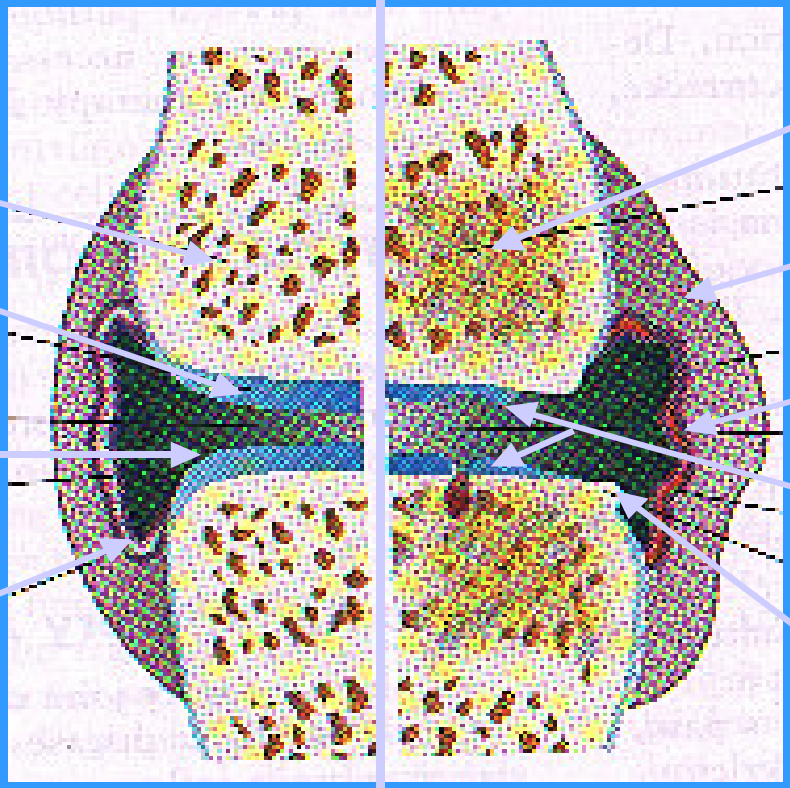
Osteoarthritis: what is it?



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Clinical features of OA

- Common sites are hips, knees, neck & hands
- Pain – gradual onset as opposed to acute onset of RA
- Pain worsens with movement & relieved by rest
- If c/- pain at rest - indicates advanced disease
- Generally not considered to be inflammatory but inflammation can occur
- Loss of movement & bony enlargement from osteophyte development

OA continued

- Peri – articular muscle weakness
- Joint stiffness generally worse at waking, persisting approximately 30/60
- Stiffness usually worse when joint not moved for some time – “Gel phenomenon”
- Joint instability and malalignment
- Crepitus – “feel and/or hear joint movement”

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OA contributing factors

- Obesity
- Trauma
- Mechanical – malalignment, overuse
- Genetics

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Rheumatoid Arthritis (RA)

- Auto immune disease
- 75% of patients are women with onset generally between 30-50 years OR 65-75 years
- Affects approximately 1% of population

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Clinical features of RA

- Morning stiffness – longer than 2/24
- Synovitis – active (flare) & chronic
- Structural damage (cartilage & periarticular bone loss) = joint deformity & loss of function
- Extra articular manifestations – systemic condition with fatigue probable & fever possible

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RA continued

- Other organ involvement- skin/lungs/eyes/heart
- Generally symmetrical presentation
- Can affect most joints – commonly wrists, metacarpal phalanges, hips, knees, feet
- Pattern of highly variable symptoms with random onset

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RA contributing factors

- Genetic
- Random triggers – infection, trauma, stress
- Ideopathic

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What is the psychosocial impact of arthritis?

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Your role in supporting the patient become a better self manager

- Information
- Pain management
- Medication
- Exercise
- Self management courses
- Complimentary therapies

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Information

- Arthritis Victoria - website, information sheets, resource centre, education sessions

- Community Health centres – referral for allied health – physio, OT, podiatry, dietician.

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Pain Management

- Appropriate physical activity with physio referral for specific programs
- Encourage activity to reduce pain levels
- Use of heat / cold
- Relaxation
- Massage
- Positive self talk

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Medications

- **Analgesics** eg. Paracetamol
- **NSAID's** eg. Diclofenac sodium (voltaren), Naproxen (naprosyn) and Ibuprofen (nurofen, brufen)
- Cox-2 inhibitors eg. Celecoxib (celebrex), Rofecoxib (vioxx), Meloxicam (mobic)

  MIMS "only prescribed with symptomatic Rx of OA and RA"
- **Corticosteroid's** eg. prednisolone

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Medicines continued

- **DMARD's** (for RA/JA) e g.salazopyrin, methotrexate & new TNF's (etanercept, remicade, adalimumab)

- NOTE - All DMARDs have substantial side effects that need input & monitoring by a rheumatologist once every three months

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Physical Activity

- Strength training
- Tai Chi
- Warm Water Exercise
- Walking
- Chair based exercise
- Nb. Programs may be intermittent - dependant on fluctuating fitness levels and flareups.

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What are the benefits of physical activity for people with arthritis?

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Why is physical activity important?

- Increases strength and flexibility
- Provides nutrients to joints
- Prevents stiffness and deformity
- Increases general fitness and wellbeing
- Increases ability to perform daily tasks
- Strong muscles support sore joints

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Self management

- Flinders University Model. Assessment tools, promotes collaborative goal setting and individualized care plans. www.som.flinders.edu.au
- Stanford University Model. Courses aim to increase patient confidence in how they manage the problems resulting from living with arthritis - eg. fatigue, pain, feelings of anger, fear and frustration, depression. More information: www.arthritisvic.org.au
- Peer support – self help groups

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Complimentary Therapies

- Important to remind patients that “natural” treatments have side effects and potential drug interactions – need to discuss openly with GP & specialist
- Glucosamine - limited evidence that it improves symptoms & maybe (not proven) able to slow OA progression
- Chondroitin – insufficient evidence to date. Combination of both – limited evidence that symptoms improved

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Complimentary Therapies cont.

- Acupuncture – evidence indicates large placebo effect

- TENS – evidence suggests this is effective with pain control but more studies required to make treatment recommendations

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Complimentary Therapies cont.

- Capsaicin (cream) – limited evidence this may improve knee pain (from capsicum)
- Soya bean & avocado (herbal therapy) – limited evidence beneficial effect on pain control & function
- Omega 3”s (fishaphos) or cod liver oil effective in RA
- Medicines Line – 1300 888 763

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