Editorial
This issue of Synovium is packed with practical advice, derived from research evidence, for the primary care clinician. We also feature two studies on novel treatments for fibromyalgia so that colleagues are forewarned when patients attend with their latest internet downloads. At Synovium we are constantly intrigued by the eclectic range of treatments trialled for fibromyalgia (FMS). Regular readers may recall a previous report on mudbaths! You may also spot a familiar name as co-author on our final offering. This interesting piece of research, undertaken by a former GP trainee, grew out of a slightly heated discussion with a patient about whether an x-ray was a good idea in simple mechanical back pain. We think it needs wider readership.

Adrian Dunbar

Referral of patients with osteoarthritis for consideration for joint replacement surgery
With osteoarthritis (OA) being one of the most common musculoskeletal conditions, and with the ageing and increasingly sedentary population, referral of patients whose joint symptoms are difficult to manage is increasing in primary care.

A study published in the British Journal of General Practice looked at the outcomes of 257 patients referred to a regional orthopaedic centre for consideration for joint replacement. Only 50% of patients with OA hip and 33% of patients with OA knee had undergone joint replacement 12 months after referral. Having a new joint was associated with increased frequency and severity of pain and stiffness, a shorter duration of symptoms, poorer physical function and use of a walking stick. The decision-making around joint replacement is complex and multidimensional, as the authors acknowledge. It is influenced by many factors in addition to those directly related to the joint in question. Patient preferences, comorbidities and alternative treatments are some that were not examined in this study. The authors advise that referring clinicians should ensure that patients are fully informed, fully educated, and both agreeable to and fit for surgery before making the referral. We would add that patients should have also explored all the simple, safe and cost-effective treatments that Synovium has previously featured.


Starting treatment for polymyalgia rheumatica
Polymyalgia rheumatica (PMR) is one of the commonest inflammatory rheumatic disorders and is usually completely managed in primary care with oral prednisolone. Guidelines suggest a starting dose of prednisolone of between 15 mg and 20 mg daily; however this is not based on much evidence from controlled trials evaluating the effects of different treatment doses. One trial showed that doses ≤10 mg were associated with a higher incidence of symptom recurrence and doses ≥20 mg with a higher incidence of adverse effects. A new study followed 60 consecutive patients treated with 12.5 mg of oral prednisolone daily. This dose was found to be effective in controlling symptoms and normalising erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) levels in 47 of the 60 patients (78.3%) within 1 month. Interestingly, among a number of clinical parameters, low body weight
best predicted a good response to the treatment. The mean dose of prednisolone per kilogram of body weight in responders was 0.19 mg (± 0.03) compared with 0.16 mg (± 0.03) in non-responders. This provides some evidence for calculating the starting dose of prednisolone.


New treatments for fibromyalgia syndrome

Two studies catching the editorial eye recently in connection with fibromyalgia syndrome (FMS) were ‘hypnosis with guided imagery’ and implantation of a vagus nerve stimulator. Guided imagery – if you were not aware – is ‘a dynamic, psychophysiologic process in which a person imagines and experiences an internal reality in the absence of external stimuli’. Sadly the systematic review found that most of the studies were of poor quality and concluded that this treatment could not be recommended. With regard to vagus nerve stimulation, however, in an uncontrolled study 7 of 14 women with a 2-year history of FMS fitted with a vagus nerve stimulator were significantly improved after 11 months, and 2 patients no longer fulfilled the FMS diagnostic criteria. However, unanticipated or serious adverse events occurred in 4 patients. Interesting stuff. We suspect that it is going to be difficult to mount a double-blind, placebo-controlled trial of vagus nerve stimulation in sufficient numbers of subjects to persuade most of us that this is a treatment worth pursuing in these austere times, especially with such a high incidence of serious adverse effects.

We are reminded of a very wise old general practitioner who (among many such pronouncements) often said, ‘The more treatments there are, the less confident you can be that any of them are effective!’


How to consult with a patient with simple back pain

A study published in International Musculoskeletal Medicine reported some really interesting findings that we (humbly) suggest every clinician who consults with patients complaining of back pain will find helpful. The study asked (by questionnaire) 81 GPs and 427 patients from 12 practices about their views on the utility – or otherwise – of 8 possible components of the consultation. These were:

- taking a history, physical examination, requesting lumbar spine x-rays; prescribing or advising medication, referring for physiotherapy or osteopathy, advising back exercises, referring to a specialist, and ‘allowing nature to take its course’. Subjects were given 6 possible responses for each component: essential, useful, occasionally useful, not useful, a waste of time/money, or potentially harmful. The patients were also asked to state if they had ever consulted a GP about back pain. It was interesting to find significant differences in the values placed on some components of the consultation by doctors and patients. Predictably the subject of x-rays revealed most disagreement, with very few doctors (<3%) rating x-rays as valuable, unlike the majority of patients (>60%). Patients valued specialist referral significantly higher than doctors (57%: 1%) but were negatively disposed (43%) to allowing nature to take its course and let the back ‘heal over time’ – a small number of patients thought this potentially harmful, whereas most doctors (83%) valued this approach. Perhaps the most surprising was the relatively low value doctors placed on examination of the back compared with patients (70%: 90%). Interestingly there was no difference in the patients’ responses depending on whether or not they had previously consulted for back pain. The importance of these findings is that they can guide the clinician towards a more effective consultation, avoiding issues that might lead to patient dissatisfaction. Patients want to be examined. They need an explanation about why an x-ray is not a useful investigation. They need a discussion about the utility of referral for physical therapy and a specialist opinion. They will happily accept back exercises. And if all this is covered they may perhaps accept the advice that back pain is not usually serious, is part of the normal human experience, is usually self-limiting and safe to leave to nature to heal.


Osteoarthritis: more than just ‘wear and tear’

Recent years have seen significant advances in the clinical management and understanding of osteoarthritis. The Autumn 2011 Issues of Hands On (our serial publication for GPs and those managing rheumatological conditions in primary care) and Topical Reviews (aimed at rheumatologists in training and other interested health professionals) are linked around the theme of osteoarthritis, providing a comprehensive overview.

The reports can be accessed via www.arthritisresearchuk.org/medical-professional-info.