RhAPP

RHEUMATOLOGY ADVANCED PRACTICE PROVIDERS

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Pearls for the new Rheumatology APP

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Faculty Disclosures

- Advisory Board: UCB, AstraZeneca, Boehringer Ingelheim, Janssen

Introduction

- Kyle George PA-C
  - 7.5 years experience in Family Medicine at FQHC
  - 7 years experience in Rheumatology
    - Private Practice with 3 MDs and 3 APPs
      - Lab and Ultrasound
  - 4+ years involved with RhAPP and current board member

Objectives

- Share clinical “Pearls” that have proven useful to me as an APP in Rheumatology dealing with various disease processes
- Offer strategies that help facilitate patient understanding when discussing rheumatologic disease and treatment options
- Hopefully, this present serve as a quick resource/reference for the new APP

Accreditation Statement

- Sample Text

The “Gray Area” of Rheumatology

- By and large, there is a lot of Black/White thinking in medicine
  - For example, HTN and Diabetes have values with definitive cut-off values
- Rheumatology is “Gray”
  - Symptoms plus Labs plus response to steroid/other therapy
  - A lot of diagnostic criteria can be complicated

History Taking Pearls

Ask about preconceptions: Some patient come in with the notion that they already have a diagnosis such as Lupus, because they had a positive ANA and that's what their PCP told them.

Flare vs. decreased efficacy of med: Recognizing the difference can prevent unnecessary medication changes. If the patient was well controlled prior to fairly abrupt episode of pain, swelling, etc. think flare. If gradual worsening of symptoms over time, think decreased efficacy of med. If there is uncertainty, consider treating as a flare and monitoring for return of symptoms which would suggest decreased efficacy.

Physical Exam[1]

- Anatomical distribution
- Local signs of inflammatory process
- Anatomical abnormality/disruption or injury
- True muscle weakness
- Constitutional symptoms to suggest systemic process

Risk

- “Frontload” with education, and taking the time with your patients to answer questions that they may have
  - this *will* save time down the road for yourself, as well as your office staff
  - This will also help to establish a trusting relationship with your patient

Risk

- “it seems like the treatment is worse than the cure….”
  - In my experience, patients tend to OVERestimate the potential side effect risks and UNDERestimate the potential outcomes of deferring therapy.

Lab Pearls

- I often explain to the patients that the routine lab monitoring is my concern. I don’t want them preoccupied with results.
  - We will let you know if there are concerns
  - Always review labs in the context of “trends” and explain this reasoning to your patients.

Lab Pearls

- Inflammatory markers can fluctuate with disease activity
  - May not be elevated in early disease
- ESR and CRP can be influenced by other variables
  - Age, race, obesity, and other non-rheumatologic factors

Quick reference for the ANA[2]

Homogenous (diffuse)	
• DNA-histone (nucleosome)	SLE, drug-induced LE, other diseases
• Mi-2	Dermatomyositis (15%–20%)
Rim (peripheral)	
• dsDNA	SLE

Quick reference for the ANA

Speckled	
• SS-A (Ro)	SLE, SCLE, primary Sjögren's, systemic sclerosis, other diseases
• SS-B (La)	SLE, primary Sjögren's, SCLE
• RNP	MCTD, systemic sclerosis, SLE
• Sm	SLE
• Ku	SLE, polymyositis/systemic sclerosis overlap

Quick reference for the ANA

Nucleolar	
• Topoisomerase I (Scl-70)[a]	Systemic sclerosis (diffuse type) (20%–30%)
• RNAP III[a]	Systemic sclerosis (diffuse type) (4%–20%)
• Fibrillarin (U3-RNP)	Systemic sclerosis (diffuse type) (8%)
• TH/TO	Systemic sclerosis (limited type) (5%)
• PM- Scl (PM-1)	Polymyositis overlap (1%)

Quick reference for the ANA

Centromere (kinetochore)	
• CENP	Limited scleroderma

CENP, centromere protein; *LE*, lupus erythematosus; *MCTD*, mixed connective tissue disease; *RNAP*, RNA polymerase; *RNP*, ribonuclear protein; *SCLE*, subacute cutaneous lupus erythematosus; *SLE*, systemic lupus erythematosus; *SS-A*, Sjögren's syndrome-related antigen A.

Axial Spondyloarthritis

- I like to explain this to patients as an “umbrella term” for a “family” of disease states.
- Arthritis symptoms may precede inflammatory bowel symptoms in up to 30%[3]
- Arthritis symptoms may precede skin manifestations of psoriatic arthritis in up to 15%[4]

Back pain[5]

- Estimated 80% of the population experiences back pain at some point in their life
- Is the most common musculoskeletal complaint
- It is important to distinguish between mechanical back pain and inflammatory back pain.

Inflammatory back pain

IPAIN mnemonic[6]

Insidious onset

Pain at night

Age of onset <40

Improvement with exercise

No improvement with rest

Imaging for evaluation of inflammatory back pain[7]

- MRI of the lumbar spine and/or sacroiliac joints to help evaluate inflammatory component
  - Order T1, T2, and STIR images.
  - No contrast necessary

Psoriatic Arthritis Pearls

- Ask specific questions
  - In my experience, patients will not offer up information regarding rashes in the gluteal cleft, unless asked about it.
  - Educate about various forms of PSO. This may lead to additional insight in personal and family history
  - Ask specifically about enthesitis and tendon it is history

Rheumatoid Arthritis Pearls

Control of symptoms within initial 6 months of diagnosis increases likelihood of remission

Presence of high titer serologic abnormalities (RF, anti-CCP), erosive changes, extra-articular manifestations confers greater disease severity

Consider Rituxan vs. Orencia if extra-articular manifestations of seropositive RA

Allow for some uncertainty with diagnosis of seronegative RA (may not yet meet criteria for psoriatic arthritis, etc.)

Polymyalgia Rheumatica Pearls

- Always consider possibility of GCA
- Consider possibility of seronegative rheumatoid arthritis in patients unable to taper off prednisone, particularly if peripheral joint involvement
- Slower, gradual prednisone taper less likely to result in relapse than shorter tapers

Connective Tissue Disease Pearls[8]

UCTD: about 25% of Rheum referrals present with UCTD, with approx 25% of those patients evolving into a defined rheum diagnosis within 1-3 years

Ask about respiratory symptoms in patients with CTD, and work up possible pulm involvement

Vasculitis Pearls

Consider vasculitis in the presence of petechiae/palpable purpura on exam

Order full ANCA panel if vasculitis suspected

- MPO vs PR3

Myositis Pearls[9]

Consider MCTD if other factors present

All patients should be counseled re: age related cancer screenings

Some types more closely associated with increased cancer risk: TIF-1gamma, anti-p 155/140, NXP-2, anti-MJ, anti-p140

Approx 70% of cancers associated with inflammatory myopathies include cervical, lung, ovarian, pancreatic, bladder, and stomach.

Gout Pearls

- Management of gout can be incredibly satisfying to treat
- Management of gout patients can be incredibly frustrating to treat
- They can be “reliably unreliable.”

Gout Pearls[10]

- Press the new patient on history
  - Migratory mono/oligoarticular inflammatory arthritis
  - Food/beverage triggers
  - When in doubt, treat the gout
- ACR gout treatment guidelines
  - Importance of prophylaxis

Osteoporosis treatment[11]

- Osteonecrosis of the jaw.
  - Follows INVASIVE dental procedures
    - Routine cleanings, fillings and root canals are okay.
    - Extractions and Implantations are the risk here.
  - Some risk with poor oral hygiene, DM, use of GCs and age >65
- Absolute risk of ONJ is 25/100,000 patient years (0.1%-0.15%/year)
  - 28X more likely to suffer Osteoporotic fracture!

Osteoporosis treatment

- Atypical femur fracture
  - Occurs almost exclusively in patients on long-term antiresorptive therapy (greater than five years)
  - Drug holidays (from bisphosphonates) reduce the risk of atypical fractures by 70%
- Absolute risk is 2, 20, and 100/100,000 patient years after 2, 5, and 10 years of use.
  - Osteoporotic fracture is 286x more likely than AFF!

Osteoporosis treatment - Prolia

Need for replacement therapy if patient is going to discontinue, due to backsliding/bone density loss, increased risk of vertebral fracture if abrupt discontinuation after their 2nd dose.

DMARD Timeline to Efficacy

- These therapies take time
  - Leaky faucet analogy
- Allow 6 weeks to note ANY benefit
- Allow 6 months to note DEGREE of benefit

cDMARD Pearls

Hydroxychloroquine

If patient having difficult with compliance with 200mg BID dosing, ok to combine to once daily 400mg

Methotrexate

Common initiation dose: 4 tabs weekly x 2 weeks, then 5 tabs weekly x 2 weeks, then 6 tabs weekly thereafter

GI adverse effects, especially nausea common especially with oral form.

Dose can be divided to bi-weekly to minimize adverse effects if needed

Oral tablet # converts to injectable cc's (eg 6 tablets = 0.6 cc's), but injectable considered slightly "stronger" than oral equivalent.

bDMARD Pearls

Humira: if experiencing significant drop off effect with 14 day spacing, can increase frequency of dosing to 10 days; however, not always covered by insurance

JAK inhibitors: increased risk of shingles, thrombosis

IL-17 inhibitors: can unmask IBD

Orencia: Lower risk of infection than other bDMARds

Biologic Nurse Partner Program: many pharmaceutical companies offer these programs to patients, encourage your patients to use them such as for troubleshooting mild injection site reactions, as this will save time for your office staff.

TNF Therapy

- Remember contraindications
  - Multiple sclerosis
  - Congestive heart failure
  - Active infection
  - Melanoma/skin cancer and lymphoma
    - Always consult with patients oncologist

TNF therapy and the C-word[12]

- Most large studies show that risk of lymphoma is comparable to the risk associated with the underlying rheumatologic disease.
  - Baseline risk 2-3x greater than general population
- Risk of solid tumors is not increased
- Melanoma and other skin cancers may be increased
  - 1.79x and 1.45x

Steroid Use

- Common doses/tapers used in our clinic
  - Medrol Dosepak
  - Prednisone 15 mg/day x 1 week, 10 mg/day x 1 week, 5 mg/day x 1 week
  - Kenalog 60 mg IM
- Prednisone 5 mg = 4 mg of Methylprednisolone

Steroid Use[13]

- Peptic ulcer disease risk is increased 3x at doses of >10mg concurrent use of NSAID
- Dose dependent Infection risk >6-10 mg/day
- Pneumocystis pneumonia risk >15-20 mg/day for >3-4 weeks
  - Bactrim 3 days/week, Dapsone 100 mg/day
- Provide Medrol Dosepak to patients for travel, camping, vacations, etc.
- If possible, HOLD initiation of steroid until after labs, Ultrasound, other imaging, etc.

Efficiency Pearls

Utilize handouts, especially for medications and diagnoses.

Utilize EMR QuickText or .dotphrases, dragon shortcuts, etc.

Preempting common concerns can minimize phone calls, office staff workload.

Efficiency Pearls

Medical assistant - Scribe

- Can be cost effective
- Increase productivity
- Increase patient satisfaction
- Increase accuracy of charting
- Work/Life balance

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Questions

Any questions in regards to what we have discussed?

Any questions in regards to other disease states, medications, patient education, etc.?

Any suggestions on what you would have liked to see from today’s presentation?

Sample Table

Text	Text	Text	Text
Text	Text	Text	Text
Text	Text	Text	Text
Text	Text	Text	Text

Sample Chart