40 Years of Rheumatology has taught me…..

Jack Cush, MD
Executive Editor, RheumNow

Disclosure Facts

ACCME Credit hours	1
Sponsor (Support)	-
Conflicts Stock/own	0
Investigator	None
Consultant	Abbvie, Amgen, BMS, Novartis, UCB
Coverage Life	Clinical skills
Observations	Guidelines
Daily dealings	Safe prescribing
Treatment connundrums	Ethics

This talk represents my views of the above, sometimes with the aid of evidence based medicine. Corporate relationships and conflicts should NOT influence lecture content. Send your critique of the fair balance of this presentation/content to me at jackcush@rheumnow.com

Steve Blank - Modern Entrepreneurship

“Starting out, I lacked a lot of skills – and I still do – but I had two important ones: being able to operate in massive chaos; and then, among that chaos, being able to see patterns in lots of data,” he says.

“…it’s a think-piece…”
- Lester Banks (Almost Famous)

- Conversation
- Fishing a bit …. here’s my opinion
- On being a Rheumatologist
- No offence intended

38 years of Rheumatology has Taught me…

- Rheumatology is immensely satisfying
- You get better – more so with a plan and re-work
- Who are the Best Rheumatologists?
  - Talk less, listen more = Wise
  - “HOPE – GOALS – RULES"
- 2 types of Rheums– money makers and change makers
- Prepare now for your career changes (inevitable)
- Showing up

RheumatoidArthritis

RheumatoidArthritis

RHEUMATOIDARTHRITIS

Diverse Fate of Seronegative RA

"Seronegative, is your reminder to reconsider the diagnosis over time" – Dr. Ronan Kavanaugh

Finnish 10 yr study of 435 early, SNRA Pts

- 3% became erosive or seropositive RA.
- 32% could not be reclassified
- 65% evolved to other Dx
  - **PMR (16%),**
  - **psoriatic arthritis (11%)**
  - **spondyloarthritis (9%)**
  - **osteoarthritis (10%)**

- 3% reclassified as seropositive or erosive RA
- 16% polymyalgia rheumatica
- 11% psoriatic arthritis
- 10.8% seronegative spondyloarthritis
- 10% osteoarthritis
- 8.7% spondyloarthritis
- 3.4% plausible reactive arthritis
- 2.3% gout
- 3.9% pseudogout
- 1.4% paraneoplastic arthritis
- 1.4% juvenile arthritis
- 0.5% haemochromatosis
- 0.7% ankylosing spondylitis
- 0.5% giant cell arteritis
- 8 miscellaneous diagnoses.
- 9.4% had transient arthritis
- 49 (11.2%) remained were not reclassifed.

Paalanen, et al Clin Exp Rheumatol. 2018 Jun

My New RA Paradigm

USUAL Paradigm

1. Methotrexate 1st
2. TNF inhibitor cycling 1..2….3..
3. 12+ wks to Assess/Monitor
4. Other MOA 3rd, 4th, not RTX
5. When to use JAKis
6. Waiting for Biomarkers

Cush Paradigm

- **My Methotrexate**
- MTX vs JAKs
- 6 wks FUV→ Cont or Change
- other MOA over TNF cycling
- How to consider Difficult RA

My Methotrexate Rx

	Cush
Starting Dose	15 mg/wk x 4weeks, 17.5 x 4wk, 20 mg …….
Top Dose	20 to 25 mg / week
Po vs SC?	**@15 mg - Split dose bid every Wednesday**
If no response	Maintain MTX and add on…..
Oral ulcers, diarrhea	Vitamin A 8000 IU EVERY DAY (80%)
MTX Blahs”	Dextromethorphan - Mucinex DM w/ MTX BID next Day (80%)
Pso/PsA	Use MTX 1st (PsA-SEAM)

You Don’t Know JAK

JAK > MTX

JAK > ADA

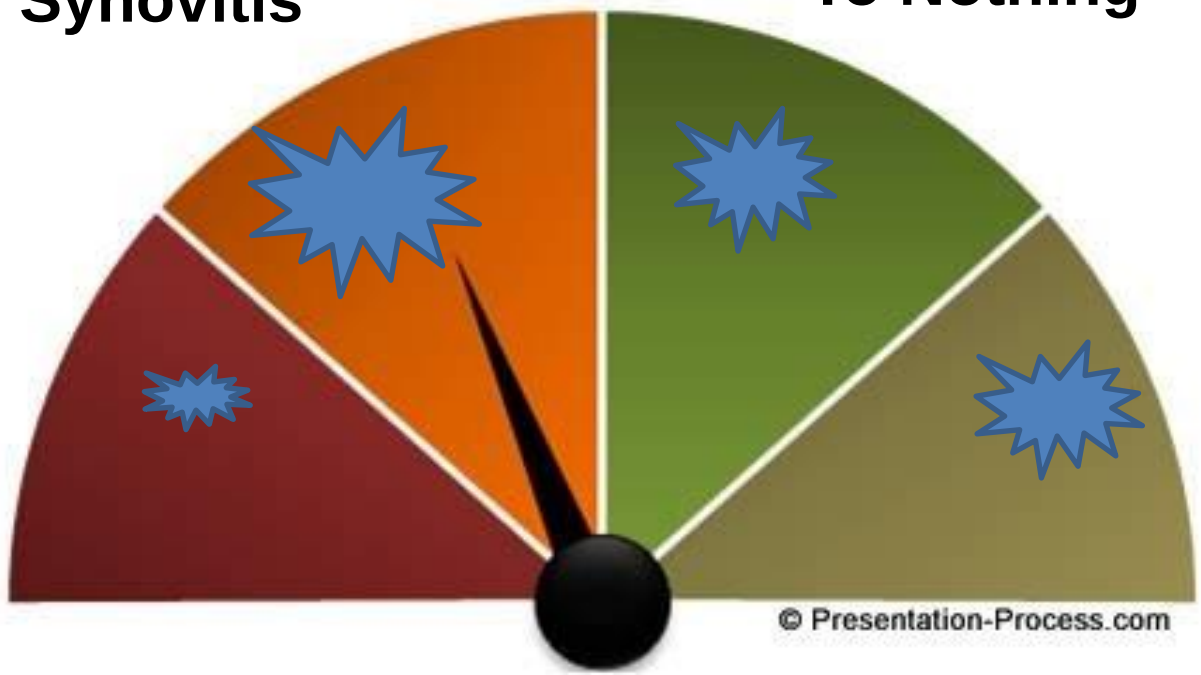
JAK(efficacy) **> ABA**(safety)

Difficult-to-Treat RA (D2T-RA)

Uncertain
Presumed
Synovitis

Recalcitrant Synovitis

Responds To Nothing



To Far Gone (Damage)

Hell Traits

- Noncompliant
- Negativistic thinkers
- Poor Pt Managers
- Intelligent/assertive
- Vacci-NOTs
- Poor Sleepers/FM
- Denial

Difficult RA Checklist

- ❑ Rethink the diagnosis
- ❑ Pain and damage mandates referral and a “team approach”
- ❑ Unsure of pain or problem – get medical imaging
- ❑ Treat inflammation with another MOA
- ❑ Reboot the patient Ctrl-Alt-Del
- ❑ Avoid Polypharmacy
- ❑ Deal with Depression, Bad Behaviors
- ❑ Ask the patient
- ❑ Don’t be handcuffed by Safety – ask someone who knows

Dealing with Infections

- **Rule #1** - Infection is way more related t
- **Rule #2** - Everyone gets thei
- **Rule #3** - RA has hi
- **Rule #4**
- ostly in the worse pts
- based on drug target
- old or stop a biologic when hospitalized; T > 102ºF

I Blame → the Disease, Steroids, Comorbidities

Communicating Risk
The 800 lb Gorilla Approach

How to Handle Patients who are more afraid of 1/1000 risk than RA

- Need a communication strategy
- 800 lb Gorilla vs. the Flea
  - Understand the magnitude
  - Compare the risk
- More information, more confusion
- Everyone is a Doomsday thinker
- Speak from strength

Safety Rules to Live By

1. Longer you're on the drug; safer it becomes
2. Lower doses are Not always safer
3. Never let someone who knows less than you manage your drugs
4. Riskiest thing may be to "play it safe"
5. Patient needs to know your "rules" to keep it safe
6. Safe thing: is to know and accept low risk, safeguard or avoid high risk

"People don't believe what you tell them.

They rarely believe what you show them.

They often believe what their friends tell them.

They always believe what they tell themselves."

- SETH GODIN

The Difficult Patient Conversation

Listen & Understand Them

What is the Story They are Telling Themmselves?

Speak from Strength

- I've spent the last 20 yrs studying your condition
- My guidance & prescriptions TRUMPs google, neighbors, BFFs, and what "people say…"
- This RX took 10 years and $2 billion to develop
- Studied for 20 yrs, 2-5K pts in RCTs,>?million patients
- This drug was made for you …

Trust = Compliance

Pharma

Pharma

PHARMA

PSR Office Rules

1. No scheduled appointments; If I have time, I will see you
2. No talking to patients
3. Deliver only samples requested
4. Do NOT litter my office with company pamphlets, patient info, promotional droppings
5. Do NOT go through my staff to influence me
6. Don’t knock the competition or their products
7. Do NOT double-team me – 1 rep, 1 visit per product
8. No meals…No food…..No gifts … No Kidding
9. Don’t try to teach me about research I did or teach on.
10. Don’t ever say “can you give me 3 scripts?”
11. PSRs Don’t speak at CME conferences
12. PSRs Don’t influence educational content

What Happened to My PSRs?

- >100,000 PSRs → quest for “blockbuster drugs”
  - Progressive restrictions
  - Rep-accessible HCPs 80% → < 45%
  - COVID happens….
- World has gone Digital, AI, Bots
- Burnout, No-See, No-Time Doctors
- Future: PSRs will need to be multimodal, Digital
  - Relationships/partnerships to develop DOLs
  - Need a new metric (not “calls) “engagements”

EMRs

EMRs

EMRS

EMRs will Mame and Tame You

- EMRs are an Advance
- Save time?
- Improve efficiency
- Facilitate research
- MD Burnout

  "doing the same thing over and over and expecting a different outcome"

- Backwork the problem
- Template to save time
- Include the data you need
- Lists:C/O,findings,probs
- Time: more pt; less 'puter

- 71 yoF w/ CCP+ RA, FM, Bronchiectasis, MRSA, atypical mycobacterial infx, recurrent pneumonia, DVT, Vertebral Fxs, shoulder surgery x2;
- Rx w/ prednisone, Xeljanz, Plaquenil, Mobic, cymbalta, zanaflex, gababpentin.
- Chronic, symmetric arthritis, nodules, ^^CRP
- Prior Rx: Pred, Gold, MTX, HCQ, SSZ, ETN, LEF, Remicade, AZA, RTX

NOT YET Rx w/ ANAK, ABA IL-6, CYA, CTX, Chlorambucil, MMF,

- Has LBP, AMS, pain in hands and knees

Exam: deformities, Swelling in knee, RMCP2, TJC 11, SJC 2˚ GAS=24, Trigger points+

What will you do?

1) Seropositive rheumatoid	+M06.09	Active	1-1-1996	2) Essential tremor	G25.0	Active	1-1-1998
3) Depression	F32.9	Inacti>	5-1-2003	4) Hypercholesterolemia	E78.0	Active	1-1-2001
5) Nephrolithiasis	M15.4	Inacti>	1-1-2003	6) Anemia	D64.9	Inacti>	1-1-1996
7) Fibromyalgia	M79.7	Active	1-1-1998	8) Carpal Tunnel Syndrome	G56.01	Inacti>	1-1-2002
9) headaches	R51	Inacti>	1-1-1998	10)Herniated disc	M51.26	Inacti>	1-1-1973
11)Tubal pregnancy	O00.1	Inacti>	1-1-1973	12)Tonsillitis	J02.9	Inacti>	1-1-1951
13)Cesarean section		Inacti>	1-1-1979	14)Hysterectomy		Inacti>	1-1-1991
15)Colon Resection	G47.33	Inacti>	1-1-1991	16)Cholelithiasis	M81.0	Inacti>	1-1-1999
17)Neuroma		Inacti>	1-1-2000	18)Sciatica	M54.30	Inacti>	1-12-2005
19)Rash	R21	Inacti>	5-3-2005	20)Diverticulitis	K57.92	Inacti>	7-12-2005
21)Cervical Stenosis	M48.06	Active	5-1-2007	22)Arachnoid cyst		Inacti>	5-1-2007
23)Rotator cuff surgery		Inacti>	5-1-2007	24)Dog bite	W54.0XXA	Inacti>	2-15-2008
25)Tendon tear	M66.9	Inacti>	2-15-2008	26)Arthritis	M81.0	Active	7-21-2008
27)Low back pain	M54.5	Active	1-20-2008	28)B12 deficiency		Active	12-1-2008
29)Heating pad burn		Inacti>	12-1-2008	30)Knee replacement	M81.0	Inacti>	2-24-2009
31)ATYPICAL MYCOBACTERIOSIS	A31.9	Inacti>	4-1-2009	32)Lung nodule	J98.8	Active	5-26-2009
33)Bronchitis	J40	Inacti>	9-15-2009	34)Carpal Tunnel Syndrome	G56.01	Inacti>	8-1-2009
35)C DIFFICILE COLITIS	K58.9	Inacti>	8-17-2010	36)Falls		Inacti>	5-20-2011
37)Degenerative Disk Disease	M50.30	Active	1-1-2009	38)Scoliosis	M81.0	Active	1-1-2009
39)Pneumonia	J18.9	Inacti>	9-20-2011	40)Pneumonia	J18.9	Active	9-1-2011
41)MAC	A31.9	Inacti>	10-1-2011	42)Shoulder surgery		Inacti>	2-17-2012
43)Shingles	B02.7	Inacti>	12-25-2012	44)Bronchitis	J40	Inacti>	1-15-2013
45)Cataract surgery		Inacti>	12-1-2012	46)Bronchiectasis	J47.9	Active	1-1-2011
47)Cellulitis	L03.90	Inacti>	12-10-2013	48)Fracture shoulder	S42.90XA	Inacti>	4-1-
49)Shoulder surgery		Inacti>	4-1-2014	50)DVT	M81.0	Inacti>	5-1-2014
51)Pneumonia	J18.9	Inacti>	8-20-2014	52)Hemoptysis		Inacti>	8-26-2014
53)Hamstring tear		Inacti>	2-6-2015	54)Osteonecrosis	M87.00	Active	4-6-2015
55)Osteoarthritis	M17.12	Active	4-6-2015	56)Polyneuropathy	G62.9	Active	10-11-2011
57)Falls		Inacti>	9-6-2015	58)Rotator cuff syndrome	M75.100	Inacti>	10-6-2015
59)Neuropathy	M15.4	Active	7-1-2015	60)Vertebral compression Fx	M48.40	Inacti>	1-21-2016
61)Pneumonia	J18.9	Inacti>	1-15-2016	62)Spondylolisthesis	M81.0	Active	1-21-2016
63)Osteoporosis	M85.00	Active	3-2-2016	64)Hemarthrosis	M25.00	Inacti>	9-15-2016
65)Knee replacement		Inacti>	11-17-2016	66)Bronchitis	J40	Inacti>	5-25-2017
67)Diarrhea	R19.7	Active	9-9-2017	68)Dog bite	W54.0XXA	MEDICATIONS:	

Clinic Evaluation Form

- Global assessment
- Morning stiffness
- Sleep - Quality Issues
- Comorbidities
- Review of systems
- Joint exam - pain
- Pain
- ADL–mHAQ
- PCP, health, exercise

Welcome to the Arthritis Clinic. Answer each line and question below with your answer or mark in the space provided. This survey will help your doctor to evaluate and treat you.

Your Name: Age: Date:

Since last visit, I'm doing: Excellent Very Good Good Fair Poor Very Poor Horrible Better Worse

What bothers you most today?

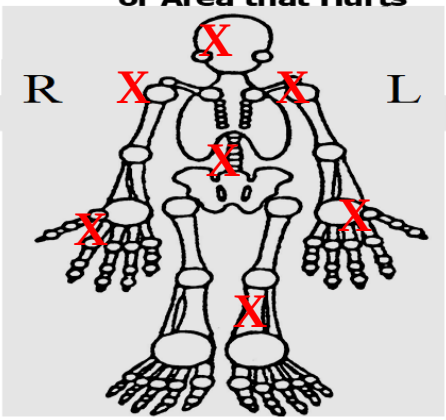
I am having(Circle): Pain Stiffness Aching Soreness Muscle pain Weakness Numb/Tingling

How Severe is your **Morning Stiffness?** None 0 1 2 3 4 5 6 7 8 X 9 10 *MOST SEVERE*

Describe your night-time **Sleep** (mark box): · Great · Normal · Fair · Poor · Very Poor
· Can't Fall asleep · Can't Stay Asleep · Wakes Early · Snoring · Restless Legs · Night Pain

Since last visit Ive had:		**New Medicines Started?**
No Problems	· Stomach Ulcer	
New Diagnosis _____	· Accidents or Fall	
Infection _____	· Eye problem	
Heart or Lung Problem	· Cancer	
Hospitalization	· Joint Injection	
	· Joint Surgery	

Mark or Circle the Joint or Area that Hurts



Have you recently had?		
Fever	· Dry mouth/eyes	· Chest pain
Weight loss or gain	· Sore throat	· Cough
Fatigue	· Sores in mouth	· Edema/leg swelling
Stiffness/ soreness	· "Cold"/ stuffy nose	· Short of breath
Pain in muscles	· Sinusitis	· Purple fingers
Weakness	· Ringing in ears	· Low back pain
Skin rash	· Difficult swallowing	· Numbness/ burning
Itching	· Heartburn/indigestion	· Headaches
Hives	· Nausea	· Poor memory
Hair falling out	· Vomitting	· Depression
Nosebleeds	· Diarrhea	· Difficulty sleeping
	· Constipation	· Dizzy spells

In PAST WEEK, how much pain have you had? (circle a number or put a mark thru the line below)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 *MOST SEVERE PAIN*
Mild *Moderate* *Severe*

TODAY ARE YOU ABLE TO (check box)	No Difficulty	Some Difficulty	Much Difficulty	Cannot Do
Dress yourself; including laces & buttons?		X		
Get in and out of bed?			X	
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?		X		
Wash and dry your entire body?				
Bend down & pick up clothing from floor?				
Turn regular faucets on and off?		X		
Get in and out of a car?			X	

Are you working? · Full-time · Part-time · Homemaker · Retired · School · Disabled · Apply for disability
Who is your Primary Care Doctor (PCP)? _____ Date last PCP visit? _____
Do You Smoke? · No · Yes Have you had a DEXA/bone scan in last 2 yrs? · No · Yes Where_____
Do you exercise? · None · Walk outside · Bike · Pool · Run · Gym · Weights · Stretching/Yoga
How do you pay for medication? · Insurance · Co-Pay · 3mos Mail-away · Medicaid · Cash
Do you need refills today? · No · Yes _____

https://rheumnow.com/content/download/clinic-evaluation-form

F2F EMR – Template based, Keyboard Entry

No.	Diagnosis	ICD	Activ.	Date Start	No.	Diagnosis	ICD	Activ.	Date Start
1)	Low back pain	M54.5	Active	1-1-2005	2)	HLA-B27+		Active	9-10-2015
3)	Plantar fasciitis	M72.2	Inacti>	1-1-2011	4)	Insomnia	M15.4	Active	9-10-2015
5)	Frozen shoulder	M24.619	Inacti>	1-1-2011	6)	Frozen shoulder	M24.619	Inacti>	1-1-2013
7)	ankylosing spondylitis	M45.9	Active	9-10-2015	8)	Hypovitaminosis D	E56.9	Active	10-15-2015
9)	Neck pain	M54.2	Inacti>	12-8-2015					

MEDICATIONS: Multivitamin 1 tab qd; Fish oil 1000 mg bid; Saw Palmetto 1 tab qd; Fiber qd; Zanaflex 4 mg ii tab qhs sleep prn; Vitamin D 2000 IU qd; Tramadol 50 mg 1-2 tab rarely; Enbrel mini autotouch 50 mg i SQ QWEEK; Heat "bed buddy" hot pack to neck bid prn (2:22 in microwave). **ALLERGIES:** None.

Visit Type: Scheduled routine follow-up visit. **Last seen:** 5-1-2019

Hx: 48 yr old male with HLA-B27+ ankylosing spondylitis, poor sleep, neck pain, Frozen shoulders, mild CRI 1.25 Rx w/ Enbrel, was off Enbrel x 4k .

- Dx is based on intermittent neck and Low back pain, w/ AM stiffness (not typical inflammatory back pain), w/ onycholysis, plantar fasciitis, sacroiliitis, +HLA-B27+ :
- Since last visit he has been been Good (3). Pain (0-10) = 1 - He complains of stiffness in neck NO SWELLING and has < 10 minutes morning stiffness.
- Sleep pattern is fair and no longer improved by taking Zanaflex . Will change to Flexeril
- Drug safety: He denies medication side effects.
- Intercurrent problems: had a bad upper lip infection, saw Dr. Clay Cockerell did better w/ Clindamycin and Valtrex. Pt sent picture that looked like cellulitis, with a large area of swelling erythema and purulence from lip to nares 2-3cm wide. - Exercise: walking.

ROS: denies: fever rash N/V Chest pain SOB headaches weight loss diarrhea, GU (dysuria, discharge), GI (diarrhea, bloating), ocular Sxs (pain, iritis), Psoriasis.

Exam: Weight:207 BP:108/69 P: 77 R:16 T afebrile BMI:27.4 kg/m2 No acute distress, Oriented x 3

Skin: no rash or lesions, MILD UPPERLIP ERYTHEMA (resolving) Chest: clear to auscultation CVS: sinus, RRR, normal S1, S2, no murmur or rub

Joint Exam: There is no deformity effusion synovitis or nodules. . Tender joints= 0 ; Swollen joints= 0; Global arthritis score (GAS)= **1, was 2, 1, 3, 2, 5, 1, 2, 1, 14, 1, 6.** (GAS ≤3 remission; ≤7 low disease activity; ≥12 active dz; ≥20 high disease activity). raw mHAQ (0-24)= 0 Deformity: none Range of Motion: normal ROM, no pain

Trigger points: none **Labs:** 05-01-2019 WEIGHT 207 pounds 05-01-2019 HEIGHT 73 inches

Assessment: HLA-B27+ ankylosing spondylitis: stable and good response to therapy. MD Global= 2. His main problem is recent infx . There is no drug toxicity..

- Limitations: none

Plan: Return to clinic 6 months. - Continue current medications and dosages. tramadol, Enbrel

- Start Flexeril 10 mg qhs for sleep and Pt told to call if not sleeping better.
- CBC w/diff, CMP, ESR, CRP, to r/o drug toxicity - Counseling: side effects and benefits of new meds reviewed
- Pt Education: the patient was educated and counseled about above diagnoses, prognosis, Meds
- Health Maintenance: influenza vaccine administered today -. Counseled pt on diet and exercises.

-Patient was given copy of his current medication list and this note. The above recommendations were reviewed with the patient and questions were answered to his satisfaction. He was told to call if status changes or worsens.

- cc: PTID 7818

John J. Cush, M.D.

- Future: ambient AI notes
- Now: Scribe, type, dictate
- DO IT WRITE!
- Survey form: CC, PMHx, ROS, Assess by Metrics
- SOAP

(refer to Meds, Probs, ROS)

- S: AS here for refills, LBP
- O: T=0, S=0, +enthesitis
- A/P 1. AS w/ enthesitis

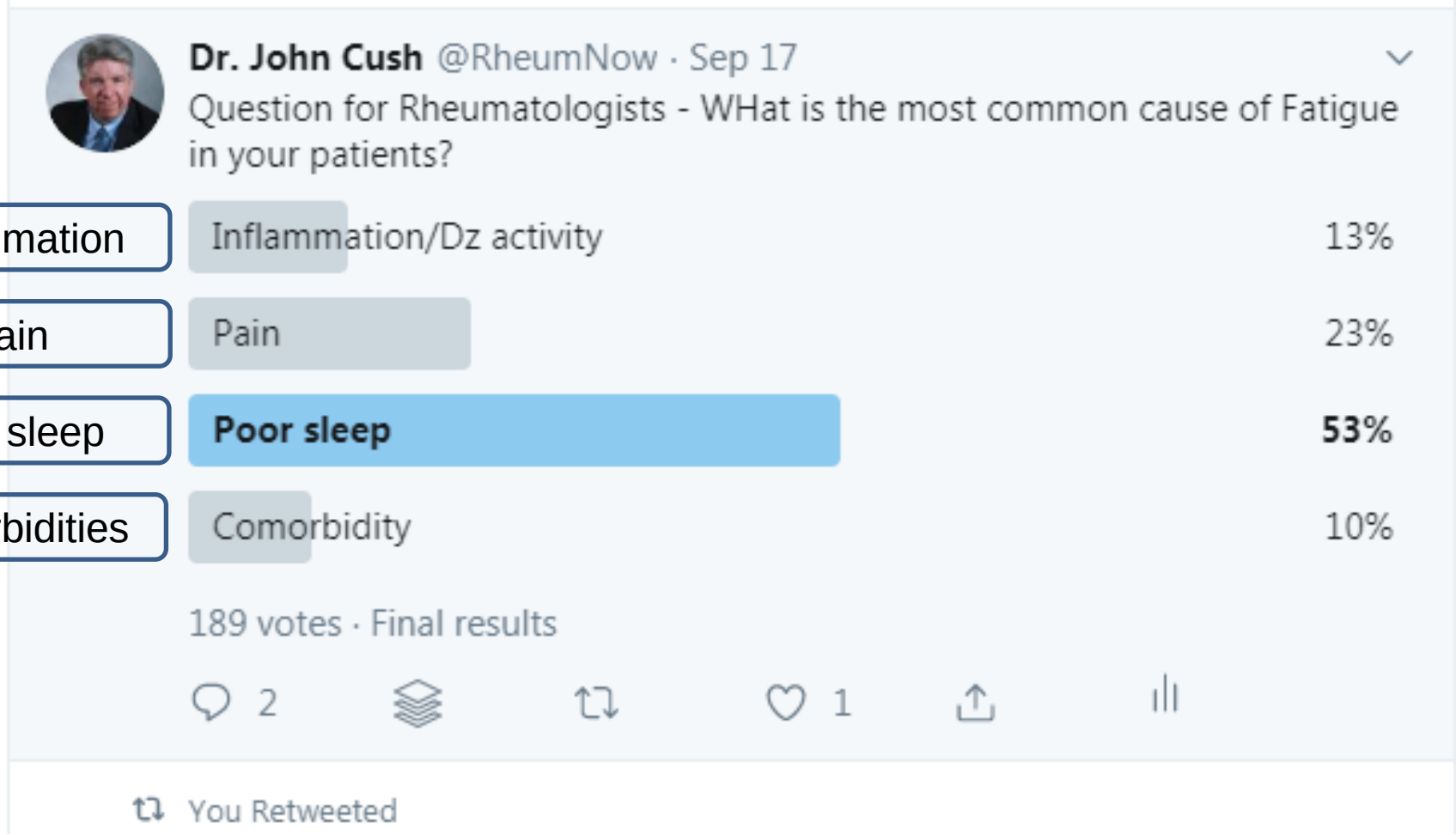
2. Change to JAKi

GetAclue

GetAclue

GETACLUE

What is the Most Common Cause of Fatigue in Your Pts?



Inflammation

Pain

Poor sleep

Comorbidities

Twitter Poll 17 Sept 2019.

RheumNow

The Wake-Up

- Fatigue
- Sleep
- Fibromyalgia

Sleep Hygiene
12 Steps for Good Sleep

1. ***You need great sleep every night – at least 7 hours for most people.***
   Do not over sleep - Too much sleep is not a good idea. Extra sleep (especially during the day) weakens the refreshing power of a good nights sleep and may interfere with good sleep the next night. *Sleep only as much as you need to feel well rested during the following day.*

2. ***Develop and keep a regular sleep schedule and routine.***
   Go to bed and get up at the same time every day (including weekends, holidays). Do not take daytime naps. This will "steal" from your night time sleep. If you must, limit afternoon "power naps" to 30-50 minutes. Get plenty of morning and/or afternoon sunlight. If you work nights – maintain the same sleep schedule – even on your days off.

3. ***Do not struggle at falling asleep or get frustrated when falling asleep.***
   Don't go to bed until you are drowsy. Use TV, reading or hot baths to wind down and make yourself sleepy. If you can't fall asleep, go to another room where you can relax. Return to bed when drowsy.

4. ***Establish a constant sleep environment.***
   Keep your bedroom quiet, dark, and at a comfortable sleeping temperature. Position the bedroom clock so it will not bother or wake you. Sleep in your bed and not on the sofa or recliner.

5. ***Your bed is your special place for sleep only.***
   Do not read or watch TV in bed. Your bed should be free of books, magazines, remote controls, computers, cell phones, food, children, pets, snoring spouses. Your bedroom is *NOT* a place to hangout; it is *NOT* your office; and it is *NOT* "command central" for you or your family.

6. ***Do not go to bed hungry, as hunger may disturb sleep.***

Ya' know, its really not ___

- Sjogrens = Sicca + FM (Dryomyalgia)
- Seronegative spondyloarthropathy
- Back pain + FM = Back-o-myalgia
- Lupus + Gout + RA + Sciatica + ????
- Behcets = Oral ulcers + FM
- Red ears + FM = Relapsing polychondritis (Elfomyalgia)
- TMJoMyalgia, ANAoMyalgia, StrangeOmyalgia
- ADHD (adderallomyalgia)
- Ehlers-Danlos, hypermobility syndrome, Chiari malformation, chronic fatigue, POTS (postural orthostatic tachycardia)

CLUES TO DIAGNOSIS

1. Suspect Fibromyalgia First
2. Widespread pain - but NO PHYSICAL FINDINGS
3. Globally Positive ROS (+organ recital)
4. NOTALGIA (Pt brings so many notes, that YOU hurt)
5. Multiple Chemical Sensitivities – multiple allergies
6. “I just don’t like taking medicines”
7. Arthritis + Psychiatric Disorder = Fibromyalgia
8. Lyme disease in Texas
9. Hospitalized 6 weeks ago - Still wearing ID bracelet
10. Folds like a $20 card table when you touch ‘em
11. Sick n’ Tired of being ….. Sick n’ Tired

TheExam

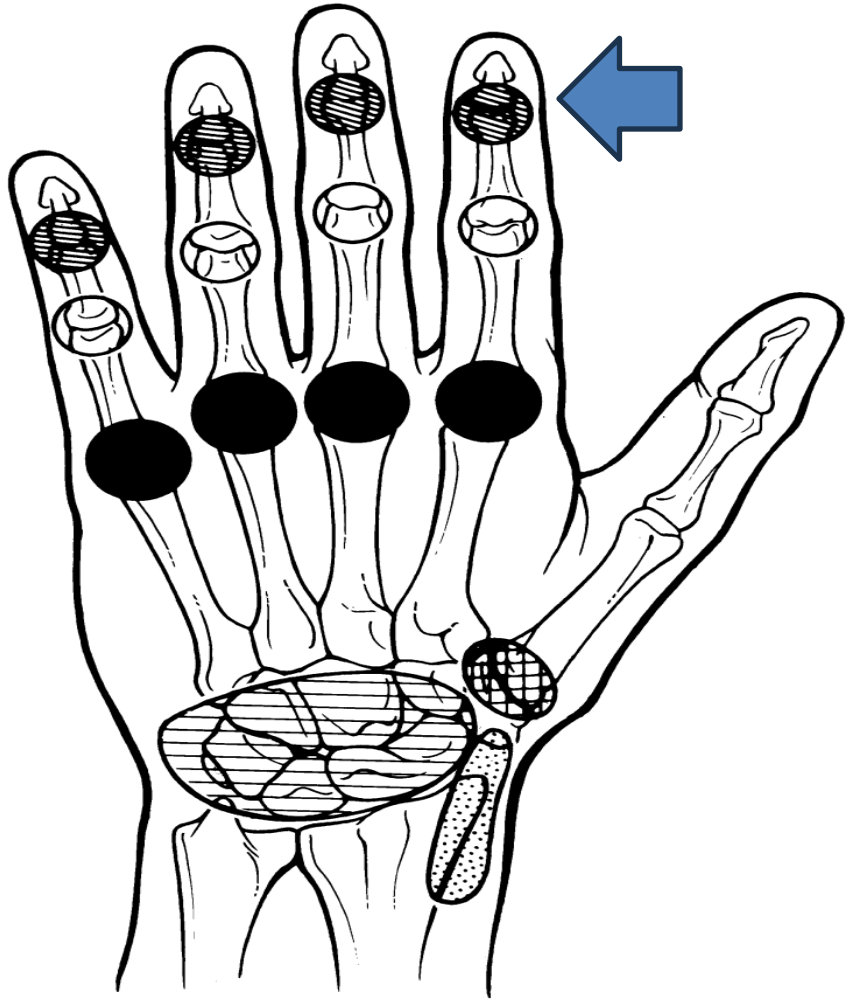
TheExam

THEEXAM

What's the Diagnosis?

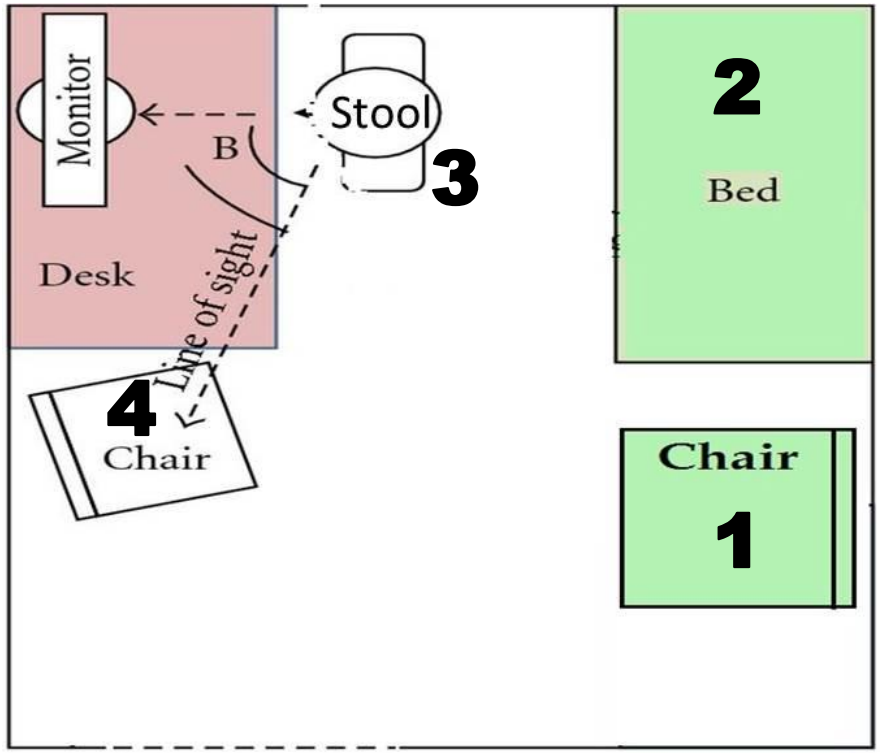
- Joint exam: DIP5 pain

- Lagodynia- delayed register



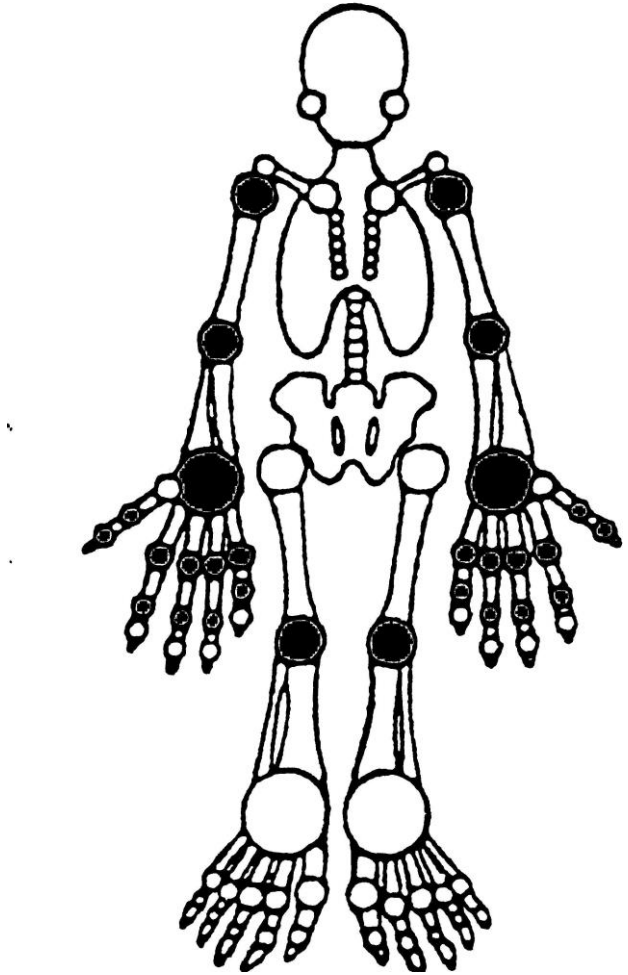
Why My Patients Sit Where They Sit

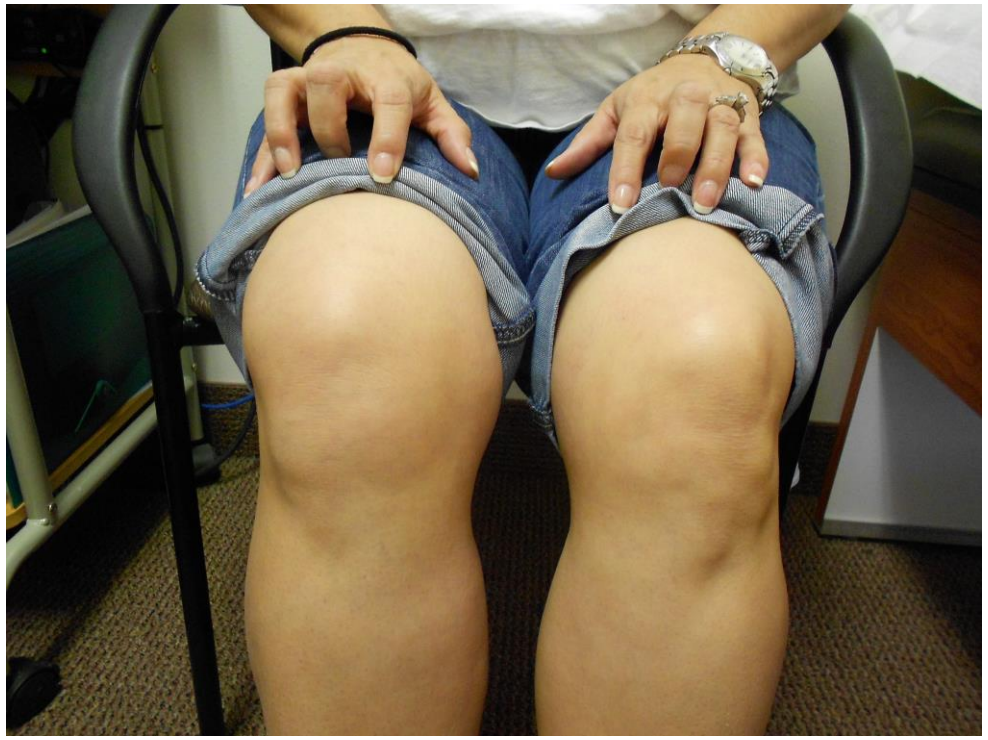
1. **The Chair Furthest (from the Doctor's Desk)**
   Most patients, rather NOT be in the room
2. **The Exam Table**
   Sick people, rule followers, and sleepy heads.
3. **The Physician's Rolling Stool**
   4-year-olds, socially inappropriate rule breakers, physicians
4. **Preferred - The Chair Next to Doctor's Desk**
   Happy collaborative types, the unafraid, and the well trained



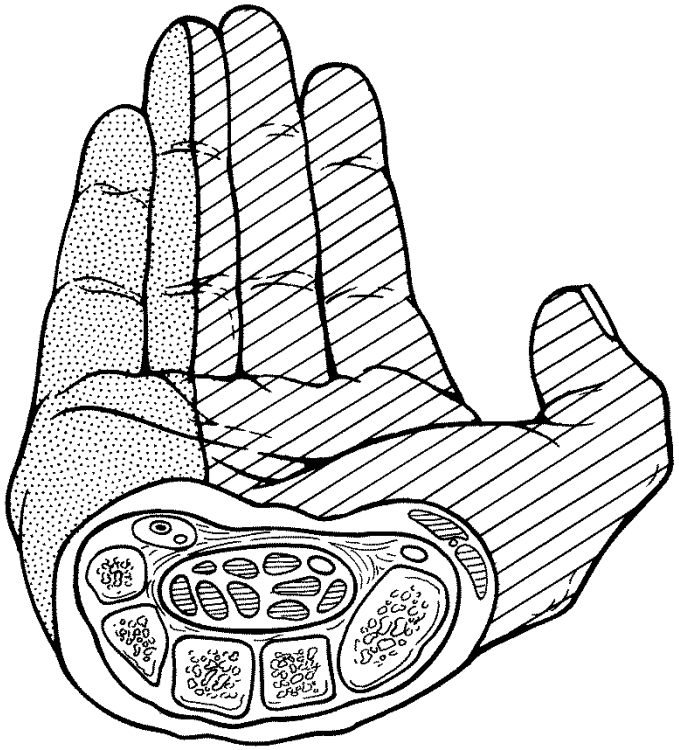
The Exam Table

28 or 66 or Not at all



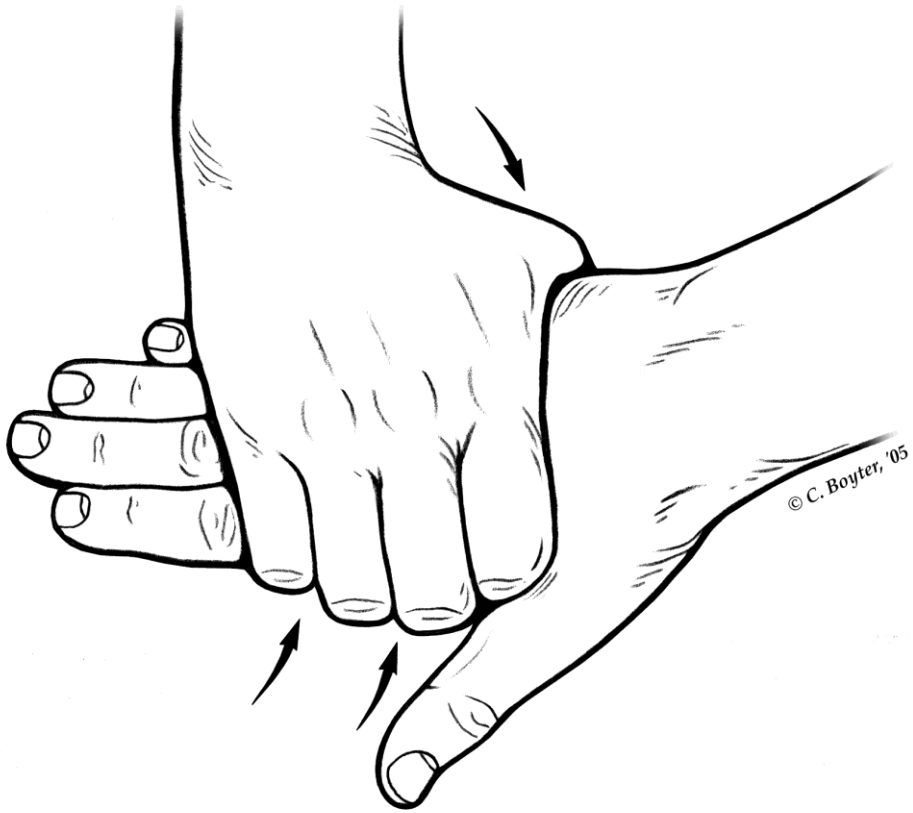


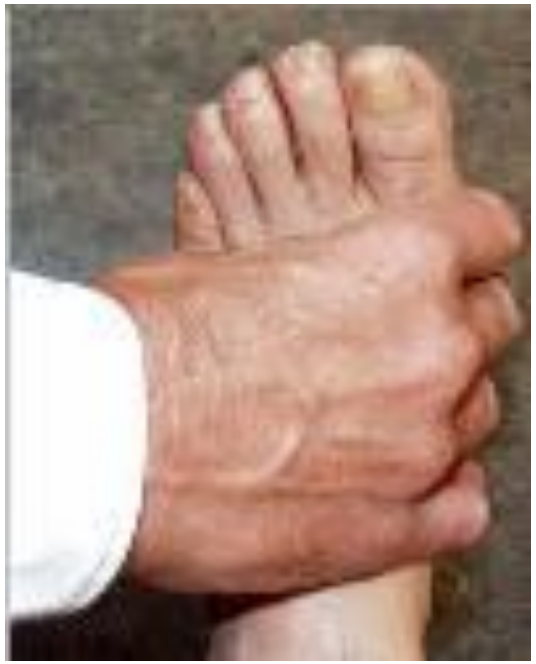
The Clinical Diagnosis of Carpal Tunnel Syndrome

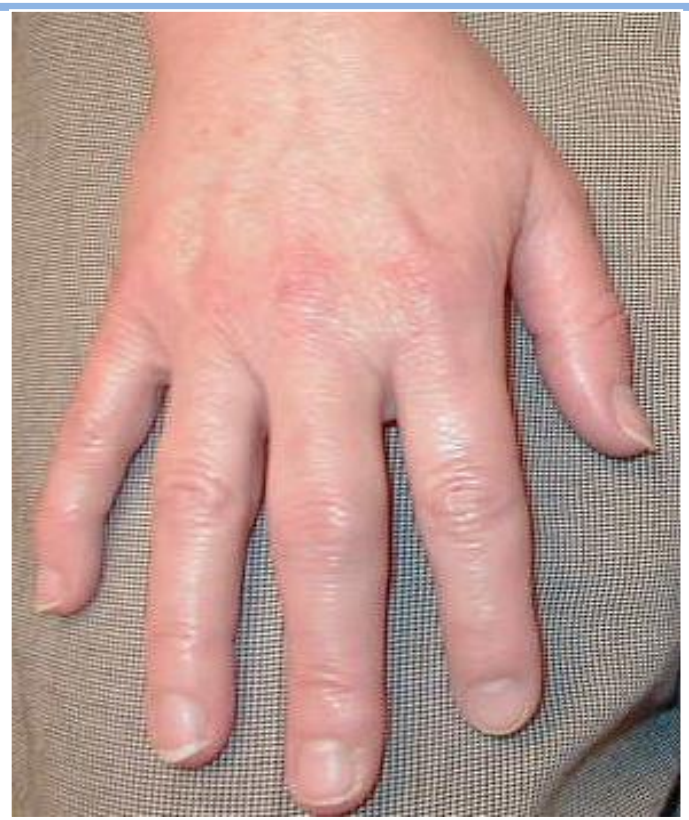


Durkan Test for CTS is when the Examiner presses the thumbs over carpal tunnel and holds pressure for 30 seconds. The onset of pain or paresthesia in the median nerve distribution within 30 seconds is a positive result .

The “Squeeze Test”

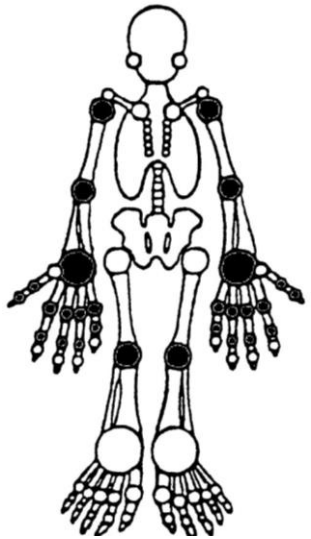




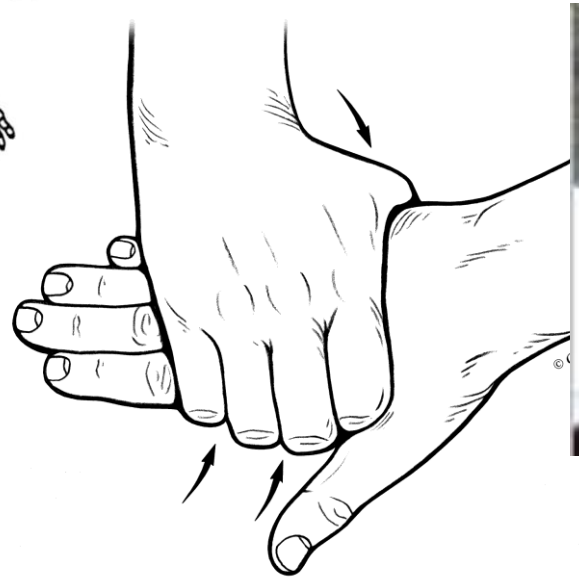


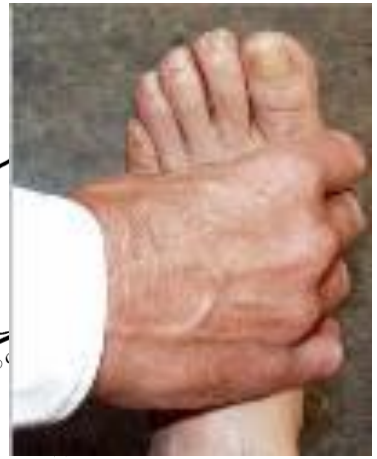
Musculoskeletal Exam

We are suppose to be good at it



- 2 min 28 Joint Exam
- 10 Sec Squeeze Tests





4 minute Virtual Video MSK Exam

The Virtual Video MSK Exam

- Inspection, ROM, function, contralateral comparison
- Frontal hand view, nail inspection
- B/L MCP squeeze, finger squeeze, Wrist squeeze
- Praying for prayer sign, followed by Finger flexion, Fist, wrist flex
- Fist bump to camera, Elbow extension
- Hands on ears, elbows out → elbows midline
- TMJ palpate and open mouth
- Neck Flex, extend, Lateral bending R and L
- Rise and walk to/fro

You're No Good

You're No Good

YOURENOGOOD

What are we (Rheums) not good at?

- Treat to Target – RAPID3 >> mHAQ >> CDAI
- Treating Gout (T2T)
- Changing DMARDs “moderate to high” disease activity
- Knowing when to NOT Rx DMARD (What if they don’t want it?)

Bring Back “GOLD Clinics”

- Nurse/Pharmacist Run Gout Clinics
  - Only 40% of gout patients receive urate-lowering therapy, <60% achieve target SUA, 300 mg allopurinol
  - UK study: 517 gout patients enrolled: 255 were assigned nurse-led care and 262 usual care.
  - Results were staggeringly in favor of nurse-led care, especially with regard to:
    - Uptake of and adherence to urate-lowering therapy (96% vs 56%, p = 0·0053)
    - Achieving target urate at 2 years (95% vs 30%, RR 3·18, 95% CI 2·42–4·18, p<0·0001).
    - Fewer flares after 2 years (8% vs 24%; p <0·0001)
    - The cost per QALY gained for the nurse-led intervention was £5066 at 2 years.
  - 2 Other trials at ACR 2018 with Pharmacist lead gout care.
- Team Approaches
  - Gout
  - RA/PsA/AS/SpA F/U on DMARDs

Changing Minds

Changing Minds

CHANGING MINDS

ACR Guidelines - Facts or Foe?

- 8 guidelines - 403 recommendations
- 58% based on level C evidence
- 23% based on level A evidence

Table 1. Guideline Recommendations by Level (Quality) of Evidence

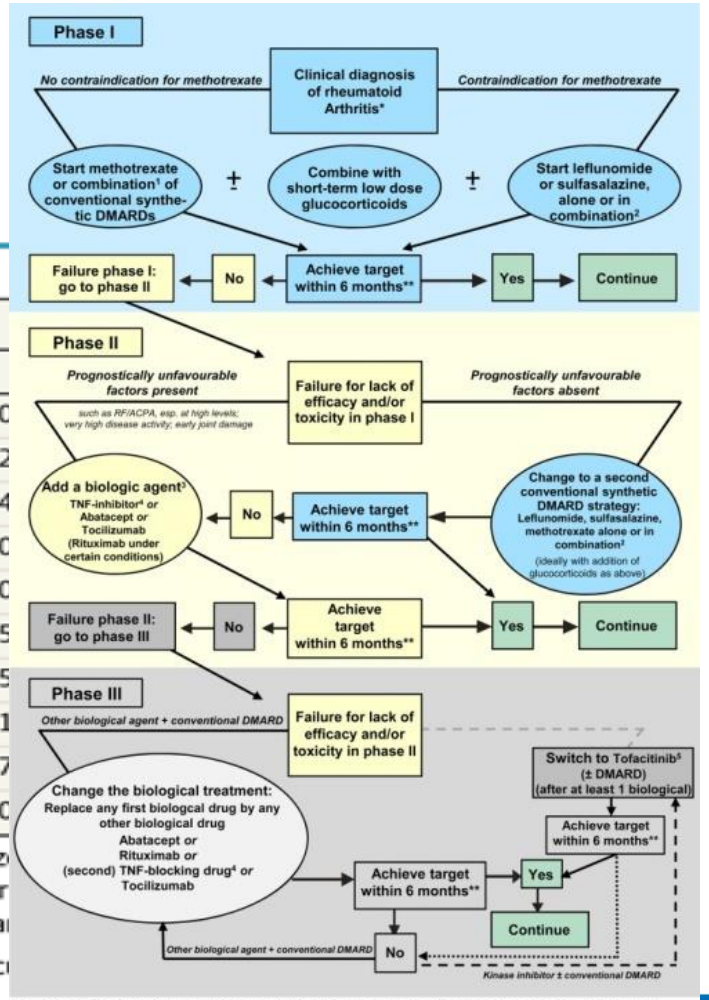
Guideline	No.	Year	Methodology	Level of Evidence, No. (%)[a] A	B
GIOP	37	2010	ACC/AHA	13.0 (35)	7.0
JIA	102	2011-2013[b]	Oxford	1.7 (2)	12.2
Gout	88	2012[c]	ACC/AHA	18.5 (21)	27.4
LN	33	2012	ACC/AHA	8.0 (24)	2.0
OA	60	2012	GRADE	35.0 (58)	10.0
SpA	38	2015	GRADE	11.0 (29)	7.5
PMR	10	2015	GRADE	1.0 (10)	4.5
RA	35	2015	GRADE	4.6 (13)	6.1
Total	403			92.8 (23)	76.7
Median % (IQR)				23.0 (12-30)	18.0

Abbreviations: ACC/AHA, American College of Cardiology/American Heart Association; GIOP, glucocorticoid-induced osteoporosis; GRADE, Grading of Recommendations and Assessment, Development, and Evaluation scoring system; IQR, interquartile range; JIA, juvenile idiopathic arthritis; LN, lupus nephritis; OA, osteoarthritis; Oxford, Oxford Centre for Evidence-Based Medicine; PMR, polymyalgia rheumatica; RA, rheumatoid arthritis; SpA, spondyloarthritis.

[a] Level A evidence to multiple randomiz… meta-analyses; level B to single RCT or… opinion of experts, case studies, or sta…

[b] Includes JIA guidelines of 2011 and foc…

[c] Includes gout part 1 and part 2 guideli…



JAMA Int Med 201…

Do You Use/Consider ACR21 vs EULAR22 RA Guidelines

	ACR 2021	EULAR 2022
Time to T2T Decision	Vague Revaluated q 3 mos.	50%⇩ 3 mos Remission LDAS 6 mos
Initial low dose Steroids	No MTX without short-term steroid	Yes (MTX + GC; strong rec)
Poor Prognostic Factors (PPF) in 2nd tier decisions	Not used (PPF had less impact…)	Yes (if present →biologics,JAKi)
JAKi positioning	After MTX (FDA following TNFi)	Phase 2, +PPF, Consider CV/CA risk factors
When to taper?	After >6 mos @target	“persistent remission”
Which to taper first?	csDMARD > bDMARD	Most Expensive biologic 1st

Smolen JS, et al. EULAR 2022, Copenhagen Fraenkel L, et al. Arthritis Rheumatol. 2021. PMID: 34101376

MEDICAL EDUCATION

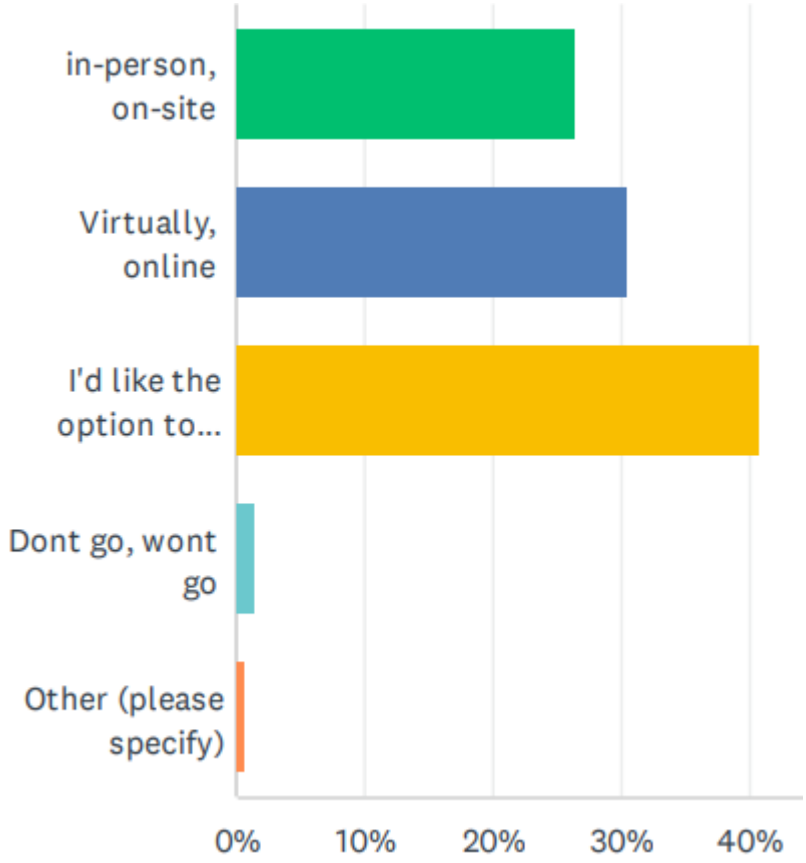
Medical Education 2033

HOW WE ENGAGE

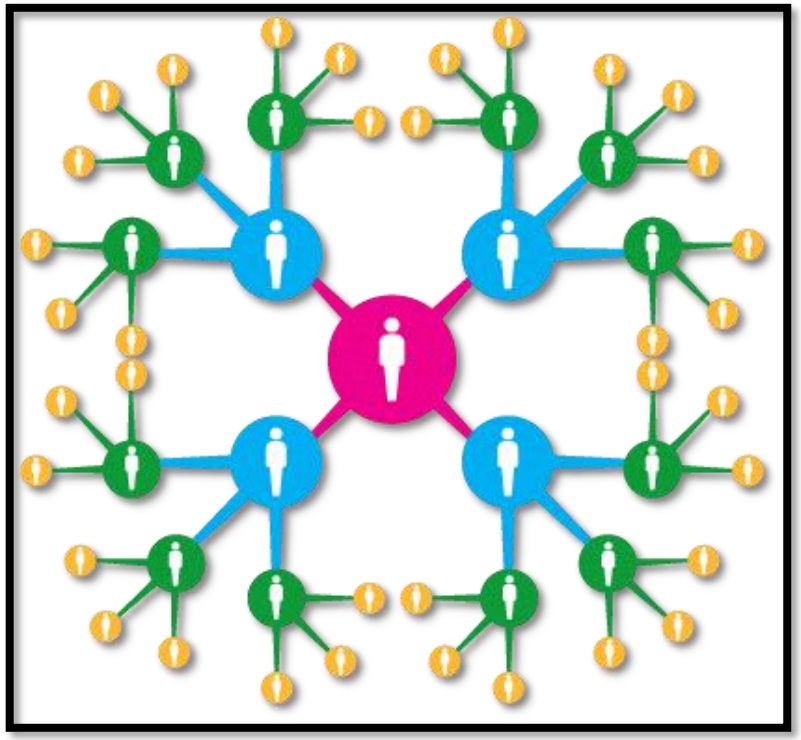
- F2F or virtually
- Meetings, advisories, journal clubs etc

- From 2018 to 2023 – Rheums wanting to to to the Big Annual ACR Convention?
  - 2018: 84%
  - 2022: 59%

Rheum CME meeting, I would prefer to attend



Educational impact & choices



Medical Education 2033

HOW WE LEARN

- Core competencies certified (taught) with modules or workshops online (GME)
- Fellowships will be fewer→research, leaders
- 1º - Technology integration for diagnosis, staging, Rx
- 2º – Precision Algorithms for chronic disease treatment
- Digitally Assisted MD

Change to:

- Workshops & Certification (not board exams)
- Performance Reporting & Learning?
- Group learning:
  - Small Groups – Journal clubs, masterminds, etc
  - Local – Group, City, etc
  - Regional/National: Virtual or onsite MedEd
- Education and information management
  - Bite-size, tailored, time efficient
  - Social media

Problem of Information Overload

Information Overload

- "Sum of all human information doubles every 18 mos" (>30K journals, 2.5 mill papers)
- Ken Jennings (Jeopardy champ x 74 wks) lost to IBM Watson
  - Knowledge (Know-it-alls) "are now obsolete"
  - Computers are better at info/data than you *(why take Boards?)*
- Digital info has advantage of volume & time
- There's too much information AND "filter failure"

https://www.forbes.com/sites/johnnosta/2018/08/02/ibm-watson-and-the-precarious-balance-between-medicine-and-marketing/?sh=326ad2ac179d

BMJ 2010;341:c7126

Medical Education 2033

- Journals/magazines will be use for kindling during Zombie apocalypse
- Books, textbooks prized relics found only in museums (prev. called “libraries”)
- Local education: while you are at home (w/ phone, VR gear, brain stimulation)
- F2F conventions (eg, ACR) will be showcase events for sponsored products
- Novel studies to be reported & promoted through competition (idiocracy voting)
- Blogging and podcasts will continue to replace books and journals
- There will only be digital learning

Solutions for Info Overload

- Schedule time for essential info (email, SM, Text, phone)
- Electronic versions and your cell phone (tablet)
- What's your plan for Bite Size learning ?
- Triage: Scan, read or file
- Rely on authoritative sources
- Use Pharma/PSRs for info searches
- Curate what interests you:
  - RSS readers (protopage, Ighome,
  - RSS Services (Feedly)

The almighty cell phone

Applications

- Search
- Learn
- Inform
- Assess
- Medical tool: Stethoscope, EKG, ophthalmoscopy, US
- Social media tool: networking, podcasts, video instruction
- Polling

- **80% of Physicians use smartphones for health info**
- **Millennials spend 5.7hrs/d or >2000 hrs/yr on cell phone**

https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---doctors-use-of-social-media_pdf-58833100.pdf?la=en&hash=DE606B88646D1FA2CA3708125445FC8BEC9F4B32www.provisionliving.com/smartphone-screen-time-baby-boomers-and-millennials/

Do I Meet the Criteria for Still's Disease?

Begin by confirming the diagnosis of Still's disease using our calculator.

Calculate my Risk

Still's Diagnosis Calculator

- ○ Age less than 16 years
- ✓ **Age less than 35 years**
- ○ Daily or nightly fever (not measured)
- ○ Daily/nightly fever (between 100-102°F)
- ✓ **Daily/nightly fevers always above 102°F (>39°C)**
- ○ Muscle pains (myalgia)
- ○ Joint pains (arthralgia)
- ✓ **Swollen painful joints**
- ○ Many swollen joints (polyarthritis)
- ○ Carpal ankyloses (wrist fusion)*
- ○ Cervical ankyloses (neck fusion)*
- ○ Tarsal ankyloses (ankle fusion)*
- ✓ **Intermittent faint red/pink rash (arms, legs, trunk, neck only)**
- ○ Sore throat (preceding fevers, rash)
- ✓ **Pleuritis or pleural effusion**
- ○ Pericarditis or pericardial effusion
- ○ Generalized lymphadenopathy (many swollen lymph nodes)
- ✓ **Splenomegaly (enlarged spleen)**
- ○ Hepatomegaly (enlarged liver)
- ○ Elevated hepatic (liver) enzymes (AST, ALT)
- ○ Low albumin < 3.0 (hypoalbuminemia)
- ✓ **Negative tests for ANA (lupus) and RF (RA)**
- ✓ **Elevated "sed rate" (ESR) > 40 mm/hr**
- ✓ **Elevated WBC > 12.5**

	Cush Criteria	Yamaguchi Criteria	ILAR Criteria
Minimum Threshhold for Diagnosis:	10 points	>5 points>2 Major	A+B+C+ >1 D
Your score:	**12**	**5**	**B,C,D**

Sti...

RheumNow

Login / Register

Search

Friday,

HOME | FEATURED | NEWS | BLOG | SOCIAL | DAILY DOWNLOAD | ACR VIDEO

Anti-Rheumatic Rx | Autoimmune/Lupus | Biologic/Novel Rx | Bone/OP&OA | Drug Safety | Education/ACR/EULAR | Fibromyal

Featured Article

Famous Rheumatologist Quotes – Par

ACR VIDEO

Peter Merkel, MD: AN
Associated Vasculitis
Remis

Scie

h, MD

In RA TN

were less likely to discontinue their first biologic when that treatment was a tumor necrosis factor (TNF) inhibitor than if it was a non-TNF biologic, and especially if treatment was initiated prior to 2005 [...]

Have crony capitalism and medical

RheumNow

PODCAST

RheumNow

Know it Now

Daily Digest

04 Dec 2015

FEATURED ARTICLE

Physician Burnout on the Rise

By Jack Cush, MD

Burnout among U.S. doctors affects more than half of practicing physicians, according to a new study published in Mayo Clinic Proceedings.

TODAY'S HEADLINES

RA TNF-Inhibitors Prove To Be Durable Choice

Patients with rheumatoid arthritis (RA) were less likely to discontinue their first biologic when that

SOCIAL

Physician Burnout is a rising concern. But is it happening in Rheumatology too? https://t.co/XeYJeCLZrz

@RheumNow

In a placebo controlled RCT, 3 mg/kg infliximab injx fails to improve Sciatica from PostOp peridural lumbar fibrosis https://t.co/4dnmhLOZ4F

@RheumNow

Drug use decreases in the Yr following Hip Replacement 14% decrease in opioids, 18% NSAIDS, & 13% drop in analgesics https://t.co/1rJ8iZel8k

@RheumNow

RT @DrPetryna: @RheumNow NOREPOS study: combination of low serum VitK1 and VitD associated with

Drug use decreases in the Yr following Hip Replacement 14% decrease in opioids, 18% NSAIDS, & 13% drop in analgesics https://t.co/1rJ8iZel8k

@RheumNow

1 day ago

You Can Give!

Hope – Goals – Rules