Lucy Bemand-Qureshi

RHEUMATOLOGY

Elective report – Rheumatology at Barts and the London NHS Trust

1. What are the prevalent rheumatological conditions seen in patients at BLT?

2. How are rheumatology services delivered at BLT?

3. To audit the treatment of early arthritis against national guidelines.

4. To find out what a career as a rheumatologist involves. Do I feel that this is a career that I will enjoy and one which will suit me? How can I go about developing the necessary skills and experience to obtain a training post?

The rheumatology department at BLT has strong commitments to research into the causes and treatments of rheumatological conditions, and to undergraduate and postgraduate education. The commonest conditions in the case mix are rheumatoid arthritis, osteoarthritis, osteoporosis, fibromyalgia, and systemic lupus erythematosus. Many patients cannot, however, be given just one label. For example, in my audit I found patients with inflammatory arthritis who also had connective tissue disease or osteoarthritis. Several patients had fibromyalgia, with soft tissue tenderness at multiple points, as well as an inflammatory arthritis. This can make it difficult to assess the inflammatory arthritis using the DAS-28 scoring system as, due to the chronic widespread pain of fibromyalgia, patients will give a very high score for their global assessment level of activity of their arthritis.

As well as general rheumatology clinics, there are a number of specialist clinics for, for example, Sjögren's syndrome, lupus, osteoporosis, acupuncture, and early arthritis. The early arthritis clinic particularly aims to offer rapid – within a fortnight - and easy access, with early diagnosis, patient education, treatment, and symptom control. The use of the latest technology, with ultrasound assessment of synovitis and neovascularity, enables clinicians to make an accurate assessment of disease activity. I am recording in the audit whether or not the ultrasound is compatible with the DAS-28 – as mentioned above, certain patients may have an artificially inflated DAS due to co-morbidities.

The audit I am undertaking is on a large scale. I first printed off lists of all patients seen in the Early Arthritis Clinic in the past six months. I then had to produce my own list of patients plus their hospital numbers, making sure there were no duplicated records. This produced a list of 444 patients, not all of whom will be included as although the patients are being seen in the early arthritis clinic, a significant number do not have early arthritis. Indeed, so far only half of the patients have proved suitable for inclusion. The next stage involves collecting the actual data. There are up to 100 fields to be completed in a specially designed database, for which I need to consult electronic clinic letters, paper notes, and blood test results. As each patient can take well over an hour, plus I have to consult seniors with queries, this is not something I can complete during the elective period, but I look forward to continuing my work alongside a third-year medical student and a Foundation Year 2 doctor.

As part of my audit I looked at the interval between GP referral and the date when patients are first seen in the Early Arthritis Clinic in the Out-Patients' department.

Those referred as 'urgent' are seen within two weeks but even those whose referrals are labelled 'routine' are seen within fewer than twelve weeks, and often much sooner. Patients with early arthritis are, however, often not referred as such by their GPs, even though the early arthritis clinic is available on Choose and Book, and specific referral guidelines are available online. Instead, patients are often seen in a general clinic first, which inevitably delays the start of treatment.

Many patients with rheumatological conditions need to be seen frequently - those with early arthritis a minimum of six times per year. As well as the doctors' clinics, there are clinics run by specialist nurses and pharmacists, which are particularly important for patients on disease-modifying anti-rheumatic drugs and biological therapies (such as infliximab, etanercept, adulimumab and rituximab) that require close monitoring. These biological agents have enabled two-thirds of those patients with aggressive inflammatory arthritis and who have not tolerated or not responded to DMARDs to become pain-free with significantly improved mobility. At the Mile End site there are phlebotomists, musculoskeletal physiotherapists, occupational therapists, foot health services (podiatry and chiropody), and some radiology. Many patients with rheumatological conditions have mobility problems – a sign on the door of the phlebotomists' room states 'only one wheelchair at a time', and you only have to look around the waiting room to see numerous walking aids in use – so it is helpful to patients that they can access multidisciplinary services on one site. As I was using whatever workstations were available I frequently shared an office with administrative staff. I observed how much clinical knowledge the administrative staff had and how they would do their best to accommodate patients who wished to be seen again sooner than planned due to a deterioration in their condition.

Rheumatology differs from many other medical specialties at Barts and the London in that there are very few in-patients. Most treatment is started and monitored on an out-patient basis, although some patients are admitted for the day for intravenous infusions of biological therapies or cytotoxic drugs. There is a designated 'consultant of the month' responsible for ward patients and referrals. Clinics are extremely busy and even the Foundation Year 2 (Senior House Officer) doctors spend a significant amount of time in the Out Patients' department rather than on the wards. Having been immersed in preparation for Finals for the past few months I welcomed the opportunity to clerk new patients under supervision and I certainly became proficient at administering intramuscular injections, something I had only practised in the clinical skills laboratory before.

In order to become a rheumatologist it is necessary, after two years in the Foundation Programme, to undertake two years of Core Medical Training or Acute Care Common Stem (Medicine), for which there is a selection process. After that, there is again competitive admission to higher specialty training, a process which is managed by the Severn Deanery. Between CT1 and ST3 trainees will need to pass MRCP. Many specialist registrars will undertake a period of research and some will go on to combine clinical work with academia.

Even with the increasing use of ultrasound assessment, rheumatologists still need excellent clinical skills in order to manage patients with a wide range of disorders. They practise clinical medicine in a broad sense – for example, rheumatoid arthritis

can have many extra-articular features – and in District General Hospitals some consultants may also have duties in General Medicine. It is also possible to develop a sub-speciality interest. As chronic disease management is central to the specialty there can be satisfying long-term therapeutic relationships with patients. There is a stated goal of one rheumatologist per 85,000 of the population. In 2010 the Royal College of Physicians estimated that a 61% expansion of consultant numbers would be required so, despite the demanding training, perhaps job prospects are good!

I was warmly welcomed into the department by everyone - secretaries, consultants, nursing staff, specialist registrars, senior house officers, and allied health professionals. I would like to take this opportunity to thank them all for their help and encouragement during my elective.

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