Changes in physiotherapy for rheumatoid arthritis over the years

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I was first introduced to rheumatology patients in 2009, during my Master's program. At that time, our curriculum included specific modules focused on working with individuals diagnosed with rheumatoid arthritis (RA). These modules featured guest speakers who shared their personal experiences, highlighting the profound impact RA had on their lives. This provided invaluable insight for us as novice physiotherapists, fostering a deep sense of empathy long before we began treating patients directly.

At that stage, rheumatology remained a distinct and specialised field within physiotherapy, often viewed as a challenging domain, particularly for those without prior experience or a comprehensive understanding of the complex symptoms these patients presented with.

In my early days as an outpatient physiotherapist, I would see patients referred for the specific reason of 'rheumatoid arthritis' marked on their referrals. It would then detail various aspects of which the patient was struggling with, such as multiple joint stiffness and pain in numerous different regions, severe morning stiffness, loss of function and disability, and pain upon movement, which then would lead to weakened muscles due to their inability to continue with exercise or adequate muscle use.

Patients would often be referred to rheumatology-specific physiotherapists, who would handle the overlapping and multifaceted conditions the patient was suffering with, often varying between appointments. This would depend on the area causing the most discomfort or disability at that time and would make physiotherapy a responsive therapy,

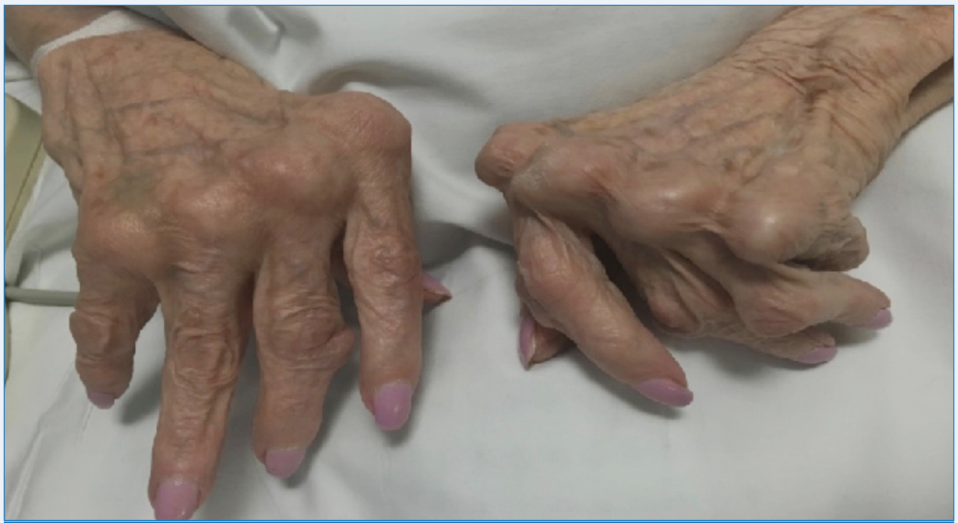

Figure 1: Typical rheumatoid hands, rarely seen now.

Figure 2: Supervised hydrotherapy.

adapting each treatment session to the current symptoms. Often as treatment commenced on one region, at the follow-up appointment another region had become problematic.

In my early days as an outpatient physiotherapist, I would frequently refer patients back to the rheumatologist for medication reviews to assist in trying to alleviate their symptoms. This was particularly the case when physiotherapy proved insufficient in alleviating the severe and disabling pain that any form of movement brought on. More recently, physiotherapy success would differ depending on the drugs the patient was on, if the right dose had been achieved, and how the patient responded.

Previously, physiotherapy interventions largely focused on educating patients about how to modify their rest and exercise routines, with particular emphasis on managing flare-ups of rheumatoid arthritis (RA). During active phases of the condition, patients were advised to prioritise rest in order to minimise joint inflammation, pain, and the systemic fatigue associated with RA. Once the condition was more stable, they were gradually encouraged to increase their level of exercise. Pain management strategies would be implemented and the use of hot and/or cold applications, TENS machines, and even referral to therapeutic hydrotherapy classes, where the warm water would offload the joints and allow the patient some movement supported by the soothing water.

Joint stiffness would often particularly prevail in the hands and fingers, given their multi-joint nature and requirement for constant use. Paraffin wax baths were particularly useful for providing heat to the joints, where the heat would encourage blood vessel dilation and enhance circulation, relaxing the stiff joints and soothing the joint pain. This restoration of function, albeit temporary was of huge relief to patients where they regained some basic hand functions with less pain.

Longer lasting functional restoration would often be found in the prescription of various braces or splints to provide external support, warmth, and offload painful joints. Very commonly, Fischer sticks or Pulpit Walkers would be used to support hips and lower limb pains, where the handles provided a slight increase in comfort than normal walking aid handles.

Long grabbers and shoehorns may also be provided to help with independence of basic everyday tasks. >>

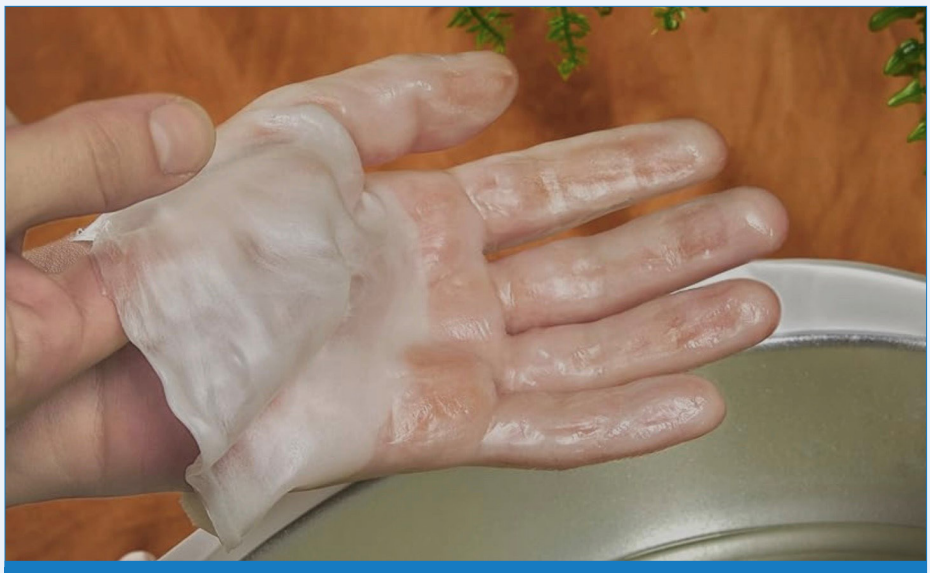

Figure 3: Paraffin wax bath.

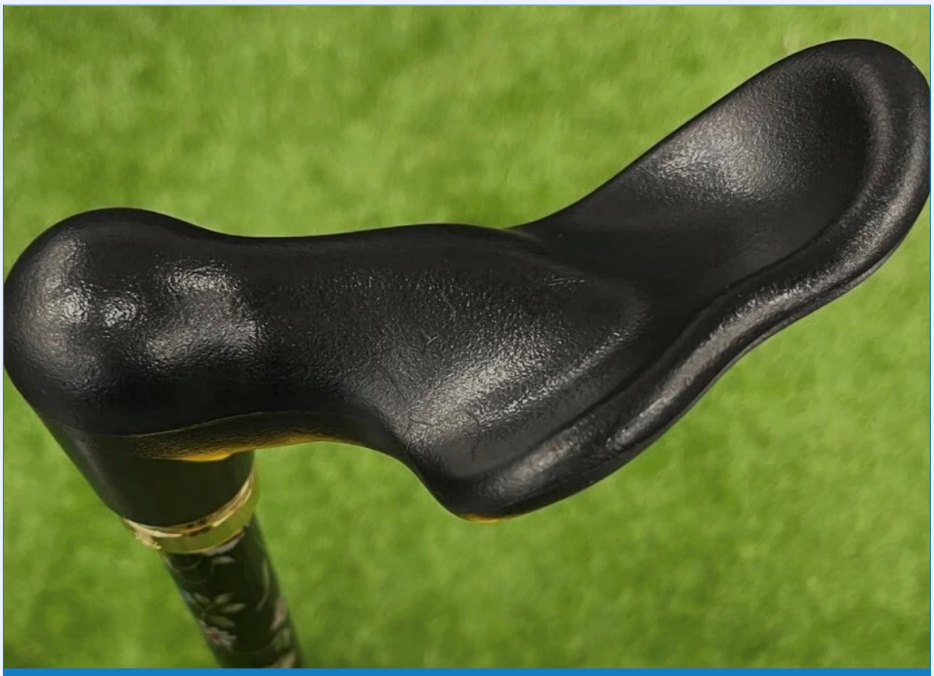

Figure 4: Fischer handle Stick. Kinder to painful hands.

For a number of years now, RA is virtually not even mentioned within physiotherapy, and not because we don't see these patients, but because they are presenting with a primary musculoskeletal or orthopaedic complaint, rather than a direct result of their RA. Gone are the distinct RA referrals and typical patient presentations, and instead, referrals for a specific musculoskeletal or orthopaedic problem, and a mention of RA in their past medical history. The orthopaedic complaints could previously be related to the long-term steroid use, or years of chronic, uncontrolled RA before effective medicines were in place. RA would speed up the process of bone loss, and joint replacements would be required to preserve or restore function. RA is also a risk factor for the steroid-induced osteoporosis, therefore patients may have presented with either pain or muscle weakness as a result of the bone loss, or post-fracture and subsequent orthopaedic intervention. Either way, they would be rehabilitated with progressive exercise prescription to enhance joint function and strengthen the musculature supporting the affected joint.

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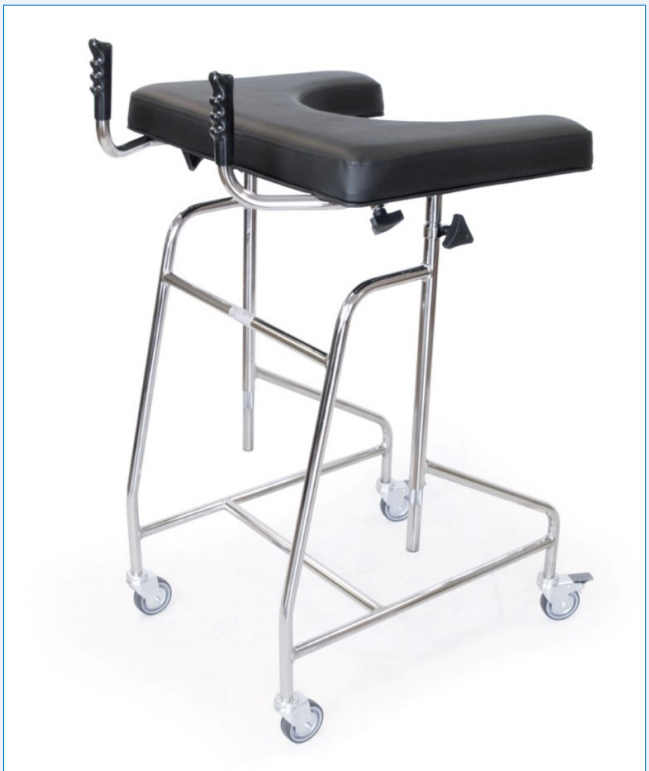

Figure 5: Pulpit Walker.

The revolutionary advances in rheumatic medicines has truly changed physiotherapy practice for these patients, and virtually eliminated specialities in this area. These patients are now seen by the relevant musculoskeletal or orthopaedic specialist rather than a specific rheumatology specialist. Patients presenting with musculoskeletal or orthopaedic problems can be treated similarly to those presenting without RA, however, a thorough understanding of the condition is still paramount. The physiotherapist would be aware of laying caution with any joint manipulations or intense manual therapy treatments, and predominantly guide patients in self-managing their condition, with symptom awareness in the event of flare-ups during their rehabilitation.

The physiotherapist would be diligent in joint protection and caution in not progressing rehabilitation too quickly or intensely. A longer, more steady-paced rehabilitation programme may be considered. They would monitor symptoms and install early management in the prevention of worsening flare ups. This presents as gentle, mobility-based exercises for maintaining joint motion, and strengthening exercises for non-inflamed regions, with advice on pacing and gradually returning to activity levels with careful evaluation of symptoms throughout.

In general, thanks to the medical advances and the careful modern management of RA, these patients do well in their physiotherapy rehabilitation and can overcome musculoskeletal problems or recover from orthopaedic surgery as per normal expectations, often with a hugely positive mindset that they are relieved to be in control of their condition and improving their health. ■