INTERNATIONAL LETTER

SWEDISH RHEUMATOLOGY IN GOOD HEALTH AT 50

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The Swedish model for social security and health care was dependent on a growing economy and full employment. With some 8.5% of open unemployment and facing with growing national debt problems, severe cuts have been implemented in the system and more are to come. How has this affected rheumatologic care? The number of hospital based units remains intact but a general reduction in beds has taken place. Our department in Lund as an example used to have four wards with a total of 62 beds, 12 of which are for day care. This has been reduced to 48, 11 of which are for day care. A complete integration of out- and in-patient services has allowed some staff reductions. However, this has also reduced the total capacity and leads to long waiting lists for out-patient revisits.

As the direct costs paid by patients have increased, health care workers are faced with the novel experience of patients’ difficulties to pay medication or afford hospitalization. It should, however, be mentioned that there is an annual maximum of fees for medication of 1300 SEK and services including hospitalization of 900 SEK. One SEK corresponds to approximately 75 pence. However, the most serious threat to the patients is the overall reduction of capacity. In this context new ethical issues have to be faced, and in a typical Swedish way a commission was formed to deal with priorities in health care [1]. This was headed by an emeritus professor of oncology, Jerzy Einhorn, and its strength lies in the fact that all political parties were represented and reached a broad consensus. The highest priority was given to ‘care of life-threatening acute diseases and diseases which, if left untreated will lead to permanent disability or premature death’, followed by ‘care of severe chronic diseases, palliative care and care of people with reduced autonomy’ [1].

The universities have not escaped cutbacks but so far this has not affected rheumatology in any major way. The department at Karolinska in Stockholm has, under its new professor Lars Klareskog, undergone a very dynamic rejuvenation and is starting ambitious clinical and experimental programmes. Johan Rönnelid defended his thesis on reactivity to type II collagen and C1q in various clinical situations May of 1997. The resources in Stockholm have now been concentrated to the two teaching hospitals, with Bo Ringertz and Ingiäld Hafström in charge at Karolinska and Huddinge, respectively. The Huddinge group is continuing their research on neutrophil function in inflammation.

In Gothenburg Andrej Tarkowski was appointed as professor in 1996. He has developed a strong academic programme dealing with a new model of septic arthritis, which started with a chance observation by a laboratory technician and which has generated a number of PhD thesis projects, the first was completed by Thomas Bremell, now chief physician of the department. Hans Carlsten is pursuing hormonal influences on experimental models of arthritis. Basic T-lymphocyte work is connected with therapeutic investigations, for instance the use of cholera toxin B in induction of oral tolerance. Tarkowski’s group has also recently produced good evidence for lymphocyte traffic from the gut to the synovium.

Giant cell arteritis has been studied for a number of years in Gothenburg starting with the thesis of B. A. Bengtsson and E. B. Malmwall in 1981. The most recent thesis was defended in May 1997 by Christopher Schaufelberger, and included T-lymphocyte cloning and early work on use of T-cell receptors by lymphocytes in peripheral blood and in the lesion. Epidemiologic data showed increased mortality among biopsy negative patients with polymyalgia rheumatica. This disease was also studied in Umeå by Agneta Uddhammar.

In Uppsala, Professor Roger Hägglren has been interested in the study of local events in the gut wall by using a catheter technique allowing local sampling in closed segments. In collaboration with Professor Brandzaeg in Oslo surface immunoglobulins can now be studied in a more precise way. Hägglren has also recently presented data indicating the rationality of administering prednisolone at 2 a.m. rather than in the early morning.

In Lund Tore Saxne’s group is now also involved in studies of early events in osteoarthritis and Ingemar Petersson will soon complete his thesis dealing with cartilage and bone derived serum markers in this disease. Of particular interest are results regarding COMP and its relation to clinical, radiological, and other imaging data including scintigraphy. One message will be that bone and cartilage changes both seem to commence early and may be able to distinguish between stationary and progressive phases of the disease. Gunnar Sturfelt’s group is involved in SLE studies, making use of a prospective epidemiological cohort and incidence study in a defined population. They find constant annual incidence figures around 5/100 000, and increased mortality in vascular diseases notably early myocardial infarcts in young women. Eva Fax and Kerstin Eberhardt are studying their cohort of rheumatoid arthritis patients. One-third of these patients, despite optimal conventional care,
lose working capacity during the first year of observation. However, on a positive note the remainder continue work over the following 5 years. Radiologic progression is not taking place in erosive patients who on clinical grounds were selected not to receive DMARD therapy. This may indicate that as many as 25% of the initially erosive patients do fare well even without the now so popular early aggressive therapy. ESR/CRP are good predictors.

In Malmö Associate Professor Lennart Jacobsson is interested in other aspects of rheumatoid arthritis. One is related to extra-articular manifestations and one to disease severity now compared to 1978 indicating that although demographic data are very similar patients are doing better than two decades ago. Similar data have previously been published by Heikki Isomäki in Finland. Yeva Lindroth working full time in private practice has defended her thesis on patient education in rheumatoid arthritis and osteoarthritis under controlled conditions. She concludes that certain effects are transient and others more lasting, but that patient education well defends its place in the armamentarium of a comprehensive arthritis programme.

These were just some examples of research activities by members of The Swedish Society for Rheumatology, which celebrated its 50th birthday in 1996 at Södersjukhuset in Stockholm, the site where it actually was founded. The festivities were orchestrated by associate professor Ingiäld Hafström shortly before her move of the unit to Huddinge hospital. A book was published by the Society and edited by Dr Ido Leden and associate professor Ola Nived. Unfortunately, it was decided to use the Swedish language in this publication [2].

Swedish rheumatology is in the process of standardizing the initial assessment and therapy of patients with rheumatoid arthritis and entering data into a common computer program. The annual autumn meetings in Stockholm will continue but will move to Gothenburg every second year starting in 1998. In addition spring meetings will be held, next time in April of 1998 in Lund, where the author of this letter will soon add the prefix of emeritus to his title, although he would prefer the Italian word ‘senator’.

REFERENCES