Editorial

Raising the profile of musculoskeletal disorders with governments

Simplifying the message

The musculoskeletal community has struggled to secure from health policymakers and providers the level of engagement the disease burden demands. Considerable effort has been expended to define boundaries of conditions within which there is a spectrum of severity but between which there is substantial overlap. Acknowledging this, rheumatologists have long debated the value of lumping vs splitting, without a unified answer. There should be little surprise at the resultant public and policymaker confusion, which adversely affects prioritization for action.

We argue that rheumatologists should be consistent in policy forums and present arthritis and related conditions in two broad groups: (i) systemic inflammatory disorders requiring ongoing specialist care and (ii) common disorders of musculoskeletal pain, including mechanical and degenerative disorders, generally managed in primary care. This concept is epidemiologically and clinically justified for these key audiences and should be the underpinning data guiding health service planning and maximizing political awareness.

The case for lumping all the inflammatory disorders is compelling. They are all characterized by the consequences of autoimmune inflammation of synovial joints, including axial joints. They affect all ages and typically involve multiple joints. Susceptibility genes are generally those associated with immune system regulation. The clinical course is unpredictable, but generally progressive and requiring lifelong drug therapy and monitoring. They share the long-term potential for irreversible joint damage in the absence of aggressive therapy as well as extra-articular long-term sequelae such as increased osteoporotic risk. They are also associated with increases in life-threatening morbidity, especially from cardiovascular disease [1, 2].

Health care needs require similar access to and interpretation of specialist blood tests and imaging [3]. The therapeutic approach focuses heavily on suppressing or modulating the underlying immune response safely, which requires specialist experience. Modern expensive biologic therapies are used across the spectrum with no clear distinction in their relative effectiveness [4]. Broadly, the same specialist rheumatology multidisciplinary team is required for optimal global patient management.

Barriers between traditional diagnoses are being broken as the benefits of early therapy for inflammatory arthritis are becoming apparent [5], with dedicated clinics to new-onset undifferentiated inflammatory arthritis. The priority is to educate both the public and primary care services for early specialist referral independent of any diagnostic group. Sub-classification into cogent disease groups is less likely to drive treatment decisions than shared cross-disease features such as the level of synovial inflammation.

There is a similar compelling case for combining the common degenerative disorders such as OA and tendinopathies with regional and widespread pain syndromes, such as back and shoulder pain, and FM. They share the cardinal symptom of musculoskeletal pain, and incidence increases with age. Their occurrence is strongly associated with excessive loading, including overuse, as well as obesity, and symptom severity and outcome are related to psychological factors.

There are also several problems in attempting further subclassification. First, pinpointing the site of pain is imprecise, for example, distinguishing between neck and shoulder pain or the boundaries of the back [6]. Second, regional pain syndromes rarely occur in isolation. Patients with chronic back pain frequently have pain at other sites and the boundary between that and FM is unclear. Third, the relationship between pain and structural tissue damage, defined by X-ray or even MRI, is insufficiently strong for robust attribution [7]. Indeed, given the high population prevalence of radiographic change, there is a debate as to whether OA is less a cartilage or bone disorder but rather one of pain.

In clinical practice it is the symptom phenotype rather than the pathological diagnosis that has been more useful in guiding interventions. Thus in chronic low back pain, for example, shared psychosocial factors have greater utility than a structural diagnosis [8].

Care planning for this group is generally based in primary care, with the aim of preventing chronicity and secondary disability [9]. Management focuses on modifying symptoms such as pain, encouraging lifestyle modification such as physical activity and weight loss and supporting self-management approaches with identification and management of associated comorbidities, especially depression and anxiety. Referral to specialist care for treatment of these conditions is generally reserved for those with severe problems for whom surgery, for example, may be beneficial.

In summary, we propose that a conscious decision should be made to consistently present musculoskeletal
disorders to policymakers under the two umbrella groups of (i) systemic inflammatory disorders and (ii) musculoskeletal pain disorders. Epidemiological data for health needs assessment should reflect these concepts and should be used to provide an overarching framework for each group to develop service delivery models based on their respective needs for specialist and primary care.

Individual patients, when appropriate, need access to very specific diagnostic, rehabilitation and surgical interventions that may be informed by their diagnostic label or equally by their level of severity, independent of such a label. Identification of homogeneous subgroups is also needed for research and prognostication to guide interventions. Further, this is not an attempt to divide rheumatological textbooks into two halves, but more an attempt to provide a clear and easily understood framework for service planning. Such a distinction should also not preclude coherent service design for disorders not easily covered by this dichotomy; for example, gout and polymyalgia are best managed in primary care, although there are concerns about the quality of care in this setting [10]. Complex chronic pain syndromes such as FM are often managed in secondary care, although many rheumatologists suggest that primary care ownership is more appropriate [11]. Finally, the needs of patients with complex autoimmune disorders will only be covered in part by the umbrella of inflammatory arthritis.

The underlying ideas and concepts behind this are not new. Indeed, many practitioners reading this will no doubt find this split instinctive and in keeping with their clinical decision-making approach. Debates about lumping or splitting and how best to classify and subclassify will continue, although the growing development of biomarkers aims to achieve less emphasis on specific single diagnoses and more on coherent treatment decisions across diagnostic groups.

However, we propose that the commonalities of the disorders within these two broad groups warrant the use of this simplified approach in presenting the epidemiological burden of musculoskeletal disorders as a whole, both nationally and locally, to help define the service configuration. Policymakers need this simplicity, and debates about subclassification should be relegated to the pages of this and other journals.

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