Foreword

Rheumatology: Modifying Disease, Changing Medical Practice

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Consulting Editor

Medical practice these days is hardly without its hassles. Tedious administrative burdens, overly complicated electronic medical records, and onerous systems for reimbursement vex physicians at every turn. But one criticism that cannot be leveled at medical practice is that it is stagnant. Hardly. In fact, medical practice, including diagnosis and treatment, has evolved dramatically over the past decades. We can treat patients and prevent or forestall complications of chronic illness that in the past seemed inexorable. And that goes a long way toward mitigating the impact of all those hassles. I hope you agree.

Rheumatology, as much as any specialty, exemplifies how much the practice of medicine has changed. I can recall as a house officer in the 1970s caring for rheumatoid arthritis (RA) patients in the hospital (yes, in the hospital) with an armamentarium that by today’s standards seems downright primitive. We already were cautious about the use of corticosteroids, appreciating that this class of drugs are, as John Cush, MD, warns in his article on RA in this issue of Medical Clinics of North America, “acutely wonderful, but chronically hazardous.” Nonsteroidal anti-inflammatory drugs, however, had just come into use. Gold and plaquenil were available, but were not helpful in the short term. So, we relied upon salicylates, and we administered them at doses that by today’s standards would be unconscionable. Patients were dosed with aspirin until they developed tinnitus, and then the daily dose was reduced by a tablet or two.

Apart from our seemingly prehistoric approach to therapy for RA, we harbored a fundamental concept of the disease that differs so greatly from how we regard RA now. RA was viewed as a chronic, unrelenting illness leading inescapably, it seemed, to nodules, bony erosions, and joint deformities. Joint replacement surgery, including replacement of the small joints of the hand, was much more common then than now.
Today, our approach to RA is fundamentally different. The diagnosis now is regarded with a sense of urgency. Yes, as Cush reminds us, the diagnosis cannot be made with confidence within 6 weeks. But once the diagnosis is established, patients should be managed with a disease-modifying strategy without delay. How different that approach is from how we managed patients decades ago. In contrast to what was available during the early phase of my career, RA patients are treated without delay using disease-modifying medications (eg, methotrexate) and also biologic and biosimilar agents (eg, eternasept or infliximab), none of which were available, of course, when I was inducing salicylism as my patients’ joints were eroding. This more aggressive and more targeted approach to RA is but one of several equally fundamental paradigm shifts that the past several decades have brought to the practice of rheumatology. Readers will find these clearly identified and explained throughout this issue of Medical Clinics of North America. Dr Mandell and his authors have done a wonderful job in providing this timely update for nonrheumatologists. It is an exciting read, and certainly the advances that are described are a good deal more heartening than dwelling on the aforementioned hassles of medical practice.

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