Regional Rheumatic Disorders and Rehabilitation in Older Adults: An Update

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KEYWORDS

- Regional rheumatic pain syndromes • Geriatric rehabilitation
- Rehabilitation medicine

KEY POINTS

- To review key components of the rehabilitation medicine evaluation of older patients with regional rheumatic disorders.
- To understand the rationale behind rehabilitation medicine treatment interventions of older patients with regional rheumatic disorders.
- To review future research considerations of older patients with regional rheumatic disorders.

INTRODUCTION

Musculoskeletal (MSK) problems are the most frequently reported complaints among community-dwelling older adults.[1,2] In patients more than 60 years old, the prevalence of pain was more than 2 times that reported for patients less than 60 year old.[3,4] In developed countries, the fastest growing portion of the population are individuals who are older than 75 years of age.[4,5] The impact of the aging process on skeletal muscles and joints can have a profound effect on the functional ability of individuals with and without disabilities.[6] Despite its universal occurrence, the mechanisms of aging are not fully understood.[7,8] Structural and mechanical changes of aging occur in skeletal muscle and the articular cartilage, resulting in biomechanical changes that affect mobility, self-care skills, and activities of daily living (ADLs). This article reviews the rehabilitation medicine approach to the evaluation of older adults with regional rheumatic disorders and the approach to clinical intervention.

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WHAT IS A REGIONAL RHEUMATIC DISORDER?

For the purposes of this article, a regional rheumatic disorder is a localized dysfunction related to nonarticular or periarticular soft tissue. The disorder may involve the bursa, muscle, fascia, ligament, tendon, cartilage, joint, bone, nerve, or overlying skin and how these tissues relate to each other.[9] Local trauma is the most common initiating event for regional rheumatic disorders. A macrotraumatic injury involves a single episode of acute tissue destruction, whereas a microtraumatic injury can result from chronic overload or repetitive overuse.[10] Intrinsic and extrinsic factors affect these injuries and predispose to inflammation, degeneration, tear, or rupture.[10] Examples of intrinsic factors include age-related changes, biomechanical malalignment, muscle imbalance, hypermobility or hypomobility, poor vascular supply,[10] undermobility and lack of exercise, and comorbidities. Tendons become less flexible and elastic with aging, making them more susceptible to injuries.[11] Extrinsic factors relate to external environmental issues that may affect individuals, such as uneven walking surfaces, tripping hazards, lack of accessibility in the home, lack of access to exercise opportunities, poor exercise training techniques, exposure to extreme temperature fluctuations, and/or financial barriers to exercise/environmental modifications.

PATIENT EVALUATION CONSIDERATIONS

Given the absence of specific standardized laboratory tests, markers, or imaging tests for regional rheumatic disorders, a comprehensive medical history and physical examination are essential. The initial medical history should differentiate whether the complaint is articular or nonarticular, inflammatory or noninflammatory, acute or chronic, and localized or widespread.[9]

Pain is often the primary symptom in patients with MSK complaints. Critical elements of a pain history include pain onset, location, duration, type of pain, and associated factors that may aggravate, exacerbate, or decrease pain. Clinicians should query patients for a history of recent or remote trauma. Associated symptoms, such as weakness, edema, effusion, redness, warmth, fevers, and chills, are important in the differential diagnosis.

REHABILITATION MEDICINE HISTORY

A comprehensive functional history is critical for identifying activities that may be related to symptoms of regional rheumatic disorders. This includes an understanding of the premorbid level of functioning, which includes inquiring about ADLs and mobility in the home and community. Mobility tasks include transfers, walking, curbs, stairs, driving, use of mobility aids (canes, walkers, or wheelchairs), and avocational activities. Inquiring about a patient's level of function (independent, required assistance, or dependent) prior to an MSK complaint is also important to document. ADL history includes self-care skills in the areas of bathing, toileting, personal hygiene, upper and lower limb dressing, meal preparation, home maintenance/laundry. The inability to put on deodorant or a shirt because of restricted shoulder range of motion in the case of a shoulder tendinopathy or rotator cuff tear is an example of how MSK problems can have an impact on ADL function.

In addition to gathering the traditional information, clinicians should consider some unique factors that influence the trajectory of older adults with regional rheumatic disorders from disease to disability (**Box 1**).[12–14]

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