The rheumatological history

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Abstract

Rheumatology is a multisystem discipline that requires a multisystem approach to history-taking. The symptoms can be wide-ranging, and the novice is best served by following a thorough and systematic approach to history-taking. The more experienced physician with rheumatological expertise will swiftly identify an emerging pattern of symptoms and build a picture of a likely diagnosis, using more selective questioning to illustrate associated features and exclude important differential diagnoses.

Keywords Arthralgia versus arthritis; inflammatory joint pain; MRCP; multisystem approach

Key points

- Rheumatology is a multisystem discipline that requires a multisystem approach to history-taking
- Inflammatory pain is classically worse in the morning or with inactivity. Significant early morning stiffness lasts >30 minutes
- Inflammatory pain and stiffness improves with movement and as the day goes on, whereas degenerative pain (e.g. from osteoarthritis) tends to be worse towards the end of the day or following increased usage and can be relieved by rest

Introduction

> *'There are, in truth, no specialties in medicine, since to know fully many of the most important diseases a man must be familiar with their manifestations in many organs.' William Osler*

Rheumatological diseases can affect multiple body systems and thus clinicans require a wide-view lens and a multisystem approach by the physician, as suggested by Osler.

Joints

Many rheumatological disorders with varying levels of systemic involvement and differing aetiologies came under the remit of the rheumatologist because of one common factor: involvement of the joints. There can be pain without swelling (arthralgia), or pain with associated inflammation and swelling of the joint.

An important distinction to make is that between inflammatory and degenerative joint pain. Inflammatory pain is classically worse in the morning or with inactivity, with associated early morning stiffness that improves with movement and as the day goes on. Degenerative pain (e.g. from osteoarthritis) tends, however, to be worse towards the end of the day or following usage, and can be relieved by rest.

Asking the patient about the pattern of joint involvement (distribution) can give clues to the diagnosis. For example, monoarthritis can be suggestive of septic arthritis, classical crystal arthropathy or one of the seronegative spondyloarthropathies (psoriatic oligoarthritis, reactive arthritis, enteropathic arthritis).

Combining these two important pieces of information (inflammatory versus non-inflammatory, distribution) can help significantly narrow the differential diagnosis. For example, a symmetrical, inflammatory-sounding small joint polyarthropathy mainly involving the hands can point to classical rheumatoid disease or polyarticular small joint psoriatic arthritis, whereas predominantly distal small joint, non-inflammatory polyarthropathy of the hands suggests osteoarthritis (Figure 1).

The rate of symptom onset gives similar clues: septic arthritis and gout tend to be of acute onset. Autoimmune inflammatory arthritis, for example rheumatoid disease, manifests over a period of weeks to months, and osteoarthritis over many years.

Autoimmune rheumatic disorders such as systemic lupus erythematosus (SLE) can present with either arthralgia or arthritis. Classical lupoid arthritis is a non-deforming polyarthopathy known as Jaccoud's arthropathy, although patients with SLE more commonly have arthralgia, and sometimes an erosive arthritis is seen.

Repeated episodes of Achilles tendonitis or plantar fasciitis can suggest a predisposition to the seronegative spondyloarthropathy.

Widespread or 'total body' pain can be seen in patients with chronic widespread pain or fibromyalgia. In these patients, the pain is often ever-present, with no diurnal variation. Patients can also describe having very 'bendy' joints or being very flexible if they have joint hypermobility. This is turn increases the risk of mechanical joint pain and fibromyalgia-like pain.

Constitutional symptoms

Fevers, fatigue, weight loss and night sweats are non-specific symptoms that can reflect primary rheumatological disease but should also act as red flags to trigger the exclusion of other pathologies such as malignancy and infection.

Poor sleep is commonly seen in patients with fibromyalgia, and is thought to contribute to continuing problems with pain sensitization. Patients with inflammatory pain can wake with pain in the night as a result of significant stiffness.

Mucocutaneous features

Skin rashes are a common feature of rheumatological disease. Key features to ask about are photosensitivity and distribution.

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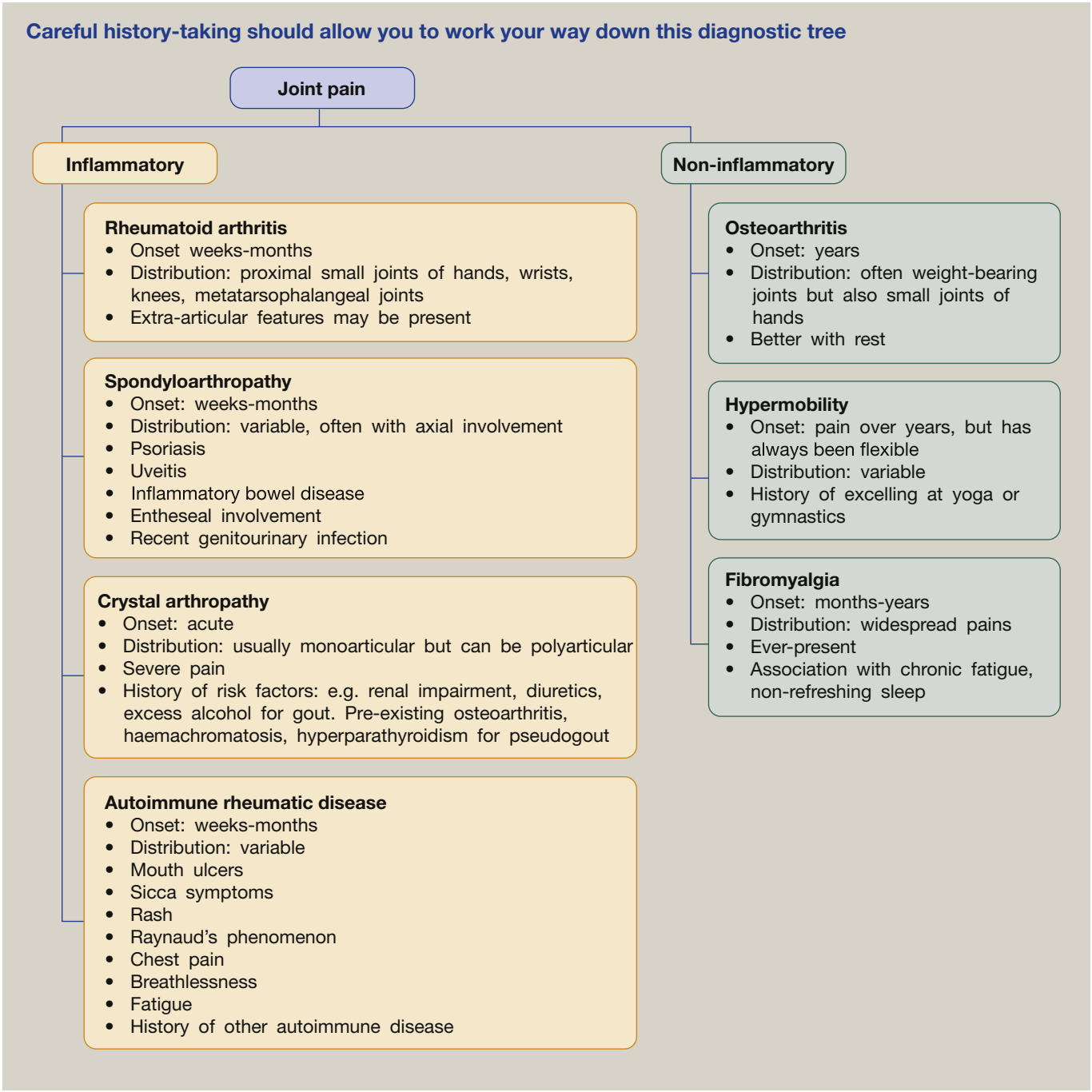

Figure 1

Lupus can cause a variety of photosensitive skin rashes including the classical malar 'butterfly' rash and subacute cutaneous lupus erythematosus involving the upper torso and arms. Discoid lupus can occur on its own without systemic involvement and causes scarring with loss of hair in the affected area. A number of the characteristic rashes of dermatomyositis, such as the V sign/shawl sign, occur in sun-exposed areas.

In systemic sclerosis, the patient may have noticed the development of telangiectasia, along with tightening of the skin around the fingers (sclerodactyly).

A personal or family history (first-degree relative) of psoriasis can make psoriatic arthritis more likely.

Asking about painful nodules on the shin may reveal a history of erythema nodosum, which can be part of a presentation of sarcoidosis or a post-streptococcal arthritis.