is as good as any other.

Dr Dudley Hart: I prefer to call it the " R.B. syndrome " myself, then I know I am not fooling myself about a purely imaginative pathology. I remember reading in an old book that the one characteristic thing about fibrositis was that there was a normal sedimentation rate.

Dr Newton: One becomes very chary of the diagnosis if a week after a diagnosis of fibrositis of the chest is made, the patient dies of myocardial infarction. I think a lot of general practitioners will have had similar experiences.

Professor Kellgren: Another thing nobody has mentioned is epidemic myalgia.

Dr Hodgkin: I have not seen an epidemic of this at all, but only isolated cases. Epidemics seem to be very rare, but when they come they are obviously very striking.

INFLAMATORY POLYARTHRITIC DISEASE

I

Problems facing the General Practitioner

K. H. Pickworth, M.B., B.S. (*Barnard Castle*)

Inflammatory polyarthritis is a term for a group of diseases, some of which are quite common. Seldom does a week go by without the general practitioner seeing a patient suffering from a disease which may be included under this heading. Since many of the diseases which involve joints are of long duration, it is not surprising that sooner or later problems arise, the alleviation of which falls particularly into the province of the general practitioner. I practise in Barnard Castle, which is a market town on the borders of County Durham, and the North Riding of Yorkshire. My area, which is crossed from west to east by the River Tees, extends for about ten miles around the town. The sort of people I look after are farmers, factory workers from the local Glaxo laboratories and from a leather

factory, shop assistants, retired people from some of the larger towns, and a small number of foundry workers. Our nearest hospital is fifteen miles away.

Inflammatory polyarthritis refers to those forms of arthritis which are not primarily degenerative or traumatic, and includes rheumatic fever, rheumatoid arthritis, septic arthritis, and the arthropathies which are thought to occur in conjunction with infectious diseases like paratyphoid or rubella. The problems which are connected with these may be divided into two groups. These are, firstly, those problems associated with early diagnosis and with correct treatment, and secondly, those which arise in dealing with the management of the chronic case.

Early diagnosis is most important in acute illnesses, such as rheumatic fever. There is no doubt that rheumatic fever can be a problem for the general practitioner, for there is much at stake, both for himself and for his patient. In an early case, it can be quite a triumph for a doctor who makes the correct diagnosis at the first visit. It is a simple matter for him to keep his patient at rest, and on salicylates, until he can be sure of the position. However, he must play for time carefully, because the illness may turn out to be osteomyelitis, septicaemia, or glandular fever, and some of these alternatives are serious matters. He must not take too much time over the diagnosis because there is the possibility of these serious alternatives, and because rheumatic fever is an illness well known to parents and feared by them. A mother may come right out and ask, " Do you think it's rheumatic fever? ", and since mothers are often uncannily correct, the answer needs to be cautious, but at the same time definite. A doctor must judge the people he is dealing with, and may possibly taken them into his confidence. He may communicate to them his suspicions, and yet at the same time assure them that it is safe to wait until the morning. This is often the best way, but it goes to emphasize the fact that something positive must be done soon.

If the doctor then declares that the case is one of rheumatic fever, he is committed to a course of action, which in all probability means sending his patient to hospital. If he is correct in his diagnosis, this may well mean a considerable stay for the child, and the length of stay may depend to some extent upon the doctor's assessment of the home conditions. He may also have taken the opportunity, whilst the child is in hospital, to prepare the parents for the after-care and prophylactic regimens. A child home from hospital needs salicylates, rest, and supervision. A great deal depends upon the doctor's ability to assess the intelligence of the parents, and upon his ability to convince them of the essential nature of this treatment. As a rule

it is relatively easy to ensure that the child has adequate rest. It is unfortunately often another thing to ensure that he takes his twelve aspirin and penicillin tablets every day. He will manage all right for the first week or two, but after a month things begin to slide, and the dosage level may easily be allowed to fall. I think it is very important for parents to know at the outset that prophylactic penicillin treatment must continue for some years. Professor Bywaters has mentioned five years for twice daily oral penicillin, and this is really a very long time. I think it becomes much more difficult later on to ensure all-round co-operation if the doctor keeps adding on to the duration of treatment further periods of, for example, six months. It becomes not a matter of doctor's orders, but of doctor's persuasion and interest. Yearly checks of cardiac and general condition are of course necessary, but it may sometimes be wise to have these checks carried out more frequently in order to remind the patient and his parents of the importance of the treatment, and to make sure that the patient is in fact taking his pills. Unfortunately, all homes are not good, and I can think of some families which would be quite unsuitable for a child on full dosage of these drugs to return to from hospital. As to prophylaxis, I know of situations where oral penicillin would certainly not be maintained for long, and where the continuance of even intramuscular penicillin for some years would be extremely uncertain.

Rheumatoid arthritis has as a rule a relatively insidious onset. A patient may complain of stiffness and swelling in one or two fingers only. If after a few consultations these apparently trivial signs have not cleared, then the doctor must face the problem of his next move. This may well be to seek further advice, but sooner or later must come a time for explanations. I think it is important for the doctor to have clearly in his mind just what he is going to tell his patient and how much. He must say something about the natural history of the condition, and be able to prepare his patient for a long illness, though perhaps not necessarily a serious one. In the same breath he must offer hope of good and conscientious treatment. In my experience it takes a considerable effort to convince a patient that mere aspirin is probably his best line of treatment. Aspirin nowadays is used for the alleviation of so many widely differing symptoms that people tend to look down their noses at it. A doctor who prescribes just aspirin must defend himself against the charge that he is not doing enough, preferably before that charge is made. He may well combine aspirin therapy with other medicaments. In this case he must watch carefully for the patient who leaves off his aspirin and takes only the new prescription, since something new always appears to have a better chance of success, just because it is new. Aspirin

intolerance is of course a really difficult problem, and sometimes there is no answer to it. Soluble aspirin and enteric-coated aspirin do much to help here, although whether their effects on intolerance are due to their different modes of presentation or rather to this combined with suggestion is not always clear. It is, however, often surprising how much aspirin a patient can tolerate, often more than he thinks he can. In spite of this, aspirin intolerance, although not very common, is sometimes intractable, and as such it has to be accepted. Occasionally a patient may be found to be a poor absorber of aspirin and this also has to be accepted.

It is not always necessary or even wise to seek physiotherapy for all cases of rheumatoid arthritis. In my part of the country where a trip to hospital often means a long ambulance ride, sometimes around a few farms collecting other people, the good that has been done in the physiotherapy department may be undone by the rigours of the trek home. In order to overcome this, I sometimes try to persuade my patients to do a few little exercises at home, possibly in the bath, such as quadriceps drill, passive movements, and so on. Firm encouragement is needed about these things, because a patient does not see an immediate return for his efforts. In these circumstances, particularly when a patient is alone, his efforts over any significant time are likely to be rather poor; in other words, the stimulus of the hospital and the group is not present at home.

I have said something already of problems concerned with implementing treatment prolonged over years, and it is here that the general practitioner's ingenuity may be taxed severely. Rheumatoid arthritis sometimes ends with considerable residual disability, and I think most practices will contain at least one severely handicapped patient. These people are sometimes fixed in chairs or even in beds, and have often accepted in large measure their infirmities. They nevertheless look to their doctors for continuing help, and frequently this can take the form only of administration of analgesics. The doctor's eagerness to help, possibly combined with some pressure from the patient or relatives, may lead him into the injudicious use of steroids. One of the differences between a consultant and a general practitioner is that the former sees the patient only once or twice, whereas the latter sees him over and over again. This may often be regarded as of some advantage to the general practitioner, but unfortunately it is not always so. The frequency, the constancy, and the monotony of his visits may lead the best-willed doctor in the world to forget that help for his patient may come from directions other than tablets. I refer of course to surgical measures and to advice which can be obtained in respect of gadgets for the disabled and even of alterations to the structure of the house. It is understandable that a patient wants to

try all the various remedies about which he has read, and all the new ones he has been told about. The doctor faces the long-drawn out problem of steering his patient away from obviously spurious remedies, yet not forbidding all. He must encourage the invalid to continue with the old and well-tried things, and at the same time avoid seeming to be bored or uninterested in the case. All this he must do whilst retaining the patient's confidence in the face of the knowledge which is shared between them, namely, that medical science has in fact failed to avert the patient's present unfortunate condition. When a doctor treats a patient for the same disease over many years, there can be no avoidance of the plain truth. Their relationship becomes a simple one, that of one human being doing his best to help another.

When I was writing this script I tried to think of problems which affect only the general practitioner. Those concerned with details of differential diagnosis and of treatment I have avoided. I have spoken of only two conditions, because I believe that from the point of view of problems of management and of living with one's patients these form two extremes. One of them commences urgently and has a foreseeable end; the other begins gently, even stealthily, and its end is unpredictable. I think that they present problems which may occur in greater or lesser degree in all members of the group of diseases which we are here to discuss. What I have mentioned are the problems of management of patients and sometimes of relatives in acute cases, the problems of securing the constancy of relatively long-term treatment, and problems to do with the establishment of the best relationship between doctor and patient in the long-term chronic case.

Chairman, **Professor J. H. Kellgren:** There is a clear differentiation between rheumatic fever and the allergic arthropathies which occur with viruses, drugs and the like, and which present with the picture of acute polyarthritis, and on the other hand the group of chronic inflammatory polyarthropathies largely lumped together as rheumatoid arthritis when affecting peripheral joints. Some 20 years ago chronic inflammatory polyarthritis if peripheral was called rheumatoid arthritis, and if central ankylosing spondylitis, and that was the end of it. Over the past 20 years this rather simplified view has become increasingly untenable and it has become apparent that chronic peripheral rheumatoid arthritis is not really a homogeneous condition. There are various sub-groups, some serious ones associated with auto-immune phenomena like the presence of rheumatoid factor and with certain kinds of visceral and vascular lesion, and others less serious, such as Reiter's disease, the arthritis of psoriasis, the spondylitis which presents predominantly with peripheral joint

involvement, and a whole host of rather rare arthritic conditions, some of which are still not fully characterized. There does appear to be a much bigger diagnostic problem than was apparent some years ago, and this may be important both as regards treatment and prognosis.

II

The Management of Rheumatoid Arthritis

J. J. R. Duthie, M.B., CH.B., F.R.C.P. (*Edinburgh*)

Rheumatoid arthritis can be briefly defined as a chronic inflammatory polyarthritis affecting mainly the peripheral joints, running a prolonged, fluctuating course, accompanied by signs of general systemic disturbance, and rather unpredictable. Females are affected two or three times as commonly as males, at least clinically, and the mean age at onset is around 40, though no age is immune.

As regards incidence, according to Dr Lawrence's figures the minimal prevalence of this disease in people over 15 is about 2.1 per cent in males and 5.2 per cent in females, the prevalence rising with age in both sexes. Dr Lawrence states that studies in some seven areas in northern Europe have not produced any evidence of striking difference in regional incidence. On this basis it can be estimated that there are approximately 1,740,000 people in Great Britain over 15 years of age who may be suffering from rheumatoid arthritis of a definite or probable type. I think we must all agree that this constitutes a very formidable problem, particularly so when we must admit that it is a disease of unknown aetiology, running a variable and largely unpredictable course, for which we have as yet no satifactory cure but which is best controlled by a regimen of treatment involving a period of rest in bed under skilled supervision, followed by a carefully graduated course of remedial activity and prolonged and assiduous after-care.

It can be readily seen that in any service for the diagnosis and treatment of the chronic rheumatic diseases, rheumatoid arthritis will make heavy demands on both time and facilities. My own experience over the last ten years amply confirms this view. An