Dealing with the Disadvantaged

Coping with the arthritic patient

PAULINE BOWER

About six million adults and 12 000 children in Britain suffer from some form of arthritis, which is often painful and disabling. No one knows why we suffer in this way—and have done, all over the world, for hundreds of thousands of years—and no one knows how to cure us. This is no reason, however, for dumping us on the rubbish heap, which is unfortunately what happens all too often.

So I would ask that, when faced with a troubled patient complaining about stiffness, odd swelling, increasing difficulty in coping with the practicalities of life and therefore depression, stabbing pains, and general malaise, you please:

(1) Think of arthritis as a possible diagnosis and take the appropriate tests. Do not just dismiss the individual as a malingerer, or tell him or her that we all suffer like this at times, or that they are simply growing pains, or that it comes to us all with age, or resort to any of the other dismissive clichés. And please do not be too practical over the tests: remember, even when doing something supposedly simple like taking a blood sample, that it is only too easy to hurt your patient.

(2) Since no one can yet say what causes arthritis, do bear in mind that many people suspect it may be triggered by different things such as shock or a fall or that it may be an allergic reaction. This means that vague rheumatic pains can be tackled through attention to the patient's environment even before there is a positive result from the tests.

(3) When you have to tell a patient that he or she has got, for instance, rheumatoid arthritis, do try to express a little concern and sympathy. It does make the news slightly easier for the patient to bear, even if it is fairly routine for you, the doctor.

(4) Please do not leave it at the bare diagnosis either. Explain that there are many things that can be tried and that might help greatly—because the patient will be only too well aware of the limitations and difficulties imposed by the illness but will need to be told of the practical, positive possibilities now open to him or her. In other words, do not impart a defeatist attitude.

(5) As there is as yet no definite cure for arthritis, do not jeer at folk remedies, copper bracelets, different diets, etc. One of them might well help your patient (I have experienced the value of some of them myself) and they are anyway probably less harmful and less expensive than most of the drugs you might be tempted to prescribe.

(6) If you yourself do not have time to discuss the various treatments—and their possible consequences—with your patient, do introduce him or her to someone who can do so with authority, and then hand the patient on quickly to a physiotherapist and to an occupational therapist, who will be able to help with the problems of daily living—and they are legion—with practical understanding.

(7) Remember that constant pain and frustration may make the patient extremely tired and cross. He or she might well find consolation and help from fellow sufferers, so suggest that your patient should get in touch with Arthritis Care (the new, more manageable name for The British Rheumatism and Arthritis Association). Its headquarters are at 6 Grosvenor Crescent, London SW1 (tel: 01-235 0902), and it will put your patient in touch with the nearest branch. The Disabled Living Foundation at 346 Kensington High Street, London W14 (tel: 01-602 2491), will also help.

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A right-handed 46-year-old stonemason developed a right axillary vein thrombosis. No haematological, biochemical, or physical abnormalities were found to account for his thrombosis, and he has recovered well taking anticoagulants. Might his condition have been related to his occupation?

It might have been, especially if he had had a spell off work. Axillary vein thrombosis commonly results from unaccustomed use of the arm, including upward movements that compress the vein between clavicle and first rib.

I perform minor operations in a small operating suite in a health centre. How best can I monitor the bacteriological suitability of the suite?

Semmelweis[1] taught that with strict attention to aseptic principles it was possible to avoid septic complications even in "a dirty barn."[2] Indeed, some poor law hospitals inherited by the NHS function on this premise with considerable success to the present day. Operative infections originate either from the hands or nose of the operator or in gross instances from a septic lesion if he has one (when, of course, he should not be operating). More commonly they arise from the patients own body flora, often the skin flora, and the surroundings are therefore largely irrelevant[3] so long as they are socially clean and large enough to allow the surgeon to proceed unhampered. Adequate handwashing facilities are absolutely essential, and washing is best followed by using an alcohol-based hand rub. The site of operation should be cleaned with alcoholic chlorhexidine, which must be given time to dry after application. Access to a guaranteed supply of heat-sterilised instrument packs either from a hospital store or a commercial source is also necessary. Storing instruments in spirit and boiling them and other apparatus in fish kettle "sterilisers" is not acceptable. If these essential precautions are diligently observed bacteriological investigation of any sort, least of all of the environment, is not necessary unless three or more consecutive infections occur, in which case they must be investigated to exclude a common source.

[1] Semmeleweis 1861. Cited by Colebrook L. The story of puerperal fever: 1800-1950. *Br Med J* 1956;i:247-52.
[2] Wise RI. *The problem of staphylococcal infections and their control in hospital in institutionally acquired infections.* Atlanta, Georgia: Public Health Service, Communicable Disease Centre, 1964:113-7. (DHEW publication No 1188.)
[3] Altemier WA. *Some epidemiological considerations of surgical infections in institutionally acquired infections.* Atlanta, Georgia: Public Health Service, Communicable Disease Centre, 1964:118-25. (DHEW publication No 1188.)