Hospital Topics

Are combined orthopaedic and rheumatology clinics worth while?

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Abstract

The practice of holding combined orthopaedic and rheumatology clinics is widespread, but no attempt has been made to assess their usefulness. In a one year prospective study patients were randomised either to a combined clinic with a rheumatologist and an orthopaedic surgeon or to a clinic with an orthopaedic surgeon alone. The details of the patients' disease, the interview, the surgeons' and rheumatologists' responses, and the patients' opinions were recorded on questionnaires. Interviews were appreciably longer in the combined clinic, and more referrals for surgery were made. The rheumatologist correctly predicted the need for surgery in 95% of cases, and his presence in the clinic was considered desirable by the surgeon, principally when the referral letter was inadequate.

It is concluded that most patients with rheumatic diseases can be seen more efficiently in routine orthopaedic clinics provided a good quality letter of referral is sent.

Introduction

Combined orthopaedic and rheumatology outpatient clinics are a feature of many rheumatology units. A physician and a surgeon consult together, and paramedical staff are often in attendance. Although such clinics are thought by many to be the best means of planning medical and surgical care for patients with complicated joint disease,^{1,2} they have not been formally evaluated.

We therefore carried out a pilot study of our combined clinic to assess its value to the physician, surgeon, and patient.

Methods and results

Patients who had a chronic rheumatic disease that a rheumatologist thought required assessment for surgery were alternately allocated either to a combined clinic or to one in which they saw only an orthopaedic surgeon. All patients were referred by a rheumatologist who was unaware of the type of clinic the patients would ultimately be seen in. Both clinics were held in the same rooms with the same nursing staff. After the consultation a questionnaire was completed by the surgeon, physician, and patient.

There were differences between the two groups in the proportion of patients with problems in the upper and lower limbs presenting to each clinic, the proportion referred by a consultant, and the proportion who

received second or third line treatment (table I). The interview time was significantly longer in the combined clinic ($p < 0.01$) (table II), and more decisions for surgery were made ($p < 0.05$). Conversely, more patients were referred back to the rheumatologist after attending the surgeon only clinic ($p < 0.05$). The waiting time for surgery was similar in both groups.

TABLE I—Details of patients in the study (percentages in parentheses)

	Surgeon only clinic	Combined clinic
No	22	23
Age (years) (mean $\pm$ SD)	61.9 $\pm$ 9.3	60.2 $\pm$ 10.9
M:F ratio	3:18 (16)	6:17 (35)
Source of referral:		
Consultant	3 (13.6)	15 (65.2)
Registrar	17 (77.2)	7 (30.4)
Senior house officer	2 (9.1)	1 (4.3)
Diagnosis:		
Rheumatoid arthritis	15 (66.6)	22 (95.6)
Ankylosing spondylitis	2 (9.1)	1 (4.4)
Other	4 (17)	
Disease duration (years)	16.0 $\pm$ 10.2	13.0 $\pm$ 7.1
Time in presenting limb	6.4 $\pm$ 6.2	3.2 $\pm$ 2.8
Drugs:		
1st line	12 (54.5)	9 (39.1)
2nd line	7 (31.8)	12 (52.1)
3rd line	2 (9.1)	2 (8.7)
Presenting joint:		
Shoulder	10 (45.4)	9 (39.1)
Elbow	2 (9.1)	13 (56.6)
Hip	4 (18)	
Knee	4 (18)	1 (4.3)
Other	2 (9.1)	

TABLE II—Details of clinics (percentages in parentheses)

	Surgeon only clinic	Combined clinic
Waiting time to clinic appointment (weeks)	5.1 $\pm$ 3.2	5.7 $\pm$ 2.9
Length of interview (min)	12.2 $\pm$ 3.1	20.9 $\pm$ 9.1
Outcome of clinic:		
Waiting list for surgery	8 (35)	17 (72.7)
To be seen in orthopaedic clinic	3 (15)	2 (9.0)
To be seen in rheumatology clinic	10 (45)	3 (13.6)
Physiotherapy	1 (5)	1 (4.5)
Time to surgery (weeks)	15.3 $\pm$ 4.6	14.6 $\pm$ 2

Analysis of the surgeon's questionnaire (surgeon only clinic) showed that the presence of a rheumatologist would have been appreciated in 61% of interviews, but this was dependent principally on the surgeon's assessment of the referral letter. When the letter was considered to have insufficient information (53% of referrals) the rheumatologist would have been appreciated in all cases to provide details of drugs in 65% and general background or social information in 45%. Conversely, his presence would have been useful in only 29% of those interviews in which the letter was considered to be satisfactory to provide further information about the effects of previous drug prescription.

The rheumatologist's questionnaire showed that he thought that he

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contributed constructively during the interview in the combined clinic on 60% of occasions (details of drug prescription in 50% and general "background" details in the remainder). He could have predicted the surgeon's decision in 78% of cases and the requirement for surgery in 95% of cases. He correctly identified all patients that the surgeon thought required total joint replacement, but in four cases was surprised when the decision was for more minor surgery (excision radial head in three and synovectomy of the knee in one). One other patient was referred for physiotherapy only.

The educational value of the combined clinic was limited for both consultants. The physician indicated that he had learnt something new in 36% of interviews (details of surgical technique in 80% and indications for surgery in the remainder) and the surgeon had learnt something new in 23% of consultations (details of drug treatment in 85%). There was no correlation between the impressions of the two consultants about whether any one consultation was educationally valuable or not.

All of the patients who were seen in the combined clinic appreciated the presence of a physician, and none was intimidated by the large number of medical staff. Only 38% of patients who consulted the surgeon alone would have preferred that a rheumatologist was present.

Discussion

Combined orthopaedic and rheumatology clinics are widely held and are thought by many to be an efficient way of managing patients with complicated arthritic disease. Indeed attendance at such clinics is a requirement of some higher training programmes. Despite this our study is the only one that we know of that has investigated the efficacy of the combined approach. Unfortunately, subtle differences between the two groups of patients have made comparisons difficult. For example, the rheumatologist may have been able to persuade the surgeon to intervene in a larger number of cases than if he had been working alone. The larger proportion of patients on second and third line drugs, the greater number with elbow

problems (the surgeon having an interest in elbow surgery), and the larger proportion of consultant referrals, however, may also explain the higher incidence of surgery in the patients who attended the combined clinic.

The results of this pilot study show that the educational value of the combined clinic was limited for the consultants who took part, who were previously experienced in rheumatology and thought that the "learning curve" was relatively short. There is no doubt, however, that the combined clinic is popular with postgraduate doctors, and it improves lines of communication between physician and surgeon.

The outcome for most patients was similar in both clinics, with identical waiting times for surgery and an equal length of stay in hospital. The combined clinic was popular with patients but this may reflect the fact that patients tell doctors what they think they want to hear.

If, as the results of this small study indicate, the rheumatologist can predict the surgeon's decision in almost 80% of cases and the requirement for surgery in 95% then most of the patients could have been seen adequately and in a shorter time in a routine orthopaedic clinic as long as a satisfactory letter of referral was available.

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Clinical Algorithm

Management of Parkinson's disease

F B GIBBERD

Previous clinical algorithms on tremor and Parkinson's disease have considered the process by which the diagnosis of Parkinson's disease and its various subdivisions, such as postencephalitic and drug induced parkinsonism, are made.^{1,2} This algorithm concentrates on the management of Parkinson's disease. The algorithm is compiled for idiopathic Parkinson's disease, but other forms are managed in a similar way with the additional treatments that associated problems necessitate. The algorithm is divided into two parts, on non-drug management and on drug treatment. For ease of presentation the algorithm is shown as two diagrams but in practice the two would be used together so that social support and remedial therapy would occur in parallel with drug treatment.

Drug treatment: notes on the algorithm

(1) Drugs which exacerbate Parkinson's disease include the phenothiazines (for example, chlorpromazine), the butyrophenones (for example, haloperidol), and the thioxanthenes (for example, chlorprothixene). There is an antagonism between levodopa and pyridoxine, although this does not occur if a dopadecarboxylase inhibitor is also given.

(2) Several groups of drugs are used to treat Parkinson's disease.

Anticholinergic drugs—Used in the early stages of the disease anticholinergic drugs may delay the need to give levodopa drugs and hence be of clinical value, but in the late stages of the disease they should be used cautiously because they may impair memory or hasten dementia. The drugs include the following (see the *British National Formulary* for the precise formulations and dosages):

- benzhexol (Artane, Bentex, Broflex) up to 5 mg three times a day,
- orphenadrine (Biorphen, Disipal) up to 100 mg four times a day,
- benztropine (Cogentin) up to 2 mg three times a day,
- methixene (Tremonil) up to 10 mg three times a day,
- procyclidine (Arpicolin, Kemadrin) up to 10 mg three times a day.