Rheumatology in MSK

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Jack March I Rheumatology.Physio

Slides

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https://rheumatology.physio/courserheum

Who am I?

RHEUMATOLOGY.PHYSIO

Nuffield Health

CHEWS HEALTH

THE physio matters PODCAST

Other Resources

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TRUST ME ED

Why discuss Rheum in MSK?

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Some questions for you..?

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Recognition

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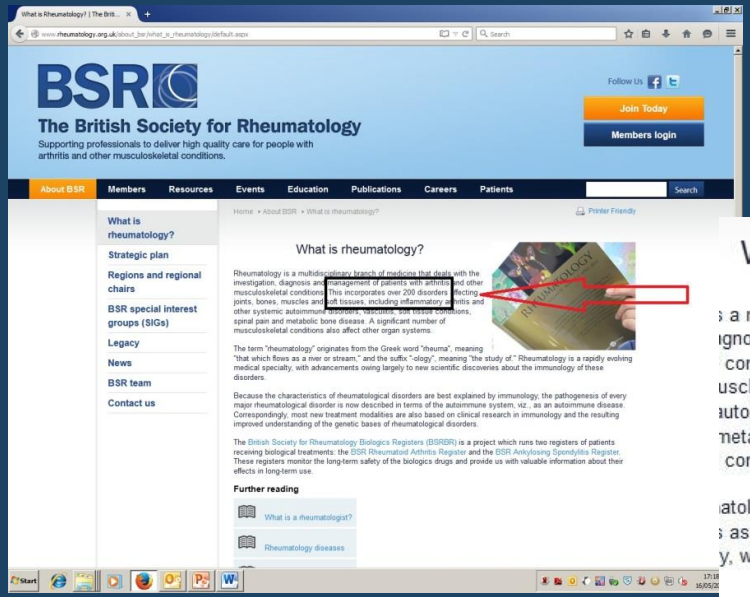

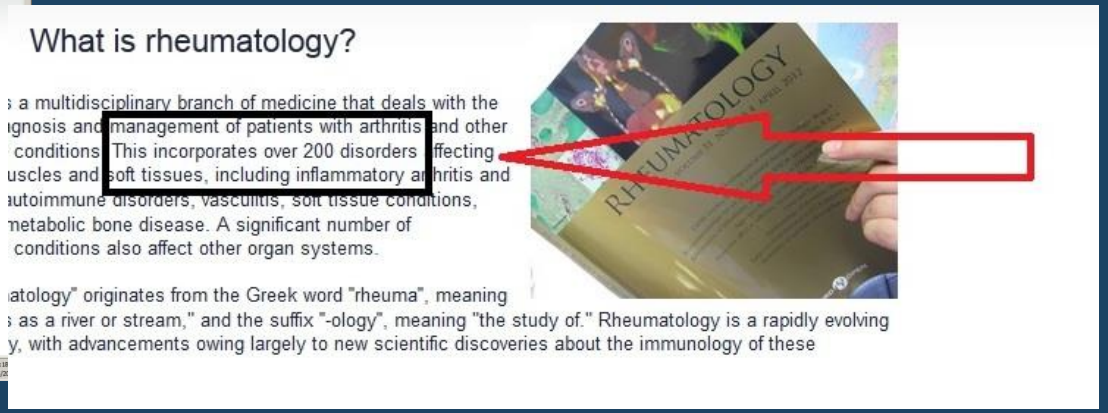

Conditions (Arthropathies)

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Rheumatoid arthritis

Spondyloarthritis

- Ankylosing spondylitis
- Psoriatic arthropathy
- Enteropathic spondylitis

Reactive arthritis

Juvenile Idiopathic Arthritis

Crystal arthropathy

Septic Arthritis

?

Conditions (Arthropathies)

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Conditions (CTDs)

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Lupus

Sjogrens

Scleroderma

Myositis (variants)

Mixed/undifferentiated

Hypermobility (variants)

Vasculitis

Giant Cell/Temporal Arteritis

?

Conditions (CTDs)

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Features of Inflammation

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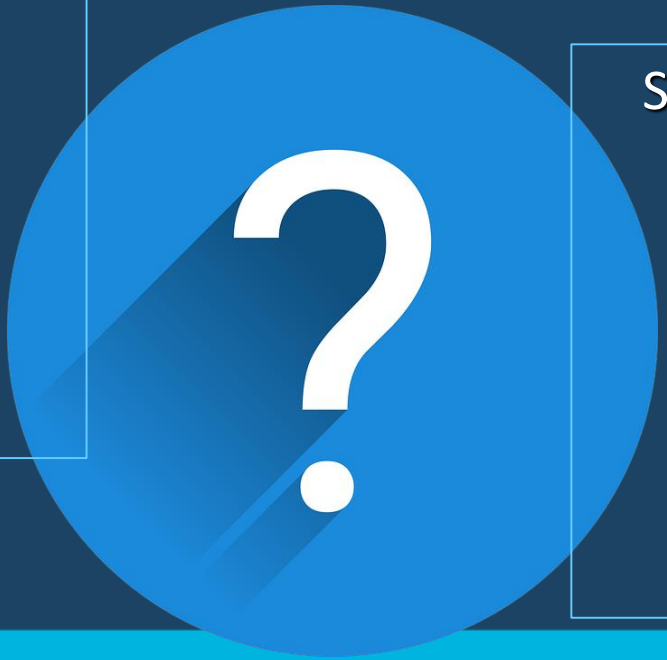
Heat

Redness

Swelling

PAIN



Stiffness (Early morning >30mins)

Night pain

Better with activity

Worse with rest

Better with anti-Inflammatories

Systemic Condition?

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Multiple systems

- Skin
- Eyes
- Gut
- Nails
- Enthesitis
- Dactylitis

Evidence of relevant:

- Past medical history
- Family History
- Concurrent conditions
- Onset

Specific conditions

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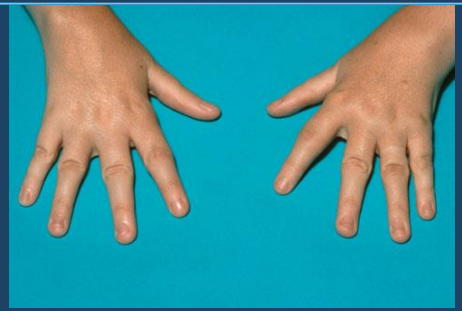
Psoriatic Arthritis

Spondyloarthritis

Rheumatoid Arthritis



Specific conditions

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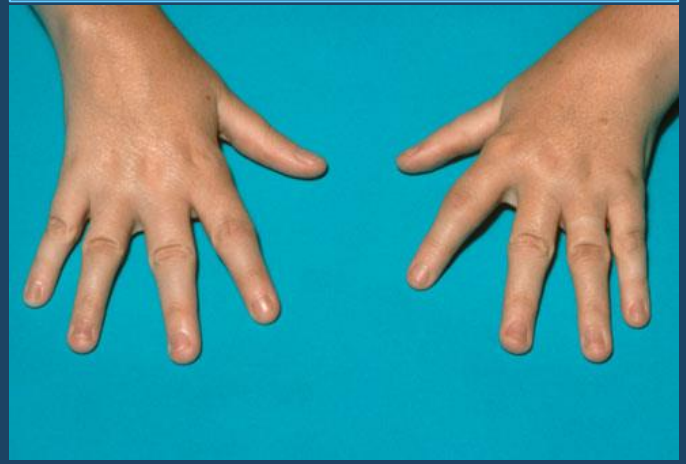
Rheumatoid Arthritis



A progressive, (symmetrical) form of autoimmune arthritis, usually involving the small joints of the hands and/or feet.

Multi-systemic, can affect the heart, lungs and eyes.

(NRAS website)

Specific conditions

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Rheumatoid Arthritis

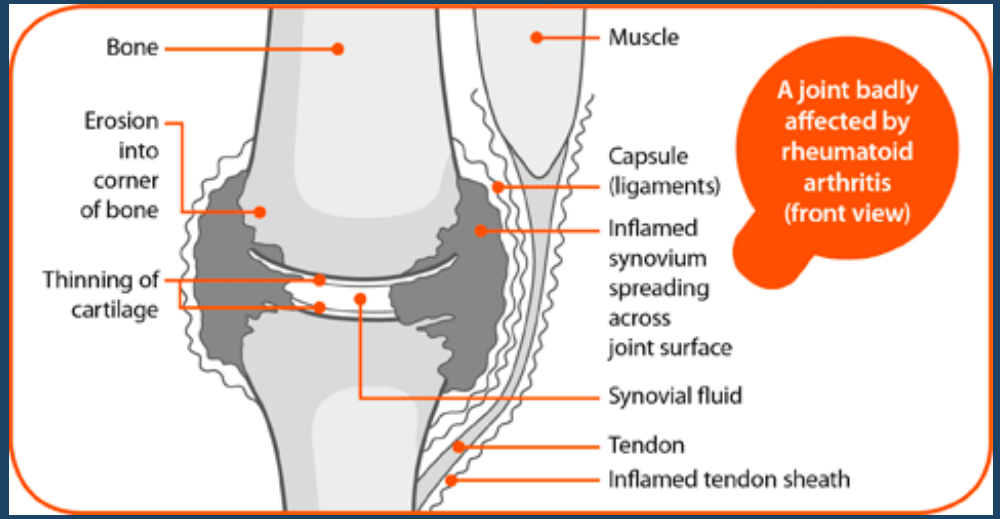

Image courtesy of ARUK

Specific conditions

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Diagnosing "Clinically Suspected Arthralgia"

1. Joint Symptoms of recent onset (<1 year)
2. MCPJs affected
3. Morning stiffness (>60 mins)
4. Symptoms worst in early morning
5. 1st degree relative with RA
6. Difficulty making a fist
7. Positive MCPJ or MTPJ squeeze test

A score of 3+/7 is consistent with "Clinically Suspected Arthralgia"

Advice for Physiotherapists Suspecting Rheumatoid Arthritis

Stage 1

Diagnosing "Clinically Suspected Arthralgia"[1]

1. Joint Symptoms of recent onset (<1 year)
2. MCPJs affected
3. Morning stiffness (>60 mins)
4. Symptoms worst in early morning
5. 1st degree relative with RA
6. Difficulty making a fist
7. Positive MCPJ or MTPJ squeeze test

A score of 3+/7 is consistent with "Clinically Suspected Arthralgia"[1]

Stage 2

Assessing level of risk (patient scores 3+ on above or clinician retains high suspicion)

Leiden Clinical Prediction Rule.[2]

1.	What is the age in years? Multiply by 0.02		_____
2.	What is the sex?		
	a. In case Female	1 point	_____
3.	What is the distribution of involved joints?		
	a. In case small joints hands/feet:	0.5 point	_____
	b. In case symmetric	0.5 point	_____
	c. In case upper extremities	1 point	_____
	d. In case upper and lower extremities	1.5 points	_____
4.	What is the score for morning stiffness on a 100-mm VAS?		
	a. In case 26-90 mm	1 point	_____
	b. In case >90mm	2 points	_____
5.	What is the number of tender joints?		
	a. In case 4-10	0.5 points	_____
	b. In case 11 or higher	1 point	_____
6.	What is the number of swollen joints?		
	a. In case 4-10	0.5 points	_____
	b. In case 11 or higher	1 point	_____
7.	What is the C-reactive protein level?		
	a. In case 5-50 mg/litre	0.5 points	_____
	b. In case 51 mg/lire or higher	1.5 points	_____
8.	Is the patient Rheumatoid Factor positive?		
	a. If yes	1 point	_____
9.	Are the anti-CCP antibodies positive?		
	a. If yes	2 points	
		Total score	_____

A score of 9+ is optimal prediction, 8+ is high risk.[3]

Stage 3

Clinical application.

If clinically suspected Arthralgia is present and/or score of 8+ on Leiden CPR further investigations are warranted.

If clinician retains suspicion but above scores are not met due to lack of investigations completed or other reasoning commence further investigations.

Proceeding in presence of suspected RA risk

1. Referral to Rheumatology must be completed as a matter of priority before requesting any other investigations.
   a. Discuss with local Rheumatology department regarding procedure/access.

2. If able request following investigations
   a. C-Reactive Protein blood test
   b. ESR blood test
   c. Rheumatoid Factor blood test
   d. Anti-CCP blood test

Stage 4

Advise patient on modifiable risk factors. These can reduce likelihood of progression to RA
   a. Smoking
   b. BMI
   c. Diet

Note

Differential Diagnoses – other conditions can masquerade similar to Rheumatoid Arthritis. These may have differing onset, associated symptoms/conditions and presentations.

Gout, Other inflammatory arthropathy (Psoriatic Arthritis, Lupus, Axial Spondyloarthropathy, Reactive Arthropathy), Osteoarthritis, Persistent pain conditions.

This document is a guide only , it should not replace clinical reasoning or judgement. If unsure seek further advice as appropriate.

References

1. van Steenbergen et al. EULAR definition of arthralgia suspicious for progression to rheumatoid arthritis. Ann Rheum Dis 2017;76:491–496.

2. van der Helm-van Mil et al. A Prediction Rule for Disease Outcome in Patients With Recent Onset Undifferentiated Arthritis. ARTHRITIS & RHEUMATISM 2017 56(2):433–440

3. Mcnally et al. Diagnostic accuracy of a clinical prediction rule (CPR) for identifying patients with recent-onset undifferentiated arthritis who are at a high risk of developing rheumatoid arthritis: A systematic review and meta-analysis. Seminars in Arthritis and Rheumatism 2014 43:498–507

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What to do?

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- Priority 1 - RHEUMATOLOGY

- Bloods – ESR, CRP, Anti-CCP, RF
- U/S
- Advice

Stage 4

Advise patient on modifiable risk factors. These can reduce likelihood of progression to RA

a. Smoking
b. BMI
c. Diet

Differential Diagnosis

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Differential Diagnosis

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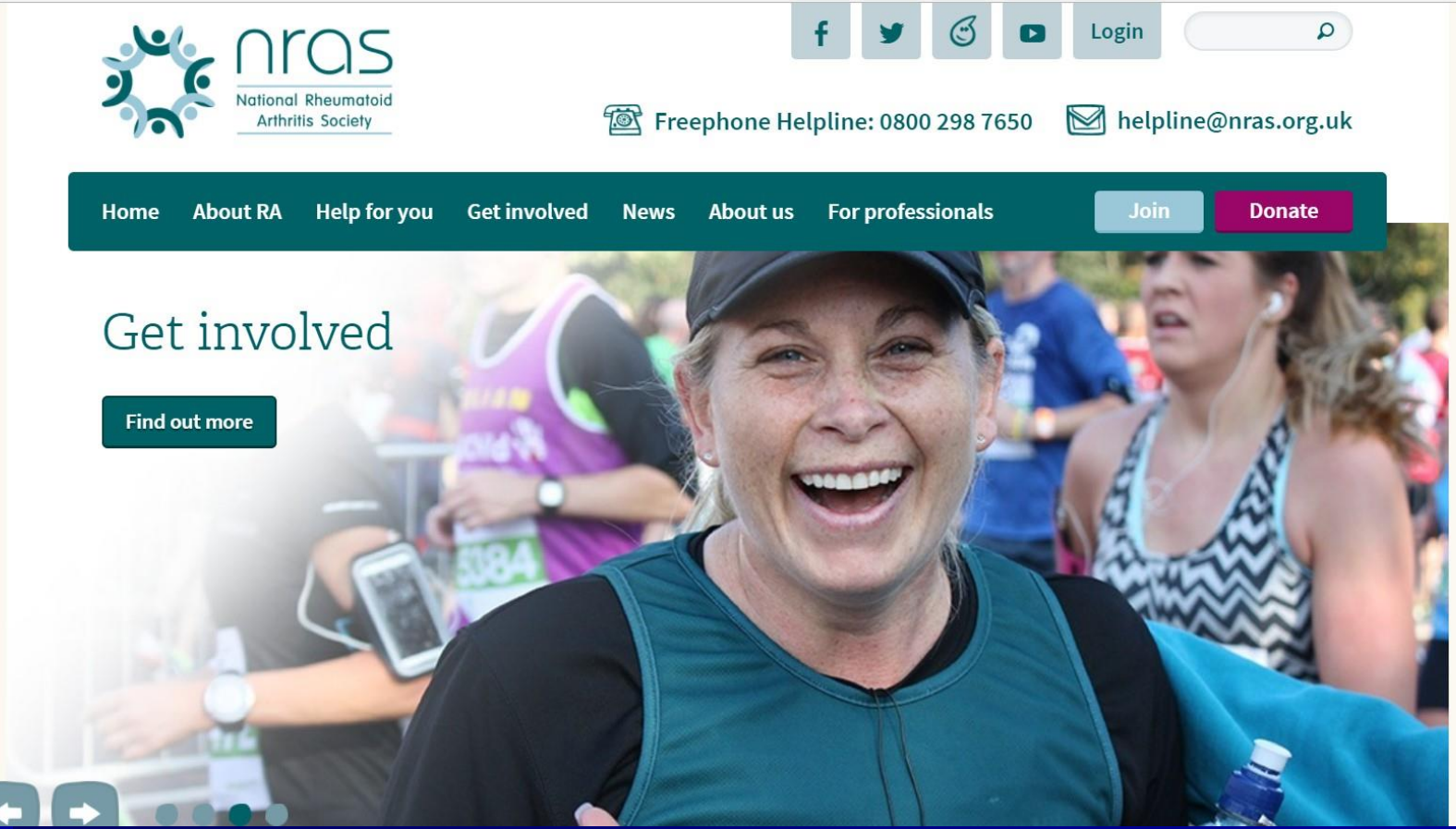
- Gout
- Other Inflammatory Arthropathy (PsA, AxSpA, Lupus, Reactive Arthritis)
- Osteoarthritis
- Persistent pain conditions
- Ca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Specific conditions

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Spondyloarthritis

A painful, progressive form of inflammatory arthritis. It mainly affects the spine but can also affect other joints, tendons, ligaments, eyes and bowels.

(NASS website)

Inflammatory Back Pain

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- Stiffness
- Nocturnal pattern
- Better with activity/worse with rest
- Onset. Insidious <45
- Improvement with anti-inflammatories

Extra articulars

- Psoriasis
- Inflammatory Bowel Disease
- Uveitis
- Crohns/colitis
- Dactylitis
- Enthesitis

- Fibromyalgia

Eyes/Fingers…

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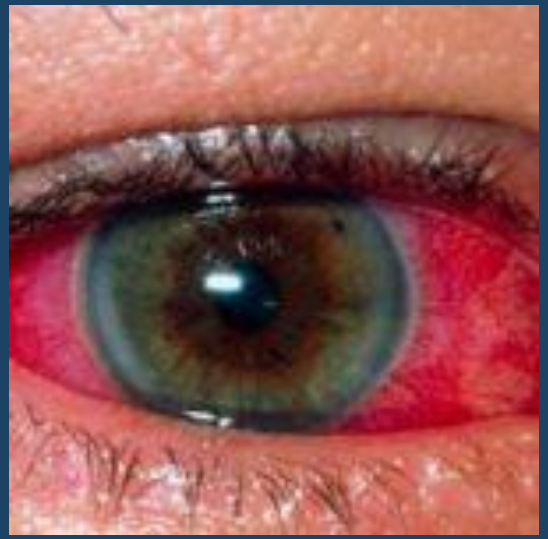

SCREEND'EM
BEFORE YOU TREAT'EM

A clinical tool to help identify spondyloarthropathy (SpA) in patients with tendinopathy.

SKIN

6-42% of patients with psoriasis develop psoriatic arthritis.

COLITIS OR CHROHN'S

Arthritis is one of the most common extra-intestinal manifestations of inflammatory bowel disease. The prevalence of SpA in patients with Chrohn's is estimated to be 26% at 6 year follow up.

RELATIVES

There is a strong relationship between SpA and HLA-B27 positive patients.

Family members of patients with SpA who are HLA-B27 positive have a 16-fold increase chance of developing ankylosing spondylitis if they are also HLA-B27 positive.

EYES

Acute anterior uveitis (AAU) can cause a painful, red eye with photophobia and blurred vision. 40% of patients presenting with idiopathic AAU have undiagnosed SpA. 50% of patients with AAU are HLA-B27 positive and >50% of these have SpA.

EARLY MORNING STIFFNESS

Inactivity related stiffness that lasts for more than 30 minutes is suggestive of inflammatory disease.

NAILS

Nail lesions occur in 87% of SpA patients and include:

- small depressions in the nail (pitting)
- thickening of the nails
- painless detachment from the nail bed (onchylosis).

DACTYLITIS

Sausage like swelling of the digits is a hallmark sign of psoriatic arthritis, occuring in 50% of cases.

ENTHESITIS

98% of SpA patients have at least one abnormal enthesis. The most common sites are the Achilles tendon, plantar fascia and patellar tendon.

MOVEMENT & MEDICATION EFFECT

SpA patients report improvement with activity but not with rest, and a favourable response to NSAIDs.

Created by Paul Kirwan

@pdkirwan

ISBN/EAN: 978-90-75823-92-9, d18 page 32

THE KNEE RESOURCE

designed by freepik.com

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Thanks to:
Paul Kirwan
@pdkirwan

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RUNNINGPHYSIO
BETTER. FASTER. STRONGER

Name..... Date of Birth.....Date.....

Tendon Health Questionnaire

Tendon health can be influenced by a host of different factors. Please spend a few minutes completing this questionnaire so we can use the information to help form the best treatment plan for you.

Please tick any boxes that apply to you then your therapist will discuss this with you in more detail;

Past medical history

Have you or any member of your immediate family had any history of the following?

Ankylosing Spondylitis ☐ Psoriasis or Psoriatic arthritis ☐ Rheumatoid Arthritis ☐ Thyroid problems ☐
Inflammatory bowel disease ☐ Crohn's ☐ Diverticulitis ☐ Diabetes ☐ Previous history of tendon pain ☐

Medication

Have you taken any of the following medications in the last year? Please provide the names if known;

Antibiotics ☐ Statins ☐ Steroids ☐ Medication names.....

General Health

Height ..... Weight..... BMI (if known).....

Have you had any of the following symptoms in the last year?

Early morning stiffness ☐ Red, hot swollen joints ☐ Eye problems (redness, pain, blurred vision) ☐
Changes to your skin or nails (rashes, nail pitting, thickening or colour changes) ☐ Back or buttock pain ☐

Any history of stress, anxiety, or depression? Yes ☐ No ☐

Mental well being at present - please tick which best applies to you;

I am not anxious, stressed or depressed ☐
I am moderately anxious, stressed or depressed ☐
I am extremely anxious, stressed or depressed ☐

On average, how many hours sleep do you get per night?..... Do you wake feeling refreshed? Yes ☐ No ☐

Do you have raised cholesterol? Yes ☐ No ☐ or high blood pressure? Yes ☐ No ☐
Are you approaching the menopause? Yes ☐ No ☐
Are you a smoker ☐ Ex-smoker ☐ or non-smoker ☐ (please tick as appropriate)

Do you worry about causing lasting damage to your tendon?
Please tick one answer that best applies to you at present;

Never ☐ Seldom ☐ Quite often ☐ Very often ☐ Always ☐

Thank you for completing this form!

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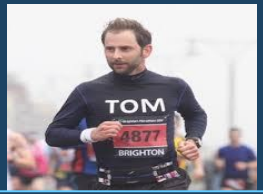

Thanks to:
Tom Goom @tomgoom

www.running-physio.com/tendonq/

What to do?

RHEUMATOLOGY.PHYSIO

- Priority 1 - RHEUMATOLOGY

- Bloods – ESR, CRP, HLA-B27
- MRI (SpA protocol)
- Anti-Inflammatories?

MRI protocol

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- Whole spine and SIJs
- Sagittal T1 and STIR
- Talk to your Radiology department!

Example MRI referral – Suspected Spondyloarthritis, coronal images of SIJs, sagittal images of whole spine, please include T1 and STIR sequences.

Differential Diagnosis

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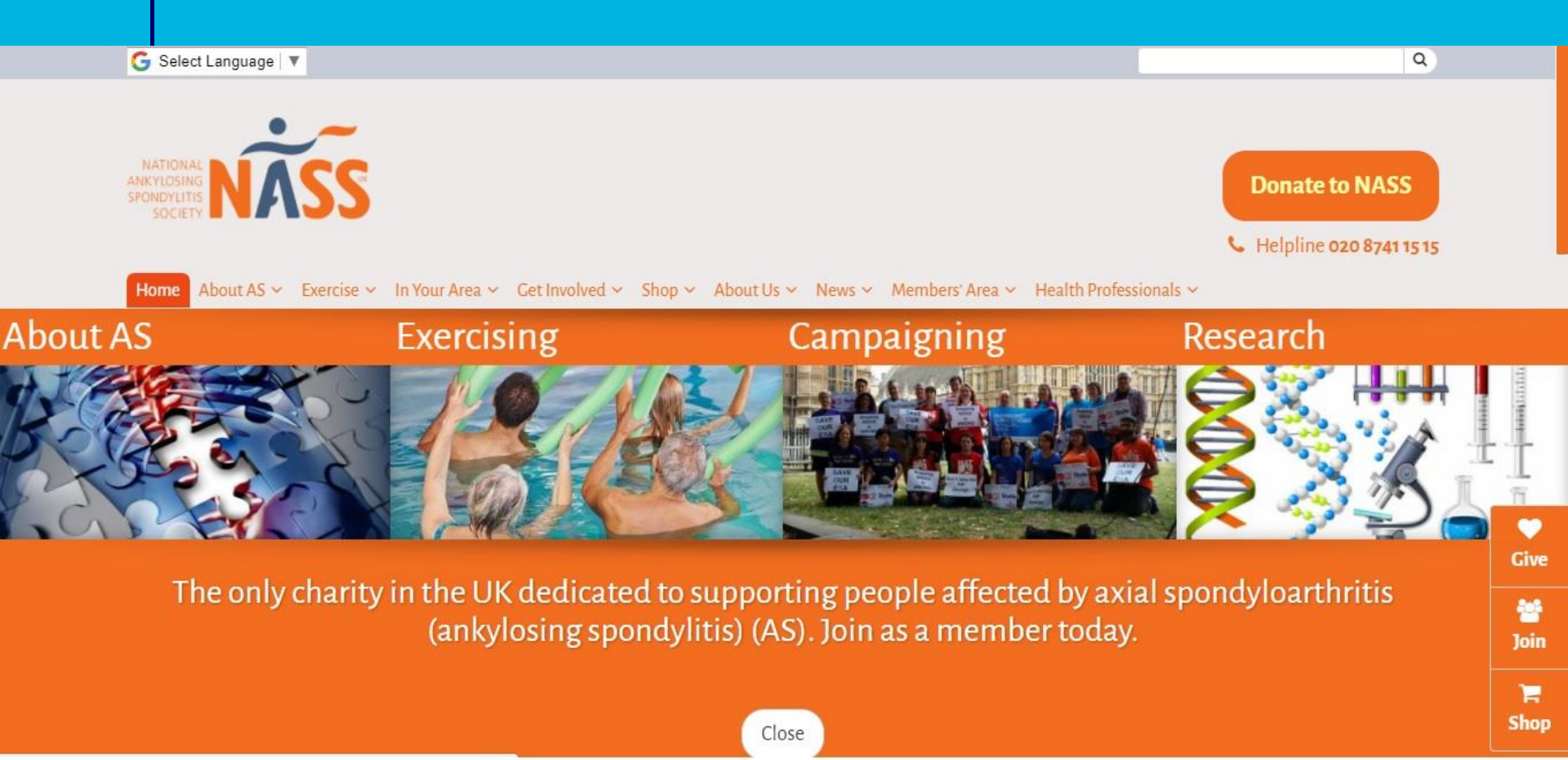
DDx

- DISH
- Back pain (non specific…)
- Vertebral Fracture
- Reactive arthritis (gastroenteritis etc)
- IBD related (crohns, ulcerative colitis)
- Discitis
- Boney metastasis
- Pagets (SIJ fusion)
- Osteitis Condensans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Coffee…

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Specific conditions

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Psoriatic Arthritis

Inflammatory joint disease associated with Psoriasis (Ps)

Prevalence in Ps population is c. 30%

https://www.psoriatic-arthritis.co.uk/

A proportion will have arthropathy symptoms prior to skin involvement… (15-20%)

Extra articulars

RHEUMATOLOGY.PHYSIO

- Current, history or family history Psoriasis
- Nail pitting
- Dactylitis
- Inflammatory back pain
- Enthesitis

Nails…

RHEUMATOLOGY.PHYSIO

Nails…

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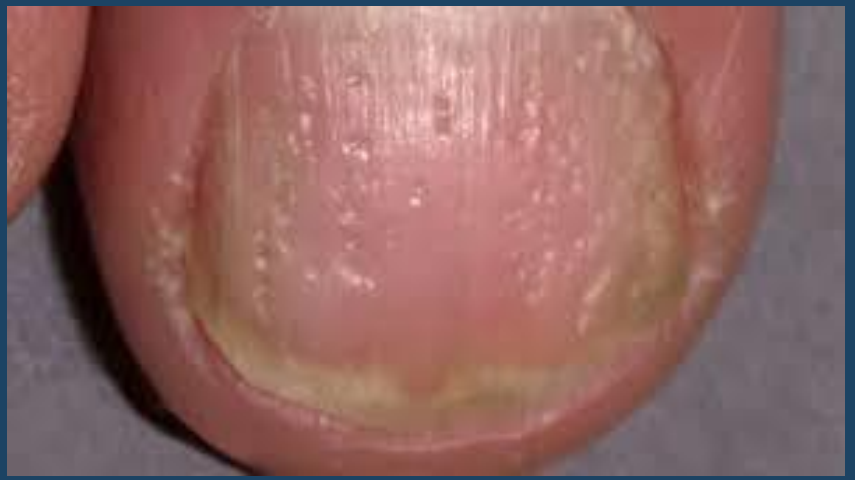

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Thanks to:
Paul Kirwan
@pdkirwan

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What to do?

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- Priority 1 – RHEUMATOLOGY

- Bloods – ESR, CRP, RF*, (HLA-B27**)
- MRI/ultrasound
- Anti-Inflammatories?
- Dermatology?

* -ve 87%

** 50-60%

Case study time

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Specific conditions

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Gout/Pseudogout

- Sudden onset often at night
- Swelling, heat, redness, pain peaking after a few hours
- Attack lasts a few days then settles
- 1/14 men (anytime after puberty), 1/35 women (uncommon before menopause)
- Risk factors, BMI (especially abdominal), alcohol (especially beer ☹), FH, DM, vascular conditions (MI, Stroke, high BP, PVD, high cholesterol)

Specific conditions

RHEUMATOLOGY.PHYSIO

Fibromyalgia

Specific conditions

RHEUMATOLOGY.PHYSIO

Fibromyalgia

Table 3
Fibromyalgia criteria—2016 revision

Criteria

A patient satisfies modified 2016 fibromyalgia criteria if the following 3 conditions are met:

(1) Widespread pain index (WPI) $\geq$ 7 and symptom severity scale (SSS) score $\geq$ 5 OR WPI of 4–6 and SSS score $\geq$ 9.

(2) Generalized pain, defined as pain in at least 4 of 5 regions, must be present. Jaw, chest, and abdominal pain are not included in generalized pain definition.

(3) Symptoms have been generally present for at least 3 months.

(4) A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses.

Specific conditions

RHEUMATOLOGY.PHYSIO

Fibromyalgia

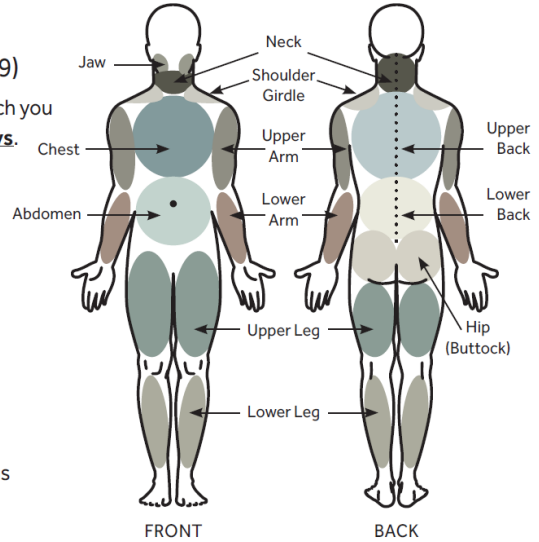
Widespread Pain Index (WPI)

(1 point per check box; score range: 1–19)

Please check the boxes below for each area in which you have had pain or tenderness **during the past 7 days**.

- ☐ Shoulder girdle, left
- ☐ Shoulder girdle, right
- ☐ Upper arm, left
- ☐ Upper arm, right
- ☐ Lower arm, left
- ☐ Lower arm, right
- ☐ Hip (buttock) left
- ☐ Hip (buttock) right
- ☐ Upper leg left
- ☐ Upper leg right
- ☐ Lower leg left
- ☐ Lower leg right
- ☐ Jaw left
- ☐ Jaw right
- ☐ Chest
- ☐ Abdomen
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ None of these areas

WPI score: _____



Specific conditions

RHEUMATOLOGY.PHYSIO

Fibromyalgia

Symptom Severity (score range: 1–12)

For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

	No problem	Slight or mild problem	Moderate problem	Severe problem
Points	0	1	2	3
A. Fatigue	☐	☐	☐	☐
B. Trougle thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed	☐	☐	☐	☐

During the **past 6 months** have you had any of the following symptoms?

	Points	0	1
A. Pain or cramps in lower abdomen		☐ No	☐ Yes
B. Depression		☐ No	☐ Yes
C. Headache		☐ No	☐ Yes

SS score: _____

Specific conditions

Osteoporosis

- Incidence increases with age
- Uncommon prior to age 50
- 2:1 Female:Male

Osteopenia

- Over 1/3 women and 1/5 men will sustain a fragility fracture in their lifetime
- At age 75-84 the absolute 10 year risk for sustaining a fragility fracture is approx. 24% for women and 14% for men.

Specific conditions

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Osteoporosis

- Early menopause
- Low BMI
- Crohns/colitis/IBD
- Inflammatory Arthropathies
- Smoking/high alcohol intake
- Eating disorders or food intolerances
- Cancer

- Parental fractured neck of femur
- Osteoporosis

- RED-S (Relative Energy Deficiency in Sport

Specific conditions

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Osteoporosis

- FRAX
- DXA scan

Mostly GP managed, Rheum for biologics

Physio for loading program

Case study time

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Assessment

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- Subjective
- Objective
- Ongoing Monitoring

- Aims and Objectives of treatment

Assessment

- Subjective
  - Disease control
  - Function
  - Sleep
  - Mental health
  - Understanding
  - Goals

Assessment

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- Objective
  - Range of motion
  - General conditioning
  - Functional tasks
  - Specific joint assessment*

Assessment

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- Ongoing monitoring
  - Bath indices yearly
  - QRisk yearly
  - FRAX 5 years*

Treatment

- Specific management
- Guidelines
- Signposting

Specific conditions

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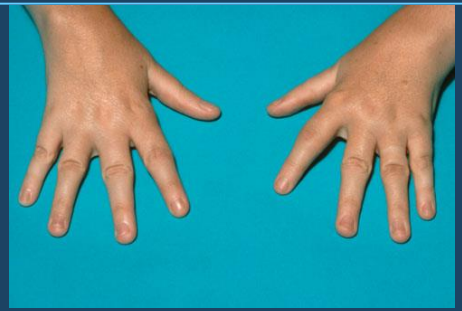
Psoriatic Arthritis

Spondyloarthropathy

Rheumatoid Arthritis



Specific conditions

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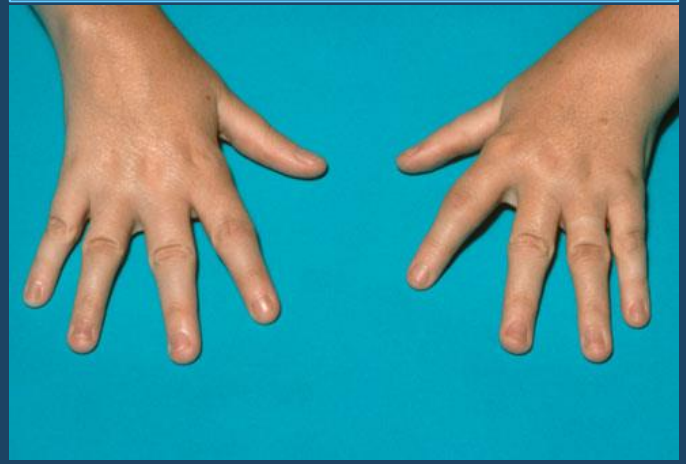
Rheumatoid Arthritis



A progressive, (symmetrical) form of autoimmune arthritis, usually involving the small joints of the hands and/or feet.

Multi-systemic, can affect the heart, lungs and eyes.

(NRAS website)

dance)

and one or more DMARDs. (B)

(12) Patients with RA require early assessment of sleep patterns. (A). Early management of sleep disturbance should include tricyclic agents, behavioural therapy and exercise. (B). Consider the impact of fatigue on quality of life in early RA. (B)

(13) Evidence for effectiveness of complementary therapy is conflicting. (B)

(14) Timing and format (group/individual/written) of education to meet individual needs should be considered. (A). Patients should be offered a cognitive behavioural approach to patient education, delivered at the appropriate time, to promote long-term adherence to management strategies (C). Patients should be helped to contact support organizations such as the National Rheumatoid Arthritis Society (NRAS), Arthritis Care (AC) and the Arthritis Research Campaign (ARC). (B)

(15) Patients should be encouraged to pace activities and recognize the limits of physical activity, facilitating a realistic readjustment of expectations. Patients should be helped to participate in exercise programmes. (C)

(16) Aerobic exercise should be encouraged to help combat the effects of RA on muscle strength, endurance and aerobic capacity, without, in the short-term, exacerbating disease activity or joint destruction. (B)

(17) Hydrotherapy should be accessible to maximize positive effects on pain, function and self-efficacy. (C)

lack standardization. (C)

(19) Heat and cold applications may provide short-term symptomatic relief of pain and stiffness, but there is no grade of recommendation of long-lasting benefit. Paraffin wax baths and exercise are beneficial for hands in arthritic conditions. (C)

RHEUMATOLOGY.PHYSIO

Targets for treating

RHEUMATOLOGY.PHYSIO

Targets for treating

RHEUMATOLOGY.PHYSIO

Hand based treatment is suggested for all diagnosed.

Development and delivery of an exercise intervention for rheumatoid arthritis: Strengthening and stretching for rheumatoid arthritis of the hand (SARAH) trial

Heine, P.J. et al.

Physiotherapy , Volume 98 , Issue 2 , 121 - 130

Table 3
SARAH exercise programme.

	Exercise	Frequency	Sets	Repetitions	Initial Hold	Initial Load	Progression
Mobility	MCP flexion	Daily	1	x 5	5 seconds (where required)	-	Step 1: Increase up to 10 repetitions Step 2: Increase up to 10 second holds
	Tendon gliding						
	Finger radial walking						
	Wrist circumduction						
	Finger abduction						
	Hand-behind-head						
	Hand-behind-back						
Strength	Eccentric wrist extension	Daily	1	x 10 (minimum 8 repetitions; maximum 12 repetitions)	-	between 3 to 4 on modified 10 pt Borg Scale	Step 1: 2 x 10 repetitions Step 2: 4 - 5 on Borg Scale Step 3: 5 - 6 on Borg Scale Step 4: 3 x 10 repetitions
	Gross grip						
	Finger adduction						
	Pinch grip						

MCP flexion

Finger abduction

Tendon gliding

Wrist circumduction

Combined shoulder & elbow ROM

Radial walking

Eccentric wrist extension

Finger pinch

Gross grip

Finger adduction

RHEUMATOLOGY.PHYSIO

Joint dysfunction related to Rheumatoid Arthritis

JACK MARCH BSc (Hons) MCSP
Clinical Lead, Chews Health Rheumatology Clinic

Rheumatoid Arthritis (RA) can have a seriously deleterious effect on joint function and, while medical advances have made good strides in improving function and quality of life over the long term, for people diagnosed, management of these dysfunctions remains a necessity. Physiotherapists can play a pivotal role in providing education and interventions to manage joint dysfunction as part of the multidisciplinary team.

LEARNING OUTCOMES
TO SUPPORT PHYSIO FIRST QAP

1 Overview and characteristics of Rheumatoid Arthritis.
2 The impact of Rheumatoid Arthritis on joint function.
3 Physiotherapy management.
4 Practical considerations.

a common association. Previously, it was thought that ulnar drifted metacarpal phalangeal joints (MCPJs) and large joint replacements at a young age were an inevitability. Advances in management from our medical colleagues, with earlier interventions and more efficacious medications, means that this is no longer the case for many, if not most, of those newly diagnosed with RA.

management strategies that will benefit their joint function, RA management and general health in the long term.

Overview and characteristics of Rheumatoid Arthritis

RA is a chronic inflammatory disease characterised by joint swelling, joint tenderness and destruction of synovial joints (figures 1 and 2), leading to severe disability and premature

Specific conditions

RHEUMATOLOGY.PHYSIO

Spondyloarthropathy

A painful, progressive form of inflammatory arthritis. It mainly affects the spine but can also affect other joints, tendons, ligaments, eyes and bowels.

(NASS website)

1.5 *Non-pharmacological management of spondyloarthritis*

1.5.1 Refer people with axial spondyloarthritis to a specialist physiotherapist to start an individualised, structured exercise programme, which should include:

- stretching, strengthening and postural exercises
- deep breathing
- spinal extension
- range of motion exercises for the lumbar, thoracic and cervical sections of the spine
- aerobic exercise.

1.5.2 Consider hydrotherapy as an adjunctive therapy to manage pain and maintain or improve function for people with axial spondyloarthritis.

1.5.3 Consider a referral to a specialist therapist (such as a physiotherapist, occupational therapist, hand therapist, orthotist or podiatrist) for people with spondyloarthritis who have difficulties with any of their everyday activities. The specialist therapist should:

- assess people's needs
- provide advice about physical aids
- arrange periodic reviews to assess people's changing needs.

Targets for treating

RHEUMATOLOGY.PHYSIO

Specific conditions

RHEUMATOLOGY.PHYSIO

Psoriatic Arthritis

Inflammatory joint disease associated with Psoriasis (Ps)

Prevalence in Ps population is c. 30%

https://www.psoriatic-arthritis.co.uk/

A proportion will have arthropathy symptoms prior to skin involvement… (15-20%)

1.5 *Non-pharmacological management of spondyloarthritis*

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- assess people's needs
- provide advice about physical aids
- arrange periodic reviews to assess people's changing needs.

Targets for treating

RHEUMATOLOGY.PHYSIO

Treatment

RHEUMATOLOGY.PHYSIO

Acknowledgement of co-morbidities

- Depression (30%)
- Obesity (>RA + >gen pop)
- Smoking

Treatment

RHEUMATOLOGY.PHYSIO

- Plan
- Holistic
- Global
- Specific
- Reassuring

Holistic

- Sleep
- Smoking
- Positioning
- Education

Global

- General fitness
- Proximal and Peripheral
- Meaningful

Specific

- Task Specific
- Patient load specific
- Sufficient

Table 3
SARAH exercise programme.

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	Gross grip						
	Finger adduction						
	Pinch grip						

Reassuring

- Reasoning
- Promote robustness

Target Based Treatment

RHEUMATOLOGY.PHYSIO

- Acupuncture/Dry needling etc.
- Manual Therapy etc.
- Electrotherapy etc.

Signposting

RHEUMATOLOGY.PHYSIO

Select Language

NATIONAL ANKYLOSING SPONDYLITIS SOCIETY NASS

Donate to NASS

Helpline 020 8741 15 15

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About AS

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Research

The only charity in the UK dedicated to supporting people affected by axial spondyloarthritis (ankylosing spondylitis) (AS). Join as a member today.

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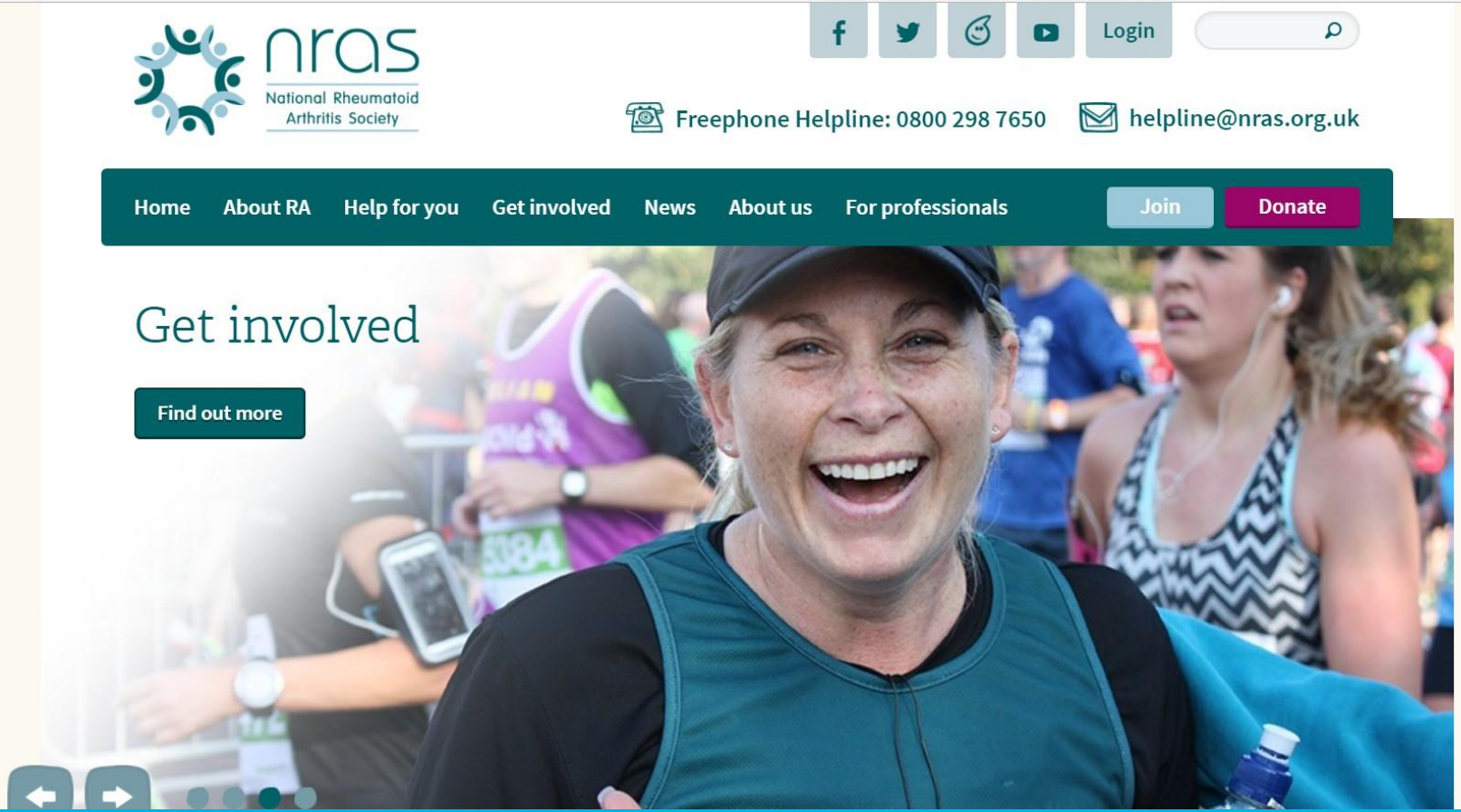
NASS.co.uk

Rheumatology.Physio


nras
National Rheumatoid Arthritis Society
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Freephone Helpline: 0800 298 7650
helpline@nras.org.uk
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Donate
Get involved
Find out more
NRAS.org.uk

Case study time

RHEUMATOLOGY.PHYSIO

Take home messages

RHEUMATOLOGY.PHYSIO

- Be vigilant for inflammatory symptomology
- Get friendly with your Rheumy
- Get friendly with your Radiologist

Thank you

RHEUMATOLOGY.PHYSIO