

# Preface

## Providing Rheum with a View



Brian F. Mandell, MD, PhD, MACR, MACP  
*Editor*

Providing care for the population of patients with rheumatic and musculoskeletal diseases in the United States is problematic and likely to become even more so over the next decade. Approximately a third of hospital discharges and 20% of office visits include a musculoskeletal diagnosis. These are common disorders, common yet with enormous heterogeneity and varied complexity. The breadth of rheumatic disease and related symptoms of patients wandering into an internist's office is staggering. Rheumatic diseases do not afford physicians the common courtesy of targeting a single organ. Instead, they often present as a box of jigsaw puzzle pieces without the picture of the completed puzzle on the box cover. And the symptoms overlap enormously. Patients with necrotizing myositis, systemic lupus, aortitis, and fibromyalgia all may voice the complaint of fatigue and a general sense of weakness and some degree of musculoskeletal pain. Teasing these syndromes apart is not always easy and most certainly is not made easier by indiscriminate testing using "autoimmune" serologies. The diagnosis of rheumatic syndromes is most reliably made based on the clinical history and physical examination, which then may be supported (sometimes refuted) by laboratory tests. This approach, to be successful, takes time for reflection and clinical acumen with good judgment. The former to most of us is a luxury that we do not have, and the latter obviously only is acquired over time with reflection. Thus is the problematic nature of caring for patients with rheumatic disease.

Rheumatologists with focused experience and training (but also often not enough time) provide the backup of specialty care. But the shortage of rheumatologists in the United States has been estimated to be >4000 full-time equivalent by the year 2030. So, despite the rapidly expanding understanding of pathophysiology, the linked explosion of new effective molecular targeted therapies, emphasis on early recognition and precise diagnosis of patients, there is already an evident gap in clinicians able to navigate this landscape. Successful management of patients with rheumatic disease is dependent upon the skill and knowledge of internists and other primary care clinicians

to provide initial care and appropriate referral to subspecialists when needed. Just as important is the shared responsibility by specialists and primary care providers to provide ongoing care of patients with their many comorbidities (eg, increased cancer risks, drug- and disease-associated complications, need for bone and infection prophylaxis).

I have gathered in this issue a group of clinicians highly skilled in the management and treatment of particular rheumatic conditions. But more importantly, they all have a passion and gift for sharing their experience and expertise with others with the hope of improving the care of patients with rheumatic diseases. I have asked them not to write introductory topic reviews, but to offer their practical, evidence- AND experience-based approach to their topics, directed to practicing clinicians. They have graciously volunteered their time to do so, and I thank them.

I sincerely hope that you find the material presented in this issue to be of value to you and to your patients.

Brian F. Mandell, MD, PhD, MACR, MACP  
Department Rheumatologic and  
Immunologic Diseases  
Cleveland Clinic Lerner College of Medicine  
at Case Western Reserve University  
Cleveland Clinic  
9500 Euclid Avenue A50  
Cleveland, OH 44195, USA

*E-mail address:*

[MANDELB@ccf.org](mailto:MANDELB@ccf.org)