

Preface

It is our pleasure to introduce an exciting new textbook that provides a much-needed and different perspective on rheumatology. Our outstanding contributors have put in a lot of effort and thought delving into the aging process per se, the older population, and how they affect the future of rheumatology.

Let face it, our patient population is aging. Although patients over 65 years of age still compose around 15% of the total population, they are consuming about 50% of rheumatology resources. Innovative ways of doing research, patient care, education, and policy need to be addressed in order to improve quality of care, patient satisfaction, and the safety of our older population.

Multi-disciplinary teams have always been the hallmark of geriatrics but they are cost-prohibitive in times of healthcare system reforms and social changes. As the age of retirement increases, it is crucial to keep the older patient with rheumatic conditions functional or – even better – active in the work force. We invite you to continue thinking in new terms and adapt to their needs, considering new models that are economically sustainable.

Patients with rheumatic diseases are getting older and attaining closer-to-normal population life expectancies. On the other hand, patients *without* rheumatic diseases are living longer too, thanks to improved therapies and advances in public health. This allows the development of a variety of elderly onset rheumatic diseases with often atypical presentations. Furthermore, immunosenescence complicates the geriatric rheumatology panorama with a combination of suppressed immune responses, low-grade chronic inflammatory reactions (also called *inflamm-aging*), and clinically non-significant autoantibodies that raise questions and puzzle even the more reputable experts. Moreover, uncontrolled inflammatory autoimmune conditions accelerate atherosclerosis and may give the false impression of an equally accelerated intrinsic aging, since morbidity and aging both decrease the physiological reserves.

Older patients present to rheumatologists with a milieu of baseline co-morbidities. This fact has highlighted the need to group rheumatologic with non-rheumatologic diseases such as diabetes, hypertension, atrial fibrillation, and cardiovascular diseases in the future. For example, it is starkly different to treat a patient with polymyalgia rheumatica and uncontrolled diabetes than a patient without diabetes. Until older rheumatic disease patients with multiple co-morbid conditions are included in clinical trials, it will be impossible to have high quality evidence-based treatment guidelines for the older arthritis patients.

Different specialists have created a pharmacological vicious cycle by prescribing increasingly more medications; once the number of medications reaches the double digits, sophisticated drug inventory management techniques may be required. Older patients are known to have voluntary or involuntary compliance problems; drug cost, dementia, and visual problems are the main issues. Medications are justified but at times, they are not withdrawn promptly when the acute problem subsides, creating a list of necessary and unnecessary medications. As a consequence, the cycle is closed by a new round of problems attributed to medications, such as peptic ulcer disease (due to nonsteroidal anti-inflammatory agents [NSAIDs]), gastrointestinal bleeding (due to medications interacting with Coumadin), falls with fractures

(due to narcotics or psychotropic medications), infections (due to immunosuppressive therapy), or heart diseases (related to NSAIDs or anti-TNF [tumor necrosis factor] agents).

The cache of biological therapies available to rheumatologists is ever expanding. Simultaneously, they are creating reactivation of old diseases (such as fungal invasive infections and tuberculosis or herpes zoster), malignancies such as lymphoma, or new autoimmune diseases (drug-induced lupus). Surveillance, vaccination, and early diagnosis are becoming the rule rather than the exception. The question rheumatologists constantly face is whether to be aggressive or more conservative when treating the older patient. The focus of elder care is on cure (if possible), improvement in quality of life, rehabilitation, and palliative care. Some older patients and their families are coming to the clinic with new expectations of cure as they are better-informed, but they may also be confused due to the overwhelming amount of unfiltered internet information.

Ultrasound technology controlled by rheumatologists is already at full swing in Europe, and it is becoming the new joint-stethoscope for rheumatologists around the world. Providers are enhancing their physical examination skills and becoming more precise and efficient doing procedures. Older patients with dementia, or those unable to talk due to hospitalization or delirium, can be examined by use of ultrasound for synovitis or fluid in unexpected areas for diagnostic arthrocentesis to allow prompt therapy and prevent unnecessary treatments.

The health-care landscape is rapidly changing and the average age of rheumatologists is also rising. Much of rheumatology practice takes place in the outpatient setting. Instead of seeing the patient in the hospital for a secondary consultation, patients may be discharged home with the expectation that they will be seen promptly in the rheumatology clinic. While Internal Medicine is undergoing a hospitalist movement, primary care overall is shifting to advanced practice providers, increasing demand for rheumatology consultations. The older patient is trapped in the midst of all these changes; our book *Geriatric Rheumatology: A Comprehensive Approach* encourages you to think from the older patient's perspective.

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