Introduction

The bland statement “there is nothing more to be done” is frequently made to the patient with chronic arthritis and reflects observer ignorance and indifference. There is much palliative, supportive and reconstructive care which can and should be provided at each stage in the disease. If a medical practitioner feels unable to offer constructive aid, consultation with medical and paramedical colleagues is mandatory. There is always something which can be done, and a disabled patient who is looking for help should not be disappointed. The following points are relevant (and should be read in conjunction with relevant sections in Chaps. 2, 3 and 4).

Assess, Discuss, Educate, Reassess

Full medical and social assessment is the first step in management. Thereafter discussion with the patient and family or friends is important. The choice of treatment should reflect both the severity of the disease and the expectations of the patient. Some uncertainty in predicting the course of disease and likely response to therapy is inevitable, and the medical practitioner needs to show cautious optimism tempered with realism. The constant aim is to minimise disability, but denial of disease makes achievement of this aim more difficult. Above all, throughout all management of such patients must run strongly the thread of constantly defining and refining the therapeutic goals and of monitoring the progress of the patient towards the achievement of these goals.
Multidisciplinary Teams

Heroic pharmacological or surgical measures are rarely necessary: many of the skills of the multi-disciplinary team will be neglected if the medical practitioner sees no further than multi-coloured capsules and prosthetic joints. "Shared care" is not merely a catch phrase but is essential in the management of chronic arthritis. Members of this team include:

1. Patient
2. Family and extended family
3. Employer/religious advisor
4. Community organisers (housing, transport, welfare, disablement resettlement officer, voluntary organisations, e.g. arthritis care, disabled incomes group etc.)
5. Paramedical staff (hospital and community): nurse, physiotherapist, occupational therapist, medical social worker, chiropodist, pharmacist, orthotist
6. Medical practitioners: general, medical and surgical

Co-ordination in the team requires careful planning and frequent reassessment. Leadership is important since the patient needs to feel that someone is in command of the situation and a coherent plan needs to be followed by all. The leader of the team will vary according to circumstances but is usually the general or hospital practitioner. Some autocracy may be necessary to ensure that one aspect is not unduly emphasised at the expense of others. Case conferences which allow group discussion of individual problems are helpful.

General Measures

These are of considerable importance and should provide a background for drug and surgical treatment.

Rest and Exercise

Many patients ask about the advisability of exercise and the importance of striking a balance between rest and exercise should be stressed. The majority learn to adjust their lifestyle to variations in activity of their disease, and no active intervention is required. Acute inflammation may necessitate splinting or bed rest or a combination of the two. As the acute phase settles, gradual mobilisation should begin. Frequent gentle exercise is almost invariably