Arthritis: not just your grandmother’s disease

Public awareness about what it really means to have arthritis is slowly growing, but a significant amount of work remains to be done to implement the Alliance for the Canadian Arthritis Program (ACAP)’s priority standard number one: all Canadians must be aware of arthritis. This means that the public must understand that arthritis is not just the inevitable aches and pains of growing old; rather, it is a disease with many faces.

Arthritis can be deadly or mild; devastating or just inconvenient; agonizing or uncomfortable; heartbreaking or hardly noticeable.

In this issue of JointHealth monthly, we present two very different disease spotlights, on osteoarthritis and juvenile idiopathic arthritis. We have grouped these forms of arthritis together precisely because they are so very different. In fact, these types of arthritis differ on almost every level: age of people most likely to be affected, symptoms and treatment. Each of these forms of arthritis can be mild or very severe. What they have in common is this: they are both arthritis.

Our challenge as a community is to help the public, our elected representatives and our governments understand that arthritis has many faces, takes many forms and affects many people. The next time someone tells you that arthritis is a disease of the elderly, show them this issue of JointHealth™ monthly, and tell them the true story of arthritis.

Spotlight on osteoarthritis

Osteoarthritis is by far the most common type of arthritis. It is estimated to affect more than 3,200,000 Canadians—about 1 in 10.

Osteoarthritis is caused by the breakdown in cartilage in the joints. Cartilage is a protein substance that acts as a cushion between bones in joints, allowing joints to function smoothly.

Osteoarthritis can affect any joint, but hands and weight-bearing joints—including the spine, hips and knees—are most often affected. Other joints, like shoulders, elbows and ankles, are less likely to be affected unless the joint has been damaged by injury.

Unlike some other forms of arthritis where women are most affected, women and men are equally likely to be affected by osteoarthritis. It strikes most commonly after the age of 45.

Spotlight on juvenile idiopathic arthritis

Juvenile idiopathic arthritis (JIA) is chronic inflammatory arthritis developing in children under the age of 16. Previously called juvenile rheumatoid arthritis (JRA), juvenile idiopathic arthritis strikes up to 1 in 250 children and is one of the most common chronic diseases among children.

Autoimmune diseases generally occur when the body’s immune system begins to malfunction and attack healthy tissue in various parts of the body, causing inflammation and damage. In JIA, joints are attacked by inflammation and become stiff, painful and swollen. Some children with JIA develop inflammation involving their eyes as well; in some severe subtypes of JIA, organs such as the heart or lungs can be involved.
Oligoarticular—children may have the most severe form of Psoriatic arthritis. Extended oligoarticular—this form of arthritis affects five or more joints. The most common joints affected are knees, ankles or wrist. Up to 20% of children diagnosed with the oligoarticular form will develop arthritis in many joints. There is a small percentage of these children who go on to develop ankylosing spondylitis. A small percentage of children go on to develop ankylosing spondylitis.

Enthesitis related arthritis—this form of juvenile idiopathic arthritis affects large joints such as the hips, knees, ankles, as well as the back and neck. Some of these children have inflammation of ligament and tendon attachments, called enthesitis. A small percentage of these children develop ankylosing spondylitis.

Psoriatic arthritis—children may have arthritis and psoriasis, or arthritis and a strong family history of psoriasis. This form of arthritis can affect any joint.

Systemic onset—the most severe form of the disease, affecting about 10% of children diagnosed with juvenile idiopathic arthritis. Children with systemic onset JIA present quite ill with high fevers, rash and inflammation of organs in addition to inflammation in the joints. The most common complaint of children at the time they develop juvenile idiopathic arthritis is joint pain, accompanied by swelling or stiffness. Other warning signs which may be present at the onset of disease include:

- Change in ability to keep up with normal activities, such as sports or school work because of physical joint pain
- Irritability, especially in a young child who is in pain

Overall, JIA affects girls slightly more often than boys. JIA can affect children of any age, from infancy to 16 years. While it has no known cure, there are effective treatments for JIA which can often lead to remission and prevent permanent joint damage and disability.

Diagnosis of juvenile idiopathic arthritis

There are seven subtypes of juvenile idiopathic arthritis, defined by the ILAR international criteria:

- Oligoarticular—the most common form of the disease. About half of children with juvenile idiopathic arthritis are diagnosed with the oligoarticular form. Generally, one to four joints are affected. Most common joints include knees, ankles or wrist. Up to 20% of children diagnosed with the oligoarticular form of juvenile idiopathic arthritis will develop uveitis (inflammation in the eyes).

- Extended oligoarticular—approximately 30% of children whose JIA starts in fewer than 4 joints will develop arthritis in many joints at some point in their disease; this is called ‘extended’.

- Polyarticular (rheumatoid factor positive and rheumatoid factor negative)—JIA affecting five or more joints. Any joint can be involved, and usually the arthritis is symmetric (the same on both sides of the body). Children who have a positive rheumatoid factor (RF) have a more persistent and severe type of polyarticular disease.

- Psoriatic arthritis—children may have arthritis and psoriasis, or arthritis and a strong family history of psoriasis. This form of arthritis can affect any joint.

- Systemic onset—the most severe form of the disease, affecting about 10% of children diagnosed with juvenile idiopathic arthritis. Children with systemic onset JIA present quite ill with high fevers, rash and inflammation of organs in addition to inflammation in the joints. The most common complaint of children at the time they develop juvenile idiopathic arthritis is joint pain, accompanied by swelling or stiffness. Other warning signs which may be present at the onset of disease include:

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Treatment for juvenile idiopathic arthritis

While there is no cure for juvenile idiopathic arthritis, treatment advances are allowing more children to live normal lives. Medications have been developed that can reduce pain and even slow or stop the inflammation that causes devastating joint damage. As well, physical and occupational therapy can help to allow children to participate in normal activities, and to prevent long-term disability.

Once a diagnosis of juvenile idiopathic arthritis is suspected, the child should be referred to a pediatric rheumatology team, a group which includes a pediatric rheumatologist, nurses, pediatric physiotherapist, pediatric occupational therapist, social worker, and sometimes a psychologist.
cardiovascular, kidney or gastro-intestinal side effects, like stomach ulcers; for this reason, it is vital to speak with your doctor before adding an NSAID to any treatment plan for osteoarthritis.

Cox-2 inhibitors are a newer class of NSAID, which work to reduce inflammation but do not carry the same risk of gastro-intestinal side effects. Celecoxib (Celebrex®) is an example of a cox-2 inhibitor. It is important to note that, while cox-2 inhibitors cause fewer gastro-intestinal side effects, research has shown that they have the same or higher risk of cardiovascular (heart) side effects compared to traditional NSAIDs.

Sometimes, an injection of corticosteroid (sometimes called ‘cortisone’) into the affected joint can help to reduce the inflammation of advanced osteoarthritis. Cortisone injections can help in situations where mobility is impacted or pain is severe, but it is important to note that these injections should only be done intermittently (less than three per year) into each affected joint, as multiple corticosteroid injections may actually weaken the cartilage, causing further joint damage. Corticosteroid injections are not a long-term treatment, but rather something to be used very occasionally when pain and inflammation is particularly bad.

As with many forms of arthritis, maintenance of a healthy body weight is a very important part of a well-rounded treatment plan for osteoarthritis. Osteoarthritis often affects load-bearing joints, like the hips and knees, and research has shown that being overweight, by even 10 to 20 lbs, can significantly increase the risk of knee damage. One of the best things a person with osteoarthritis can do to improve their arthritis is work to achieve and maintain a healthy body weight.

Exercise is another important component of a plan to treat osteoarthritis. The key is to participate in the right kinds of exercise. Generally, exercises that put less stress on joints, like swimming and other water-based types of exercise, are ideal.

Many people find it difficult to get started on an exercise program because of their pain. In this case, many doctors recommend taking a pain reliever (such as acetaminophen or Tylenol®) about 30 minutes prior to starting exercise. Depending on a person’s joint complaint, using ice or heat, according to one’s preference, is a non-medicinal treatment that may be effective at helping people with osteoarthritis exercise effectively—and with enjoyment.

Joint surgery is an option if joint damage progresses to the point where mobility is seriously compromised. The most common type of joint surgery for osteoarthritis is joint replacement; knees and hips are the most common joints to be treated with joint replacement surgery.
Arthritis Consumer Experts

Who we are

Arthritis Consumer Experts (ACE) provides research-based education, advocacy training, advocacy leadership and information to Canadians with arthritis. We help empower people living with all forms of arthritis to take control of their disease and to take action in health care and research decision making.

ACE activities are guided by its members and led by people with arthritis, leading medical professionals and the ACE Advisory Board. To learn more about ACE, visit www.arthritisconsumerexperts.org

Guiding principles and acknowledgement

Guiding Principles

Health care is a human right. Those in health care, especially those who stand to gain from the ill health of others, have a moral responsibility to examine what they do, its long-term consequences and to ensure that all may benefit. The support of this should be shared by government, citizens, and non-profit and for-profit organizations. This is not only equitable, but is the best means to balance the influence of any specific constituency and a practical necessity. Any profit from our activities is re-invested in our core programs for Canadians with arthritis.

To completely insulate the agenda, the activities and the judgments of our organization from those of organizations supporting our work, we put forth our abiding principles:

- ACE only requests unrestricted grants from private and public organizations to support its core program.
- ACE employees do not receive equity interest or personal “in-kind” support of any kind from any health-related organization.
- ACE discloses all funding sources in all its activities.
- ACE identifies the source of all materials or documents used.
- ACE develops positions on health policy, products or services in collaboration with arthritis consumers, the academic community and health care providers and government free from concern or constraint of other organizations.
- ACE employees do not engage in any personal social activities with supporters.
- ACE does not promote any “brand”, product or program on any of its materials or its web site, or during any of its educational programs or activities.

Thanks

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Disclaimer

The material contained in this newsletter is provided for general information only. It should not be relied on to suggest a course of treatment for a particular individual or as a substitute for consultation with qualified health professionals who are familiar with your individual medical needs. Should you have any health care related questions or concerns, you should contact your physician. You should never disregard medical advice or delay in seeking it because of something you have read in this or any newsletter.

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