

## Editorial

# Rheumato(Philes): A Publication Option for Rheumatology Devotees' Creative Works

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**Abstract:** This journal for Rheumato(philes) has provided a vehicle for the interdisciplinary sharing of the challenges and interventions of our specialty. The provision of state-of-the-art information is not at the expense of the basics from which it has grown. From its initial status as a source of discomfort, a review of back pain diagnostics and therapeutics provides a background for facilitating contemporary practice. We have met the enemy in the form of COVID-19, addressing its many rheumatologic complications, and have been introduced to the vagaries of IgG4 disease. Our clinical skills are tested in recognition of primary hypertrophic osteoarthropathy. The relationship of dental health to rheumatoid arthritis and nutritional issues is currently undergoing scientific review. A unique feature, one we seldom seem to discuss, is the evaluation of disease manifestations when the customary tools are not available. The latter brings us full circle in the evolution of our field. When our colleagues found diagnostic or treatment approaches elusive, they did not call for Ghostbusters; they called for us.

**Keywords:** *Rheumato*; back pain; fibrotic disease; therapeutics; diagnostic techniques

## 1. Introduction to *Rheumato*

Please allow me to introduce you to *Rheumato* (ISSN 2674-0621), a peer-reviewed, open access journal that provides a home for research descriptions and reviews related to both the fundamentals and developments encompassing the spectrum of musculoskeletal/rheumatologic afflictions.

The goal of this journal is to provide a platform to expose the characteristic renaissance which originally formed the basis of what is now ensconced in rheumatology itself. We started as a field of wonder, with many serendipitous but prophetic and prescient observations driving us to suggest and test theories leading to effective intervention. This journal provides the opportunity to return to “the thrilling days of yesteryear” (with apologies to Clayton Moore).

The journal’s mission is to share the broad spectrum of which we are composed, welcoming submissions from all components of the treatment team: direct medical care providers and our intrinsic support staff (e.g., nurses, assistants), physical and occupational therapists, psychologists, dietitians/nutritionists and pharmacists, although I’m sure I’ve left out someone of importance (e.g., patients).

Rheumatology might be thought of as a “central field”, around which everything else revolves. After all, the disorders in our diagnostic/therapeutic complement are multidisciplinary in their manifestations. All fields of medicine (both basic and clinical sciences) are necessary components for our patient assessments and choice of intervention options. The fundamentals are still expanding with the addition of molecular, immunological, radiological and computer science innovations and the unclear future roles of artificial intelligence and remote care (e.g., telemedicine).

Rheumatology is a relatively new (at least compared to other fields of medicine) specialty, continuously reviewing its understanding of and impact on disease. Challenges



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are frequently derived from attempts to channel new technologies and test new concepts of disease. Our skin-deep observational skills are now enhanced by diagnostic ultrasound, although the depths to which it provides accessibility are as yet unknown. This often obviates concerns of radiation exposure (e.g., of X-rays) permitting potentially obtainable information.

## 2. What Papers Are Especially Appropriate for *Rheumato*?

The interface of apparently disparate fields provides a nurturing environment for the development of a meaningful understanding of ourselves and the world within which we live. This is exemplified by the content of the past year, which ranged from fundamental guidance to recognizing and organizing intervention for rheumatologic disease in attention deficit-afflicted individuals to the clinical problem that seems to challenge many of our colleagues—back complaints. We portray rheumatology as it originally developed, ranging from the recognition of unusual causes of common problems to the recognition of previously unrecognized manifestations of a new disease. Previous articles tackle the spectrum of fibrosing diseases beyond that of scleroderma, the treatment of which has so long proved challenging, and examine the subtleties of Kawasaki syndrome and its complication by macrophage activation syndrome, as well as the relatively mundane topic of plantar fasciitis. The latter brings us full circle in the evolution of our field. When our colleagues found diagnostic or treatment approaches elusive, they did not call for Ghostbusters; they called for us.

## 3. The Breadth of Articles Published

Let us now explore in detail the value of diversity and its lessons. Neurodivergent may be a foreign term to most of you; it certainly was to me. An umbrella term for individuals with varying communication challenges, those so afflicted may not actually be so different from the rest of our patients. Determining why a patient comes to see us has always been challenging. We hear (hopefully) the reason they express, but we still have to “ferret out” what is really on their minds. The article by Martin’s group highlights the challenges we face in interacting with all patients. It emphasizes care previously compromised in their attempts at problem resolution and our importance in uniquely breaching the communication barrier. The article reminds us of the devastating effect that distraction imparts, whether it be pain (e.g., from fibromyalgia) or dis-coordination related to such entities as Ehlers–Danlos syndrome. Recalling that many plane crashes (catastrophic excepted) are the result of pilot distraction, we should not be surprised by the effects of distraction on our ability to extract meaningful, pertinent information; instill appropriate, essential information for patient participation; and to motivate them to not only pursue, but maintain a particular course of action. While Martin’s group specifically addresses women and the disorders with which they are more often (than men) afflicted, the lessons advanced apply to all our patients.

Sir William Osler once opined that a physician’s office should have two doors, one for the patient to enter and one for the physician to take his or her leave, when the patient’s visit is back-pain-related. Training/education in our specialty was somewhat limited because the supervising physicians in our fellowships found the subject uninteresting and engineered appointment opportunities accordingly. It rapidly became obvious that we needed to develop such expertise. As our specialty became recognized for its diagnostic and therapeutic skills, we became the recipients of a greater variety of clinical “challenges”, with patients perhaps perceiving us as the “office” of last resort. If that was not enough to motivate training programs to expand their curricula, one might think that our involvement in recognizing the various forms of spondyloarthropathy (and distinguishing them from other sources of back pain) and its complications (e.g., vertebral fracture) would do so. In reality, it took an edict from the Residence Review Committee to incorporate general training for back issues, and programs often had to reach out to other programs for such training. The curricula, however, have perhaps not yet been sufficiently expanded. While

the recognition of vertebral shape variation is critical, it is perhaps more important to distinguish between what is prominent, although of little clinical import (e.g., vertebral centra osteophytes, lumbarization or sacralization), and what may be quite subtle, but of existential importance (e.g., vertebral centra scalloping by aneurysms, loss of height related to osteoporosis). Equally important is the recognition of the static and movement-related postural components of back pain and the value of perseverance with exercises to strengthen back extension. We, as rheumatologists, have an exhaustive background with disorders that have long afflicted the human race. While perhaps not the most interesting facet of rheumatologic practice, it is still up to us to apply that background in the service of those individuals seeking our advice. If not us, then who?

The expansive background acquired during rheumatologic training and through subsequent experience often enables us to recognize underlying diseases, but only if we think about them.

Lipoma arborescens is one such disease. It is curable by resection, if diagnosed. Moretti's group reminds us of the importance of a search for masses when monoarticular effusions are identified in the absence of joint instability, and especially when associated with positional reproduction of pain.

The review by AbdelMassih's group represents a return to our specialty's halcyon days, when it was not uncommon to report previously unrecognized manifestations of a new disease. COVID-19 has had a draconian impact on society worldwide. It seems to be a "gift" that keeps on giving, one not limited to what has been called "long covid". Its autoimmune/autoinflammatory character seems analogous to rotavirus A, which can induce gluten sensitivity/celiac disease and post-streptococcal cardiac (e.g., rheumatic fever) and renal diseases. The COVID-19 phenomena develops within the first two weeks of acquisition and is especially prevalent in children under six years of age, but spares no age. Complications include demyelinating disorders (e.g., encephalomyelitis, optic neuritis), hepatitis (e.g., sclerosing cholangitis), hemophagocytic lymphohistiocytosis, hemolytic-uremic syndrome, immune thrombocytopenic purpura, psoriasis, systemic lupus erythematosus, vasculopathy mimicking Kawasaki disease (see below) and possibly Type 1 diabetes mellitus. The article provides a roadmap for surveillance considerations, as well as a reminder that some of the disorders seen at varying frequencies in our practices might not be idiopathic.

Scleroderma, perhaps the original poster child for fibrosing diseases, was the tip of the iceberg. The challenges related to its management are highlighted in our awakening to a multitude of disorders in which fibrosis is a major manifestation. These include idiopathic retroperitoneal fibrosis, IgG4-related disease and Erdheim-Chester disease (in which IgG4 is not involved). IgG4-related diseases are characterized by sclerotic material replacement. IgG4-related diseases produce round or wedge-shaped nodules in the pancreas and kidneys (with subsequent chronic or end-stage disease), retro-orbital pseudotumors, glomerular involvement with nephrotic syndrome and, of course, retroperitoneal fibrosis. Erdheim-Chester disease is a clonal neoplastic histiocytic (but non-Langerhans cell) disorder which also coats the aorta and involves the retroperitoneum, kidneys, urinary tract and retro-orbital tissue, in addition to the skin, adrenal glands, hypothalamic-pituitary axis and nervous system. It is, however, the associated osteosclerosis which often leads to recognition of the underlying pathology.

Pachydermoperiostosis is another of these pattern recognition phenomena, not because of its primary symptoms, but because of associated facial [1]. Kamruzzaman's group present such a case. The general diaphyseal periosteal reaction is potentially recognized as hypertrophic osteoarthropathy. This usually occurs secondary to an underlying disease (e.g., pulmonary mass) and, as such, might precipitate a "million dollar workup"—unless the facial alterations are noted.

The work by Corinaldesi's group examined the subtleties of Kawasaki syndrome and its complication by macrophage activation syndrome. It examined treatment with

corticosteroids, intravenous immune globulin and the interleukin-1 receptor antagonist anakinra, suggesting the value of the latter and the critical importance of early intervention.

Rheumatology has generally been far ahead of the curve in our scientific assessment of the efficacy of therapeutic interventions, often leading medicine in such endeavors. The article by Moneim's group is of this type, examining alternative therapies for chronic plantar fasciitis. Extracorporeal shock wave therapy is a technique in search of applications, and Moneim's group provide validation for its use in the management of this foot ailment. This contrasts with the review by Ogbeivor's group, which documented a lack of high probability support for the application of the technique in patients afflicted with myofascial pain syndrome. The article by Chhikara's group continues in the vein of physical and occupational therapy contributions to our ability to improve the lives of our patients, documenting the efficacy and cost-effectiveness of finger splint development and provision. Burton described an approach for non-surgical rehabilitation of tendon pathology. Restricting arterial blood flow to and venous outflow from the affected region reduced the amount of training load required with resistance modalities, providing an additional safety factor. Biomechanics forms the basis for many of the standard approaches utilized by physical and occupational therapists. Aleixo's group provides such a foundation by examining the effect of rheumatoid arthritis on the individual components of knee movement during ambulation. Divided into knee flexion, knee extension and a second flexion, it was the latter that was most affected, perhaps the explanation for the common stiffness complaint.

Other therapeutics were not neglected. Ortiz-Uriarte's group reviewed the inadequacy of physicians' prescription of urate-lowering therapy and motivation of patients to maintain its long-term use. They disabused the perspective that such agents were responsible for the aggravation of cardiovascular and kidney disease. One of the controversies in the treatment of knee pathology relates to indications for knee replacement therapy and choice of modality: uni-compartmental versus total. They found a better post-surgical range of motion with the less complex uni-compartmental approach. Studies were not limited to adults. Congenital heart block is a challenging manifestation of neonatal lupus, or at least in the offspring of individuals with maternal lupus or Sjögren's syndrome. Sharobim's group relates the efficacy of plasmapheresis in removing the responsible antibodies, resolving or precluding the worsening of heart block, at least in the short term. López's group addressed a herbal approach to pain modulation utilizing the phenylethanoid relative of phenethyl alcohol, hydroxytyrosol, Omega 3 fatty acids and curcumin, a component of the ginger family product turmeric.

Ancillary topics were also included. These ranged from alternatives to renal biopsy in lupus reported by Lim's group to the role of periodontal health in rheumatoid arthritis (RA), discussed by Proud's group. The latter examined the role of dentists and rheumatologists in the management of RA. The discussion of evaluating renal status in lupus is more complex. Lim's group presented a conglomeration of non-invasive variables which had ~78% sensitivity and 61% specificity for proliferative glomerulonephritis, an approach considered when biopsy opportunities are inaccessible. The latter brings us full circle in the evolution of our field. When our colleagues found diagnostic or treatment approaches elusive, they did not call for Ghostbusters; they called for us.

**Conflicts of Interest:** The author declares no conflict of interest.

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