

THE RHEUMATOLOGIST

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Text

RHEUMINATIONS

Crossing the Line

When medical workforce grievances lead to strikes

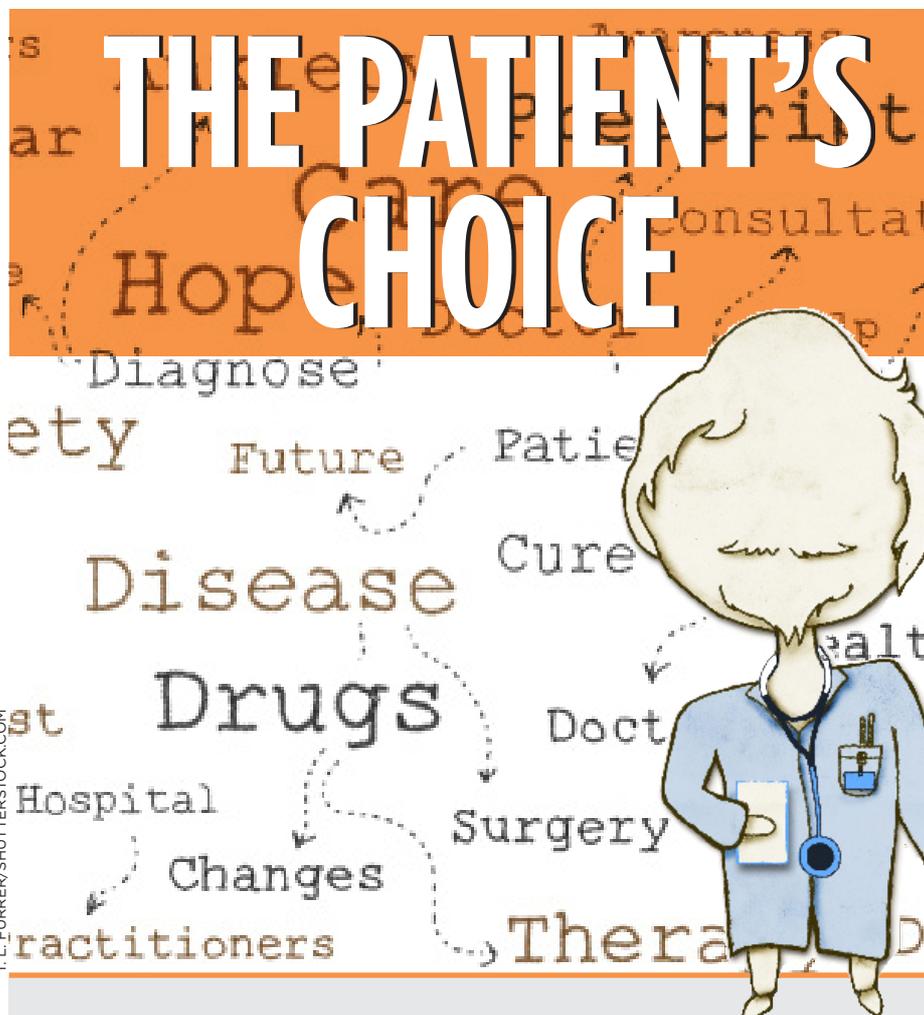
BY SIMON M. HELFGOTT, MD

Picket Lines: June 27 was marked on my calendar as the day to watch. No doubt the union organizers shrewdly selected it to be their strike day because of its proximity to July 1, an auspicious date for teaching hospitals, when rookie interns and residents anxiously assume their heightened roles of responsibility within the medical hierarchy. The operational disruption and relative inexperience of new cohorts of physicians has been termed the “July effect,” and evidence suggests that mortality rates rise among higher risk patients admitted to academic medical centers at the start of the academic year in July compared with May.¹

The 3,300 nurses of the Brigham and Women’s Hospital (BWH) in Boston had voted to authorize a one-day strike to protest their treatment by the hospital leaders who, according to the chair of their bargaining unit, “disrespect and undervalue the nurses who provide the vast majority of patient care at the hospital.”²

Usually workers strike for greater pay, but the financial gulf between the two sides was not wide at all. With an average base salary of \$106,000 (excluding benefits) and an established contract that already guaranteed annual pay increases of 5% for their first 18 years of employment, the nurses’ grievances primarily focused on non-monetary issues. These included their opposition to

CONTINUED ON PAGE 10



WHEN YOU’RE THE 2ND (OR 3RD) OPINION

BY CHARLES RADIS, DO

Outside Exam Room No. 5, the chart rack was empty, so I assumed my new consult was late. Just in case, I looked back over my shoulder as I passed by the partially open door and glimpsed the lower half of a woman holding a three-ringed binder on her lap. I squinted and took a step closer. The left knee looked swollen.

Hmm ... I ambled over to the nursing station, where Joanne was on the phone with a local pharmacy. The inability to review the records before seeing the patient had taken me out of my normal routine. “Room 5?” I asked, as Joanne hung up. “Is she my next consult?”

Joanne ran her finger down the patient printout. “Right. Emily Corinth. She said she wanted to hold onto the records. I told her you usually like to review the records before the visit, but she said she’d prefer to tell you the story from the

CONTINUED ON PAGE 24

SPEAK OUT RHEUMATOLOGY



No More Corticosteroids?

PAGE 60

OSTEOARTHRITIS



Pain & Inflammation

PAGE 19

OUTCOME MEASURES



The Total Joint Arthroplasty Outcome Measures Toolkit

PAGE 32

PATIENT PERSPECTIVE



Learning from a Fall

PAGE 28

NEWS: FIRST PUBLISHED ONLINE AT THE-RHEUMATOLOGIST.ORG

The ACR & Simple Tasks Announce First-Ever Rheumatic Disease Awareness Month

PAGE 16



beginning. Fresh.”

“Okay,” I said, the inflection in my voice indicating otherwise. “That’s fine. Nothing else for me to review ahead of time? Did she fill out the office questionnaire?”

“No.” Joanne smiled. “Good luck.”

“Thanks.”

I lingered outside the exam room. A binder usually means that multiple consultants have seen the patient. Having it fed to me selectively, page by page, makes it clear that the patient disagrees with some or all of the previous opinions. Lab or radiographic studies may be conflicting. Medications have been prescribed, and they’ve been either ineffective or poorly tolerated. I am about to hear a medical journey from a particular viewpoint. Hold it. Take a deep breath. She’s a patient with a problem. Focus.

I turned back toward Joanne and whispered, “What did she look like when you roomed her?”

“She was limping,” Joanne answered.

“Okay. It’s her knee. That’s helpful.”

I stepped back toward the door. It’s not a good sign when I have to consciously clear my preconceptions before a consultation. I felt at a distinct disadvantage not knowing anything about Ms. Corinth’s case and—I’m willing to admit—mildly irritated. Based on my previous experiences, this next hour will not go well for either of us. On the other hand, I reminded myself, hearing the story from the beginning may provide clarity rather than grayness. Don’t prejudge. Clear your mind; she has a swollen knee. Let’s see if you can help.

The Journey Begins

“Ms. Corinth,” I extended my hand.

“Good morning. What can I do for you today?”

“I’m looking for advice.” She shifted the left knee and grimaced ever so slightly.

“Let me start at the beginning, two years ago, when I contracted Lyme disease ...” She opened the binder. The fingers of her hands were slender and delicate, and as she licked her right index finger to turn the page, I assessed the left knee. The normal anatomy was distorted. Fluid within the joint bulged outward, making it difficult, if not impossible, for her to fully extend the joint.

“One morning, I was bitten by a tick. I didn’t think much of it at the time; my property is infested with ticks, it’s overrun with ticks. I’m constantly pulling them off the dogs. But this one was embedded, and it was quite a process to remove it.”

The knee held, I estimated, more than a cup of synovial fluid—roughly two full large syringes. Behind her was a cane. I’m not surprised. An effusion that large must make it difficult to walk.

“Well, I went to the doctor,” she continued, “and showed her the remains of the tick. We both agreed it was a deer tick, not the larger, innocuous dog tick, and she gave me a single dose of doxycycline in a dose of, let me see here,” she flipped to a tab titled, **TREATMENT**, “that would be

FAST FACTS

Lyme Disease

- The infection is caused by the bacteria *Borrelia burgdorferi* and spread primarily by the *Ixodes dammini* tick.
- The characteristic rash, erythema chronicum migrans, occurs in about 50% of patients between three and 14 days after the initial tick bite and represents the leading edge of the infection.
- The bacteria, in the same spirochete family as syphilis, can be successfully treated with antibiotics.

Aug. 24 slightly more than two years ago. Here it is: 200 mg of doxycycline.”

“And did that help?” I asked.

“Evidently not.” She hiked up her ruffled skirt for me to better view the affected knee. “Can you imagine, a single dose of doxycycline? What was the doctor thinking?”

My thoughts: The standard dose for prophylaxis against Lyme disease after pulling off an embedded tick is indeed 200 mg of doxycycline.

I stared at her mid-thigh, trying to be discreet. There was a reddened, slightly scaly, quarter-sized rash on the anterior inner aspect. I leaned forward to get a better look. She tugged the skirt down, covering the rash, so I placed a hand on the knee. “There’s a large amount of fluid in this knee. Has it ever been aspirated?” I asked.

“Once. An orthopedic surgeon insisted on giving me a cortisone shot. But we’re getting ahead of ourselves.” She took off her sunglasses and cleaned them thoroughly before going on.

At a guess, she was 45 or so, red hair, blue eyes. Crow’s feet fanned out from the outer margins of her eyes. On the upper right forehead, a patch of discolored, slightly irregular skin looked pre-malignant, probably an actinic keratosis related to sun damage. With her left hand, she reached up and ran her fingers through her hair. There. Another patch of flaky, scaly red skin flashed at the elbow before disappearing beneath a sweater sleeve.

She placed the sunglasses on her head and turned the page. “Okay. So after the tick bite, I didn’t notice much. I’d heard about Lyme disease—everyone’s heard about Lyme disease—but it wasn’t until the next spring—that would be eight months after the embedded tick bite—that I became sick. At first, I thought it was the divorce. I wasn’t sleeping well, and I’ve always been prone to headaches, but every day, my head throbbed. I gained weight. My glands felt swollen. At work, I was so tired I could hardly drag myself back to the office after lunch.”

“And the knee swelling?” I asked.

“When did that first happen?”

“Two months later. It blew up out of the blue. I took some sick time off, but that didn’t help.”

“And is that when you saw the orthopedist?”

“Right. He drew some blood.” She opened up the binder and handed me the lab results. I scanned through the normal chemistries and thyroid testing. An

ELISA test, a screening test for Lyme disease, was negative. “He told me the X-ray looked normal. I didn’t need a surgery. Then he injected the knee.”

“And did that help?” I asked.

“It was great. I went back to work. But in retrospect, that was probably the worst thing he could have done. I’m sure you’re aware that injecting a Lyme-infected knee allows the infection free rein. When the swelling relapsed, I felt like someone exploded a bomb inside it. That’s when I began to see Dr. F., a Lyme-savvy doctor in Massachusetts.”

Doctor No. 2

“That would be, what, a year ago?” I asked.

“Yes. Here’s his original consult. I was a train wreck. I took a leave of absence from work. I felt light-headed all the time, woozy, I couldn’t concentrate.”

I read the consult. Dr. F. noted that although a second Lyme test was negative, Ms. Corinth demonstrated 32 out of 42 symptoms commonly associated with Lyme disease. This tally came from the circled YES/NO answers Ms. Corinth provided on the Lyme Disease Symptom Checklist. Included in the non-specific symptoms suggesting Lyme disease were: *disturbed sleep, headaches, mood changes and twitching.*

“Dr. F. told me the negative Lyme test represented a false negative, probably related to the inadequate initial treatment of the embedded tick the previous year. He emphasized that Lyme is a clinical diagnosis. Testing is notoriously iffy. No, I don’t think he used the word *iffy*, but you know what I mean, the symptoms, the big picture, that’s what he was looking at to make the diagnosis of Lyme disease. He was frustrated that the diagnosis had been delayed for so long, but he was optimistic that a full recovery was possible, even expected. Full recovery could still be achieved, that’s what he told me. So for three months, I took doxycycline in combination with the antibiotics, ciprofloxacin and azithromycin.”

She turned the page. “After that, well, we tried different combinations of oral antibiotics and supplements. The theory, well, you may already know this, but the Lyme spirochete, it’s a type of bacteria, evades the immune system. That’s when he recommended the intravenous antibiotic—let me make sure I say this right—ceftriaxone.”

My head was spinning. An embedded

tick promptly treated with the appropriate dose of doxycycline, two negative Lyme tests, and a boat-load of antibiotics later, and we're still focused on Lyme disease?

She resumed: "During the first four months of antibiotic treatment, I thought I was turning the corner, but then almost overnight the swelling in my knee doubled. The tick was fighting back. My short-term memory was shot. My mood swings were horrific. And the fatigue—I could barely will myself out of bed each morning. My veins were blown. I was losing the battle. That's when Dr. F. recommended that I have a port placed." She reached up and ran her finger over the upper right chest where an egg-sized implant was palpable beneath the skin.

Ports are often used in cancer patients when monthly chemotherapy is required, but this was the first time I'd seen one in a patient with presumed Lyme disease.

"Once the port was in, he doubled the dose of the IV ceftriaxone. It was a last-ditch effort, but it wasn't enough. I lost my job and applied for disability—that would be four months ago."

"I'm sorry it came to that," I replied. I scanned the Lyme Disease Symptom Checklist hanging limply from my hand. In a matter of 20 minutes I had acquired more than half of the symptoms. I maintained an even tone. "You've been through a lot." I reached into the cabinet above the sink and unfolded a cloth gown. "Let me step out for a minute while you change. You can keep your underclothes on, but I want to do a complete examination. I'll be back in a few minutes."

About Lyme

Back in my office, I slumped into my swivel chair and drifted back to a simpler time. Years ago, as a visiting internal medicine resident at Yale New Haven Hospital, I rotated through the department of Clinical Immunology and Rheumatology. Yale, and more specifically Allen Steere, MD, was considered ground zero in the emerging Lyme epidemic. In 1975, two local women from the nearby town of Lyme, Conn., Polly Murray and

Judith Mensch, contacted the Connecticut State Health Department. Both of their children had been diagnosed with juvenile rheumatoid arthritis (JRA), and they knew of other children and adults in the small community with similar symptoms. Because JRA is an uncommon immune system disease affecting about one in 1,000 children, and the initial reports suggested an unexplained cluster, Dr. Steere at the Yale Department of Rheumatology met with them to investigate further.

Dr. Steere eventually identified 39 children with the disorder in the community and realized that although their illness superficially resembled juvenile rheumatoid arthritis, there were critical differences. Many of the families Dr. Steere interviewed remembered their child coming down with a flu-like illness and an unusual expanding rash before experiencing joint swelling. Carefully tracking the onset of symptoms made it clear that most of the children first became ill during the summer or early fall, suggesting an infection as the trigger rather than an immune system disorder.

Dr. Steere published his findings in the journal *Arthritis & Rheumatism* in 1977 in an article titled, "An epidemic of oligoarticular arthritis in children and adults in three Connecticut communities."

By the time I arrived at Yale in 1984, this much was known about Lyme disease: The infection is caused by the bacteria *Borrelia burgdorferi* and spread primarily by the *Ixodes dammini* tick. The characteristic rash, erythema chronicum migrans (ECM), occurs in about 50% of patients between three and 14 days after the initial tick bite and represents the leading edge of the infection. The bacteria, in the same spirochete family as syphilis, can be successfully treated with antibiotics. In untreated patients, the infection may disseminate, leading to heart rhythm abnormalities, recurrent joint swelling, and a variety of central nervous system and peripheral nerve disorders.

But beyond these basic shared truths, nearly everything else about Lyme disease has proven contentious. Does a positive

Lyme test correctly identify those with the disease? Is a negative test sufficient to rule out the disease? Do early antibiotics prevent later manifestations of Lyme disease? If so, in 99% of cases? In 50%? How do physicians treat a patient who clearly has Lyme disease, is treated with standard doses of antibiotics, but fails to fully recover?

My Exam

Returning to Ms. Corinth's room, I decided to examine the affected knee last. Instead, I began with the hands and assessed each individual joint for signs of swelling or limited motion. These were unremarkable. But as I was about to go on, I noticed that even through the thin layer of cream-colored nail-polish, one fingernail was clearly abnormal. I asked her if she'd noticed the tiny pits in the nail before.

"Sure. That's why I usually put an extra coating of polish on that particular finger, to hide the dimples. I hate it," she said emphatically.

"Any other problems with the nails?" I asked.

"This one." She held up the pinky finger on the other hand. "The edge is separating from the rest of the nail. I showed it to Dr. F. last year, and he said the fingernails are a window to our health. Since then I've been taking supplements." She reached over to her pocketbook and pulled out a sheet of paper cataloguing more than a dozen herbs and vitamins. "Dr. F. said that I'd know when the Lyme infection was on the run when the nails began to heal."

"And are the nails looking any better?" I asked.

"I sometimes think they are," she replied.

The heart, lungs, throat, ears were normal. The thyroid gland was in its usual position, shaped like a miniature bow-tie just above the breast bone. There were no enlarged lymph nodes in the neck or under the armpits. The shoulders and elbows were ... hmm ... the skin over the back of the elbows was raised and slightly reddened. A thick silvery scale adhered to the coin-sized lesion. Psoriasis.

"I have a cream for that," Ms. Corinth said as she pulled the gown down. "It works if I keep applying it every day, but I've run out."

I asked her to lie down and, while palpating the left knee, confirmed that the red patch of skin in the mid-thigh I'd glimpsed earlier in our visit was also psoriasis. Interestingly, the discoloration and separation of the fingernail (i.e., onycholysis) and the small pits are also commonly associated with psoriasis.

I methodically assessed the motion in the knee. One measure of chronicity of fluid within a knee is the development of a joint contracture, the inability of a joint to fully flex or extend. Ms. Corinth's knee lacked the last 10 degrees of normal extension and flexed to only 85 degrees. Patients who cannot normally flex or extend the knee fully often experience instability and frequent falls. Even with successful treatment, it will take months of physical therapy to restore function, that is, if the knee

isn't already cooked. Fluid within a knee this chronically inflamed can accelerate damage, destroying normal cartilage in less than a year.

"Dr. F. MRI'd the knee three months ago," she said, reaching down and massaging the soft tissues. "He worried there might be something else inside keeping me from a full recovery, maybe a torn cartilage, but it was normal. Normal except for the Lyme fluid," she added.

On a hunch, I asked her if she'd slip off her shoes and socks. Doctors tend to ignore the feet. We rarely examine them during a physical unless we palpate for pulses or check for reflexes. But here was another clue. The third toe on the right foot was reddened and ballooned like a sausage. When I reached down and pressed on the joint, Ms. Corinth flinched.

"That's funny that you noticed the toe. I thought I stubbed it last week. Is it the Lyme? I've been off the intravenous ceftriaxone for months. My insurance company is refusing to pay for further treatment, and my fatigue has come roaring back."

Now I get it. The insurance company won't pay for further treatment with IV antibiotics unless a second opinion confirms the original diagnosis and agrees with long-term IV antibiotics. That's why she's here.

Home infusions are expensive, running into thousands of dollars per month. But it's not only the cost of treatment. IV antibiotics are not innocuous. During daily hookups, bacteria may be transferred from the skin surface into the bloodstream through improper sterile technique. A small, but significant, percentage of patients on long-term IV antibiotics become septic, require hospitalization, removal of the port and IV antibiotics to treat the new infection. That is, if they don't die from complications of an infected heart valve or kidney failure.

Which happens.

I reached up and scratched my forehead. "Let's have you get dressed and I'll be back in a few minutes." I pressed on the foot pedal to lower the table.

Persistent Symptoms

Then I walked slowly back to my office. There, I cracked open a pistachio nut and considered my strategy.

There are nearly endless permutations in Lyme consultations. Some are clear-cut, some are complex and nuanced. Nearly all are highly charged emotional encounters requiring time and patience. For example, there is the low-lying fruit of recent unexplained solitary wrist or knee warmth and swelling in a child or adult. I examine the patient for evidence of alternative explanations for inflammatory arthritis and am *relieved* when Lyme testing is positive. This is a good thing, I explain to my patients. Instead of having a chronic, life-long immune system disorder, you have an infection. It is usually cured by a single month of oral doxycycline, and if it persists, either another month of oral

continued on page 26

FAST FACTS

Psoriatic Arthritis

- Psoriatic arthritis is a chronic arthritis. In some people, it is mild, with just occasional flare-ups. In other people, it is continuous and can cause joint damage if it is not treated. Early diagnosis is important to avoid damage to joints.
- Psoriatic arthritis can occur in people without skin psoriasis, particularly in those who have relatives with psoriasis.
- Psoriatic arthritis typically affects the large joints, especially those of the lower extremities, distal joints of the fingers and toes, and also can affect the back and sacroiliac joints of the pelvis.
- For most people, appropriate treatments will relieve pain, protect the joints and maintain mobility. Physical activity helps maintain joint movement.
- Psoriatic arthritis is sometimes misdiagnosed as gout, rheumatoid arthritis or osteoarthritis.

Learn more on the ACR's website at <http://www.rheumatology.org/I-Am-A/Patient-Caregiver/Diseases-Conditions/Psoriatic-Arthritis>.



Unlike such diseases as rheumatoid arthritis, which requires life-long treatment, reactive arthritis associated with Lyme arthritis usually burns out, & medications can eventually be discontinued.

doxycycline or, in some resistant cases, a course of intravenous ceftriaxone.

There *are* rare cases in which Lyme arthritis seems to be resistant to repeated courses of antibiotics, but here again, research (much of which has come from Dr. Allen Steere's observations—he has published more than 50 papers on the subject) has begun to clarify the basic question: Is this persistent infection or has the Lyme spirochete triggered a form of reactive arthritis? Reactive arthritis is similar to a hit-and-run accident. The patient's own immune system may react with the infection in such a way that it clears the infection but doesn't down-regulate. That is, the system remains turned on, and cells that are activated continue to secrete inflammatory proteins long after the infection is gone.

In some cases of persistent Lyme arthritis, a similar hyper-immune process may be in play. The spirochete can no longer be cultured from inflamed fluid. Antibodies directed against the organism gradually diminish even as inflammation persists. And certain genes, particularly those recognized as risk factors for rheumatoid arthritis, are often present in these patients, suggesting that immunologically driven Lyme arthritis shares certain risk factors for rheumatoid arthritis.

How is this variant of Lyme arthritis managed? Not with further antibiotics. Instead, medications such as methotrexate, which down-regulates inflammation, are usually successful when antibiotics have clearly failed.

The good news: Unlike such diseases as rheumatoid arthritis, which requires life-long treatment, reactive arthritis associated with Lyme arthritis usually burns out, and medications can eventually be discontinued.

Where the waters are murkier is the subgroup of patients who present with a typical Lyme disease manifestation—perhaps Bell's palsy, weakness of the muscles on half or both sides of the face; a heart rhythm abnormality; or arthritis—and undergo appropriate antibiotic treatment, but have not fully recovered. The physical manifestations of the disease and laboratory markers of inflammation, such as a sedimentation rate or C-reactive protein, normalize, but subjective symptoms, such as muscle or joint aches, fatigue, headaches and decreased endurance, persist. Patients may have difficulty with concentration or experiencing tingling sensations in the extremities. These *post-Lyme* symptoms are extraordinarily frustrating to both the patient and treating physician, and management is difficult. Because it is nearly impossible to prove that low-level infection is not completely cleared, repeated courses of antibiotics are often administered.

There is some guidance from five published trials in this sub-group.¹⁻⁵ Patients with persistent symptoms in the trials were assigned to receive IV ceftriaxone followed by an additional course of oral doxycycline or placebo. The duration of IV ceftriaxone and oral antibiotics varied between the trials. In one of the studies,

the IV ceftriaxone group experienced a small, but statistically significant, improvement in disabling fatigue, but this did not translate into measurable improvement in cognitive function. The other trials did not demonstrate any difference between the placebo and antibiotic groups.

The importance of including a placebo group in these antibiotic trials is critical in ferreting out whether long-term antibiotics improve outcomes in Lyme disease. The placebo group, along with the active antibiotic group, improved as much as 40% from baseline in the antibiotic trials.

Back to the Case

But Ms. Corinth's case is not within the spectrum of Lyme disease. Her diagnosis was based solely on a questionnaire. Her Lyme tests were never positive, and her subjective symptoms, although often seen in Lyme, overlap with symptoms of stress, anxiety, depression and a host of other painful medical conditions. The key to her diagnosis is the swollen knee. In my mind, if this can be diagnosed and treated, the other symptoms may slowly dissipate. After all, the bottom line is that she has gone from working full time to being disabled, from healthy to chronically ill.

So it was with some sense of optimism that I returned to the room and stated my case. "I have some good news for you, Ms. Corinth. I'm confident that I can treat your knee and get you back on track. I can't comment on what happened to you two years ago. I don't know if you had Lyme disease then, but I'm quite sure you don't have Lyme disease now. What I think you ..."

For a moment, stunned silence. Then her face collapsed, and she buried her head in her hands, sobbing uncontrollably. "You don't believe me either. I knew it. My sister said I should come see you, but you don't believe me. You don't believe me."

I handed her a tissue, and she dabbed her eyes. Could I have phrased my thoughts differently? "Please. Wait. Let me explain. I believe I can help you," I continued, as she gathered her notebook and purse to leave. "Do you need a minute? I can wait."

I cracked my neck to the right. My throat was dry. An involuntary, barely visible tremor in my right index finger drew my attention. Hello old friend. To occupy the index finger, I surreptitiously palpated my pulse on the other hand. That's strange. I'm sweating like a pig and about to ignite from stress and my pulse is a rock-steady 60 per minute. Go figure. The human body is a strange admixture of mind-body interactions. Some make sense; some don't.

She stood and dropped her glasses, bent and an envelope fluttered to the floor. Collapsing back in her seat, she held the notebook against her chest as if I might pry her story away. Week by week, month by month, she has battled progressive pain and fatigue, learned all she could about the mystery and complexities of living with chronic Lyme disease, and I'm telling her the doctor she's placed complete trust in has it all wrong.

Psoriatic Arthritis

"The good news is that you have psoriatic arthritis. The scaly patches on your elbow and thigh are psoriasis. The pits on the fingernail and the lifting up of the edge of the nail represent psoriatic nail involvement. The swollen knee: psoriatic arthritis."

Ms. Corinth readjusted her glasses and considered my opinion. She carefully placed the notebook on the table and smoothed the edge of her skirt. "Then why do I feel better when I'm on IV antibiotics? Is that a treatment for psoriatic arthritis?" she asked finally.

"There are many reasons why people feel better with a treatment they believe in. In fact, in several scientific trials in chronic Lyme disease, when IV ceftriaxone was compared with an IV saline placebo, both groups improved. The problem is, the placebo group improved as much as the antibiotic group. But remember, I'm saying symptoms. Your knee swelling, that's not a symptom like fatigue or difficulty with concentration, it's a sign, a measurable objective finding. I don't see where that has improved with long-term treatment with antibiotics. Has it?"

She glumly looked at her knee. "I'm not sure. Sometimes I think it's getting better."

"Right. Only it's not. Look at how much you've declined during the past two years. A year ago, you didn't need a cane to walk. A year ago, you were working. If you allow me to treat you for psoriatic arthritis, we can both see if the swelling responds to changes in medical management. I can re-aspirate it periodically and assess if the number of inflammatory cells in the fluid is diminishing."

She rubbed her knee and flexed it slowly back and forth. "What kind of medication would you suggest?"

"Okay. So this is what I think we should do. I want to begin a weekly medication called methotrexate. It's an older drug; it's been around more than 40 years, so we know a lot about how it works, the risks, the benefits. It's usually very effective for psoriatic arthritis and ..." As I talked, I noticed she was typing in information on her iPhone. "Although we need to monitor it for side effects with blood counts and liver testing, the knee swelling should respond ..."

"It says here," Mrs. Orthodoxy interrupted me, "It says here, that methotrexate is a drug that is used in chemotherapy. It's an immunosuppressant, a cancer drug."

"That's true." The tremor in my finger was back. I swallowed and fought back the urge to escalate the conversation. But from the tone in her voice, I can tell we're done. She has no faith in my assessment or recommendations.

I could emphasize that the dose of methotrexate we use in inflammatory arthritis is about 2% the dose that is used in chemotherapy. I could say that in low doses, it is not an immunosuppressant but rather an anti-inflammatory medication. I could say that in the practice of rheumatology, methotrexate is a bedrock of treatment, the benefits far outweighing the risks. Some of our patients have been safely on methotrexate

for more than two decades. If methotrexate fails, a new class of medications, biologic response modifiers, such as etanercept and infliximab, are often remarkably effective in the management of psoriatic arthritis.

Instead, I stood and said, "I'll be back in a moment. I need to check with my nurse on something."

Outside the exam room, I leaned against the wall and shut my eyes. There is no way forward. From past experience, I know where this is going. I can't convince this woman that she does *not* have Lyme disease. It's as if logic is irrelevant. She has a belief system, a systematic, comprehensive belief system, which is at its core, contradictory to my belief system. We belong to different churches. We subscribe to different religions. She won't convert, because my facts are not enough. Progressive disability is not enough.

I am the establishment. I am playing the role of the Catholic Church in the Dark Ages, and she and Dr. F. are Galileo and Copernicus claiming that the earth orbits around the sun and not the other way around. I represent the status quo; convinced that the Lyme spirochete follows the accepted rules of infection, that it is susceptible to routine courses of antibiotics, and that standard scientific methods can help us unravel the mystery

of why some patients with Lyme disease recover and some don't. Except that there is no great mystery here: Ms. Corinth has psoriatic arthritis and not Lyme disease.

I can bring up the fact that her swollen toe began *after* antibiotics started. I can explain that her laundry list of symptoms—her progressive pain and disability—is shared by many patients with progressive arthritis. The tremor in my finger resolved. This is not a consult, it is an ecumenical meeting. I can only offer what I can offer. I returned to the exam room.

"Okay, now where were we?"

"We were talking about medications," Ms. Corinth replied.

"Right. And I assume you've had a chance to read more about methotrexate?" I asked.

"I have. And I would never take a drug like methotrexate. Dr. F. has a plan. He's explained to me that the Lyme infection hides out inside cells. It's constantly changing and evolving. That's why I need to bathe my system with combinations of antibiotics, to catch it when it emerges.

My immune system has been devastated. We need to build it up with supplements and changes in diet, and you're asking me to ingest a drug that will tear down my immune system and poison my liver."

"So then, I guess we'll need to agree to

disagree." I realized I was no longer actively engaged. I chose my words carefully. "I'm sorry, that so far, your inflammatory arthritis, what I am calling psoriatic arthritis, hasn't responded to what Dr. F. has prescribed. And if you don't want to take the kind of medications I suggest, I'll summarize my thoughts to your primary care doctor and leave the door open to see you in the future. If you change your mind, I can ..."

The Patient's Real Goal

"That's fine, except for one thing. I need a letter so that I can keep getting the IV antibiotics through my port. That's all Dr. F. and I need from you. I've just started a gluten-free diet, and I think it's already helping."

"No. I'm sorry, but I'm not willing to do that. I wish you the best. I really do." I stood up and extended my hand. The visit was over. "If you change your mind ..."

I don't remember what she said as she gathered her belongings and stormed out. Her limp was real. Her disease was real, only it was the wrong disease.

I watched her turn the corner toward the check-out counter and then turned my attention to the chart on the wall of my next patient. I cleared my mind as best I could and reviewed the history.

Okay. Let's see if I can help. **R**

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