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Chapter 1 : About | Rheumatology Advances in Practice | Oxford Academic

Pediatric Rheumatology in Clinical Practice, 2nd Edition provides accessible information about conditions peculiar to young patients, to assist pediatricians, general practitioners as well as rheumatologists in the diagnosis and management of these diseases.

Published online May Find articles by M. Find articles by A. Find articles by D. Find articles by N. This article has been cited by other articles in PMC. A role for vitamin D in the pathogenesis of autoimmune and inflammatory diseases is emerging. We undertook an audit of hydroxyvitamin D 25OHD investigation and treatment in rheumatology outpatients. Serum 25OHD requests were matched to electronic medical records from rheumatology and metabolic bone clinics April â€"March Values were compared with healthy adults to calculate geometric z-scores. Improved guidelines for managing hypovitaminosis D in rheumatology patients are needed. We found a high prevalence of hypovitaminosis D among secondary care patients in rheumatology and widespread supplementation with IU cholecalciferol. Substantially reduced levels of serum 25OHD were identified among patients with inflammatory arthritis and chronic pain. Vitamin D deficiency, Vitamin D, Osteoporosis, Immunopathology, Autoimmune disease, Biochemical analysis, Inflammatory arthritis, Fibromyalgia Introduction Inadequate levels of serum hydroxyvitamin D 25OHD are not only detrimental to musculoskeletal health [1] and calcium homeostasis but may also have a role in immunopathology. Understanding of the role of the active vitamin D hormone 1,hydroxyvitamin D in immunodysregulation via down-regulation of Th1 immunity is increasing [2]. Indeed, it is even hypothesized that the latitude-related prevalence of autoimmune diseases is at least in part due to regional differences in the prevalence of hypovitaminosis D [2]. Recently, 25OHD levels were found to inversely correlate with disease activity scores in RA [3], inflammatory arthritis [4] and SLE [2] but little has been published regarding the assessment and management of 25OHD the stored and readily assayed metabolite in routine clinical practice. Just as understanding of cardiovascular risk and its profiling in rheumatological practice has increased, so rheumatologists are ideally placed to assess and manage hypovitaminosis D in the outpatient clinic setting. We wished to audit patterns of investigation and treatment of hypovitaminosis D by serum 25OHD assay in general rheumatology patients and osteoporotic patients among local physicians. For rheumatology patients, there is a dearth of formal guidance on investigation for hypovitaminosis D levels in high-risk individuals with no specific recommendations to guide routine rheumatological practice. However, from a general medical perspective, a recent consensus position statement CSP; from Australia identified high-risk groups in whom a serum 25OHD assay should be performed [5]. Here we assess whether these guidelines would adequately identify hypovitaminosis D in rheumatology patients. For patients with low bone mass, we audited our vitamin D treatment against existing UK clinical guidelines [6]. By matching consultant codes to the local biochemistry database we identified 25OHD requests in patients 7. Records were anonymized and requesting and prescribing were audited as part of standard rheumatological practice. Sixteen patients with a documented diagnosis of hyperparathyroidism were excluded leaving We audited two main aspects of vitamin D management in secondary care; investigation and treatment. Standard 1â€"investigation For osteoporosis Group 1 , existing UK clinical guidelines [6] do not specify vitamin D investigation in individual patients. Neither do standards nor recommendations exist for the investigation of serum vitamin D among rheumatology patients. In the absence of satisfactory national audit standards, we used an alternative approach. We sought to establish how many patients outside these CPS categories had hypovitaminosis D in routine practice in order to assess if these standards were appropriate for investigation of rheumatology and osteoporosis patients in the UK. Data on skin colour was not available. We also examined documentary evidence of vitamin D supplementation or dietary modification advice in general rheumatology patients Group 2. The reference intervals determined were validated for the IDS assay by linear regression studies data not shown. The use of z-scores meant that measurements were no longer season dependent. Definitions of hypovitaminosis D a level insufficient to prevent secondary hyperparathyroidism are controversial.

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Chapter 2 : Rheumatology - Clinical Practice - ReachMD

The American College of Rheumatology places a high priority on developing methodologically rigorous, evidence-based clinical practice guidelines that take into consideration the expertise and viewpoints of multiple stakeholders in a transparent fashion. Individuals and organizations interested in.

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Chapter 3 : Hypovitaminosis D among rheumatology outpatients in clinical practice

Evidence-based updates of best clinical practice across the spectrum of musculoskeletal conditions.. Best Practice & Research: Clinical Rheumatology keeps the clinician or trainee informed of the latest developments and current recommended practice in the rapidly advancing fields of musculoskeletal conditions and science.

Advanced Search Abstract Objective. Remission constitutes the best achievable state in patients zwith rheumatoid arthritis. We aimed at evaluating sustained remission in a large cohort of patients followed prospectively in clinical practice and to evaluate available instruments to define remission for their stringency in defining this state. We analysed remission and sustained remission in patients who had two consecutive and complete clinical observations; the average period between the two visits was 92 days median; quartiles: Sustained remission was defined as remission at both consecutive visits. Remissions at any one of the two visits were seen in Sustained remission was observed in much lower proportions of patients between Sustained remission is an achievable goal in clinical practice even with the most stringent of the definitions studied. Therapeutic goals and strategies have changed over the last decade with high dose weekly methotrexate MTX portending the change in the treatment landscape before the era of biological agents [1 , 2]. Importantly, however, since high disease activity is associated with poor outcome of RA [3â€”6], therapies have recently aimed at achieving low disease activity. In fact, two very recent trials targeting low disease activity states by changing treatment in conjunction with tight control strategies have revealed that this concept, when compared with less stringent strategies, improves functional and radiographic outcomes over the short term [7 , 8]. Nevertheless, even under such apparently ideal therapeutic settings, mean or median joint damage still increased significantly over time in states of low disease activity [7â€”10]. This suggests that such states might not constitute the optimal therapeutic aim. Indeed, a need to achieve remission has been recently advocated [11â€”13]. On the other hand, the term remission is still ill-defined, and the various remission criteria allow different degrees of disease activity to be called remission [14â€”19]. Nevertheless, remission as a reflection of no, or at the most, minimal disease activity ought to ensure maximal reversal, preferably normalization of functional impairment and minimal progression of joint destruction, ideally halt and even healing of joint destruction [10 , 20â€”22]. This issue will need to be addressed thoroughly in future trials to learn if asymptomatic synovitis, which does exist according to sonographic studies [23], is also associated with progression of joint damage. However, the vast majority of patients with absence of clinically discernible synovitis do not progress individually [24] and as a group irrespective of the type of therapy [25]. Clinical trials are idealized situations in which, by virtue of study design and control of case record forms, adherence to study principles is high. Inclusion and exclusion criteria require studying a pre-selected group of patients, often greatly differing from most patients seen in clinical practice. In contrast, observational studies usually include all patients seen, irrespective of their disease activity, underlying comorbidity or therapy, and the data generated, therefore, reflect routine care situations. Routine clinical care is influenced by patient and physician preferences and potential biases. Thus, while controlled clinical trials provide first line evidence of efficacy and safety of a therapeutic or treatment strategy in a selected group of patients, observational studies inform on effectiveness in the long term [26]. Moreover, rather than allowing judgement on the relatively few patients engaged in successful arms of randomized controlled clinical trials, results of observational studies help understanding transpositions of new paradigms or treatment guidelines into daily care and the degree of benefit from such translation of study results into practice. Currently, it is still insufficiently known how frequent patients achieve remission, this foremost desired state, under conditions of routine clinical care. Therefore, in the present study we aimed at determining remission by various validated indices among an observational RA patient cohort who underwent regular, prospective control examination employing mandatory use of a clinical database at every visit. Patients and methods Patients and clinical assessment Over a period of 12 months in , patients with RA according to the ACR classification criteria [27] were followed in our out-patient clinic prospectively using a database established for routine clinical CAre of RA CARAbase. Of these patients, complete datasets for two consecutive visits were available in patients within the month

period studied. Baseline demographic data of these patients are shown in Table 1.

Chapter 4 : The Brigham Board Review in Rheumatology | Rheumatology |

For rheumatology patients, there is a dearth of formal guidance on investigation for hypovitaminosis D levels in high-risk individuals (with no specific recommendations to guide routine rheumatological practice).

Chapter 5 : What is a Rheumatologist?

The American College of Rheumatology (ACR) convened a Working Group (WG) to comprehensively evaluate the validity, feasibility, and acceptability of available RA disease activity measures and derive recommendations for their use in clinical practice.

Chapter 6 : Assessing remission in clinical practice | Rheumatology | Oxford Academic

Pediatric Rheumatology in Clinical Practice will be of particular interest to rheumatologists in practice, residents on rotation through the rheumatology clinic, primary care physicians, hospital doctors, as well as to senior nursing staff.

Chapter 7 : Clinical Practice Guidelines

Find clinical practice guideline summaries for the Rheumatology medical specialty area. These clinical guideline tools are designed to assist clinicians in evidence-based best practices and improving patient outcomes.

Chapter 8 : Best Practice & Research: Clinical Rheumatology - Journal - Elsevier

Read the latest articles of Best Practice & Research Clinical Rheumatology at www.nxgvision.com, Elsevier's leading platform of peer-reviewed scholarly literature.

Chapter 9 : Rheumatology in Practice - Immunology - Clinical Care Options

A rheumatologist is an internist or pediatrician who received further training in the diagnosis (detection) and treatment of musculoskeletal disease and systemic autoimmune conditions commonly referred to as rheumatic diseases. These diseases can affect the joints, muscles, and bones causing pain.