Mini Review

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Acute articular syndrome as a cause of disability

Abstract

The purpose of the study is to explain the newly system of acute articular syndrome (AAS) management in Saint-Petersburg. This system provides a purposeful routing for AAS patients from outpatient centers and ambulances directly to the Institute of Emergency Care with a goal to their concentration in the multispecialty hospital for differential diagnostics procedures with simultaneous beginning of symptomatic and pathogenetic therapy. We analyzed the main principles of differential diagnostics of AAS and groups of nosological forms. Recommendations on optimizing the algorithm of examination of patients were revealed.

Acute pain syndrome as the main reason of patient's disability. There are different nosological forms lead to hospital admission, but the most often are ASS in osteoarthritis, rheumatoid arthritis and goat attack.

Keywords: acute articular syndrome, pain, disability, emergency care, system of medical care

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Introduction

Most rheumatology hospitals provide only the planned hospitalization of rheumatic patients, however, the problem of hospitalization and medical care for patients with acute articular syndrome (AAS) had not previously been solved.[1,2] The publications' review didn't identify any data with analogs of our approach of creating the special ASS management system.

Methodology

Since 2008 in Saint-Petersburg Scientific Research Institute of Emergency Care named after I.I. Dzhanelidze was developed and implemented the ASS management system.[3] One of the system's main purposes was to create opportunities of hospitalization for emergency indications patients not only with any nosological diagnosis, but also with a preliminary AAS as the assignment diagnosis.

This new approach was realized at the 7/24 on duty multidisciplinary emergency medicine hospital allows using all diagnostic capabilities of the emergency department, to ensure the consultation of different medical specialists.

Results

Our system provides a purposeful routing for AAS patients from outpatient centers and ambulances directly to the Institute of Emergency Care with a goal to their concentration in the multispecialty hospital for differential diagnostics procedures with simultaneous beginning of symptomatic and pathogenic therapy.[4]

We analyzed the main principles of differential diagnostics of AAS and groups of nosological forms. Recommendations on optimizing the algorithm of examination of patients were revealed.[3] Acute pain syndrome as the main reason of patient's disability.[5–7] There are different nosological forms lead to hospital admission, but the most often are ASS in osteoarthritis,[1,8] rheumatoid arthritis[1,8] and goat attack.[9,10]

The purpose of ASS management is to stop pain syndrome, so patient became to be more mobile.[6,11] Simultaneously, we start or correct previous variant of ethiopathogenetic treatment to prevent disease

progression.[9] All this procedures make brakes disability pathogenic chains and allows improving patient's physical functioning. Complex of such methods lead to decrease hospital admission period and using of outpatient treatment possibility can minimize seek live days.[2]

We summarized the treatment experience in our Institute from a cohort of 1658 AAS patients. The distribution features of the patients with recurrence of articular syndrome in previously verified diagnosis and newly diagnosed disease requiring clarification of nosological were focused, because they can improve our hospital algorithms and decline patient's disability period.

Conclusion

Successful experience of creation and confirmed the effectiveness of the system of providing medical care for AAS patients allow us to recommend its widespread introduction.[3]
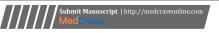
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Conflict of interest

The authors declare no conflict of interest.

References

1. Aggarval A., Chandran C., Misra R. Physical, psychosocial and economic impact of rheumatoid arthritis: a pilot study of patients seen at a tertiary care referral center. *Natl Med J India*. 2006;19(4):126–130.
2. Garbez R., Puntillo K. Acute musculoskeletal pain in emergency department: a review of the literature and implications for the advanced nurse practice. *AACN Clin Issues*. 2005;16(3):310–319.
3. Povzun AS. Principles of diagnosis and management for acute junction syndrome patients. *Osteoporosis Int*. 2012(23):144–145.
4. Jackson JL, OMalley PG, Kroenke K. Evaluation of acute knee pain in primary care. *Ann Intern Med*. 2003;139(7):575–588.
5. Barrett EM, Scott DGI, Wiles NJ, et al. The impact of rheumatoid arthritis on employment status in the early years of disease: a UK community-based study. *Rheumatology*. 2000;39(12):1403–1409.

6. Burton W, Morrison A, Maclean R, et al. Systemic review of studies of productivity loss due to rheumatoid arthritis. *Occup Med*. 2006;56(1):18–27.

7. Smith E, Hoy DG, Cross M, et al. The global burden of other musculoskeletal disorders: estimates from the Global Burden of Disease 2010 study. *Ann Rheum Dis*. 2014;73(8):1462–1469.

8. Berthelot JM, Preiss P, Langiller M, et al. Frequency, severity and duration of transient flares in rheumatoid arthritis: a survey of 403 patients. *Ann Rheum Dis*. 2014;73(2):274–275.

9. Choi HK, Niu J, Neogi T, et al. Nocturnal risk of gout attacks. *Arthritis Rheumatol*. 2015;67(2):555–562.

10. Dehlin M, Drivelegka P, Sigurdardottir V, et al. Incidence and prevalence of gout in Western Sweden. *Arthritis Res Ther*. 2016;18:164–171.

11. Teichtahl AJ, Cicuttini FM. Pain relief of osteoarthritis: the potential for a perfect storm. *Arthritis Rheum*. 2016;68(2):270–273.