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## CONTROLLING ARTHRITIS MORBIDITY — A JOINT EFFORT

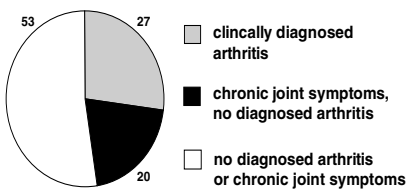
WHILE ARTHRITIS can certainly be a pain in the keister, it is better known for the pain, stiffness, and in some cases swelling it causes elsewhere. The term, as used in CDC's surveillance definition, encompasses a large, diverse (and at times bewildering) array of conditions and disease processes that affect the joints and other parts of the body. These include osteoarthritis, rheumatoid arthritis, lupus, juvenile rheumatoid arthritis, gout, fibromyalgia, bursitis, and Lyme disease. In this issue of the *CD Summary*, we'll review the impact of arthritis on Oregonians' quality of life, and discuss the benefits of physical activity in limiting the morbidity and disability it causes.

### WHAT'S THE IMPACT OF ARTHRITIS IN OREGON AND THE U.S.?

In 2001, an estimated 49 million U.S. adults had health-care provider-diagnosed arthritis. Of those, 21 million (43%) had osteoarthritis. An additional 21 million adults complained of chronic joint pain, but reported that they hadn't been diagnosed with arthritis.[1]

In Oregon, 700,000 adults had clinically diagnosed arthritis, and an additional 500,000 adults reported chronic joint symptoms. Combined, that's almost half of the adult population (see figure). This may sound like good news if you're heavily invested in aggressively marketed NSAIDs, but for the rest of us, it constitutes a major public health problem. By 2025, more than 2 million Oregonians will likely be affected by some kind of arthritis, based on the aging of the population and marked increases in obesity, both of which are risk factors for osteoarthritis (the most common form). In addition, arthritis is a leading cause of disability; it restricts people's daily activities, affects their ability to work, and decreases the quality of life of millions of Americans.[2] More than 8 million Americans report that arthritis circumscribes things most people do every day, such as walking and dressing.[3] Here in Oregon, adults with arthritis are more likely to be inactive than those without it. Among Oregonians with clinically diagnosed arthritis, 24% are inactive compared to 15% of those without the condition. In addition, 29% of adults with clinically diagnosed arthritis are obese compared to 17% of those without it. Overall, in 2002, 34% of those with clinically diagnosed arthritis under the age of 65 years reported being unable to work compared with 15% of those without arthritis. Nationally, arthritis trails only heart disease as the leading cause of missed work among employed Americans.[4]

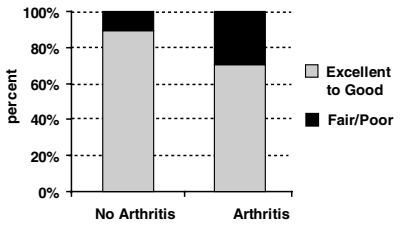
**Percentage of adult Oregonians with arthritis, 2002**




Disability from arthritis creates enormous health-care costs for individuals, their families and the state. In Oregon during 1997, the estimated direct medical expenses and indirect costs from loss of productivity due to arthritis topped $1 billion.[5]

Activity constraint occurs frequently among people with arthritis and reduces their quality of life, restricts independence and compromises health. Severe impairment of physical activity due to arthritis can increase the risk of developing or exacerbating other health conditions such as obesity, diabetes, heart disease and even several forms of cancer. In Oregon, of those who have clinically diagnosed arthritis, 40% report restricted activity due to joint symptoms. Arthritis adversely affects not only the physical well-being of the people who live with it, but their mental and emotional health as well. The figure below shows perceived health status on a scale from excellent through poor. People without clinically diagnosed arthritis are more likely to rate their health as excellent or very good. Conversely, 30% of people with clinically diagnosed arthritis reported having fair or poor health, compared to 11% of people without it.

**Reported health status among Oregonians with and without arthritis**




It is all rather daunting, but happily, there are a number of evidence-based steps that clinicians can take to limit the public health impact of arthritis and to help patients with arthritis improve their quality of life. Early diagnosis, appropriate clinical care, and use of self-management strategies such as physical activity, education, and maintaining appropriate weight can reduce the impact of arthritis.

### CATCHING THE PROBLEM EARLY

With half a million Oregonians with chronic joint symptoms but no arthritis diagnosis, we know that there are more than a few out there who might benefit

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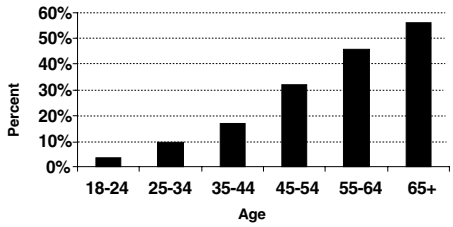
from a bit of medical attention in this area. Early diagnosis and appropriate treatment of osteoarthritis can slow loss of function, decrease chronic pain, and avoid potentially dangerous overuse of NSAIDS and acetominophen. Early treatment of rheumatoid arthritis with disease-modifying anti-rheumatic drugs (DMARDs) can improve long-term health.[6]

So who is at particular risk for arthritis? There are several readily identifiable risk factors. Three of these are non-modifiable: sex, age, and genetic predisposition. Women are more likely to have arthritis than men (32% vs. 23%). Half of Oregonians age 65 or older are affected by arthritis, and the risk of developing arthritis increases with age (see figure). That's not to say that the elderly are the only ones affected by arthritis. Nearly 66% of Oregonians with clinically diagnosed arthritis are younger than 65 years old. Finally, certain genes are known to be associated with a higher risk of some types of arthritis.

Although there is not too much your patients can do about age, sex, or heredity, there are several potentially modifiable risk factors for arthritis morbidity. These include obesity, physical "wear and tear" on joints (both of which increase the likelihood of osteoarthritis) and physical inactivity, which is associated with higher levels of arthritic pain and loss of function. (More on that later.)

**Percentage of adults with clinically diagnosed arthritis by age group, Oregon, 2002**




## PATIENT RESOURCES

Overall, 73% of people with chronic joint symptoms have seen a doctor or other health professional for evaluation of joint problems. These visits provide a great opportunity to decrease the personal and public health burden of arthritis. Self-management courses, such as the Chronic Disease Self-Management Program, have been shown to reduce pain by 20% and decrease physician visits by 40% in patients with chronic arthritis.[7] Such courses focus on management of pain, disability, fear, and depression as well as on development of more generic self-management skills to adapt to fluctuations in the level of disease activity or disability. These strategies have been shown to be effective in providing long-term pain relief. For more information, go to *www.oshd.org/arthritis/commpro.cfm #cdsmp*.

Physical activity is recommended by the American College of Rheumatology as a first-line treatment for osteoarthritis and rheumatoid arthritis. Regular physical activity of moderate intensity yields improvement in muscle strength, function, and psychosocial status, not to mention cardiovascular health and fitness — all without injury or aggravation of the arthritis. In one study, just 30 minutes of walking 3 times a week and a brief set of stretching and strengthening exercises led to clinically significant improvements in functional status and endurance, while significantly decreasing pain and analgesic use among patients with knee osteoarthritis.[8] The Arthritis Foundation has a number of courses that promote exercise and aerobic conditioning. They include People with Arthritis Can Exercise (PACE) and the Arthritis Foundation Aquatic Program. Check out the Arthritis Foundation website for information about community programs and classes around the state (*http://www. arthritis.org*). By encouraging patients with arthritis to try the exercise option, clinicians can help them open the door to increased activity, improved quality of life, better cardiovascular health, and decreased pain, all without added risk of liver toxicity or NSAID-induced gastropathy. Let them know; they'll be glad you did.

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