



IRA E-BULLETIN : ISSUE 1 | JANUARY 2020

INTERVENTIONAL RHEUMATOLOGIST

Ever-Expanding Field of Procedural Rheumatology

We must have all heard the following comments from peers and seniors when we first expressed an interest in rheumatology: ‘treating old people,’ and ‘managing disabling diseases in patients who will never get better.’ I was used to these comments when I started expressing my interest in rheumatology many moons ago. However, I was surprised when one of my colleagues informed me that his professors seemed to suggest that the specialty itself is populated by ‘lazy’ specialists. ‘Specialty for retired people’ and ‘armchair specialty’ are some of the ways in which he used to describe rheumatology. I found this perception to be pervasive not only among the general medical fraternity but among medical administrators as well. Youngsters opting for other medical specialties were sometimes drawn toward the interventions available in other specialties like cardiology and gastroenterology; rheumatology was considered a non-interventional specialty.

On the contrary, Rheumatology, since its inception, has had interventions. The disease of kings (i.e. gout) was diagnosed by synovial fluid aspiration and examination. However, in the previous decades the interventions remained a few and far between. Today, musculoskeletal ultrasound has become a standard inclusion in the rheumatology curriculum and with this, trainee rheumatologists commonly use a lot of interventional procedures in their day-to-day practice. Perceptions, sadly, have not kept pace with how our specialty has evolved.

I was glad that after a long hiatus (a decade), a half-day workshop on interventional/procedural skills was included in the recently concluded IRACON 2019 held at JIPMER, Puducherry. The presence of such a workshop in the national conference recognizes the importance of interventions in our specialty and showcases the interventions in our specialty to young doctors considering a future career in rheumatology.



“An interventional procedure is defined as any procedure used for diagnosis or treatment that involves incision; puncture; entry into a body cavity; or the use of ionizing, electromagnetic, or acoustic energy.”

There were a number of procedures that were discussed. Many others were not included but could form a part of the curriculum of future workshops (Table).

PROCEDURE	FACULTY	PROCEDURES NOT PART OF THE WORKSHOP
Arthroscopic synovial biopsies	Dr. Mihir	1. Spine–facet joint injection
Sacroiliac joint injection	Dr. Sharath	2. Temporomandibular joint injection in JIA
Hip joint injection	Dr. Vikram	3. Trigger finger injection
Muscle biopsy	Dr. Vivek Vasudev	4. Tendon needling
Minor salivary gland biopsy	Dr. Paul Antony	5. Dry needling for myofascial pain
Skin biopsy	Dr. Mithun CB	6. Renal biopsy
Nerve biopsy	Dr. Dantis Emmanuel	7. USG-guided synovial biopsy
Evaluation of dry eye	Dr. Ramesh Babu	8. Temporal artery biopsy
		9. Intralesional injections for DLE

In addition to didactic teaching, there were hands-on sessions by Dr. Vivek Vasudev who instructed delegates on muscle biopsy on a piece of mutton, using ultrasound (Figure 1). As if this was not amazing enough, the procedure for muscle biopsy that Dr. Vivek Vasudev had perfected was nothing less than a spectacular Indian invention (or ‘Jugaad’). The biopsy was done using a BARD biopsy gun (renal biopsy gun). Multiple samples are taken during the procedure and Dr. Vivek presented data on how this procedure yielded sufficient samples for making a diagnosis. “Muscle biopsy without a single cut/ stitch.”

Another session that was well received was the session on sacroiliac joint injection by Dr. Sharath. Dr. Sharath pointed out that this is a simple and effective procedure that could be used in patients with NSAID-resistant spondyloarthritis, which could reduce the need for anti-TNF in the subset of axial spondyloarthritis patients with isolated sacroiliac involvement. Dr. Vasudev said unpublished data from Armed forces showed that these patients benefit significantly from the blind injection as well. Dr. Sharath agreed with the same and presented published data from the rest of the world, which seemed to suggest that blind injection is as effective as USG-guided injection. Hence, clinicians should not be hesitant in offering the same to their patients.

The delegates (Figure 2) who attended the workshop (numbered more than 30) went home all the wiser. Hopefully, this has laid the bedrock for what is to become a regular feature in all national conferences and has inspired the delegates to innovate and come up with a rheumatological in(ter)vention of their own.

Figure 1: Hands-on demonstration of percutaneous muscle biopsy using a biopsy gun by Dr. Vivek Vasudev using a mutton piece.



Figure 2: Delegates watching the presentation on hip joint injections.



Dr. Vikram Raj Jain,
MD, DM. Consultant Rheumatologist Mahaveer Jain Hospital, Bangalore.

Disclaimer

The views expressed in this newsletter do not necessarily reflect those of the sponsor. The sponsor does not assume any responsibility for copyright infringement, if any. Please consult full prescribing information before prescribing any of the products mentioned in the newsletter. The information provided in this newsletter is for scientific dissemination to medical professionals only and does not necessarily reflect the opinions of IPCA Labs. Dosages, indications, method of use of products and all other related information by the authors may reflect their own clinical experience.