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POLYMORBIDITY PATIENT IN FAMILY PHYSICIAN PRACTICE

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Summary. The article presents the polymorbidity spectrum in rheumatoid arthritis and lupus erythematosus patients based on own research and discusses the role of family physician in these patients care.

Key words: family physician, polymorbidity, comorbidity, rheumatoid arthritis, systemic lupus erythematosus.

Резюме. У статті представлено дані, одержані у власному дослідженні, щодо спектра поліморбідності серед хворих на ревматоїдний артрит і системний червоний вовчак та обговорюється роль сімейного лікаря у ведення цих груп пацієнтів.

Ключові слова: сімейний лікар, поліморбідність, коморбідність, ревматоїдний артрит, системний червоний вовчак.

Резюме. В статье представлены данные собственных исследований о спектре полиморбидности среди пациентов с ревматоидным артритом и системной красной волчанкой, обсуждается роль семейного врача в системе оказания помощи этим контингентам пациентов.

Ключевые слова: семейный врач, полиморбидность, коморбидность, ревматоидный артрит, системная красная волчанка.

Introduction. The interest of the researchers to polymorbidity of the rheumatic patients is constantly increasing during the last decade, but the concept is not yet integrated into clinical practice.

It is well known that narrow specialist rather rarely pays serious attention to the patient's polymorbidity, mostly working by use of biomedical approach where the centre of attention is the disease as a separate entity. In contrast, for family physicians who are engaged in patient observation and treatment and use the holistic and patient centred approach, the problem of "polymorbidity patient" is mostly the rule rather than the exception. Family doctor deals with the patient as a whole, works both with undefined and undifferentiated states and syndromes, acute and chronic diseases and their combinations, and with terminal conditions as well. In each contact family doctor determines the need and direction of additional consultations and examinations, and after all puts together all patient's related issues and helps patient to make proper decisions about any needed interventions, always assessing the impact of patient's comorbidities, and all personal features, what in general means "holistic", "comprehensive" or "personified" approach. In family medicine philosophy effective management of patients is not possible without the analysis of patient's personality, comorbidity, predictors and risk factors, and calculation of the of the potential complications probability.

Polymorbidity is the presence in an individual of several diseases with simultaneous development, which can share pathogenesis and genetic basis [10, 2, 5].

Comorbidity is the coexistence of two and more syndromes or diseases in one patient which are pathogenetically interrelated or coincidental in time [11, 14].

Multimorbidity is the condition where two or more etiopathogenetically unrelated chronic diseases are present [2, 5, 9].

It is established that rheumatic diseases (RD) form one of the major groups of chronic diseases with the greatest contribution to increasing disability and also is one of the most often cases for visiting family doctor. [6, 12].

The most common condition which complicate the RD is cardiovascular disease (CVD) [7, 11], interstitial lung disease [4], osteoporosis (OP), chronic kidney disease [1], malignant neoplasms [8] and depression [13].

Objective: to evaluate and analyze the comorbidity in rheumatoid arthritis (RA) and systemic lupus erythematosus (SLE) patients.

Material and methods. The study was conducted at the Department of Family Medicine of Shupyk National Medical Academy of Postgraduate Education (based on the Kyiv Regional Clinical Hospital). The study included 126 patients with RA, 18-55 years, (102 women and 24 men), and 80 patients with SLE, 24-41 years, (all female). All patients gave written consent to participate in the study.

The control group consisted of 60 people without autoimmune diseases, inflammatory conditions and diseases; without any chronic disease in active phase; they do not take regularly any medications; all of them also gave the informed consent to participate in the study. The control group was divided into 2 subgroups: group to compare with the RA patients (n=30, 25 women and 5 men (83.3% and 16.7% respectively), the average age of 42.4±8.6 years) and the group to compare with SLE patients (30 women, average age 34.3 ± 1.0 years).

We did not include any patients with known history of the major infectious diseases (tuberculosis, HIV, viral hepatitis), amyloidosis and malignancies, signs of heart or other organs failure; SLE patients with the nephrotic syndrome or acute nephritis.

All patients underwent a careful general and rheumatologic examination. Laboratory tests have been performed in the hospital laboratory. Ultrasound examination has been performed by use of ULTIMA PRO-30 "RADMIR" equipment (Kharkiv).

Results. Different comorbidity has been found at the most RA (65.1%) and SLE (58.75%) patients, which was significantly higher than in control group (table 1 and table 2).

Table 1

COMORBIDITY IN RA PATIENTS AND CONTROL GROUP

Diseases and conditions	RA (n=126)		Control (n=30)	
	n	%	n	%
Coronary heart disease	12	9.52*	0	0
Arterial hypertension	47	37.3*	0	0
Neurocirculatory asthenia	2	1.58*	1	3.3
Dyslipidemia	76	60.32*	2	6.67
Gastrointestinal ulcer	6	4.76*	1	3.3
Chronic gastritis	29	23.0	3	10.0
Chronic pancreatitis	19	15.07	5	16.67
Nonalcoholic fatty liver disease	77	61.1*	2	6.67
Cholesterosis of the gallbladder	38	39.18*	1	3.33
Chronic cholecystitis	46	47.42*	3	10
Gall stones	8	8.25*	0	0
Diabetes mellitus type 2	3	2.38*	0	0
Thyroid diseases	5	3.96*	0	0
Autoimmune thyroiditis	35	27.77*	0	0
Chronic bronchitis	3	2.38	4	13.3
Osteoarthritis of the spine	42	33.3	6	20.0

Note: * - the difference between groups is significant, p<0.05

The main additional disease in RA patients in our study was CVD (46.8%), which is in accordance to the international data [3]. Significant proportion of comorbidity in RA patients consisted of different types of the liver and biliary tract disorders (HBTD) – 76.9%; major of the RA patients (62.70%) – dyslipidemia and DM; 69.35% of the patients had 2 and more diseases (except of RA).

COMORBIDITY IN SLE AND CONTROLS

Diseases and conditions	SLE (n=80)		Control (n=30)	
	n	%	n	%
Dyslipidemia	39	48.75*	3	9.99
Gastrointestinal ulcer	4	5.00	1	3.33
Chronic gastritis	17	21.25	5	15.25
Chronic pancreatitis	7	8.75	1	3.33
Nonalcoholic fatty liver disease	4	5.00*	0	0
Chronic cholecystitis	7	8.75	3	9.99
Gall stones	1	1.25	0	0
Menstrual disorders	10	12.50	2	6.66
Autoimmune thyroiditis	4	5.00*	0	0
Chronic bronchitis	9	11.25	3	9.99
Chronic pyelonephritis	21	26.25*	2	6.66
Osteoarthritis of the spine	10	12.50	4	13.32

Note: * - the difference between groups is significant, $p < 0.05$

In SLE patients the pathology of urinary system (pyelonephritis 26.25%) was most prevalent. Significant proportion of comorbidities was made by gastrointestinal diseases (26.25%), metabolic disorders, pathology of thyroid gland without dysfunction, menstrual disorders; 51.25% of the SLE patients had 2 and more additional diseases.

Conclusion. According to the results of our study the majority of SLE and RA patients have polymorbidity, which can seriously influence the course of RD and its treatment. Thus, all the patients with above mentioned RD need integrated medical care which involves family doctor and different specialists with further detailed consultations based on holistic and patient-centred approach to evaluate all the polymorbidities in their interactions and assist patients to make decisions regarding their health. The coordinator of this great job must be family physician, who can recognize the huge of the polymorbidity problem and can professionally combine and personify the specialist's recommendations, seeing each patient as a unique person.

References

1. Anders H.J., Vielhauer V. Renal co-morbidity in patients with rheumatic diseases. // *Arthritis Res Ther.* – 2011. - No.13 (3). – C. 222–32. DOI: 10.1186/ar3256.
2. Jakovljević M., Ostojić L. Comorbidity and multimorbidity in medicine today: challenges and opportunities for bringing separated branches of medicine closer to each other. // *Psychiatr Danub.* – 2013. – 25 - Suppl 1. – P. 18-28.
3. Luqmani R., Hennell S., Estrach C. et al. British Society for Rheumatology and British Health Professionals in Rheumatology Guidelines for the Management of Rheumatoid Arthritis (after the first 2 years) // *Rheumatology.* - 2009. - P. 1-23. (12)
4. Marigliano B., Soriano A., Margiotta D., et al. Lung involvement in connective tissue diseases: a comprehensive review and a focus on rheumatoid arthritis. // *Autoimmunity Rev.* – 2013. - No.12 (11). – C. 1076–84. DOI: 10.1016/j.autrev.2013.05.001.
5. Meghani S.H., Buck H.G., Dickson V.V., Hammer, M.J., Rabelo-Silva E.R., Clark R., Naylor M.D. The Conceptualization and Measurement of Comorbidity: A Review of the Interprofessional Discourse. // *Nurs Res Pract.* – 2013. – P. 10. DOI: 10.1155/2013/192782
6. Perruccio A.V., Power J.D., Badley E.M. The relative impact of 13 chronic conditions across three different outcomes. // *J Epidemiol Community Health.* – 2007. - No.61 (12). – P. 1056–61.