Arthritis Myths and Misconceptions

Hosts: Rebecca Gillett, MS OTR/L and Julie Eller
Guest Speaker: Andrew Laster, MD

Arthritis is complicated. Even many people who have some form of the disease have plenty of misconceptions about it. But the more you know and the better you understand arthritis, the better you may be able to manage your symptoms.

In this podcast, Rebecca and Julie talk to long-time rheumatologist Andrew Laster, MD, about some common myths and misconceptions they all have encountered – from medication side effects and the risks associated with over-the-counter drugs to gout management and psoriatic arthritis diagnosis.

Some of these myths and misconceptions – and the truths about them – might surprise you. And they might even help you have more informed discussions with your doctor about your own health.

Andrew Laster, MD, FACR, CCD, has been practicing rheumatology for nearly 35 years. A graduate of Johns Hopkins University School of Medicine, he has been in private practice since 1986 in Charlotte, North Carolina. His clinical and research specialties are immune-mediated diseases and osteoporosis, and he frequently lectures on a national level to other health care providers. Dr. Laster also serves as assistant consulting professor of medicine for Duke University and clinical instructor in medicine for the University of North Carolina School of Medicine. He is also on the Medical Advisory Panel for *Arthritis Today* magazine.

Additional Arthritis Foundation resources:

Read more about arthritis-related misconceptions in **10 Arthritis Myths Debunked**, a feature in the May-June issue of *Arthritis Today*. Subscribe to Arthritis Today and order special interest publications on psoriatic arthritis, rheumatoid arthritis and more at https://www.afstore.org/#.

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LIVE YES! WITH ARTHRITIS PODCAST:

MEDICAL MYTHS EPISODE

Released April 14, 2020

PODCAST OPEN:

Welcome to Live Yes! With Arthritis, from the Arthritis Foundation. You may have arthritis, but it doesn't have you. Here, you'll learn things that can help you improve your life and turn No into Yes. This podcast is part of the Live Yes! Arthritis Network — a growing community of people like you who really care about conquering arthritis once and for all. Our hosts are arthritis patients Rebecca and Julie and they are asking the questions you want answers to. Listen in.

Rebecca Gillett:

Welcome to the Live Yes! With Arthritis podcast. I'm Rebecca, an occupational therapist living with rheumatoid arthritis.

Julie Eller:

And I'm Julie, a JA patient who's passionate about making sure all patients have a voice.

Rebecca:

On this episode of the Live Yes! With Arthritis Podcast, we're talking about all of those myths about arthritis out there.

Julie:
So many myths, so little time. Today, we're talking with Dr. Andrew Laster. He's a board-certified rheumatologist who's been seeing patients for 35 years. He also teaches medicine at Duke University and University of North Carolina.

Rebecca:

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So today, we are talking about all these myths that people think about when they think about arthritis.

Julie:
That's right, and we're talking with Dr. Laster today. We're so excited to have you here to help bust these myths and help us separate fact from fiction. Welcome to the podcast.

Dr. Laster:
Great, thank you. And I'm really looking forward to it.

Julie:
Thanks, yeah. So, one of the myths that I want to kick us off in talking about is one of the most frustrating arthritis myths that I have heard from every which way throughout my life, which is cracking your knuckles gives you arthritis. Is this a myth? Is this a fact? Give it to us straight, Dr. Laster.

Dr. Laster:
It is a myth. There's no evidence that cracking your knuckles causes arthritis. Some people are more prone to do that, and the sound is believed to be due to releasing of carbon dioxide when you crack the knuckles. But go ahead and crack, you really don't have anything to worry about there.

Julie:
(laughs) Say goodbye to carbon dioxide.

Rebecca:
Is that true for like, you know, like I will twist and turn my back, or my neck, and it cracks. Is that the same?

Dr. Laster:
Probably as well. You know certainly if people are doing that, they may have some muscle tension and they're trying to relieve that. We can talk later about the importance of regular exercise and range of motions. Those are clearly critical. You know, we don't want people to be sedentary just sitting on a chair all day long. So, exercise is clearly good.

Rebecca:
One of the ones that I know we want to talk about is that… people are always concerned about: If I take a medication, I will get the side effects they talk about.

Dr. Laster:

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Yeah, that's a real challenge. And I think that... You know, I've been in practice for over 30 years. And it's been a real change. I think in the last decade, more frequently I have people come in who are just totally convinced that, "If I take a drug, I'm just going to have to suffer through with a side effect." And they're really surprised to hear that our goal is really to get people on medication. Not only they'll be effective, but it should be well tolerated, and you may not even know that you're taking the medication.

I take care of patients who have arthritis, and vasculitis, and then also care for people who have osteoporosis. And I think that the fear and the concern is probably greater for people who have osteoporosis who are thinking about drugs and concerned that they might cause problems with their jaw or atypical fractures. Those are real problems. They do occur, but they're incredibly rare.

There are certain biologics where there's a small risk for perforations of the bowel. And if you're an individual and you'd had diverticulitis, if you're on nonsteroidals as well, and particularly if you've had a perforation before, we would eliminate that medication and it wouldn't be one that we would put you on.

For people, for example, who are on one of the biologics, like one of the TNF inhibitors, again, there are rare side effects. Demyelinating disease, for example. I have a patient of mine who is a physician, who needed to go on a drug, but he found out (he'd been estranged from his brother…) but found out that he had MS.

And so, you know, I think that one of the jobs that we as physicians do, you really want to take a really careful history, to find out about any prior medical problems, to make sure that they might not potentially be problematic with medication we're putting people on.

Julie:
That's a great tip. And I think what I really appreciate about that story is that it's not just something, when you hear an arthritis myth, that you should just kind of accept quietly.

Dr. Laster:
Right. I think lots of people use Dr. Google, and it's really helpful.

Julie: (laughs)

Dr. Laster:
There are a lot of good things online, but I think it's kind of an echo chamber. And this all kind of boils down to what we call risk/reward. So, patients come in, and for a number of people, they have a

perception that the risk of the drug is so high that it outweighs the benefit. And in fact, for many people, It's kind of the complete opposite. The benefit is great; the risk is real but fairly small.

Rebecca:
I'm on a biologic, and a lot of people are afraid to do that. But for me, the benefits way exceed the risks. I can function so much better. And I just try not to think about the small print…

Julie: (laughs)

Rebecca Gilliett:
...of the side effects.

Dr. Laster:
Right.

Rebecca:
Because I know that when I'm not on my biologic I don't function as well. So, it's hard. But like you said, I think the point and the takeaway here is: Talk to your doctor.

Dr. Laster:
Yeah, I, I would agree with that. I think the longer people are on a drug, and once they've been through that initial phase, they get more comfortable with it. If individuals have a problem with the medication, it's really important to alert their physician about it right away. We're talking about medication, but we're also talking about the amount of the drug you're taking or the dose. For example, we're all familiar with prednisone and side effects that can happen with prednisone, which is a steroid, in terms of weight gain, and bone thinning, and cataracts, and thin skin and the like.

But those side effects are usually related to people who are taking higher doses for a longer period of time. In contrast, if you were on just a very short course of prednisone for a flare of inflammatory arthritis, maybe you're taking 15 milligrams a day for a few days, and you gradually taper down over two weeks; the likelihood of a problem is low. It's the same for methotrexate, a really commonly used drug for treatment of rheumatoid arthritis and other types of inflammatory arthritis. The doses we use are really small compared to what has been used for chemotherapy, where the doses are 10 times or greater.

So, when you look in a package insert, you're gonna hear and see about side effects, like sores in the mouth and hair loss. And although those can happen, again infrequently on the lower doses, they are typically referring to the higher doses that would be employed for treating cancer.

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Julie:
Well, that's an amazing myth we can consider busted. And I think the best thing that we can take with us is we're separating fact from fiction when it comes to this one is: You have the power to ask your doctor about these side effects and about any side effects if you haven't read the fine print, and that they can have this conversation with you about treating your arthritis holistically, to your whole person, and that's not a scary conversation to have. So…

Dr. Laster:
Great, I agree.

Julie:
...thanks so much on that one. Yeah.

Dr. Andrew:
Yeah, sure.

Rebecca:
So, our next one that we want to ask is: If medications are available over the counter, then that must mean they're safe for everyone.

Dr. Laster:
Unfortunately, people feel that if there's a drug available over the counter, without a prescription, that it has to be safe. And we know for a number of drugs, that's not true. You know, one of the more common categories of drugs are what are called nonsteroidals, or referred to as NSAIDs. These are non-prednisone, anti-inflammatory drugs. Most people are familiar with two major nonsteroidals: One is ibuprofen, which its brand names are Advil and Motrin, and others; and then there is naproxen, which is Aleve or Naprosyn.

Because they're available over the counter, because people take them for pain, they often feel that they're entirely safe. These drugs that are available over the counter are just offered in a lower milligram amount than what we might normally prescribe. So Advil, for example, is 200 milligrams of ibuprofen. If we write a script, we could write it for that, but there is a 400-, or 600-, and then 800-milligram ibuprofen as well. And these are medications where, particularly if you're older, if you have problems with hypertension, if you have impaired kidney function, if you've had an MI, we have to be really, really cautious about using them. Be cautious about using over-the-counters, talk to your doctor about them, make sure you know that they're not conflicting with another drug that you might be on.

Rebecca:

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That is really good information. Can you for us, Dr. Laster, clarify what MI means. I know what it is, but I want you to explain it.

Dr. Laster:
MI stands for myocardial infarction, but more commonly referred to as a heart attack.

Julie:
Just one more follow-up. I think that the essence of this is really important … that you really wanna be cautious and thoughtful whenever you're taking any therapy. But even those over-the-counter drugs, you can be talking to your doctor about those as well.

Dr. Laster:
Certainly, there are a number of medications that are touted as having anti-inflammatory effects. They're natural and the like. There's an elderberry extract that has been popular lately that people have used to kind of boost their immune system. But in fact, there are cases reported of that actually triggering an autoimmune disease. I have one patient who developed lupus after going on this supplement recommendation.

Rebecca:
Oh, boy.

Dr. Laster:
Care is important. If you've got a physician following you, you definitely... And if you're on other drugs, you really wanna go over those carefully with them.

Rebecca:
It's supplements, and vitamins, and stuff like that as well.

Dr. Laster:
Right, all of that.

Rebecca:
Julie and I were actually just talking about that. We're trying to, you know, stay away from the colds and the flu everybody has. And whether or not echinacea, and Airborne, and stuff like that is good. And I had said, "I don't… I can't take that stuff because I'm on immunosuppressants." Is that right?

Dr. Laster:
The biologics that people take, that you're on, for example, are kind of lowering the flame, you know? Imagine kind of a pot of water boiling over, and the dial is turned all the way up to high. So,

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the biologics are basically kind of turning the flame down so the water isn't boiling over, but it's not knocking out the pilot. We have lots of patients who, for example, are around individuals who have colds frequently. You know, preschool, kindergarten teachers, and they generally don't get cold or flu any more frequently than other individuals.

Julie:
So let's move onto our next myth. And that is that wear and tear of arthritis can really only occur to you — or must occur to you, excuse me — as you age. That everybody is going to expect to get arthritis.

Dr. Laster:
Yeah. So wear and tear arthritis, or you know what we refer to as osteoarthritis, or degenerative joint disease, is probably one of the more common types. And it's one that typically we see as we get older. And I won't get into a definition of what is old or older, but…

Julie & Rebecca: (laugh)

Dr. Laster:
...it's a lot, it's a lot more birthdays. It turns out actually that there are individuals who can develop osteoarthritis at a relatively early age. And we see this frequently in individuals as they get older with bone enlargement and pain. But in some women in particular, because this seems to occur more commonly than in men. You know, we've seen these early changes in their 30s and early 40s. So, this is a type of osteoarthritis that definitely has a genetic, hereditary component.

The hip joint, for example, is one frequently affected with degenerative arthritis, and sometimes that can occur early because people are born with certain differences in terms of how their hip was shaped. These are called congenital defects. And then there's another condition that's not as common, but certainly of concern, called avascular necrosis, or AVN, in which blood flow to a bone like the hip, or occasionally other joints, can be interrupted. And that can lead to death of the bone tissue. And then fairly rapid degeneration.

Julie:
Can you comment on post-traumatic osteoarthritis as well, related to an injury?

Dr. Laster:
If you've had damage to a joint related to an injury, or if, you know, related as we said earlier on, you're just born with a problem, that can also lead to early degenerative changes. This is usually in weight-bearing joints, knees and ankles, for example, that may have been injured and may make individuals more likely to develop early degenerative changes.

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Rebecca:
And what about weight? How does weight play a role with osteoarthritis?

Dr. Laster:
Yeah. So, if you're overweight, and you have problems with a knee, hip, ankle or your foot, the big toe, for example — adding additional weight, that impact-bearing weight loading, can hasten degenerative changes.

Rebecca:
Okay. So myth busted. Yeah?

Dr. Laster:
There's another one.

(laughter)

Julie:
There's another one. Yeah.

Rebecca:
Yeah.

Dr. Laster:
We're, we're knocking them down.

Julie:
We're knocking them down.

Rebecca:
Well, here's the next one. It's not possible to have psoriatic arthritis if I don't have psoriasis.

Dr. Laster:
This is one that we do hear about, and it comes up a lot because psoriatic arthritis is actually fairly common. And it can present in different forms. So strictly speaking, you can actually have psoriatic arthritis without having psoriasis, without ever having psoriasis. And people feel, how can that be?

What we might see on exam is just a tiny patch of psoriasis. It might be on the belly button. And you wouldn't see it unless you had the patient put a gown on and you were looking for it. It might just be

on their eyelid, and you'd only see it when the patient was lying down, because of the angle. Or they might have some very subtle nail pitting.

The amount of skin and nail involvement doesn't correlate with the amount of joint involvement. So, it can be challenging to diagnose. People think they don't have it, but on careful exam, you know, you might find a small patch. Commonly it can involve the elbows, or the knees, the scalp, often areas of trauma. There are a number of individuals who actually develop, not a large number, but who actually develop psoriatic arthritis before the skin disease. More commonly, there is a lag of about eight to nine years where you first develop skin involvement, and then develop your psoriatic arthritis later on.

Rebecca:
I had no idea. I didn't know that.

Julie:
Yeah.

Rebecca:
I always thought that there had to be some psoriasis involvement.

Julie:
And the image of you playing kind of doctor detective and looking for the eyelid patch, or the belly button patch, of psoriasis is very interesting to me.

Dr. Laster:
That's what rheumatologists do. We are the Sherlock Holmes of internal medicine. When people can't figure out something, it often falls in the hands of rheumatologists to figure out what it might be.

Rebecca:
That's so true.

Julie:
Our scientific sleuths. I love it. Well let's move onto our next myth, which is about gout. Can gout be cured by diet alone?

Dr. Laster:
Diet clearly plays an important role. We do talk to people about diet and the importance of avoiding foods and the like that are high in purines. Purines are broken down to form uric acid, which leads to the gouty attack. So, for example, shellfish, shrimp, scallops, oysters, clams, all of those are fairly high

in purines and can increase the uric acid level and lead to gout. Alcohol, especially beer, can do it. Organ meats, like liver or sweet bread. Wild game is not an uncommon reason why uric levels can be elevated. So, people who hunt and eat deer.

I have a patient with gout who also has high blood pressure, and lipids, and he had gone through major dietary changes. But he was adamant; he said, "Doc, I'm not giving up my beer sausage. That's the one thing you're not gonna take away from me. You're gonna have to pry it away from me."

Rebecca:
No brat and beers.

Dr. Laster:
Yeah. And then fructose corn syrup, which is found in a variety of drinks, also can trigger gout. And you know more esoteric things, like anchovies and sardines, also can do it. So, diet clearly can play a role. Not the only thing. Obesity can play a role. There are certain medical conditions that can do it. There are even drugs that people may not be aware that they're... They're aware they're taking them, but not aware that it can trigger gout. Again, another reason why you want to talk to your doctor and have him go over carefully your medications, your history, to make sure there aren't other factors that might trigger that.

Julie:
Yeah, your medications, your history, and anything that doesn't have anything to do with your arthritis, too, making sure that they really understand all those other components of your care. Dr. Laster, when it comes to gout, is that something that can just be cured by diet and willpower?

Dr. Laster:
That's a great question. The truth is, actually, that gout is often due to underlying conditions that are genetic, that you would inherit from your parents. A lotta cases of gout are actually due to individuals who lack an enzyme that prevents them from breaking down uric acid. Or they have problems excreting uric acid through the kidneys.

So, that leads to a build-up of uric acid, or urate, in the body. When it reaches a certain level, it then can precipitate out into joints and soft tissue. They crystallize, and that can trigger inflammation when certain cells, granulocytes, try to engulf them, right? So, that's often what leads to these acute gouty attacks. Certainly, food can play a role and can elevate the uric acid level, but for many individuals, it's a genetic susceptibility to gout.

Rebecca:

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So, here's another one that we will ask about because I am an occupational therapist. So, a myth is always: The purpose of occupational therapy is to help people do their jobs.

Julie:
It's occupational.

Dr. Laster:
You can probably address (laughs) that one better than me. But, no, that's not correct. Clearly important, in terms of making sure that just kind of normal daily movement and activity, the things that you do at home, the normal activities of daily living you can do. And often, occupational therapists can kind of help address things that one can do in terms of movement. You've got back pain, this is the way you should be lifting something. We all work from the minute we get up, whether you have a job you're getting paid for, or whether you're at home taking care of the kids. So, I think it goes far beyond just earning a wage, in terms of the benefit of occupational therapy.

Rebecca:
We help you be able to move and do the things that you want to do that occupy your time. That's where the occupational…

Julie:
Ooh, that's good.

Rebecca:
...comes in.

Julie:
Occupying your time.

Rebecca:
So that includes sleep. That includes brushing your teeth, it includes housework, it includes your job, all kinds of stuff. So, thank you for helping dispel that. It doesn't come just from the OT. (laughs)

Julie:
Rebecca's been waiting on the edge of her seat to talk about this myth the whole time.

Dr. Laster:
Somehow, I knew you were gonna try to get that one in.

(laughter)

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Dr. Laster:
So, Julie, you probably have a favorite myth. We're waiting for yours.

Julie:
(laughs) Well, my favorite myth… maybe it's not my favorite myth, but certainly one where I wanna add to our conversation today, is about back pain. I hear people say all the time, "Oh, I have back pain, so I have arthritis." Is that always true?

Dr. Laster:
No, it's not. And that's a great myth to talk about. There's lots of different reasons for back pain. Now certainly, arthritis … degenerative joint disease of the vertebrae … can cause back pain. But we know that back pain can be due to entrapment of nerves, or muscle spasm, in the back; sciatica, for example. Frequently people come and they say, "Well I have pain in my hip." And actually, when people have true hip joint pain, it's usually in their groin or inner thigh. Most people kind of refer to their hip as in their buttock area. Usually that's not the hip, it's more often related to the back. You clearly can have back pain for many reasons other than just having arthritis.

The other one, and one I see not uncommonly, relates to fragile bones and osteoporosis. People can develop fractures of their spine, of the vertebrae, often with trivial movement. Bending down to get clothes out of the dryer; they're in their car and they turn around to lift their grandchild out of the back seat, and they develop sudden pain. Because back pain is so common, they may go to a doctor. And an X-ray wouldn't be obtained because so many people have mechanical back pain, you know, related to a disc or degenerative changes.

So, we see people who had fractures that go undiagnosed for long periods of time. Sometimes never even having had an X-ray. We need to really appreciate how many different reasons there are for back pain and think about things other than just arthritis.

Julie:
Do you have tips for patients who are experiencing back pain to advocate for themself and make sure that they're getting the diagnosis that they have?

Dr. Laster:
There are I think warning signs where you should seek medical care immediately. So, if you're having pain going down your leg, particularly if you have numbness of a part of your leg, or your foot, that doesn't go away… If you find that your leg is weak, that you've got foot-drop, clearly those are reasons why it would be important to go to a doctor. Because you may be having ongoing

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neurologic damage that, if you don't work on that quickly enough to correct that, it could be permanent.

More than 20% of the population has had back pain in the past, and for a number of people, it can be chronic. But acute onset of back pain that you'd not had before needs to be evaluated in many individuals. Particularly if you're having some neurologic symptoms.

Julie:
So, key takeaway is: Go to a doctor and find out. Ask the question.

Dr. Laster:
If you've had chronic back pain that fails to get better with conservative treatment — ice to the back, use of a pain medication, low doses of a nonsteroidal — if the pain is not going away, you need to seek care.

When we think about back pain, we kind of put it into two buckets. Mechanical back pain we've been talking about is really fairly common. But we recognize that there's what we call inflammatory back pain. And that's a very different pain related to often systemic arthritis, like ankylosing spondylitis, or you can see arthritis in the back from psoriasis or inflammatory bowel disease.

In contrast, those individuals typically will wake up early with back pain. And when they get up and move about, their pain gets better. That's in contrast to individuals with mechanical back pain, where rest will actually help it, and they have pain with movement. So, it's a complicated field, and there are lots of reason for back pain. And clearly if you've got acute back pain, if you have neurologic changes, if you have chronic pain that isn't getting better, all of those are important reasons why you should go to your doctor.

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Rebecca:
I have one more thing I want you to maybe answer. So, when most people think of arthritis, Dr. Lester, they think it's one disease.

Dr. Laster:
Right. And we know it's not.

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(laughter)

Dr. Laster:
And that's what rheumatologists are involved in. It's said there are a hundred different types of arthritis. Just imagine your local shopping mall. That's arthritis. And within it, there are many different shops. There are many different types of arthritis. They behave differently. Medications that work for one may not work for another. So, it really is key. You know, one of the most important things is to try to determine the type of arthritis an individual has. Once you know that, then you have a much better feel of what treatment will be involved.

So I think that anybody who's had chronic joint pain that's going on for six weeks or longer, if you have sudden pain, and swelling, and redness of a joint, and frequently, that can be due to actually a true infection on the joint. That can be a very serious problem.

And for a number of these conditions, the primary care doctor may be able to identify what the issue is and treat it appropriately. But if they have questions, where they identify an individual who has rheumatoid arthritis and then treatment becomes more complex, they'll often then go on and refer to a rheumatologist for further treatment.

Rebecca:
People don't realize that arthritis is more than just one thing. And arthritis literally means joint inflammation.

Dr. Laster:
Correct. And arthritis occurs in young people. I think people often think about this as just occurring in people that get older. Different types occur at any age. So, for a lot of the autoimmune diseases, rheumatoid arthritis and lupus for example, they often can occur in people in their teens, 20s or 30s. And certainly, they can occur as people get older. In general, I think that's another myth. People think that if you're caring for arthritis as a physician, you must be seeing older individuals, when that's actually usually not entirely true.

Julie:
Dr. Laster, you beat me to my favorite myth, which is kids can't get arthritis.

Dr. Laster:
(laughs) Right, kids do develop arthritis. And in fact, there's an entire specialty, pediatric rheumatology, devoted to caring for infants and children who have arthritis. And this can be incredibly challenging. Clearly, for individuals, kids who have arthritis, inflammatory problems, seeking out the cure of pediatric rheumatologist is the way to go.

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Julie:
Absolutely. I think pediatric rheumatologists are some of the best people on the planet. But so too are all rheumatologists.

Dr. Laster:
Well, we're showing a lot of love for rheumatology today.

Julie:
Yeah. (laughs) We sure are. Our favorite doctor detectives and OT. There you go.

Rebecca:
Yes, gotta feel the love all around.

Julie: (laughs)

Rebecca:
The key takeaways that you would say from all of this conversation about what's fact and what's fiction would be what?

Dr. Laster:
Well it's great. I really enjoyed talking. So, I think that the key takeaways here are, number one: Arthritis is complicated, right? And it's hard often for people to figure out what they have and what to do about it. And so you should not feel uncomfortable about seeking medical care, whether it's through your primary care provider or through a rheumatologist or orthopedist. And there are lots of medications that are out there that truly work.

We've not talked a lot about the biologics, but certainly they came into play in the late 1990s, early 2000s. And they have been life-changing for patients. Far fewer individuals requiring joint replacement, developing joint damage, allowing people to work out actively, run marathons, tend their farm, whatever heavy physical labor they're doing.

The advances have been dramatic. And there's a lot that we can do now. Arthritis doesn't have to be a sentence where people are limited. Definitely if you have any type of chronic problem, also acute problems… Those are the types of things that you should go out and seek medical care for.

Julie:
This has been such an interesting conversation. We really appreciate your time.

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Dr. Laster:
Thanks again. Thanks for having me.

Julie:
Thanks so much.

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