University College London Hospitals NHS
NHS Foundation Trust

uclh

Migrant health and rheumatology

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Plan of talk

- Chronic widespread pain in migrant populations
- Chikungunya infection

Chronic widespread pain/fibromyalgia

- What has secondary care got to offer?
- How is this different for migrants?
- Barriers to care
- How can we reduce these?

Case 1: Mr K

- 48 year old man
- Born in Iran, victim of torture
  - In prison in the 1990s
  - Hung from his arms and legs
  - Beaten around the head
- Chronic widespread pain and tinnitus since then
- Variable levels, gradually worse

List of problems

1. Neck pain
2. Shoulder pain
3. Bilateral knee pain
4. Progressive pain in small joints of hands
5. Numbness in right hand
6. Chronic tinnitus
7. Poor sleep
8. Flash backs

Social history

- Sculptor
- Lives alone
- Supportive friends
- Previous contact with Freedom from Torture (Medical Foundation for the Victims of Torture)

On examination

- No synovitis
- Muscle spasm traps and paraspinal muscles
- Shoulder movements normal
- Signs of carpal tunnel in right hand
- Loss of quads muscle bulk
- Scars from torture

What can I do to help?

- Time: in one sitting
- Imaging: what should be done and where?

- Treat the treatable
- Investigate as necessary: getting the balance right
- Try not to do things that haven't worked before: good collaboration between GP/consultant

- Balance the individual issues and the overall picture

What I did

1. The easy bits
    1. Excluded an inflammatory arthritis
    2. Trial of a wrist splint
    3. Encourage exercise
2. Investigations
    1. Nerve conduction studies (pending)
    2. MRI knee (early OA)
3. Treatments
    1. Topical lidocaine patch
    2. Trial of amitriptyline (failed), gabapentin

Now what?

- Referral to pain management programme
- PTSD – pain
  - Which to treat first?
- Refugee/torture victim support groups
- Additional pressures
  - Benefits/work
- Evidence base?

Pain case 2: Mr AK

- 55 year old man
- Bangladeshi, in UK since early 20s
- Speaks little English
  - Language line versus face-to-face interpretation

- Referred with bilateral shoulder pain

- Chronic widespread pain for 10+years
- Also
  - Type 2 diabetes (insulin requiring)
  - Cirrhosis/ Hepatitis C
  - Hypertension

Previous pain treatments

- Amitriptyline
- Gabapentin
- Tramadol
- Acupuncture
- Physiotherapy
- One-to-one pain management psychology

Social history

- Lives with his wife and 6 children
- Smokes 10 cigarettes per day
- Walks with a stick
- Hasn't worked for 10 years

On examination

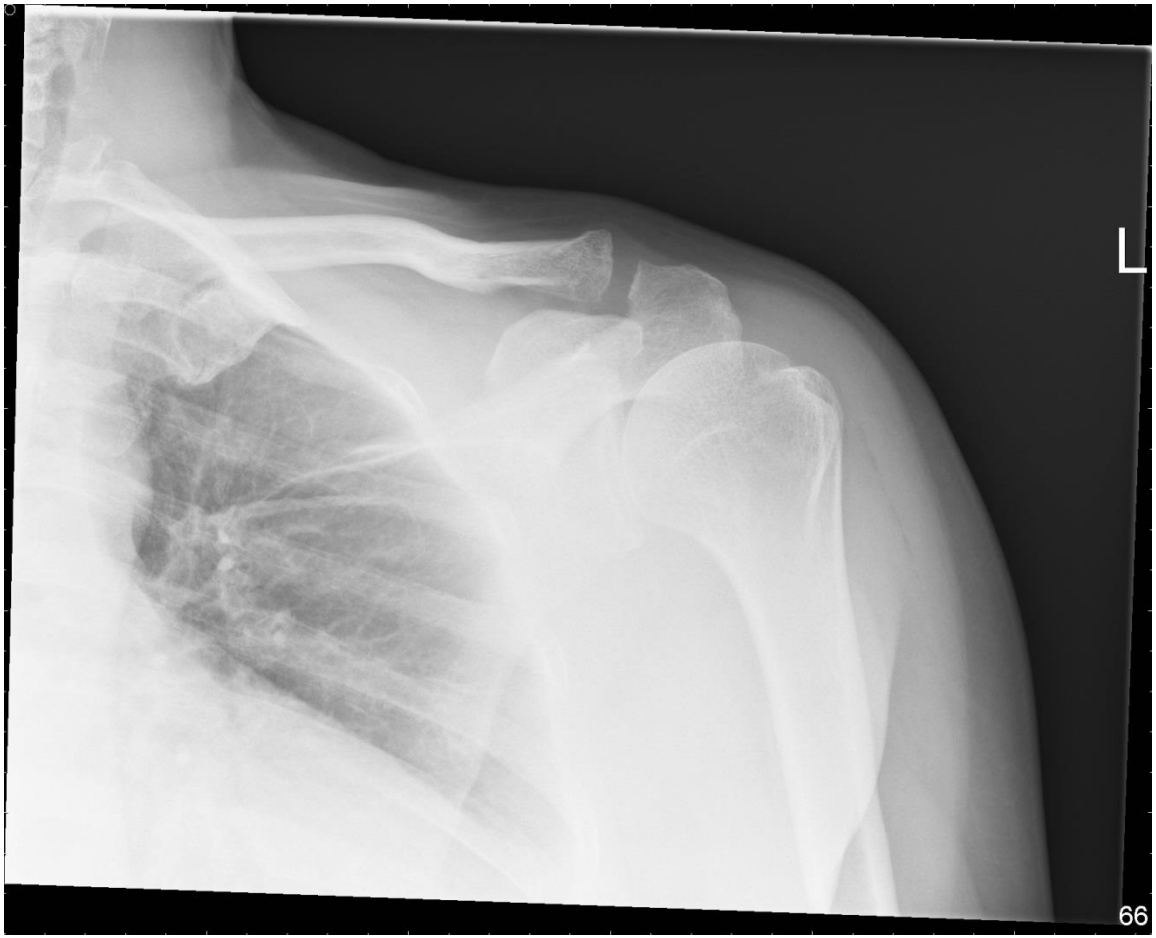
- Evidence of bilateral supraspinatous imgingement
- Widespread muscle tenderness

What I did

1. Exclude PMR
2. X-ray shoulder to exclude fracture
3. Inject
    1. Un-guided initially
    2. Then guided
4. Outcome
    1. Brief improvement
    2. Was it worth it??

- Short sharp shock won't work
    - Needs community based treatment

The use of imaging: showing the patient the cause of symptoms



Language barrier

- Psychology through an interpreter
  - Variable quality
  - “Judging”
  - interpreter’s response to distress
- Can’t access COPE

Chronic widespread pain in migrants: summary

- Complex interaction with PTSD
- Treat the treatable
- Appropriate imaging (therapeutic?)
- Language barriers to care

Chikungunya case: CN

- 67 year old woman
- Spends 4 months of each year on pacific coast of Mexico
- Onset of febrile illness in March
  - Fatigue, back pain, fever with sweats
  - Subsequent severe pain in swelling in small joints of hands and feet

- Seen by GP and referred to HTD walk-in 1 month later
- Bloods normal except CRP 5.4
- Note also hypothyroid

Diagnosis

- Chikungunya confirmed on serology
  - High titre IgG, IgM negative (too late)
- Dengue IgG and IgM negative
- Autoimmune screen negative

Treatment

- Naproxen
- Short course of prednisolone
- Follow-up: risk of chronicity

Chikungunya: Plan of the talk

- The virus and its vectors
- Clinical features
- Epidemiology
- Management

- The current epidemic
- UCLH's response

What is Chikungunya?

- Mosquito borne RNA alphavirus
- Daytime biters

- First outbreak Tanzania 1952
- Chikungunya means “to become contorted/bent up” (Kimakonde)

- Not linked to chickens!

Aedes aegypti

Aedes albopictus

Why is Chikungunya important?

- There is an epidemic now
- Huge impact on public health/infrastructure
- Chronic morbidity related to ongoing joint pain

- Ignorance amongst
  - Doctors (non-ID!)
  - The public

  - “chicken what?”

Stealthy, Debilitating Disease Is Poised t ates

o-borne
e
terrible.

It affects all age groups but more than 50% are over the age of 65 years - of which a third will die. Severe illness also occurs in children."
www.patients.co.uk

Clinical features

- Short incubation
- Abrupt onset
- Common features
  - Fever
  - Arthralgia
  - Rash
- Rarely
  - D+V
  - Eye and ear involvment
  - Neurological involvement
  - Myocarditis

- Mortality 1:1000

- **Chronic joint pathology 4-71%**

Who is at risk of chronicity?

- Chikungunya in France
- Returning travellers
- Mean age 50
- 53% women
- Predominant joints
  - Hands, ankles, feet

- Risk of chronicity (>3 months)
  - Women
  - Age >50
  - More swollen joints
  - Comorbidities
- Significant impact on QoL (SF36)

  - Couturier E et al, Rheumatology 2012

Diagnosis

- Serology (Porton Down)
  - IgM peaks at 3-5 weeks, persists for 2 months
  - IgG +ve from 2 weeks onwards
- PCR useful if in first week of illness

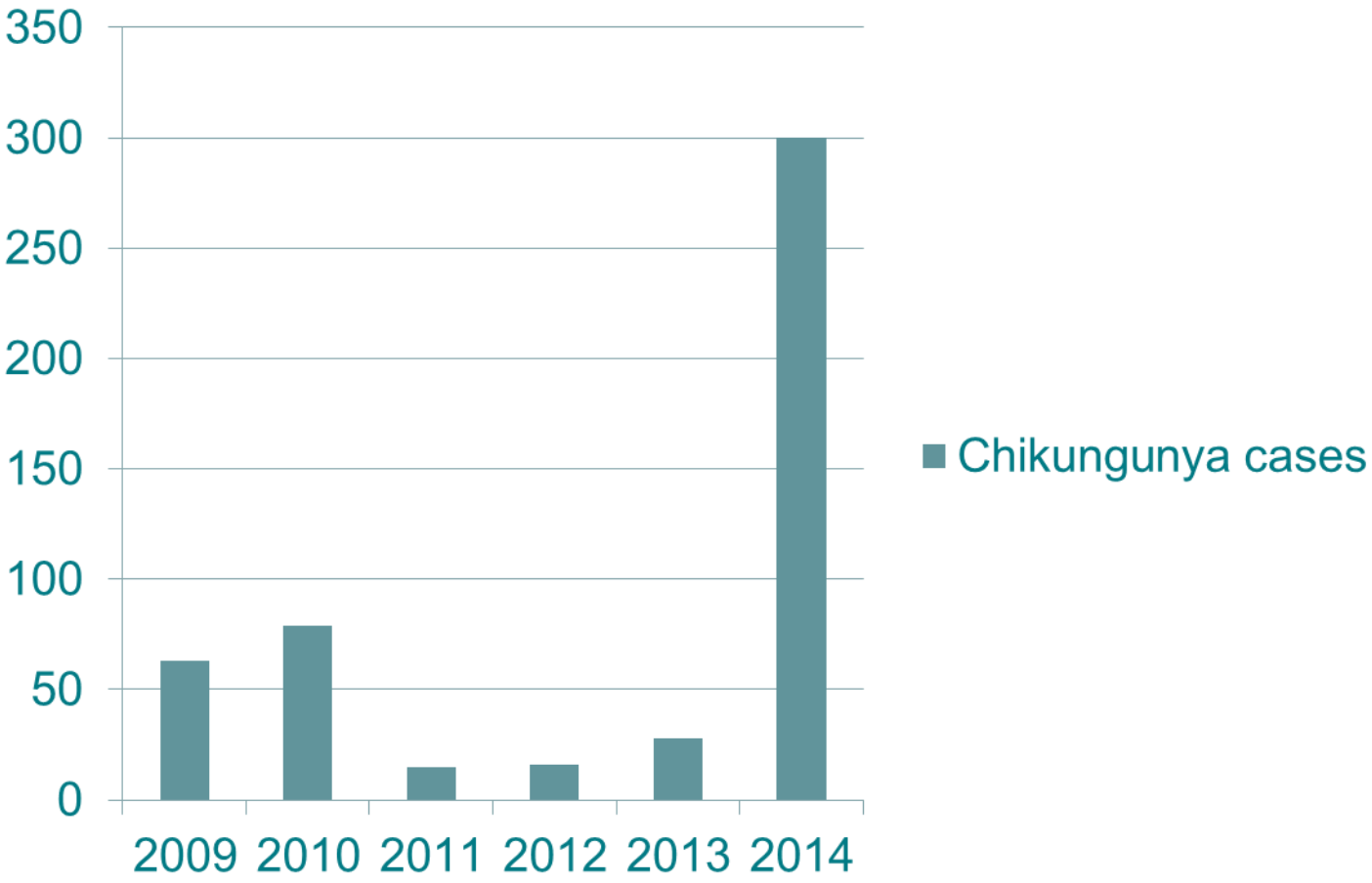
Current outbreak

- Begun in late 2013 in Saint Martin
- Already affected 1.2 million people throughout Americas

- Jamaica declared a state of emergency in November 2014

- Returning travellers in the UK

Cases of Chikungunya diagnosed in the UK (PHE)



The experience from Reunion Island

- Epidemic 2005-6
- 38% population affected (about 300,000 people)
- Huge impact on people of working age
- Overwhelmed the health service

- Well studied group

Management

1. Prevention
    1. Vector control
    2. Vaccination
2. Treatment of infection
    1. Anti-viral drugs (favipiravin, ribavarin)
    2. Passive immunization with polyclonal IgG from convalescing patients
3. Treating the arthritis

Treatment: evidence from (limited) human studies

- NSAIDs and corticosteroids
  - Several small studies generally agree about efficacy
- Sulphasalazine
  - Small observational studies suggest some benefit
- Chloroquine not more effective than meloxicam
  - Small randomized trial in India
  - Symptoms and response to tx not proportional to inflammatory burden
  - Chopra et al. A+R 2014

Chikungunya at UCLH

- Maria Krutikov
- Jon Lambourne
- Mike Brown

- In response to the current Caribbean epidemic
- Increase in patients being seen at HTD

The ID/Rheumatology clinic

- Clinical assessment

- Screen for other infectious causes
- Screen for other rheumatological causes

- Musculoskeletal ultrasound

Proposed treatment

1. Naproxen 500mg BD
2. Depomedrone 120mg IM
3. Prednisolone 20mg, reducing by 5mg per week
4. Sulphasalazine

Results: cohort

- Totals Aug 2014 – Jan 2015: 54 patients
  Aug 2013 – Jan 2014: 5 patients
  seen in chikungunya clinic: 21 patients

- Male 35% Female 65%
- Mean age 50.5 years

- 93% travelled to Caribbean
  - Jamaica 31%, Granada 19%, DR 6%

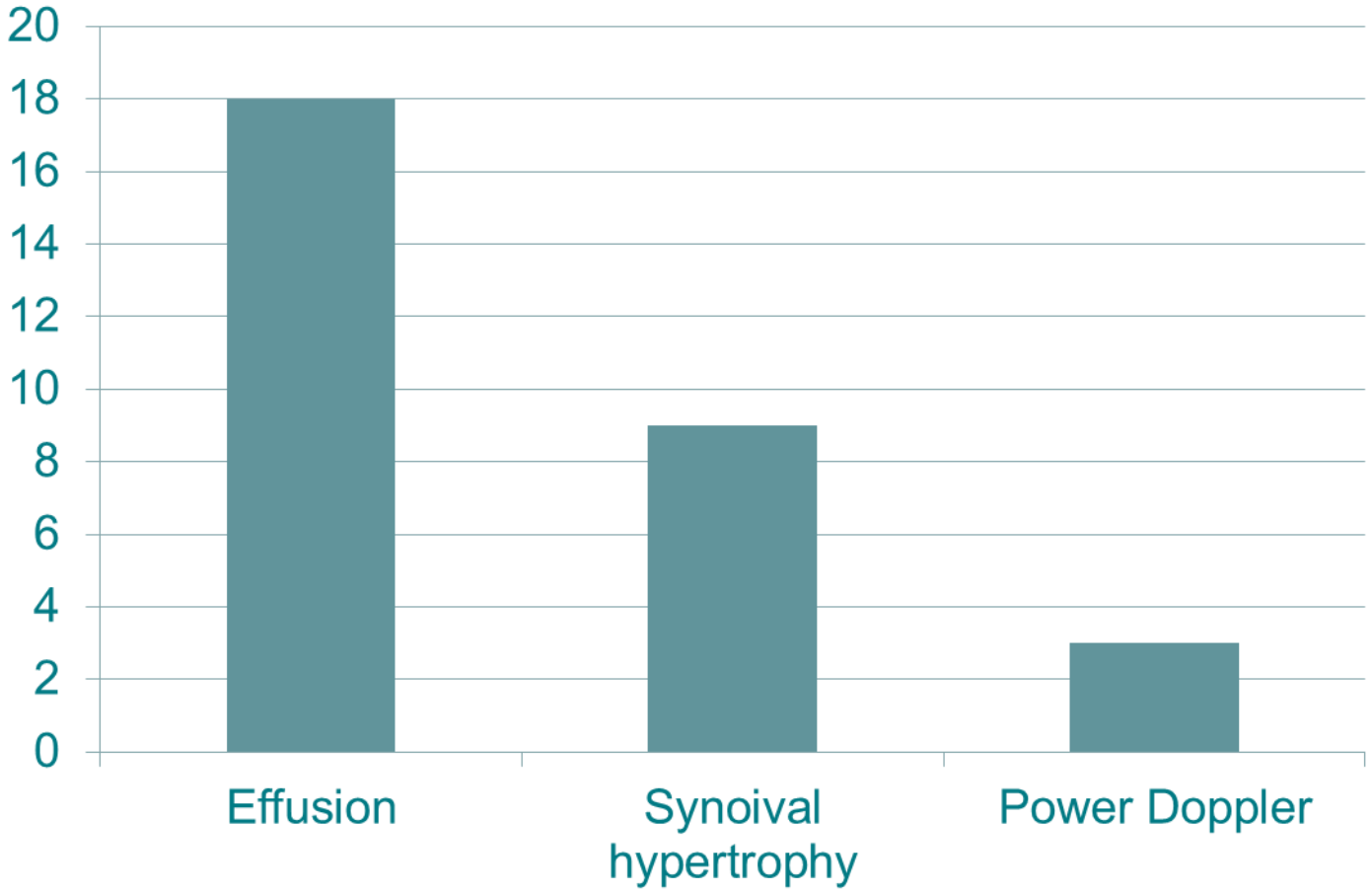
Results: initial illness

- Median time from symptom onset to first review: 25 days
- Features of initial illness
  - Diffuse arthralgia 95%
  - Fever 67%
  - Rash 62%
  - Others: fatigue, headache, GI upset (15-20%)
- At presentation, mean CRP 7, mean ESR 16.8
- 15% had elevated ALT (range 55-115)
- 2 (with dengue co-infection) had thrombocytopenia

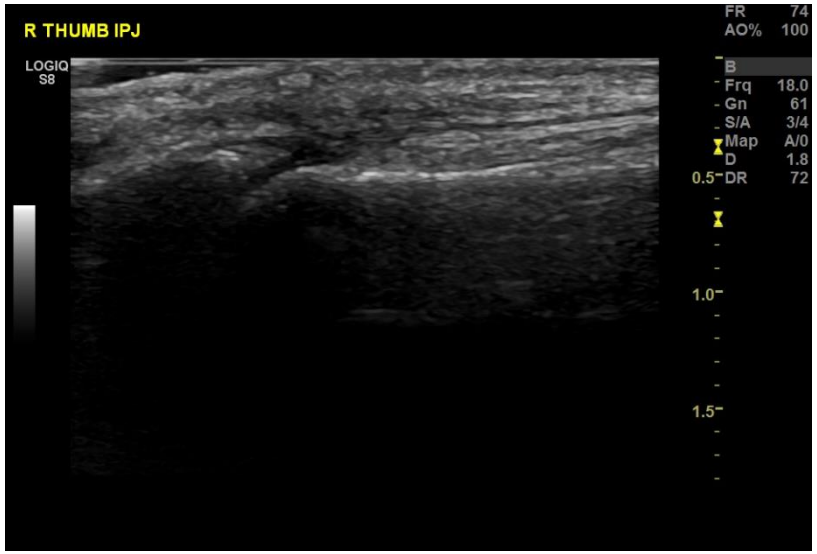
Results: Chikungunya clinic cohort

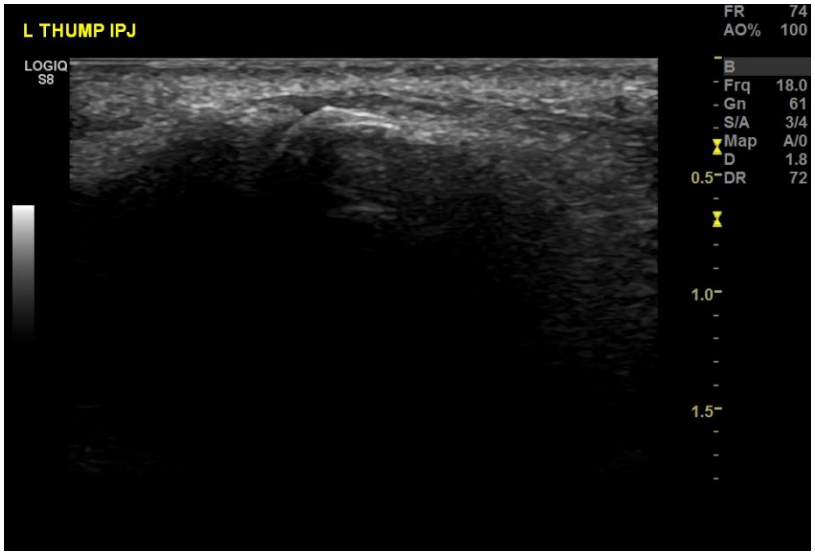
- For those with persistent arthralgia
- Median time between symptom onset & chik clinic rv
  - 12.1 weeks (5.4 weeks – 39.4 weeks)
- Joints affected: Knees (71%), Feet (62%), Ankles (57%), Hands (57%), Wrists (48%), Elbows (14%)
- Carpal tunnel syndrome: 9 patients (43%)
- 15% had positive Rheumatoid Factor (no +ve CCPs)

Ultrasound findings from the UCLH Chik clinic



Effusion and non effusion IPJ





Results: Treatment

- NSAIDs — 59%
- Systemic corticosteroids — 15% of whole cohort; 33% of chik clinic cohort
- Chloroquine + Sulfasalazine — 1 patient
- Wrist splints for carpal tunnel syndrome

Results: Follow up

- 83% of total cohort followed up (100% of ID/rheum cohort)
- Median time from 1st review to follow-up 6.3 weeks
- Progress at time of follow-up
  - 7% improved
  - 83% improving
  - 7% unchanged
  - 0 worse
- Most common on-going symptom = mild-arthralgia

Chikungunya: what next

- Spreading the word

- EULAR
- Patient.co.uk
- Extended cohort

Thank-you