Core and Explore: A Sequel to *What is a Rheumatologist?*[1]

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"What's past is prologue."
– *The Tempest* by William Shakespeare

How do past patterns of rheumatology practice affect the rheumatologists of today?

At a recent large primary care continuing medical education (CME) event, I was mingling with attendees after presenting a review on osteoporosis. A stranger approached proffering his business card and started discussing his research/business venture in the field of fibromyalgia (FM). What was "the ask": Could I please review the protocol and business plan and provide advice? I replied that, while I was flattered to be considered, fibromyalgia was no longer a core interest of rheumatologists, including myself. I referred him to the websites of the CRA and Canadian Pain Society to find someone more suitable.

That started me thinking about the evolution of rheumatology as a discipline. At the core, everyone agrees on the primacy of the inflammatory arthritides and the poorly named "connective tissue diseases." However, while gout is the most common inflammatory arthritis, particularly in men, it is clearly not part of the holy trinity of rheumatoid arthritis (RA), psoriatic arthritis (PsA) and axial spondyloarthritis (axial SpA).

Osteoporosis (OP) as a primary diagnosis is treated only by a minority of rheumatologists. Low back pain is an orphan but ubiquitous condition. Orthopedists and neurosurgeons certainly don't want to see unselected patients with this condition, nor do rheumatologists. Could this explain the relative absence of ankylosing spondylitis (AS) patients in my practice (prevalence 0.5-1% of the general population, similar to RA, but underrepresented in my practice versus RA by a factor of 5:1), as well as the commonly cited delay in AS diagnosis of five-to-nine years? In Ontario, we are expanding Inter-professional Spine Assessment and Education Clinic (ISAEC) sites to attempt to deal better with low back pain sufferers.[2] European attempts to enrich the likelihood of finding inflammatory back pain patients among the masses of chronic low back pain patients under age 45 also come to mind.

Some rheumatologists are happy to see simple conditions such as tendinitis, bursitis, rotator cuff syndrome, epicondylitis and trigger finger. Others have no time for anything but our core conditions. "These conditions should be managed in primary care" is the refrain. The issue, of course, is the limited training most primary care practitioners have in musculoskeletal (MSK) conditions such as these, as well as osteoporosis and gout, which should also ideally be handled in their offices. The limited availability of physiatrists, and their focus on complex rehabilitation and trauma/neurologic conditions, also leads to these patients being referred to rheumatologists.

Having dispensed with spinal osteoarthritis (OA) and degenerative disc disease (DDD), what about peripheral OA of the hands, hips and knees? After all, the American College of Rheumatology (ACR) and European League Against Rheumatism (EULAR) continue to produce guidelines on this topic, most recently the draft ACR/Arthritis Foundation guidelines presented at ACR 2019. This is the most common arthritis of all, but is it core to any discipline, let alone rheumatology? Tom Appleton and Gillian Hawker are prominent Canadian researchers focused on OA, but my peers certainly aren't. At the two journal clubs which I regularly attend, I can't remember the last time anyone chose to present an article about OA. Vasculitis as a topic is far overrepresented at these events, in contrast to its low prevalence. Should every patient with hip/knee OA see a rheumatologist before being directed to an orthopedic surgeon, to ensure medical management has been fully exhausted before total joint replacement? Impossible in the current Canadian context. Again, Ontario is experimenting with central assessment of such patients at dedicated Rapid Access Clinics, with triage by trained physiotherapists or nurse practitioners as the initial step.[3] Likely, these approaches are in existence or being considered elsewhere in our balkanized Canadian healthcare system.

Artie Kavanaugh made a telling comment at the ACR 2019 Rheumatology Roundup session covering the highlights of the meeting. While he did not note the draft guidelines on OA and gout presented there, he did comment on the presence of fibromyalgia research at the meeting,

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including posters and concurrent sessions, as well as the guidelines on FM promulgated by various rheumatology organizations (including the CRA). Perhaps tongue-in-cheek, he opined that if rheumatologists do not want to be considered as experts in FM care, maybe such research should not be part of our meetings. Of course, if we don't create these guidelines, who will? The intended audience are the primary care practitioners to whom we want to offload gout, OA, FM and osteoporosis, not rheumatologists.

Can we learn a lesson from the legendary Warren Buffett to help resolve these dilemmas? As do many investment gurus, he advocates that non-professional investors should "buy the market" by buying and holding broad stock and bond index exchange-traded funds (ETFs) at low cost: the core. At the same time, all investment companies recognize the desire of retail investors to hit a home run, rather than accept plodding returns compounded over decades. Hence, "core and explore": Put 80-90% of your money in the core ETFs, and use 10-20% as "mad money" to find the next Apple, Alphabet or Amazon, while staying away from the crashing cannabis sector, Uber/Lyft, and others not for the faint of heart.

You are probably wondering what any of this financial information has to do with rheumatology? Well, we can practice "core and explore" in two ways. First, we can educate our non-rheumatology colleagues and the general public that the core of rheumatology has shifted. While we may have previously accepted referrals on anything within the broad field of MSK medicine, we have now refined our core to the immune-mediated inflammatory arthritides, and whatever we choose to call "collagen-vascular diseases." Gout, peripheral OA and osteoporosis may be in the outer reaches of the core for many of us, but chronic pain, FM, non-inflammatory spinal conditions and regional soft-tissue conditions clearly are not.

Secondly, we can maintain practice variety and our competence in these common conditions which now lie at the fringes of rheumatology, but which our patients with the core conditions frequently complain of secondarily. We can choose to explore these conditions by accepting selected patients for one-to-two visits to confirm diagnoses, provide treatment plans and perhaps provide intra-articular therapies, for which we are the acknowledged experts.

Comments, kudos and criticism on this topic are welcome next time you see me.

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2. Interprofessional Spine Assessment and Education Clinics. Available at *www.isaec.org/*.
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