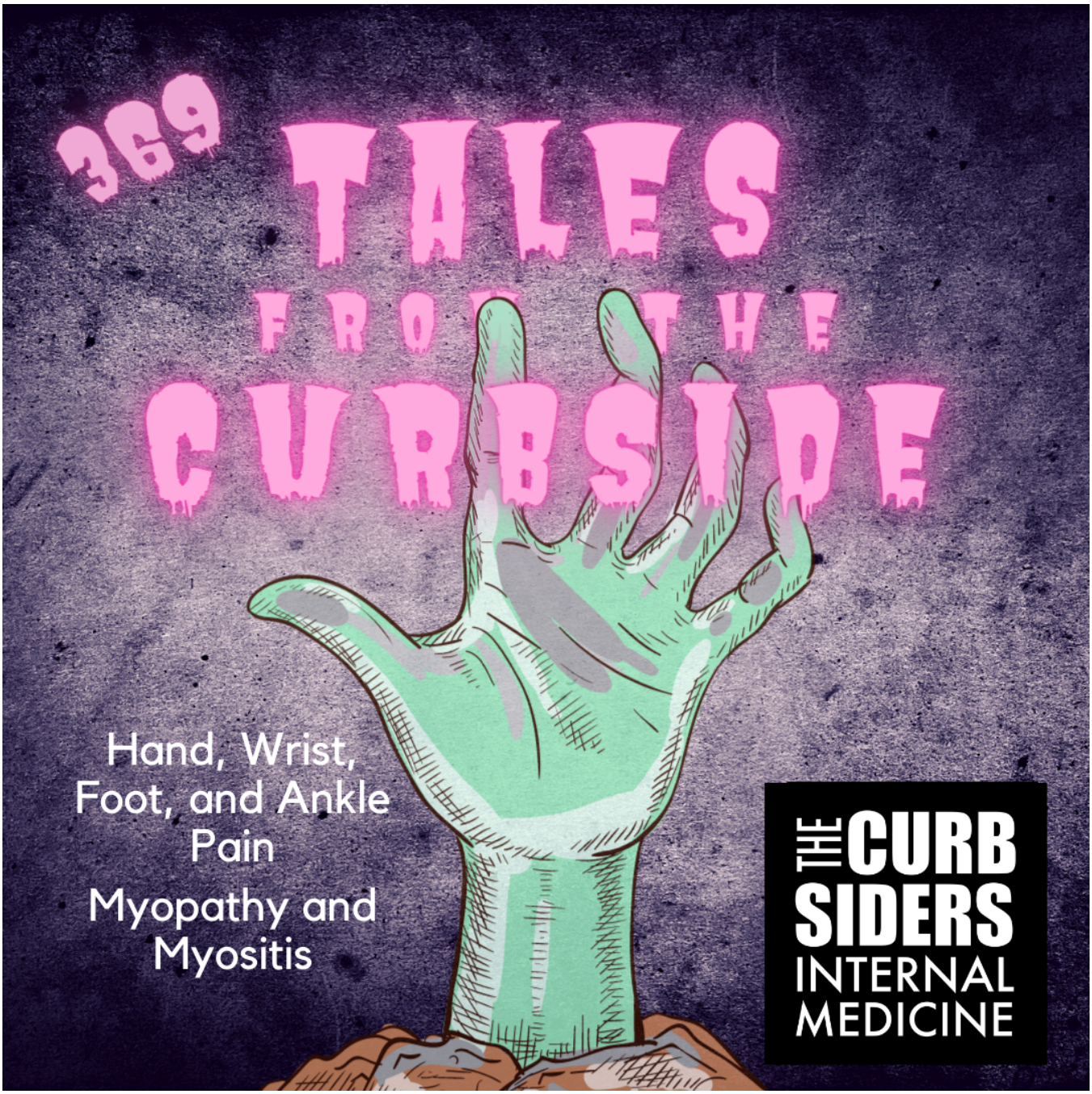
#369 Hand, Foot, Wrist and Ankle Pain, Myositis and Myopathy: A Rapid Review (TFTC)



[Curbsiders Podcast theme]

Matthew: Welcome back to the Curbsiders. This, of course, is an episode where we're going to quickly recap lots of things, Paul. We're going to talk about hand pain, wrist pain, foot and ankle pain, and of course, myopathy and myositis. How are those things related? Well, it should be self-explanatory. I'm Dr. Matthew Watto, here with my great friend, Dr. Paul Nelson Williams. Paul, how you doing tonight?

Paul: Matt, I am as good as can be expected. Thank you for asking. How are you doing?

Matthew: [chuckles] I'm doing well. You were just telling me how you are falling apart. [Paul laughs] And so, on air, we'll say we're both doing great.

Paul: [unintelligible [00:00:56] finally caught up with me. It was a good three-year run. But now I'm recovering nicely, but not fully recovered. So, if I don't sound like my usual bright-eyed, bushy-tailed self, we can blame that.

Matthew: Well, Paul, remind people what is it that we do on this podcast.

Paul: Happy to. Usually, we are the, well, we are always the internal medicine podcast, Matt. But typically, we use expert interviews to glean new clinical pearls and practice changing knowledge. This time around, we're going to recap episodes, as you alluded to earlier and talk about ourselves talking about episodes or something like that. So, we'll recap some of our favorite pearls from a couple of episodes and condense down into a high-yield format that you can take away to be better people from.

Matthew: Well, first up, number 339, hand and wrist pain with our favorite orthopedic surgeon, Dr. Ted Parks with production and graphics by the great Dr. Paul Nelson Williams. And Paul, the first question I had for you is, how can I differentiate between de Quervain tenosynovitis and CMC joint arthritis of that first CMC joint?

Paul: Great question.

Matthew: The patient vaguely just presents and says, "It hurts here on my thumb, my wrist area."

Paul: That's not vague at all. You're halfway there, if that's what they're telling you. So, I think as you mentioned, it's very common. I think we all see wrist pain in the office a lot. The big two diagnoses for pain, especially at the base of the thumb when we're talking about wrist pain here, so we actually see it on camera is, as you mentioned, de Quervains tenosynovitis versus CMC arthritis. And so, a lot of the times for musculoskeletal stuff, I feel physical examination is kind of helpful, but not super helpful. This is one where the physical exam is actually really, really helpful. So, Dr. Parks talks us through the Finkelstein maneuver. There are other eponyms to go along with this. But basically, the longest nerve you have the patient take, sorry, this is right in your face, folks. Take your thumb, wrap your fingers around it, and then the examiner will then score a point down almost like the patient's trying to stab you with a knife. If you reproduce pain that way, that is positive Finkelstein test. They'll say the patient probably has a flexor tenosynovitis.

The other test if you're looking for CMC arthritis is the CMC compression test, where basically avoiding the microphone. He talks about taking the thumb like a joystick pushing down and just moving it around like a mortar and pestle and seeing if he reproduces the pain that way. And if you do, congratulations, you've diagnosed him with CMC arthritis, which is one of the more common spastic arthritis, because the way the hand is constructed. Most of the movement is fairly linear. Flexion and extension of thumb is a lot of range of motion. So, unfortunately, because of that that's the cost of probably an increased risk for arthritis and other joint dysfunction.

Matthew: Yeah, I find people either complain that all their fingers hurt, the typical osteoarthritis or they just complain of just one thumb, whatever their dominant hand is a common complaint. Treatment for this, Paul, everyone's favorite, the thumb spica splint, Paul. And Paul, I should just keep people in that forever, no?

Paul: Apparently not in perpetuity. There's a lot of me self-disclosing the episode that I don't do a good job of counseling around bracing, and splinting, and that kind of stuff. A couple of weeks to allow time for the inflammation to calm down is probably a good place to start. You don't want to do it forever because you can lose mobility if you keep something immobile for a long period of time.

Matthew: Right.

Paul: So, the point being is, you don't say see you in three months, if you're still going to take this one off. That's bad for him.

Matthew: And like most of the stuff we'll talk about on this episode, a steroid injection can help here. You can, of course, try either topical or oral NSAIDs. As we mentioned on some recent shows, Paul, I wish I had better luck with the topical NSAIDs. I know they're kind of upfront in the guidelines now. Maybe it's the patients aren't using them often enough or maybe it's they just don't work. I don't know, Paul, but I haven't had a ton of luck, but I do try to use them at least as a first line therapy for patients with more comorbidities.

Paul: Yeah, I run more into the price issue than anything else. I think it's hard to get them covered by insurance, at least with the plans that I'm used to dealing with.

Matthew: Yeah.

Paul: They are not inexpensive for patients. It's a hard sell if they're not going to give you substantial relief and you're paying out a pocket for them. So, it could be tough sometimes.

Matthew: All right. Next up, Paul, the trigger finger. And Paul, this is a whole hand cast is how you treat this one?

Paul: The arm, yeah from the shoulder down, just immobilize the entire thing.

Matthew: [laughs]

Paul: The pathology of this is super neat. He talks about these pulleys, which are not really pulleys, but these rings that they're thick and can get stuck on. This idea of triggering is the finger comes down and then you actually have to physically unstick your finger, if you can sometimes even feel this palpable clunk and that's triggering. It's very satisfying diagnosis to make in the office. But you don't have to brace everything. You can just actually keep the very distal joints immobile. There're specialized splints for that. I don't have access to those, unfortunately. But if you're lucky enough to be able to get them that's typically all we need and again the same principles apply. It's not in perpetuity. It is for a couple of weeks and that should be enough for things to calm down. If not, then you might need to escalate their care.

Matthew: What I do in the office is I just pull up on a Google image search, splint trigger finger and then they have multiple splints that they'll prevent these joints from bending. They'll just go over the finger there, so that way, the finger can't flex and it rests this spot here where people tend to get that first pulley goes across here and then there's a tendon nodule that goes up through that and gets stuck. If you prevent them from flexing that digit, it'll prevent the triggering from happening and can rest the area.

Most other things in the hand, this responds well to a steroid injection and that may even cure it. I've had a lot of patients who had a trigger finger, got a steroid injection and just went away. Sometimes, it comes back and there is a surgery to cut that annular pulley, which then it tends to just go away and cure it. He said, "It doesn't recur if that's done." So, that was pretty easy to treat, but patients do seem quite bothered by it. It's a very common complaint in my office.

Paul: I'd love, not that I'll be doing any of the surgeries, but the fact that the common themes seem to be, you don't go after the tendons themselves. You actually just make space for them to move and actually calm down. So, there's a lot of snipping the supporting structures not trying to carve away the lump that makes intuitive sense. So, I thought that was interesting theme.

Matthew: Yeah. Now, Paul, onto carpal tunnel syndrome and this one, I think the pathophysiology, Paul is a good place to start. You want to talk a little bit about that because I think it speaks to the treatment and just understanding it.

Paul: Yeah. Dr. Parks or Ted talks about how nerves are extraordinarily susceptible to ischemia. They require a lot of energy to do their jobs. The ATPA pumps are constantly going. And so, any reduction in the oxygen supply to them can cause a pretty quick pathology, as opposed to things like tendons, which are sort of avascular and it can tolerate compression, nerves just don't do as well with that kind of stuff. So, it's just by dint of what it is going to be more prone to compressive ischemic symptoms and pathology that way, if I understand things correctly.

Matthew: Yeah.

Paul: He talks about the carpal tunnel, which we all know. There's the retinaculum, which is the fiber span that goes around in this bony tunnel that actually makes the whole thing. The treatment, if we're going right to surgery, it addresses the pathophysiology. Actually, why don't we take a step back, Matt? Talk me through the progression of how you would actually treat carpal tunnel after your diagnosis. You don't go right to surgery as satisfying as that is for surgeons, but what was that first approach?

Matthew: Because a lot of the ischemia occurs when the wrist is bent, you're bracing the person at nighttime which is when people tend to sleep with their wrist bent for whatever reason, so they can get a lot of symptoms there. If they wear the brace at nighttime that can help. And then just having the patient be mindful about the posture of their wrist, if you will, keeping that wrist in a neutral position that can offload it and that helps. So, that's one of the treatments.

Then of course, a steroid injection, he mentioned can be both diagnostic and therapeutic because if the patient doesn't respond to the steroid injection at all, it probably means either you have a wrong diagnosis or you have to look for things like thenar wasting, because if you see that maybe the patient has just progressed too far where they're just not going to respond there. This has been present for too long. Anything to add to the treatment part of this?

Paul: No, I appreciate the point that the treatment itself can also be diagnostic to some extent too. The point being is that our physical examination maneuvers for carpal tunnel specifically are notoriously horrible. Things like Phalen's and Tinel's, well, are satisfying to do. They don't have a lot of evidence behind them. We talked about even doing the Phalen's test which is that reverse [unintelligible [00:09:56]. You're supposed to have the patient hold it there for a minute, which feels like an eternity, especially if it's not a particularly good test. So, the treatment itself with a steroid injection, if they have significant relief, then you're in the right ballpark and least you're treating the right thing, even if that relief is transient, that is someone who might do better with, say, surgery.

Matthew: Yeah. The Tinel's and Phalen's are in there with Homan's and Brudzinski's and Kernig's, the ones that everyone remember them, but they don't work that well.

Paul: Yeah, but Weber and Rinne and all the eponyms on and on and on.

Matthew: [laughs] Well, I did want to just mention that we talked a little bit about the misdiagnosis of this that it should be the first two and a half fingers, so the thumb, the pointer finger, and the middle finger, the radial side. If you see different distributions than that, you should think maybe this is coming from somewhere else, maybe it's a different nerve impingement, maybe it's coming from the cervical spine, especially if it's bilateral, Paul. But if someone does truly have bilateral carpal tunnel syndrome, Paul, I was reading about this and it came up in the morning report recently that actually bilateral carpal tunnel syndrome can be a hurled for later development of cardiac amyloidosis. It often precedes it by several years, which I thought was super cool and terrifying.

I'm now praying, I don't find anybody with bilateral carpal tunnel syndrome. There are some other systemic like rheumatologic diseases, hypothyroidism, some other things that can cause carpal tunnel syndrome as well. But amyloidosis, Paul, you know I worry about stuff like that.

Paul: Well, sure. I would say that any listener who actually makes the diagnosis of cardiac amyloidosis bilateral carpal tunnel, if you could just write it into the show and let us know. That would be super dupes. I think the other example actually that Ted gave is actually jackhammer used to, by the way, which I've actually seen in my own practice. So, you can get bilateral carpal tunnel just from the repeated trauma of having a jackhammer. So, that's something else to be mindful of. So, it's not impossible, it's just uncommon.

Matthew: Well, let's move on to down the body, Paul, to the foot and ankle. This was another fantastic episode. This was with Dr. Joan Ritter and this was, of course, again produced and with graphics by great, Dr. Paul Nelson Williams. Paul, let's start off with talking about ankle sprains. I think we are probably used to seeing these in primary care. Everyone remembers the RICE therapy, throw some NSAIDs at a person for them. But what did you learn about bracing in this episode?

Paul: This has been a common theme for this episode that the listeners are listening to now and that you want to be a little bit careful with bracing. It can be helpful in terms of protection, but it's probably best to be able to brace in a way that preserves at least dorsiflexion and plantar flexion. If you have someone completely immobile or you put someone, say in a boot for an ankle sprain for a prolonged period of time, they might lose proprioception or you might impair their proprioception. By doing so that person might be set up for subsequent injury later on. So, you want to be very careful in terms of the protection that you do. It's useful, but it should be done in a thoughtful and conservative way and not again, bracing as for someone in perpetuity, I think was the point that Dr. Ritter made.

Matthew: Yeah. Talking through the different types of braces a little bit, I think it's interesting to think about these. The stirrup brace is the one that it's usually white plastic with some green cushion inside and that allows the patient to continue their plantar flexion and dorsiflexion at the ankle, but it protects them from the eversion and inversion movements that often result in a lot of the sprains. So, that's a nice brace. It does allow some movement. If you put someone in one of those lace-up ankle braces, that's going to control movement in multiple planes. If you really want to immobilize somebody, that would be like a walking boot.

As we said, you don't want to keep people in the immobilizers for too long because you want them to maintain that mobility, the muscle strength there, and their proprioception. Paul, any other things you want to talk about for ankle sprain before we move on to talking about the Achilles?

Paul: No, along the lines of maintaining and preserving proprioception, I guess the other takeaway point is to not be shy with physical therapy or at least even prescribing exercises to maintain those things.

Matthew: Right.

Paul: Oftentimes, it's so satisfying to get the diagnosis, "Okay, if this person does need imaging that some of the auxiliary stuff that is actually probably the most important stuff might get glossed over." But it's important to either prescribe exercises for the patients that you think are able to do them or even

have a low threshold to send the physical therapy just to rehab in a way that prevents subsequent ankle injuries, because once you address it once, you're going to be prone to more injuries. So, I thought that was also a helpful thing to emphasize.

Matthew: Yeah, and some of the stretches we mentioned in the show notes where they can pretend to be tracing the letters of the alphabet with their toes that will move the ankle stretching their Achilles. And speaking of the Achilles, Paul, I heard that the Achilles tendon rupture. Tell me if I'm wrong, Paul. I might be wrong. I heard that the Achilles tendon rupture is often very subtle and patients don't even notice it when it happens.

Paul: I love being set up like this, Matt. That is actually pretty incorrect is my understanding.

Matthew: [laughs]

Paul: The complete Achilles tendon rupture is often very dramatic, at least the way patients describe it. I think Dr. Ritter talks about patients may just feel like that they got kicked on the basketball court or someone actually physically attacked them, or I think even if you read the literature, someone says they felt like they got shot at the back of the leg. It's a discrete point in time that is dramatic and there's a pop felt is often how it is described. So, if someone has complete rupture, oftentimes, they know it. I think the partial tears may not happen as commonly which is why you have to do the right testing to make sure that you're not missing it.

Matthew: Right. You're alluding to this calf squeeze test, which the eponym is the Thomson test, but it's a calf squeeze test, where you can have the patient laying down on the table or they can have their leg supported by a chair with their shin facing down, and you squeeze the calf muscle, and that should elicit a plantar flexion movement if the Achilles is intact. You can compare both sides or you should compare both sides, Paul, because I'm told that if you're good enough, you could even diagnose a partial tear by an asymmetry in how much each side moves when you do the squeeze test.

Paul: Frankly, I think we're that good. I think we could that.

Matthew: [laughs]

Paul: I have faith in this.

Matthew: [laughs] I love it. Yeah, we are that good, Paul.

Paul: [laughs]

Matthew: Now, part of what I thought was the history of the Achilles tendonitis, that it's like plantar fasciitis where those first steps of the day may be really painful. I somehow had missed this. It's the same kind of pathophysiology like at nighttime your plantar fascia is tightening up because the way you're sleeping, the position your foots in, that's why those night splints help. The same thing happens to the Achilles. A lot of people, the Achilles is shortened when you're sleeping. So, when you take your

first steps of the day and stretch it out, it can be painful. That can be a sign of Achilles tendonitis. For anyone who complains of posterior heel pain, you got to think about the Achilles. And Paul, what kind of Achilles diagnoses should we be thinking about?

Paul: The Achilles tendonitis is the one that I think most commonly about. That's the one where the classic history would be say a runner who increases their training or starts going up hills more often or that kind of thing. Anyone who increases, I hate to say wear and tear, that's not exactly accurate. But increases their movement, the Achilles that's the patient might have, so this gradual onset of pain. Unfortunately, with runners specifically, the counseling around what to do next is actually to stop running, which I think is a hard thing to counsel a lot of runners for. That's the tendonitis. If you're not worried about the complete rupture, it is probably the next thing.

Mostly Achilles tendon injuries require a significant amount of rehab and rest unlike a lot of things in musculoskeletal stuff are not amenable to steroid injections. That's one thing that you're not going to be putting steroids into, because you actually can increase the risk of rupture if they haven't ruptured it already. So, don't do that.

Matthew: Now, Paul, what if I presented with a burning pain on the medial side of my ankle, maybe it goes up my leg a little bit?

Paul: [chuckles]

Matthew: Let's say that I've gained some weight and I just have not been wearing well supportive, like shoes that have good support. And Paul, you notice that I have an acquired flatfoot deformity. What might be going on there?

Paul: No, I love when you pitch underhand.

Matthew: [laughs]

Paul: This is a diagnosis that I don't know about you, but I had not thought much about or really heard much about prior to this episode.

Matthew: No.

Paul: But apparently, I probably have missed it. What you're describing is posterior tibial tendon dysfunction, which is exactly as you say, it happens in older-- I think it's more common to women, if I'm not mistaken. Overweight can certainly be a risk factor for it. And so, this burning medial ankle pain and then it's associated with flatfoot because the posterior tibial tendon actually helps support the arch and keeps things pulled up. So, if you have dysfunction of that, then you lose that arch in the foot and end up with this acquired flatfoot. One of the manifestations that is our new favorite physical exam sign, which is what Matt.

Matthew: This is too many toes sign, Paul.

Paul: [laughs] [crosstalk] on that.

Matthew: Tell people all about it, Paul.

Paul: Well, thank you for the chance too. But to me, toe signs, with all these things, you should have the patient take their shoes and socks off, which I think is probably the first step that many of us may potentially fail and I won't put [unintelligible [00:19:41]

Matthew: [laughs]

Paul: If you do that, you actually look at the patient from behind and typically you should see maybe two, two and a half toes peeking out laterally there. And someone who does not have a flatfoot or posterior tibial tendon dysfunction, if they do, you might see more toes than that. So, more toes are peeking out laterally and that is the so-called too many toes sign that points you along with these historical and key points that we gave you towards the diagnosis of the posterior tibial tendon dysfunction. So, say we made the diagnosis, we compliment the patient on how many toes that we've seen, they're mystified by the exam, then what do we do to actually manage this?

Matthew: Well, Paul, there're a lot of things. Of course, NSAIDs may be part of it and some activity modification, relative rest, but the orthotics to support the arch may be helpful. And again, low threshold to refer these patients to physical therapy. I was doing some more reading on this because I wasn't that familiar with it. Apparently, if it's really bad, sometimes they'll immobilize people with either even plaster casts or a walking boot and in really severe cases, patients may need surgery to move the tendon somehow, Paul. So, definitely outside of our purview, but I think people should look out for this. The reason we wanted to highlight on this episode is because I think maybe a lot of people hadn't heard of it if they're like us.

With the last section here, Paul, I wanted to move into myositis and myopathy. This was number 348 with Dr. Lisa Christopher-Stine. This one was produced by me with graphics by Andréa Perdigão. And Paul, the thing I wanted to start off as saying is that myopathy, myositis, there's these inflammatory myopathies. We classically thought of these as dermatomyositis and polymyositis. That's what was always taught when I was coming up in school. But now, the nomenclature and just the splitting these into these distinct phenotypes and subtypes has become much more sophisticated. So, dermatomyositis, there's a couple of different flavors of that, but that's rash and proximal muscle weakness.

But polymyositis, there's a whole bunch of other ones. Some of them overlap with rheumatologic diseases. There are some autoimmune-mediated necrotizing myopathy. There's a whole bunch of them, Paul. So, it's really a spectrum of different diseases with different prognosis and treatments. But in general, these are rare disorders. You should think of them if someone has muscle weakness and then extra-muscular manifestations, which may be the skin, arthritis, interstitial lung disease to name a few. Paul, tell me, what are some clinical features that struck you about that she taught us about in this episode?

Paul: Yeah. No, I think it's important to recognize that we're not going to, at least, I'm not going to be making this specific niche diagnosis if there's a myositis. I think the important part for the primary care doctor is at least recognize the broad features that should prompt a referral to a specialist. I think things that we talked about I didn't quite have the mental framework for this prior to this episode. But if you think about something like myositis, this is predominantly weakness and fatigue. This is not typically a painful diagnosis or I should say that you're not going to see pain in isolation. That's not going to be your presentation of myositis. You can have weakness without pain, you can have weakness with pain, but you're not going to have pain without weakness, then you're probably outside the realm of myositis.

The greatest sample in terms of differentiating weakness from fatigue because I think we all see fatigue in our offices and it's a challenging diagnosis to work up at the best of times. Myositis is simply the proximal muscle weakness is you ask the patient-- So, say you are watching a movie or in the movie theater, you're one of those chairs, you're just sunk deep down inside and there's a fire, would you be able to get out of the chair and rush to the exit or would you need someone to physically pull you out of the chair? Even with the place burning to the ground, they will still need help getting out of the chair, then you're probably more in weakness territory than you are necessarily in overall fatigue. So, I thought that was a really helpful way to at least get those basic features defined before moving on to the more niche testing and that kind of stuff.

Matthew: Yeah, exactly. Exactly. Some of the other features we might recognize, ask about rashes. Dermatomyositis, the rash is often itchy, which I found helpful.

Paul: Yeah.

Matthew: I think looking for the heliotrope rash, which can involve either eyelids upper and lower or either/or but it can involve the eyelids, the MCP and PIP joints of the hands. Patients may have new-onset Raynaud's phenomenon that could be a clue. The scalp may be involved. Paul, we know some stuff about scalp and hair loss now. If someone has itching of the scalp and a burning pain, you could think about dermatomyositis. She said that that's often one of the more prominent features that the symptoms that is bothering the people most actually, more so than the weakness is the itching, which was complete news to me. So, Paul, let's move onto the diagnostic workup a little bit here. How about the physical exam? I know you're a big physical exam geek. So, let's geek out on the physical exam.

Paul: I do love it. Increasingly it seems less and less helpful. We did get some pointers in terms of how to make sure that we're assessing for weakness appropriately and really making sure we're testing specific muscle groups. So, we went over at least in terms of talking about the neck flexors, which are important to assess with myositis and then also the hip flexors and extensors. You can be fooled. I don't want to say patients are trying to trick us. They just want to do well for these examination maneuvers. If you don't have them positioned correctly, they might recruit other muscle groups and you're not really evaluating the muscle groups that you're hoping to. To mitigate that, especially with the neck flexors, it's helpful to actually assess the patient while supine. In that way, they're not using their shoulders, they actually gently hold down the forehead and ask them to push up. You're not pushing down their neck, you're not choking off the patient, but you're applying sufficient but [Matt laughs] have to resisted.

Then similarly, for hip flexors you want the patient supine and then actually have your hand relatively close to the patient's knee so that you're resisting specifically that muscle group. And then for hip extension, ideally, the patient should be prone and the same thing. You want to be a little bit away from the actual joint that you're evaluating to really give full resistance to that. She gave some ways to do targeted muscle strength testing. And then the grip strength, Matt, I thought was super cool. I don't know why that one resonated so much, but to remind me the way I've been doing running, "All right, just grab my fingers as hard as you can is probably not the best way to do it." So, [unintelligible [00:26:23] doing it.

Matthew: Yeah, so she actually said, you flex your fingers, but you flex to the first palmar crease, which is right here. So, you're just really flexing your PIP and your DIP joints. And then you're trying to pry up the fingers there. And patients can't really cheat. It just really isolates those groups that you're looking for. Inclusion body myositis is one of the ones where she said that they can get distal muscle weakness. And so, that's what you'd be looking for there. So totally different than the way I'd normally test.

On the labs, the lab workup is fairly standard CBC, CMP, ANA thyroid and inflammatory markers. The thing that is not standard is-- So, the ANA is often positive in the myositis. But anemia is uncommon and the inflammatory markers are often normal, which is, Paul, I had no idea that would not be what I expected.

Paul: Right. Yeah, I think we talked before. With these autoimmune diseases, I feel you almost always see anemia. I think that would be my expectation and also the inflammatory markers, especially with the symptoms that these patients are having for some reason, mentally, I would expect those things to be wildly elevated and it turns out that's not the case. So, you're not ruling out the diagnosis of those things come back to normal if anything that might actually be supportive evidence.

Matthew: So, other things you might think about MRI of the thigh muscles is sometimes used to look for potential sites for biopsy and also just to identify muscle inflammation. Patients could have interstitial lung disease. So, getting a CAT scan of the lungs is something that can be done. She said she actually for the initial imaging often does a CAT scan of the chest, abdomen, and pelvis as part of just a cancer screening workup especially if they have dermatomyositis and age-appropriate cancer screening if they're men, she'll even do PSA testing and testing of the prostate exam.

There are a lot of specific antibodies, and muscle biopsy, and things that they can use to really drill down what the actual diagnosis is. But Paul with the end of our time here, I wanted to talk a little bit about what we in primary care, what is our role here? Because the case we gave here was a patient who was on a statin. Do you remember what she said about statins or why we should at least think about the statins?

Paul: Yeah, a couple of things. I think she blamed atorvastatin, not blamed. That's the wrong way to say it. But atorvastatin is often implicated. It's probably the best way to say it in part, because we also tend to go high dose with that too. So, you just go guns blazing with atorvastatin. I think she did make

the point that for most patients, a statin rechallenge is appropriate and probably okay, but she would start low and go slow. So, rather than sort of, "Okay, let's just go back to 80 milligrams every single day," maybe do 20 milligrams a couple times a week see how the patients tolerate it and that just come in guns blazing and restart at a lower level and then uptitrate to tolerability as opposed to just restarting at the prior dose of the discontinued, because these patients can be sensitive to the statin side effects.

Matthew: Yes. Her group did discover this autoimmune statin myopathy that is something that exists. It's a necrotizing myositis or myopathy. Her group did discover that but she said that once that's been ruled out, you can put people on statins as you're saying, Paul, but the start low go-slow approach, which is counterintuitive, but she said you still want to protect patients from cardiac disease. Patients actually can exercise, Paul. They don't necessarily need to do heavy resistance training, but they can do some exercise that's actually been shown to be beneficial.

Then in primary care, Paul, because these patients are going to be exposed to things like steroids and because they're going to be on immunosuppressive medications, you should think about getting vaccinations before those meds are started assessing their bone health and then sun protection, Paul, especially if they have some of the conditions that have photosensitive rashes, they need to wear really heavy, she said SPF70 or above. And you told your hat story, Paul, where her dermatologist told you to wear a hat because your coverage up top was not what you would want it to be for you, Paul.

Matthew: She was very nice and said, "I should consider incorporating a hat into my wardrobe," which I thought was as tactful as you could possibly phrase that.

Matthew: I can't disagree with that, Paul.

Paul: [laughs]

Matthew: It sounds like you're getting really great care.

Paul: Yeah, not complaining.

Matthew: If people want to get deeper into any of these three episodes we've discussed tonight, they can of course, listen to the episodes. The links will be in the show description here. We had fantastic discussions with all these guests. But Paul, all good things must come to an end. In this episode, I think it's time for an outro. So, Paul, if you will.

Paul: Let's put a bow on it. This has been another episode of the Curbsiders bringing you a little knowledge food for your brain whole.

Matthew: Yummy.

Paul: Great. [laughs] Get show notes to *thecurbsiders.com* and while you're there, sign up for our mailing list to get our weekly show notes in your inbox, plus twice each month, you'll get our Curbsiders Digest recapping the latest practice-changing articles, guidelines, and news in internal medicine.

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I wanted to give a special thanks to our production team. The show is produced and edited by the team at Pod Paste. Elizabeth Proto runs our social media and Stuart Brigham composed our theme music. And with all that, Paul, until next time, I've been Dr. Matthew Frank Watto.

Paul: And I remain Dr. Paul Nelson Williams. Thank you and goodbye.

[Transcript provided by SpeechDocs Podcast Transcription]