Arthritis-Related Conditions
Hosts: Rebecca Gillett, MS OTR/L and Julie Eller
Guest Speaker: Amanda Nelson, MD, UNC Thurston Arthritis Research Center

When you live with arthritis, you know that it rarely comes alone. Whether you have osteoarthritis, gout or an autoimmune inflammatory form, chances are you have some other disease or condition that's related to it.

In this episode of Live Yes! With Arthritis Podcast, hosts Rebecca and Julie talk to Dr. Amanda Nelson, a rheumatologist and professor with extensive experience in arthritis research. She discusses some of the conditions that commonly accompany different types of arthritis and how they are related.

Some examples: Having an autoimmune form of arthritis automatically puts you at risk of developing other autoimmune conditions. And while some related conditions, like cardiovascular disease, may occur as a result of the same systemic inflammation at the root of rheumatoid arthritis, others, like type 2 diabetes or metabolic syndrome, occur with osteoarthritis due in part to obesity. Learn more about these interactions and what steps you can take to prevent related conditions or reduce their effects.

Dr. Amanda Nelson is a board-certified internist and rheumatologist specializing in rheumatoid arthritis, spondyloarthropathies, osteoarthritis and polymyalgia rheumatica. She is an associate professor in the Division of Rheumatology, Allergy & Immunology at the University of North Carolina School of Medicine. Dr. Nelson is also a member of the UNC Thurston Arthritis Research Center, focusing on osteoarthritis research, co-director of the Johnston County Osteoarthritis Project, and medical director for the Osteoarthritis Action Alliance.

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Arthritis-Related Conditions
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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 for the growing community of people like you who really care about conquering arthritis once and for all. Take a moment to subscribe to, rate and comment on Live Yes! With Arthritis wherever you get your podcasts … and never miss an episode. 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 and osteoarthritis.

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

MUSIC BRIDGE

Rebecca:

Thanks for joining us on this episode of the Live Yes! With Arthritis podcast. Today we are going to be talking about arthritis and some of the related conditions that can occur when you have arthritis, whether it's because of the arthritis or related to it. We're gonna kind of break that down and talk about it a little bit more today, Julie.

Julie:

That's right. And we've got an amazing guest to help guide our conversation. Dr. Amanda Nelson is a board-certified internist and rheumatologist, an associate professor with the Division of Rheumatology, Allergy & Immunology at UNC School of Medicine. She's also a member of the UNC Thurston Arthritis Research Center. Her clinical specialty areas include rheumatoid arthritis, spondyloarthropathies, osteoarthritis and polymyalgia rheumatica.

Dr. Nelson's research interest is in osteoarthritis, and she herself is the co-director of the Johnston County Osteoarthritis Project and the medical director for the Osteoarthritis Action Alliance. So, we've got a perfect guest to help take us through arthritis and the related conditions that you might live with in addition to some of your chronic pain and arthritis symptoms.

Dr. Nelson, welcome to the podcast.

Dr. Amanda Nelson:

Thank you. Happy to be here.

Julie:

Well, we're so excited to kind of talk about this important topic with you and really get an overview of arthritis inflammation in the body. Can you first describe some of the differences between osteoarthritis and maybe some of the more inflammatory types of arthritis?

Dr. Nelson:

Arthritis itself just means inflammation in the joint. So, osteoarthritis also has inflammation in the joints. It's just not to the extent that something like rheumatoid arthritis might have. Also, people with these other more inflammatory types often have more systemic involvement. We'll talk later about how some other organ systems might be involved in an inflammatory arthritis that maybe isn't so much the case in osteoarthritis, which really is a disease of the whole joint and all the tissues in the joint, but maybe not so much of the whole body in the way that some of the other types are.

Rebecca:

Could you take a minute to maybe explain how arthritis can affect other parts of the body?

Dr. Nelson:

I'll use rheumatoid arthritis as an example, maybe the most familiar to people who might not have arthritis. RA is really a systemic disease, so the joints are involved, and there's inflammation within the joints. But it can also affect the lung, and there's a fair bit of literature to say it might even start in the lung. It can cause nodules in the lungs or in the skin.

It can cause a sort of scarring process inside the lung called interstitial lung disease. You can get other kinds of skin involvement. The vessels can be inflamed. And so, there's really the systemic inflammatory process going on that affects the joints but is also affecting a lot of other places.

And similarly, something like lupus or other connective tissue diseases really have these effects across the whole body. So, there's skin rashes, there's lung disease that might affect the kidney or the nerves, all in addition to having these inflammatory joint issues.

By having systemic inflammation, which is sort of required to affect all of those organ systems, that itself can increase the risk of other inflammatory conditions like cardiovascular disease. So, sometimes people don't remember or think about cardiovascular disease as being an inflammatory condition, and really those plaques in the vessels are an inflammatory process, and they express cytokines and cause inflammation of the vessel themselves.

Because of that, rheumatoid arthritis contributes to the level of cardiovascular risk at the same level that diabetes does. So, the fact that you have RA is just like having diabetes if you calculate your cardiovascular risk. It's really a systemic disorder.

In the case where it's not a systemic disorder, if you have diabetes or you have a sleep or a mood issue, those are all tied in, too, and that might be a common pathway. That might be obesity, leading to reduced physical activity, eventually causing diabetes. Maybe you get osteoarthritis after that. It might be medications. It might be side effects from medications.

Just being unfortunate and having multiple chronic conditions, it happens all the time. Most people with osteoarthritis have two or more other conditions in addition to their OA. And all of that then ties in and affects your physical and your mental well-being.

Julie:

It's a lot to juggle when you're living with a chronic condition like arthritis. Because you're right, it's not just those immediate symptoms that you think of, that swelling of the joint, but all of those other cascading impacts that maybe you don't think about as regularly or see as regularly when you're considering arthritis. What is the relationship between some of the common related conditions? Is it a cause-and-effect situation, or is it just, you know, a circumstantial kind of thing?

Dr. Nelson:

Yeah. And I think it varies quite a bit, depending on which condition, which arthritis. Certainly, systemic inflammation and rheumatoid arthritis or lupus directly contributes to increased cardiovascular risk. And CVD, again being itself an inflammatory condition, that's really a consequence of having systemic inflammation.

On the other hand, something like obesity is just kind of a common thread, right? You might have psoriatic arthritis and obesity. You might have osteoarthritis and obesity. You might just have been obese as a child and continued to have lifelong obesity and then develop some of these arthritis issues. Having obesity can increase your risk for type 2 diabetes, for example.

But then if you think about diabetes, maybe you already have diabetes, or maybe you have type 1 diabetes. So now you're in a whole different category of being more likely to develop other autoimmune conditions. So, if you have type 1 diabetes, which is different than type 2, an autoimmune condition, you are now more likely to develop psoriasis or other autoimmune diseases just based on being an autoimmune sort of person, which I think most of us are familiar with. So that's all very complicated.

Another really key aspect of this I wanted to bring up was physical activity. Reduced physical activity might be from the arthritis, or it might be from COPD or having cardiovascular disease or some other thing that contributes to your inability to exercise well. And then that can make your arthritis symptoms worse or contribute to the developing arthritis, and then make your obesity problem worse, or make you develop obesity that you didn't have before. Physical activity is a recommended intervention for essentially everything we've mentioned to this point.

This whole cycle just kind of worsens, and repeats, and makes it hard for you to really achieve any of your health care goals. Because now you can't exercise because of the

arthritis, and you can't lose weight, and you can't make your diabetes better. All these things kind of act against you in that way and trying to address each one individually.

Rebecca:

Yeah. It's almost like a domino effect. I don't even know if that's the right analogy, because it's almost a puzzle piece, right? So, you start with one piece of the puzzle and then easily, you could add in more. Because other things can easily just happen. It's that increased level of inflammation in your body in general. And then, like you said, the pain limits people from being able to do the things to manage any of these types of chronic conditions. If you have lung issues and you're having difficulty walking… Let's say walking is your thing, and then you're not getting that physical activity because of the lung issues, so then it's not helping your arthritis.

It's exhausting. I think I'm tired of just talking about this whole circle of all the chronic conditions that can happen. It's really tough. And not only is it tough to hear, but it's tough to manage if you're living it. The other question that arises a lot of times I think, Dr. Nelson, that people have is, OK, is this from my medication? Is my medication causing this?

Dr. Nelson:

I think it the same kind of problem. It might be both or neither or contributing together or, you know, combinations of things. But absolutely, some of the medications we use can make some of these other issues either develop or worsen. We know that, and we counsel patients about that very carefully.

For example, steroids are an easy one to go to. Steroids can contribute to high blood sugar, high blood pressure, changes in mood. It can contribute to loss of bone density or osteoporosis, and they can contribute to cataracts. So, all of those things can be a consequence of using a steroid medication.

Maybe you had to use that to reduce some of the other really major, potential issues related to your underlying condition. But recognizing that and counseling about that, using things at the lowest dose for the least amount of time that they're absolutely necessary, is all really important. And of course, monitoring for something.

NSAIDs — ibuprofen, Aleve, naproxen — contribute to GI bleeds, ulcers in the gut. That can contribute to kidney problems or can be worsened by kidney problems. And those are a common thing that people go to over-the-counter.

Rebecca:

Right.

Dr. Nelson:

Things that you take over-the-counter can contribute to these kinds of issues as well. Another big one in that category is liver toxicity. Right? People might take methotrexate for their RA or their lupus or various things, and that can contribute to liver toxicity. But if you also then take four, five grams of Tylenol, which is more than the recommended dose, and you also take ibuprofen, then an herbal or some other supplement that maybe has some liver toxicity that you're not aware of, those combinations can really contribute to problems related to medications. So, the thing I would say about all of that is that it's really important to communicate with your doctor. Hopefully they ask, maybe they didn't, maybe the nurse did.

I always encourage my patients if they wanna start something new, or they saw something on TV, or their friend is taking something, just run it by me. You know? I wanna check interactions. I wanna see if it's gonna have any untoward side effects that perhaps we can avoid by just talking about it and making sure we check.

Julie:

Actually, being honest and transparent about those things helps us all make better treatment decisions and maybe get on the most appropriate treatment for each of us. We all have different risk tolerance.

PROMO:
The Arthritis Foundation is always looking for new ways to inform you about the things you want to know more about. Check out our webinars — in real time or on demand. Visit https://www.arthritis.org/events/webinars to learn more.

Julie:

Dr. Nelson, can you tell us a little bit about the patients that you see and maybe their perception of risk and absolute risk, versus relative risk, as it comes to not only their comorbidities, but also maybe some treatment decisions that they make?

Dr. Nelson:

I think everybody is very individual in how they perceive risk, and everybody has a different way of coming at this. So, it might be that one patient is just... Their only concern is about joint damage. And whatever they can do to prevent joint damage over time, they're willing to accept that risk. And another patient might be willing to accept a great deal of deformity, maybe, if the pain is controlled; the deformity progresses as long as they're not going to be at increased risk of malignancy.

And a lot of this is really informed by our outside experiences. I've had patients who had a relative die of a rare infection, and they're very concerned about infection, even though the sort of absolute likelihood of them getting that infection is incredibly low 'cause it was incredibly low for the relative. That's their concern, that they're gonna get this bad thing that happened to someone they know.

An example that I use is about Sjögren's. It is really important to think about the framework of the risk. And so, a lot of the risks we talk about are dramatically increased for our patients but are very rare in the grand scheme of things. For Sjögren's, we often talk about the risk of lymphoma, right?

The risk of lymphoma is very high in patients with primary Sjögren's. And there's a couple of good studies out of Scandinavia that look at the relative risk being around 10 to 15 times. So, you're 10 to 15 times more likely to get lymphoma if you have Sjögren's than if you don't have Sjögren's. That sounds terrible.

Rebecca:

Yeah.

Dr. Nelson:

And sometimes, it's even higher. But the absolute risk is more like 1 to 5%, right? Yes, it's extremely important that we screen for this, and that we're aware of this and that you tell me if you have any lumps. But you also don't need to lose sleep over the fact that

you're gonna develop lymphoma tomorrow. If we're monitoring carefully and looking for that, we can head some of that off. So having a clear discussion about what any numbers that you're sharing mean, how they relate to these kinda different risks and understanding where the patient is coming from.

You know, if they're not gonna take something that increases risk of malignancy, no matter what, right? Then I don't need to keep trying to tell them about that. I just need to understand where they're coming from and say, "OK, so we don't wanna use this, this or this, because they do relatively increase your risk of this outcome that you're not willing to accept a risk of."

And if I understand that and the patient understands that, then we can kinda move forward with maybe something different. Having kind of an educated discussion and making sure that you're communicating clearly. And risk is a tricky one for sure.

Rebecca:

Yeah. I know a lot of patients, who either are on for an inflammatory type of arthritis, that have true fears of developing some of those long lists of things and the side effects that could happen. That can be a hard one for anybody to swallow, that "I'm gonna take a medication that could potentially cause further risk." Right? I think what you're saying is that communication and sharing that fear with your doctor is so important, because that can guide your treatment planning. Right?

Dr. Nelson:

Yeah. And I also make sure that people know it's not only the medicine. Having RA, having Sjögren's, increases your risk for malignancy whether I treat it or not.

Rebecca:

Right.

Dr. Nelson:

And so that's part of the risk conversation, too. Like, what's my risk just because I unfortunately have developed this condition? Is treating that really gonna increase the risk? And what's that level of risk? And how can we sort of come to an agreement about being comfortable about that?

Julie:

Dr. Nelson, what about some of the common conditions that are associated with each arthritis category or type? Like for osteoarthritis, are you at a greater risk of certain additional conditions? And maybe rheumatoid arthritis, do you have to look out for different types of things?

Dr. Nelson:

Most patients with osteoarthritis have two or more chronic conditions. Those typically are things like cardiovascular disease or diabetes, obesity, related things to that. But a fairly large proportion, 25, 30%, have more than five, right?

Rebecca:

Wow.

Dr. Nelson:

Then you're talking about COPD and reflux, and lots of other conditions that can come along with that. Obesity is a fairly common one across most of the conditions that we're thinking about here. Particularly OA and psoriatic arthritis patients have a particular issue with obesity and being at higher risk for developing obesity.

Cardiovascular disease is pretty across the board, and most of our conditions are associated with higher risk of cardiovascular disease. For the inflammatory conditions, there's a few kind of specific ones. So, heart failure with rheumatoid arthritis, in addition to sort of cardiovascular disease. Heart attack kind of stuff, actually heart failure.

Interstitial lung disease, which we briefly mentioned, that kind of scarring process inside the lung. Infection is more common. Again, the systemic inflammation and the immune system not quite acting right, just from the underlying condition. And we may magnify that then with our treatments.

Malignancy, as we mentioned, and osteoporosis, typically from the steroids. And then psoriatic arthritis is a little bit different. The cardiovascular disease maybe is a little bit more, obesity certainly more. They tend to be at higher risk from metabolic syndrome, which is sort of this combination of diabetes and obesity and high blood cholesterol, which then, of course, increases the risk of cardiovascular disease even more, fatty liver in association with that.

And then the spondyloarthropathies, psoriatic being one of those, can cause some weird stuff that people sometimes don't think about. They're associated with a greater risk of inflammatory bowel disease. Actually developing a Crohn's-like illness or ulcerative colitis. And uveitis, which is an inflammation of the eye.

So, when I see a patient with one of these conditions, I always warn them, "If you get a red eye and you have to go to the doctor, and they say your eye's inflamed, I need to know that." Because if I don't tell them that, they would never tell me, right? They think they had pink eye, or it was some unrelated thing. Just kinda being aware. Valvular disease and ankylosing spondylitis is another one. You can actually have disease of the valves inside the heart that can cause problems.

Diabetes obviously people think of with neuropathy. But Sjögren's and even RA in a severe situation can lead to some neuropathy. The fact that so many different things can be involved in an arthritis patient and sort of, you know, once that diagnosis is made, going through some of these things to kinda look out for and be aware of.

Rebecca:

I've had my RA for almost 20 years and picked up a few other diagnoses and conditions along the way. And a lot of times when something has happened, it was a surprise to me. I have dry eye and didn't know that that could be common with people with RA. A couple of years ago, I was having chest pain and having a difficulty breathing and ended up at the ER, 'cause my blood pressure was also high, and found out I had pleurisy, which is another thing that can be common.

I feel like I know everything about my disease and then, I hate it, something comes up, and I'm like, "Oh well, I didn't know that that was a thing, too." I'll just add that to the list of complications, because I already have an autoimmune disease, and with RA, I'm prone to it. But I also have osteoarthritis, and I have degenerative disc disease. I know that a lot of people who have one form of arthritis often will have another type of arthritis. Is that common, that you see, and how common is it?

Dr. Nelson:

Yeah, it's very common. Rheumatoid arthritis or gout, for example, can cause inflammatory damage to a joint. Then the inflammation maybe is treated, right? So, maybe you get on a really effective therapy. All the inflammation gets taken out, but

that joint is not normal anymore. That's typically what we think of as secondary osteoarthritis.

That joint starts to try and heal. It develops bone spurs. The joint gets narrowed. The cartilage is already damaged from the prior process. And now it looks pretty typical for osteoarthritis. The other thing that happens a lot is concomitant centralized pain or fibromyalgia. I tell my patients, "You know, you've lived with pain in this knee or your hands or whatever it is, for five, 10, 15, 20 years. And over time, our bodies start to sort of think, 'Oh gosh, everything hurts.'"

It's really the centralizing process that started maybe in a joint or a set of joints, but now it's really that the whole body hurts and everything hurts. And your nervous system is just hyper-sensitized to feeling pain and feeling like things are painful stimuli when maybe they weren't. So that's another really common one. Then you end up with rheumatoid arthritis, maybe a couple knees with OA or an ankle, and then you've got centralized pain and fibromyalgia on top of that. That's, I would say, almost the norm rather than the exception.

PROMO:
Check out the Arthritis Foundation's new app, called Vim, to help people with arthritis gain power over their pain. The app features expert educational content, a goal and activity tracker and opportunities to connect with others. It'll help you set attainable goals and achieve small wins that add up to big victories. Download the app at https://www.arthritis.org/vim, spelled V-I-M.

Julie:

We just released a new report, it's called the How It Hurts Report, where we analyze a lot of the patient-reported outcomes from our 40,000 plus responses in this study over the last couple of years. And what we know from that data analysis is that folks who have multiple forms of arthritis tend to have worse health outcomes than the general population as it comes to managing their pain, managing their condition, managing their disease. And it's our job as the Arthritis Foundation to help them do better.

Dr. Nelson, as you consider your patients who have multiple chronic conditions, like what Rebecca was saying, what are some steps that they can take to prevent additional conditions from becoming a part of their kind of battery of care that they need to manage and consider?

Dr. Nelson:

I think one way to look at it is that the management of all these different things actually overlaps pretty substantially. So physical activity, whether that's walking or swimming or whatever someone likes to do, is probably the most important self-guided sort of thing you can do for yourself, to try and prevent some of these other things from happening and to manage them. And that's gonna work for your osteoarthritis. It's gonna help your rheumatoid arthritis. It's definitely gonna help your fibromyalgia. It's gonna reduce obesity. It's the main treatment recommendation for diabetes and cardiovascular disease.

So, if you sort of think about it that way, then it's less like, 'I have five chronic conditions," and more like, "I can do physical activity to make everything that I'm suffering from better and make my whole physical condition better, my quality of life better." Really all of those things. And it's really any level of physical activities.

I keep a walking prescription in my electronic medical record. And I might... You know, it says 30 minutes, five times a week, right? That's sort of what we're getting to, but I'll probably change it to two minutes, two days a week for some people. Or get up off the couch once a day or something. It depends again on where the patient's starting and where they wanna get to. I think physical activity is a good thing to hold onto, that you can sort of take and control.

And then just monitoring, checkups, getting your labs done, making sure that you're not getting medication toxicity, or having some of these long-term effects develop. Just sort of keeping up with it, to the extent that you go to your doctor's appointments and kind of make sure that you're getting checked up to avoid things that are avoidable, getting off steroids, that kinda stuff. And then managing a disease optimally, whether that's your RA or your diabetes or whatever, can certainly help just kinda get everything under better control, right?

Controlling the things that you can control. Trying to get some help with the other things, whether from your doctor or whatever, and making it into a more manageable thing to deal with.

Julie:

Yeah. And it can be really hard to get started, especially when it's something like physical activity, where it can be very intimidating to be at a point in your journey

where maybe it's just, you know, walking two minutes a day, twice a week or whatever that might be.

And we've got some really great tools and resources to help you get there, including a new app from the Arthritis Foundation called Vim. So, definitely check out the rest of our episodes. Definitely check out this new tool and resource that can help you accomplish some of those goals in bite-size pieces to make it a little bit more manageable.

Rebecca:

I think one of the things that I find difficult is managing all of the specialists I see. And coordinating all of my care. It can be a full-time job for people who have multiple chronic conditions that they're managing. Do you have any advice that you would give for patients who do have multiple conditions they're managing?

Dr. Nelson:

I think, for the most part, the primary care physician is the coordinator of all of this. They're gonna get the notes from the rheumatologist and the cardiologist and the pulmonologist, and get all the recommendations and hopefully be able to sift those down and figure out which things need to be priority, and answer sort of initial questions, especially when you're not sure which person to go to with a question. Right?

So, you can ask the primary care like, "This is my issue. I'm pretty sure it's not you, but who of these other people is it?" I also find that the patient portals, which are common now in a lot of the medical records, are really helpful. But in general, I think the primary care provider is probably your first go-to.

Julie:

As you're talking, I just keep thinking to myself about how much the responsibility lies on the patient's shoulders to really advocate for themselves and to reach out, and ask the question and know the right language to ask that question or know where their patient portal is. And all of the pieces of managing so many of these conditions can just be really burdensome, and that weight can add up. It can really take a toll sometimes on our mental health. We've talked a lot about some of the physical conditions that might be related to arthritis care. But can we talk a little bit about some of the mental health effects that people might experience along with their arthritis?

I know depression and anxiety is something that many of our patients in our INSIGHTS program have reported. I know at least two-thirds of people report experiencing symptoms of anxiety and depression and fear. Why do you think so many people are experiencing these? And what guidance might you give them?

Dr. Nelson:

It's a combination of feeling overwhelmed, having to cope with a chronic illness, right? A lot of times, inflammatory arthritis happens in a young person and maybe this is their first experience with being ill. Accepting the fact that there's a chronic illness that has to be managed and that's gonna change your life.

It's very impactful and can certainly lead to depression and anxiety issues. It affects quality of life, right? Maybe I can't do the activities that I really like, and that contributes to depression. Maybe not even being able to do activities that I have to do, right? So maybe it's actually affecting daily living activities, and that's really hard.

Julie:

Yeah.

Dr. Nelson:

Socialization. And sports. And it all kind of depends again where you're coming from, but all of that affects really our feeling about who we are and what we do. I mean, the whole language is different. You learn that you have this condition and then these are the medicines.

Then there's financial issues, right? "Am I gonna be able to pay for this? What's my copay? I have to sign up for all these programs. They have these huge reams of paperwork to complete. What's my long-term prognosis? Am I gonna be around for my kids?"

I mean, just the thoughts that start to circle in your head can lead to this. And then in addition, you've got the disease process and the systemic inflammation, and the fatigue and the medication that makes you throw up in the morning. It's really hard. It's just so common and understandable.

Julie:

I think there's some stigma to it. I think it's hard to admit sometimes when you're having some of those additional anxieties or depression feelings, because the conversation, the national conversation we have around mental health, can be really stigmatized. But I love one of our patient leadership council members, he always reminds us: If you are not also treating your symptoms of depression, if you are not dealing with those as well, you're not fully dealing with your arthritis.

So, when you're talking to your patients experiencing some symptoms of anxiety or depression, what kinds of things do you look out for that maybe we can start looking out for in ourselves?

Dr. Nelson:

Noticing that maybe their affect is kind of flat, which means that they're not smiling or frowning or inflecting their voice. We look for what we call psychomotor slowing, which just kinda means they're doing everything sort of slow and monotone, and they're not really engaging in the conversation. Those are some things.

If this happens, you need to talk to someone. You can talk to me, you can talk to your spouse, your friends, your neighbor who has RA. Somebody that you're comfortable with, that's a safe space, that you can start to bring this up. I mean, it's just so common. It's even worse with COVID, right? Everyone's depressed and anxious. I would absolutely agree that if you're not addressing that piece of it, you're sort of missing out on a chance to try and get some of these symptoms addressed and get to a better state.

Rebecca:

Yeah. I feel like that should always be on your list of questions for your doctor. Are there any coping strategies that you have for people to help manage their mental health with arthritis? Because it is a huge part. It is not just physical. It does have mental health effects. So how can we better manage that?

Dr. Nelson:

Yeah. So, this is my broken record speech. Physical activity is absolutely essential. It's gonna help the pain and the other conditions that we talked about, control the weight, make your joints more healthy, but it also helps your mental state and your fatigue. Release all the happy endorphins and get things better. That's often the first thing I recommend: Just try to routinely do a little bit of something. Swimming, walking, doesn't

matter, but getting the body moving helps with all of these different aspects. And again, free, self-directed total control. You can do that on your own.

Rebecca:

Yeah. One of the things that I love that Julie has always said is: finding the movement that brings you joy. It doesn't have to be biking or running. Walking is one of the best forms, yes. But if you like dancing, and that's one of Julie's things, go ahead, do it. I have a friend who does belly dancing and loves it because she laughs like the whole time. Turn on your favorite songs and start dancing. Right? Whatever it is. You might be dancing in your chair to start out, but that's OK. Just move your body.

Julie:

Yeah. Count the things that might not be as joyful but are physical movement. Maybe I haven't exercised that day, but I did do two loads of laundry, that counts for me. Or maybe I did a couple loads of dishes in my kitchen that day, and I was up and moving and lifting and bending from the dishwasher, lifting into my cabinet, bending from the dishwasher, lifting into my cabinet. Maybe I added a couple of additional squats into the mix to make it something more substantial than just a single activity. But those things count. Count the little wins.

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Julie:

Now, Dr. Nelson, if you could close this out for our conversation today, with your top three takeaways from today's discussion about arthritis and related conditions, what would those three things be?

Dr. Nelson:

The starting one is: Arthritis is not just arthritis. It's arthritis plus every time. And it's gonna be plus different things for different people. And then my second one is: Management

overlaps, and physical activity is a cornerstone for really the arthritis and everything else. And then third: Mental health is key. And again, physical activity is helpful for improving mental health and managing those kinds of issues.

Rebecca:

I've got one thing I wanna add because I am one of those people who manages multiple chronic conditions. I have a pulmonologist, I have a cardiologist, I have my rheumatologist, right? I have all of these other conditions I'm managing. I have a medical resume.

On it is all of my health care information. I have the medications I've taken. I have my current medications. I have my allergies on there. I have all of the different conditions that I have. I have had 15 surgeries, so it never fits in those three lines that you get when you fill out a doctor's appointment form. And so, I update all of my information regularly, and I take it to my doctor's appointments. I provide this to my doctor, and it also can be a conversation starter, too. I have that saved on my computer, and it just makes life easier as far as managing multiple conditions. It's a great tool to have, and it helps keep you kind of organized. So, just wanna share that.

Julie:

Love it. Well, Dr. Nelson, thank you so much for joining us today and sharing your expertise with our listeners. It's been so helpful to get a better sense of how arthritis plus might impact you. So, thank you for joining us.

Dr. Nelson:

Thank you very much.

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