EDITORIAL

LEAGUES AGAINST RHEUMATISM

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We are living in exciting times – both politically and scientifically. When international treaties and relationships have to be re-evaluated in the face of convulsive political change, it is appropriate to consider the place the various Leagues Against Rheumatism occupy in the rheumatology community.

International League Against Rheumatism (ILAR)

The International League Against Rheumatism or ILAR is now 63 years old making it one of the oldest medical associations in the world today. Formed in Europe in 1927 the aims of ILAR have been "to stimulate and promote the development of awareness, knowledge and the means of prevention, treatment, rehabilitation and relief of rheumatic diseases". Its role is "to foster co-operation between different countries and geographical areas through existing continental, regional and national organisations most notably the World Health Organisation (WHO)"[1]. One of the functions of ILAR is to stimulate the growth of regional leagues. The other is to organise World Congresses of Rheumatology every four years.

Regional Leagues Against Rheumatism

ILAR came into existence at a time when there were but a handful of national societies of rheumatology. However with formation of national societies, regional leagues came later. Hence in 1944 PANLAR (Pan-American League Against Rheumatism) and 1947 EULAR (European League Against Rheumatism) were formed. Almost twenty years later chiefly through the efforts of the Japanese, Australian and Indian Rheumatism Associations, SEAPAL (South-east Asia Pacific Area League Against Rheumatism) was formed in 1963 in Sydney.

Asian-Pacific League Against Rheumatism (APLAR)

In April 1, 1989 chiefly through the efforts of the Singapore Society of Immunology, Allergy and Rheumatology but supported by all the other national societies, the acronym SEAPAL was changed to APLAR (Asian Pacific League Against Rheumatism). This allows for the admission of national societies of China, Iran and Iraq. Its aims and objectives are very similar to those of ILAR mentioned above. One of the main objectives of APLAR is to support the development of epidemiology, education and improved healthcare of the WHO-ILAR Community Orientated Programme for the Control of Rheumatic Diseases (COPCORD) in the Asia-Pacific region. This is accomplished through population data collection and education of the primary health care professionals. The main part of the COPCORD project has been implemented in the Philippines and Indonesia with large rural populations where the usual medical care is unavailable to the majority of them[2,3]. China is the next country targetted for the COPCORD project.

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The Singapore Scene

It has been well documented that arthritis is a major health problem in developed countries. In the US it is estimated that the healthcare for persons with rheumatic diseases and of their lost time from work will approach 1% of the gross national product (GNP) by the year 2000[4]. In Singapore in a pilot study in Whampoa constituency funded by the National Arthritis Foundation, about 6-8% of the adult population complain of significant rheumatic symptoms. In a one-day Morbidity Survey in outpatients carried out by the Ministry of Health (MoH), arthritis and rheumatism is the second commonest morbid condition seen by general practitioners and the sixth commonest condition seen in primary care health clinics[5]. All these numbers are likely to increase as the country attains a "developed" status and the population ages.

Yet in Singapore, as in other countries, rheumatology suffers from a poor image. From the public and even in some doctors' viewpoint, rheumatic disease is a natural consequence of ageing where nothing much can be done. The discipline is viewed by many trainees as being not procedure orientated, without high-technology gimmicks, poorly remunerated and involving the care of patients with chronic illness whose clinical course provides little gratification for the provider[6].

This is of course nothing further from the truth. Rheumatology covers a wide spectrum of diseases – at the last count about 180 – ranging from conditions like fibromyalgia to systemic vasculitis. It is on the cutting edge of many scientific disciplines like immunology, genetics, molecular biology and monoclonal technology. Although many rheumatic diseases cannot be cured at the moment, the majority could be controlled and the life of sufferers made more bearable through counselling, physiotherapy, occupational therapy and drugs. Within the next decade the therapy of rheumatic diseases will be revolutionalised with the introduction of biologic agents and new forms of immunotherapy. What is needed is a core of dedicated clinician-teachers or in modern day parlance "physician-champions" who are given designated time to teach and to create an exciting environment for medical students and young physicians in their formative years. They could do much to neutralise the negative impressions, emphasise the positive aspects of rheumatology and provide alternatives to the more glamorous and technically orientated specialities. There is nothing more satisfying than bringing a lupus patient through episodes of renal failure, cerebral involvement, pregnancy and delivery successfully over a decade. In this period you get to know her family, her work conditions and other members of the therapy team like the psychiatrist, the obstetrician, the physiotherapist and the occupational therapist. This is holistic medicine at its best and rheumatology offers unique features not found in many other disciplines of internal medicine. In the final analysis the development of any discipline depends on its advocates and the ball is now at our feet.

References

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