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RHEUMORS

Practice Newsletter SUMMER 2016

Survive the Summer by Managing Arthritis

BY BRENDA BROUILLETTE, RN, BS

Summer is here and it's time for outdoor activities and fun under the sun. It is important for arthritis sufferers to be proactive and to address issues that may contribute to arthritic pain during these hot summer months. Embrace these easy tips when you plan and prepare for your summertime activities and you may reduce or eliminate pain, and have a much more enjoyable summer!

SUN PROTECTION

Some medications commonly used in the treatment of arthritic conditions, such as methotrexate and hydroxychloroquine, can increase your sensitivity to the sun and other forms of light. This sensitivity could lead to a rash or severe sunburn. Be sure to use plenty of sunscreen with a sun protection factor (spf) of at least 30 that provides both UVA and UVB protection. Cover your entire body, including your face and neck. The scalp is hard to protect from the sun without a good hat. And don't forget to periodically reapply sunscreen, as necessary. These days, there are devices to remind you to reapply sunscreen that can be found in bracelets, flip-flops, sunglasses and even in nail polish that changes color after a few hours in the sunlight.

MAINTAIN HYDRATION

Staying hydrated is essential, especially if you are participating in activities outside in the heat. Avoiding strenuous exercise in hot weather may be the wiser choice

continued on back page

RHEUMYTHOLOGY:

Glucosamine and Chondroitin – Supplements for Arthritis

BY JUSTIN PENG, MD, FACR

Osteoarthritis is the most common type of arthritis. It is also called a degenerative disease because it is caused by the break-down of cartilage. In a healthy joint, the ends of the bones are covered with smooth and healthy cartilage. In osteoarthritis, the cartilage in the joint spaces is worn away, causing narrowing of the joint and spurs on the edges of bones which can result in pain, stiffness, and limited range of motion.

Glucosamine and chondroitin are commonly used as supplements by patients to help alleviate the pain associated with osteoar-thritis. But are they really effective? In the United States, they are sold as dietary supplements and are, therefore, regulated as foods rather than medicines. Over the years, they have been used with varying degrees of success.

Glucosamine is a substance that is found in the cartilage and oth-er connective tissues of the body. Glucosamine can be extracted and chemically attached to sulfate or hydrochloric acid (HCl) and used as a drug or supplement. Chondroitin sulfate is a complex carbohydrate that allows cartilage to retain water. There have been a number of clinical trials that have studied glucosamine and chondroitin in osteoarthritis.

One of the largest trials was conducted by the National Institutes of Health (NIH) in the United States and compared the effects of using glucosamine HCl alone, chondroitin sulfate alone, the combination of glucosamine and chondroitin, Celebrex, and a placebo (a substance containing no medication) in patients with

In this trial, there were no significant differences in outcome between the glucosamine and chondroitin sulfate groups and the placebo group. However, in several smaller clinical trials in Europe, the formulation of glucosamine sulfate (not glucos-amine HCl) did show some possible benefit.

The bottom line is that some patients with osteoarthritis do seem, individually, to report some benefit. The American College of Rheumatology 2012 practice guidelines do not recommend the use of glucosamine or chondroitin for the management of osteoarthritis. However, because there are very few known side effects with these supplements, most physi-cians have no objection to a trial of glucosamine sulfate for a defined period of time (i.e., three months). If there is benefit in terms of pain or function, it may be continued. Regard-less, patients should still develop a comprehensive plan with their doctors to treat osteoarthritis that includes diet, exercise, weight loss, and using standard proven medications.

PRACTICE NEWS:

Community Outreach

ARA was a proud sponsor and participant in the Lupus Walk in April, the Arthritis Foundation's Walk to Cure Arthritis in May and the Sjogren's Syndrome Walkabout in June. Our physicians and staff rallied to fundraise as well as provide educational information regarding each disease and treatment options available.

Accolades

We congratulate Justin Peng, MD, for receiving the "Marriott Lifetime Achievement" Award presented by the Arthritis Foundation to an extraordinary Rheumatologist.

New Name - Same Service

Coming soon to each of our five infusion center locations we are adopting a new name - *Arise Infusion Therapy Services*. Our expert clinicians providing superb care will, of course, continue. In addition, *Arise Infusion* is also adding more biologic medications to provide patients with additional treatment options. Among them are two new medications for treating asthma and hives, Zucala and Xolair.

arise infusion
THERAPY SERVICES

DEPARTMENT HIGHLIGHT:

The ARA Central Call Center – A Critical Link in Patient Care

Think for a moment how the patient experience would be different without Arthritis and Rheumatism Associates' central call center?

- Patients, doctors' offices and other callers would have to know which of our five offices to call.
- Callers would, more often reach an alphanumeric menu system rather than a live human being.
- If the caller actually got through to a real person, he/she probably would be placed on hold several times while the busy staff worked with patients standing in front of them in the office.
- Callers would have to leave messages more often and wait for a call back from the party they were trying to reach.

This is how most medical offices function today and, until 2003, it is also how ARA functioned. The introduction of the central call center meant that callers almost always got to speak to a live person and have their needs promptly addressed, regardless of the reason for their call or who they were trying to reach. Over time, the call center has grown and become increasingly sophisticated in its ability to handle a large number of calls efficiently.

Most recently, the central call center has undergone some new and exciting changes to improve the overall patient and caller experience. Employing data analytics and intensive call monitoring, new call center manager, Itina Viaud, has put together an outstanding customer service training program and devoted herself to the singular mission of creating a satisfying experience for all callers regardless of the purpose of their call. "Satisfied patients are the lifeblood of the practice," says Viaud. "Great customer service leaves a lasting impression. This impression is the reason it is so important for our medical call specialists to satisfy every caller, every time."

What's Behind the Growth and Changes?

Callers may be surprised to learn that our call center receives more than 9,000 calls per month. Just getting to all of those calls is a huge challenge. Picking up the phone in a timely manner and providing quick, accurate information requires a set of skills that must be developed and honed over time. It also takes a very special kind of person who naturally has a pleasant demeanor and a strong desire to help people.

ARA has made great strides in hiring people who are passionate about solving problems and delivering exceptional customer service. Additionally, changes to our tools and protocols that have enhanced our ability to serve callers include:

- *Software upgrades to enhance the speed and accuracy of the call specialists*
- *Dedicated telephone lines designed to deliver better response times*
- *Giving priority to patients needing urgent assistance*
- *Dedicated access for physician office calls*
- *Hiring top-notch talent to include bi-lingual specialists*
- *Scheduling same say urgent care appointments*

So the next time you call the central call center to schedule an appointment, you will be greeted by one of our medical call specialists: Kym, Nancy, Genae, Cardice, Tiffany, Jackelyn, Jennifer or Shari. Please be assured that they are highly trained, skilled professionals who look forward to responding to your needs and providing you with excellent customer service.

RHEUM QUESTION:

Ed Sullivan, Christopher Columbus, Mik Mars of Mötley Crüe, and Norman Cousins: Famous People Who Had Ankylosing Spondylitis

BY JEFFREY A. POTTER, MD, FACR

Ankylosing Spondylitis (AS) is a rare autoimmune disorder affecting between 0.2 – 0.5 % of the general population in the United States. It belongs to a group of diseases known as spondyloarthropathies and, although it is typically characterized by low back pain, other symptoms may include inflammation of the eyes, skin, peripheral joints, soft tissue or gastrointestinal tract.

Spondyloarthropathies, generally, and Ankylosing Spondylitis, in particular, is more commonly seen in men between the ages of 20 and 40, although they can affect anyone regardless of age or gender. The back pain seen in AS tends to be worse in the morning upon awakening, and generally improves with activity and/or use of non-steroidal anti-inflammatory drugs (NSAIDS).

Diagnosing disorders like AS can prove especially challenging as there are no laboratory tests that are definitive and imaging studies may also be inconclusive. The presence of the HLA B27 gene can be helpful in identifying those patients experiencing back pain who may be at an increased risk of developing AS and X-rays and MRIs can help the physician look for joint damage associated with inflammation. Rheumatologists use a combination of blood tests, imaging studies, and a patient's clinical history to arrive at a diagnosis of Ankylosing Spondylitis. Once the diagnosis is established, the rheumatologist will help to determine the appropriate therapies.

Treatment of AS has improved significantly over the past several years. Mainstays of therapy continue to include NSAIDS and physical therapy, especially for patients with mild forms of the disease. These therapies may also be employed in the management of patients with more severe disease as well, although they may also require disease modifying drugs such as sulfasalazine, especially for those whose symptoms are limited to their peripheral joints (i.e., heels, knees, ankles, elbows). Methotrexate is considered an alternative to sulfasalazine, although it has recently been shown to be less effective for the management of spondyloarthropathies and is now typically reserved for patients who are intolerant of sulfasalazine.

Biologic therapies have changed the landscape of spondyloarthropathy management over the past decade and they can have life-changing effects on those patients with disease activity that warrants their use.. In particular, Anti-TNF (tumor necrosis factor) agents such as etanercept (Enbrel), infliximab (Remicade) and adalimumab (Humira) have been shown to decrease pain and discomfort and to increase mobility and functionality in patients with spondyloarthropathies, especially those with symptoms of the pelvis, sacroiliac joint, spine, and shoulder. When used in combination with traditional therapies like NSAIDS and physical therapy these agents can significantly increase productivity and decrease discomfort for patients. Adalimumab, in particular, has recently been approved for management of patients who experience inflammation of the eyes as a component of their disease process.

As with most autoimmune diseases, the diagnosis and medical management of Ankylosing Spondylitis can be quite complicated and generally requires the specialized skills of a highly trained physician such as a rheumatologist. While there is no cure for AS, many people find they can manage the disease and significantly curtail symptoms through a combination of medication, diet, exercise and other lifestyle modifications.

ARA Goes to China

Dr. Herbert Baraf, managing director of Arthritis and Rheumatism Associates and Clinical Professor of Medicine at George Washington University recently returned from China where he was invited to speak at medical conferences in Beijing, Chongqing and Shanghi. Dr. Baraf reports:

"The trip was a rewarding blend of sharing information and building relationships with colleagues facing similar clinical problems on the other side of the world and touring an incredibly fascinating country with a rich cultural history. For me and my wife, this was a trip of a lifetime. We made friends and we learned so much. I was thoroughly energized throughout."

RHEUMINATION:

Sjögren's Syndrome – A Chronic Autoimmune Disorder

BY GRACE AHN, MD, FACR

Sjögren's syndrome is an autoimmune disorder that can affect people at any age. Most commonly, symptoms appear in one's 40s and 50s and they affect more women than men. Primary Sjögren's syndrome occurs when symptoms manifest by themselves, without another disease. Secondary Sjögren's occurs in conjunction with another autoimmune disease, such as rheumatoid arthritis or lupus.

Investigations and studies of the exact cause of Sjögren's are ongoing and include looking at both genetic and infectious explanations. Particular antibodies can be found in patients with Sjögren's syndrome. Their immune systems may be fighting against their own tissue, leading to inflammation. Inflammation can affect the glands that make tears or saliva and can lead to dry eyes or dry mouth as well as dryness in the nose, throat, vagina and skin.

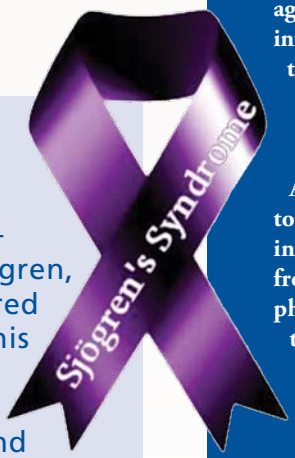
In addition to pain in these areas, the dryness can cause burning and sandy sensations and red or watery eyes. Swelling of glands around the face and neck also are common. Severe dryness can lead to damage in the external eye, tooth decay, gum inflammation and infections. Other complications from Sjögren's syndrome may include gastroesophageal reflux, joint pain, rashes, nerve irritation, as well as lung, kidney and liver diseases. In addition, autoimmune diseases like Sjögren's can lead to an increased risk of cancer, so physicians must remain vigilant on age appropriate cancer screening with Sjögren's patients.

Sjögren's syndrome is diagnosed through a full physical examination, laboratory testing and special studies that may include tissue biopsies to assess tear or saliva production.

Treatment for Sjögren's focuses on symptomatic relief. Lubricants such as artificial tears or medicated eye drops or eye gels can help dry-eye symptoms and ophthalmologists can perform procedures to repair tear ducts in severe cases. Dry mouth typically is treated with hydration, chewing gum, sprays or lozenges.There are also oral medications that can help stimulate salivary flow. Sometimes, physicians will use immunosuppressive medications to help treat Sjögren's syndrome. Patients are advised to have regular follow-ups with dentists and ophthalmologists and to have frequent monitoring by their rheumatologists to remain as healthy as possible.

DID YOU KNOW?

World Sjögren's Day was created to commemorate the birthday of Dr. Henrik Sjögren, a Swedish ophthalmologist who discovered the syndrome that would come to bear his name, in1933. On July 23, the Sjögren's Syndrome Foundation (SSF) joined with other Sjögren's organizations around the world to celebrate the 7th annual World Sjögren's Day. This would have been Dr. Sjögren's 117th birthday.



CLINICAL RESEARCH UPDATES:

Clinical Trial For Patients With Sjögren's Syndrome

Patients with rheumatic diseases have reaped the benefits of many modern medical discoveries. These breakthroughs result from the hard work of dedicated researchers and the devotion of patients who participate as subjects in clinical trials. Many brave and sincere hearts work together to demonstrate the effectiveness and safety of administering new medications to those in need. We are extremely thankful and proud of our many ARA patients who have participated in our clinical trials process. They are true heroes to the world of modern medicine.

The lives of patients with rheumatoid arthritis and systemic lupus erythematosus have been greatly improved by scientific advances in the development of new therapies. Unfortunately, patients with another common autoimmune disease, Sjögren's syndrome, have not enjoyed a similar medical breakthrough. Researchers continue to explore options, hoping to find such an intervention. Sjögren's syndrome is an autoimmune disorder characterized by the destruction of exocrine glands, the fluid-producing bodies such as tear ducts and salivary glands in the body. It can leave patients with regional dryness in the eyes, mouth and vagina, among others. Dryness results in tissue damage, such as corneal abrasions, stomatitis and recurrent infections. There are therapeutics to increase lubrication of eyes, nasal passages and vaginal tissues but no medications have been developed that can halt the cruel attack on the exocrine glands themselves.

ARA's research division, The Center for Rheumatology and Bone Research, is dedicated to helping in the search for therapies for patients suffering from Sjögren's syndrome. Towards that end, our physicians have designed a clinical trial to evaluate the effects of a promising medication on the salivary glands and other areas affected by Sjögren's syndrome. This medication is known to be a biologic response modifier in patients with rheumatoid arthritis. If you or someone you know has Sjögren's syndrome, please have them call one of our Center coordinators at 301-942-6610 to discuss enrollment in the study. Thanks so much for joining with us to help improve lives in our community and around the world.

POINTS ON JOINTS:

Osteonecrosis of the Jaw (ONJ)

BY ROBERT ROSENBERG, MD, FACR, CCD

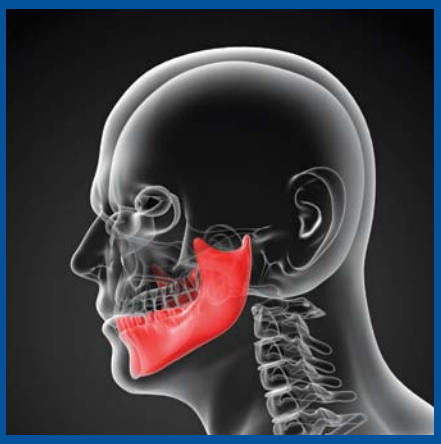
Osteonecrosis of the jaw (ONJ) was first associated with antiresorptive therapy (preventing or slowing the destruction of bone using bisphosphonate drugs, such as Fosamax, Actonel, Boniva and zoledronic acid) in 2003. At that time, dentists and oral surgeons at a dental clinic specializing in the treatment of cancer patients noted an increased incidence of ONJ in their patients who were receiving high doses of bisphosphonates and subsequently had dental surgery such as tooth extraction or implantation. High doses of antiresorptive drugs (such as bisphosphonates and denosumab/Prolia) are also used to treat certain cancers.

It is worth noting that some patients who did not have recent dental surgery also developed ONJ. ONJ is defined as exposed necrotic jaw bone that has still not healed eight weeks after dental surgery in patients who have received potent antiresorptive drugs and have not also undergone radiation therapy of the jaw. Cancer patients may receive doses of antiresorptive therapy that are 10-12 times higher than the doses used to treat osteoporosis. Still, some patients receiving traditional osteoporosis treatment doses of these medications have experienced ONJ.

The risk of ONJ in the general population has been reported at less than .001% and taking osteoporosis medications only marginally raises the risk to between .001 and .01%. Evidence does suggest some association between the risk of ONJ in patients on long-term bisphosphonate and denosumab (Prolia) therapy. The highest risk group for ONJ is cancer patients on bisphosphonates with rises to 1 to 15%.

ONJ often is without symptoms initially but symptoms may appear weeks to months later due to local inflammation. Symptoms may include jaw pain, loose teeth, jaw bone enlargement, red gums and gum ulcers. ONJ may occur at the site of a recent dental surgery and occurs more frequently in the lower versus the upper jaw.

In addition to the association of ONJ with chronic bisphosphonate and denosumab use in the treatment of osteoporosis, other risk factors include smoking, poor oral hygiene, diabetes, steroids, chemotherapy and dental surgery. Fortunately, the course of ONJ in most patients is limited, with more than 90% of patients responding to conservative management using antibiotics and oral rinses. In rare cases, limited surgical debridement of oral tissue is necessary.



Prevention of ONJ in osteoporosis patients on antiresorptive treatments involves regular prophylactic dental care and avoidance of invasive dental procedures, if possible. Even proper fitting of dentures is important. Routine dental care, such as cleaning, cavity remediation, crowns, whitening and even root canal surgery, do not appear to increase the risk.

The cause of ONJ is not understood. Some theories include over-suppression of bone production, dental infection, inhibition of new blood vessel growth, soft tissue injury and compromised immunity. ONJ has been seen in a variety of cancers as well as following head and neck radiation therapy. While there appears to be an association between antiresorptive drugs and ONJ, the evidence is unclear.

If you develop ONJ while on antiresorptive therapy, a number of clinical decisions need to be addressed. Patients with metastatic cancer to their bones may not be able to stop their antiresorptive therapy safely. Osteoporosis patients may be able to stop their antiresorptive treatment and/or substitute bone active therapy with Forteo (teriparatide), which has not been associated with ONJ. These clinical decisions need to be made with your physician.

Osteoporosis patients on medication who are facing elective dental procedures (extraction and implantation) should discuss options with their physician and their dentist. Antiresorptive therapy may be stopped two to three months prior to dental surgery and restarted two to three months following the dental procedures, provided mouth tissues have healed completely. However, this will depend on the medication the patient is taking, the severity of their osteoporosis, the risk of fracture and the urgency of the dental problems. There is no evidence that stopping osteoporosis medication prior to dental surgery reduces the risk of ONJ even though this is a common practice. Some dentists recommend bone resorption marker measurement to help determine the risk of ONJ in advance of dental surgery. Although theoretically an attractive concept, the effectiveness of this strategy is unknown.

How long should patients on bone-active osteoporosis medications continue their medications? Most of the benefit from long-term bisphosphonate use is realized in the first five years of oral treatment and the first three years of IV therapy (with zoledronic acid). Patients at lower risk of osteoporotic fracture (those with no previous fractures) might be able to take a drug holiday of two years with reassessment of fracture risk and bone density. Patients at high fracture risk (those who've had previous and/or multiple fractures) probably should continue with medication and be reassessed every one to two years. It is very important that each patient is assessed independently, with treatment and follow-up tailored to that unique patient.

Chicken Taco Rice Salad from *Eating Well to Fight Arthritis*

A favorite toss-together southwestern style chef salad with simple ingredients and big flavor.

MAKES 6 (2-CUP) SERVINGS
1 (5-ounce) package yellow rice
6 cups mixed salad greens
2 cups skinless rotisserie chicken, shredded
1 (15-ounce) can black beans, rinsed and drained
1 cup grape or cherry tomato halves
1/2 cup chopped red onion
1/2 cup shredded, reduced-fat, sharp Cheddar cheese
Salsa Vinaigrette, (recipe follows)

1. Prepare rice according to package directions. Cool; set aside.
2. In large bowl, combine cooled rice and all ingredients and toss with Salsa Vinaigrette (see recipe below).

Salsa Vinaigrette

A few ingredients magically makes a great-tasting vinaigrette. Use whatever is needed and save the remainder for another time.

MAKES 1 1/2 CUPS
1 cup salsa
2 teaspoons chili powder
1/2 teaspoon ground cumin
1 tablespoon lime juice
2 tablespoons olive oil

1. In small bowl, whisk together all ingredients.

Nutritional information per serving: Calories 327 kcal, Calories from Fat 29%, Fat 11 g, Saturated Fat 3 g, Cholesterol 57 mg, Sodium 923 mg, Carbohydrates 36 g, Dietary Fiber 6 g, Total Sugars 4 g, Protein 23 g, Dietary Exchanges: 2 starch, 1 vegetable, 2 1/2 lean meat

NUTRITION NUGGET: Think of beans as a more nutritional crouton. Sprinkle on salads or in casseroles and soups to boost your fiber intake.

Watermelon & Feta Salsa from *Too Hot in The Kitchen Cookbook*

An unusual combination, yet, a summer favorite: Watermelon salsa with sweet watermelon, fresh mint, salty olives, and feta bursting with sweet and salty flavor in each mouthful.

MAKES 16 (1/4) CUP SERVINGS
4 cups chopped watermelon
1/2 cup chopped red onion
1/3 cup crumbled reduced-fat feta cheese
2 tablespoons chopped Kalamata olives
2 tablespoons seasoned rice vinegar
2 teaspoons olive oil
1/4 cup chopped fresh mint

1. In small bowl mix together all ingredients. Serve.

Nutritional information per serving: Calories 29 Calories from fat 36% Fat 1g Saturated Fat 0g Cholesterol 1mg Sodium 98mg Carbohydrate 4g Dietary Fiber 0g Sugars 3g Protein 1g Dietary Exchanges: 1/2 fruit

SPICY ADVICE: Try the red pepper seasoned rice vinegar for a little extra zing. Raid a salad bar for fresh Kalamata olives – it makes a difference in this recipe.

Wellness Classes:

WHEATON

OSTEOPOROSIS
Thursdays ***(5-part series)***
Sept. 29 & Oct. 6, 13, 20, 27

YOGA
Mondays ***(5 part series)***
Sept. 12, 19, 26 & Oct. 3, 10

MASSAGE
Tuesdays, by appointment

ROCKVILLE

BACK SCHOOL
Tuesdays ***(2-part series)***
September 20th & 27th

YOGA
Mondays at 6pm ***(5-part series)***
SERIES 1: Sept. 12, 19, 26 & Oct. 3, 10
SERIES 2: Oct. 31 & Nov. 7, 11, 14, 21, 28

Thursdays at 6pm ***(5-part series)***
SERIES 3: Nov. 3, 10, 17& Dec. 1, 8

MASSAGE
Wednesdays
Sept. 21st & Oct. 19th

RHEUMATIC DISEASE AWARENESS MONTH

Mark your calendars and make sure to add this site to your list of resources as we move into Rheumatic Disease Awareness Month in September. This initiative is being sponsored by the American College of Rheumatology (ACR) with a campaign - ***Simple Tasks*** - to build more awareness of all the rheumatic diseases. The goal for this campaign is to educate the public in understanding symptoms, risk factors and treatment options. Check out ARA's Facebook and Twitter pages for ongoing posts during the month.

SEE MORE AT: *http://www.rheumatology.org/Get-Involved/Simple-Tasks#sthash.HFy9NRJH.dpuf*

RHEUMORS
Arthritis & Rheumatism Associates, P.C.
2730 University Blvd. West, #310
Wheaton, MD 20902
301-942-7600

RHEUMORS
PRACTICE NEWSLETTER
Summer 2016
A publication brought to you by:
Arthritis & Rheumatism Associates, P.C.
EDITOR:
Daniel Tucker, CEO
MEDICAL EDITOR:
Evan Siegel, MD, FACR
DESIGNER:
Brenda Brouillette RN, BS -
Business Development Specialist
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Survive the Summer with Managing Arthritis

continued from front page

but, if you choose to exercise, make sure you drink plenty of liquids before, during and after a workout. Dehydration can contribute to severe muscle cramps and can make you more sensitive to pain.

DRESS COMFORTABLY
Believe it or not, dressing comfortably can decrease arthritic pain. Wear clothes that are lightweight for comfort, and choose light colors because they reflect heat away from your body. Shoes that do not provide sufficient support can also lead to pain by putting more pressure on your ankles and feet. Women should definitely think twice before wearing high heels. Walking barefoot - even on the sand - can exacerbate painful feet.

EXERCISE & SAFETY
Carefully plan your activities and exercises for times during the day when you typically feel best. And, accordingly, plan no activities or do low-impact activities during those times when your pain typically flares, such as after a long day of sitting at work or while traveling in a car. Summer is a great time for water aerobic workouts in a pool because aquatic excercises put less stress on your joints.

Traveling is common during the summer months, which can contribute to joint stiffness and pain. Make frequent stops when traveling by car to take a walk and periodically stretch your legs when traveling by air.

BE PREPARED FOR WEATHER
Monitor the weather and be prepared for conditions that can affect arthritic pain. Changes in barometric pressure and temperature can affect joint pain and increase swelling or inflammation. A 2007 study from Tufts University found that every 10-degree drop in temperature corresponded with an incremental increase in arthritis pain. In addition, relatively low barometric pressure and precipitation are associated with increased pain.

(Source: The Arthritis Index is based on a proprietary forecast by the meteorologists at www.AccuWeather.com – click on the "Arthritis" hand icon.)