

RHEUMATISM

Practice Newsletter

WINTER 2016

DEPARTMENT HIGHLIGHT:

Introducing the Business Office



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While the physicians, nurses and therapists at Arthritis & Rheumatism Associates take care of your health, the business office is busy behind the scenes handling the financial details that make your life easier and ensure that ARA remains a healthy practice. Staffed with highly trained, experienced and friendly billing representa-

tives, the business office works with patients and their insurance companies to ensure that services are billed correctly and that insurance companies pay their appropriate share so that your charges are minimized. The ARA business office provides several vital services for patients:

- Verifies insurance benefits to ensure that there is coverage for the medical services that will be performed.
- Handles all billing, thereby saving patients the burdensome task of trying to understand the terms of their insurance policies and having to deal directly with their insurance company for reimbursement of the cost of care.
- Appeals of insurance denials or underpayments on behalf of patients to get issues corrected promptly that might otherwise result in patients being asked to pay more out of their own pocket for their care.
- Serves as a great resource to patients by explaining how their services are billed and paid for and how to understand the insurance company's Explanation of Benefits (EOB).

Some people are surprised to learn that ARA's business office has 17 people working full time to ensure that things go right on the financial side. The business office manager, Cecilia Pettit, has provided strong leadership in maintaining a highly productive and efficient group of specialists using a thorough initial training program and regular continuing education. Each business office specialist strives to give excellent customer service, which requires good listening skills, empathy and patience in responding to our patients' needs.

The business office staff are trained in HIPPA privacy requirements when communicating with patients and third-party payers. We also have a multilingual staff to provide answers to a variety of patient questions from "Do you accept my insurance?" to "What is my balance?" and "Why do I owe you more than a copay?" Our collections specialists work diligently with insurance companies and our patients to collect balances due in a timely manner within the guidelines established by the Fair Debt Collections Practices Act.

Please call the business office with your questions and one of our billing specialists will be eager to help explain in detail any questions relating to your statement or insurance coverage. We can be reached directly at 301-942-3126.

The DASH Diet – Is This the Answer to Control Gout?

BY HERBERT S.B. BARAF, MD, FACP, MACR

For many years physicians have counseled patients with gout about their diet. Gout is a very painful form of arthritis that is caused by excessive amounts of uric acid in the body. These deposits of uric acid tend to accumulate in joints and occasionally lead to an explosive, dramatic flare-up of joint pain, usually in a foot or ankle, with severe tenderness, swelling and redness. The typical patient with gout is male, overweight and according to folklore, consumes too much alcohol and, rich foods. In truth, the elevated levels of uric acid in the bloodstream are caused by a variety of factors, not the least of which is a genetic predisposition caused by a kidney defect that interferes with elimination of uric acid in the urine.



We know that gout patients have a higher incidence of other medical problems. They tend to be overweight and have high blood pressure and elevated cholesterol levels. Gout patients are more likely to be diabetic, have impaired kidney function and suffer from heart disease. Many experts have wondered whether the elevated blood levels of uric acid seen in gout sufferers is at the root of these other medical problems.

Modifications to diet have long been recommended to lower the blood levels of uric acid in people with gout. Diet also is recommended for the associated problems of high blood pressure, high cholesterol and high body weight. So a reasonable question to ask would be; "Can a diet that controls blood pressure, obesity or cholesterol also control high uric acid values?"

Recent reports indicate that a special diet, known as the DASH

Diet, recommended for patients with elevated blood pressure, also may lower uric acid. DASH stands for "Dietary Approaches to Stop Hypertension." The diet is simple, specifying an increase in fruits, vegetables and low-fat dairy foods and a decrease in red meat, sweets, cholesterol and trans fats. In a small study it was found that patients with a uric acid elevation of >7 (mg/dL) had an average reduction of 1.3mg/dl following the DASH Diet.

How significant is that finding? How does it compare to the effects of medication? These are the questions experienced gout patients and their doctors need to answer. Gout "diets" that are usually recommended involve avoidance of shellfish, organ meats and fatty foods but the best of these diets typically lower the uric acid level by only 1 point. The DASH diet is a little better than that, but most doctors experienced in treating gout attempt to lower the uric acid well

below 6. For my patients, I target a value of 5 or less. Clearly the DASH diet will not accomplish that in patients with uric acid values of 8 or 10, the levels we typically see in the blood of patients with untreated gout.

So diet is usually not the best method to reduce a gout patient's uric acid deposits. Medications are much more effective in accomplishing this goal. Diet may help, but not enough. Although weight reduction should always be encouraged for overweight patients with gout, I don't believe the DASH Diet or other "gout diets" will provide sufficient uric acid lowering in patients with severe gout. There are effective medications that accomplish this goal much better. Therefore, my usual advice is: Try to lose weight, avoid alcohol, and take your uric-acid-lowering medication consistently.



Community Outreach

- ARA was a proud sponsor of the Psoriasis Foundation Walk in October, in which Dr. Evan Siegel participated, promoting awareness for psoriasis arthritis.
- Arise Infusion proudly sponsored the Arthritis Foundation Jingle Bell Run. Dr. Ashley Beall, Dr. Justin Peng, and Dr. Angus Worthing were champion runners who raced to help conquer the nation's leading cause of disability.

▲ Dr. Grace Ahn, pictured above, educated members of the Korean community about rheumatologic diseases at the Washington Spencerville Korean Church and at a health fair held by the Korean Community Service Center of Greater Washington. She also presented a lecture on osteoporosis at the Senior Academy, Bethany Presbyterian Church.

- Dr. Dan El-Bogdadi was an invited guest speaker at the recent Northern Virginia Sip for Sjögren's event, sponsored by the Sjögren's Foundation.
- Dr. Jeffrey Potter presented at the Lupus Summit held at Johns Hopkins in Baltimore in October. Lupus is one of Dr. Potter's special interests.

ARA on TV - Housecalls

Dr. Grace Ahn and Dr. Jeffrey Potter were guests on the "Housecalls" program this month. Host David Dorman MD, asked questions about the rheumatological disease of gout as well as the condition of low back pain. Check out their interviews at Montgomery Municipal Cable Channel 16 @<http://www.mmctv.org/video.html>

POINTS ON JOINTS:

Osteoarthritis

BY RACHEL KAISER, MD, MPH, FACP, FACR, CCD
PHOTOS FROM ACR IMAGE BANK

INTRODUCTION

Osteoarthritis (OA) is one of the most common causes of disability worldwide. OA can involve any joint but most commonly affects the hands, knees, hips and spine. Symptoms include pain in one or more joints with motion that worsens with activity (e.g., knee pain after walking). OA can lead to deformity of the joints (see hands in Figure 1) as well as decreased function and quality of life.

CAUSES

Risk factors for developing this painful degenerative form of arthritis include being female, prior joint injuries, aging and obesity. Historically thought of as a “wear and tear” type of arthritis (e.g., wearing out of the cartilage or joint cushion), the causes now are thought to be more complex and remain under investigation to find better targeted treatments for this disease. There is no cure for OA but it can be managed well.

DIAGNOSIS

In most situations, your doctor can make the diagnosis of Osteoarthritis by talking with you and conducting a physical exam. Sometimes x-rays can be helpful when establishing the diagnosis but they are not always necessary. The x-ray images below illustrate joint space narrowing of the knee over time as the cartilage wears out. There are no lab tests that can make this diagnosis but some tests can help rule out other forms of arthritis.

PREVENTION

There is no medication that prevents or slows down the progression of Osteoarthritis. Weight loss is the only intervention clinically proven to slow progression of OA in the lower extremities. While running and other high-impact activities do not seem to cause arthritis, once you have it, it is best to abstain from such high-impact activities to avoid accelerating the progression of OA.

TREATMENT

Exercise is important to maintain joint health. Both aerobic and



Figure 1. Hand osteoarthritis

aquatic exercise can be helpful. Reaching and maintaining your ideal weight is very important. Studies have shown that even a small amount of weight loss can improve pain and function significantly. Physical therapy can help strengthen muscles around the joints and reduce pain, increase flexibility and improve function. For some patients, physical therapists may recommend an assistive device, such as a cane.

Pain medications used to treat osteoarthritis include topical pain applications (e.g., Voltaren Gel) for hand and knee arthritis. Acetaminophen is the first-line choice of oral medication followed by anti-inflammatories, which have a higher side-effect profile. For some patients, duloxetine, a chronic pain medication also approved for treating the pain of OA, can help, especially if other medications are contraindicated. Narcotics rarely are indicated in the management of Osteoarthritis. In certain patients, injections (steroids or hyaluronic acid) into a joint can provide several months of pain relief. Finally, if unacceptable pain and lifestyle limitations continue once conservative management is exhausted, a joint replacement may be indicated, especially for hip and knee OA.

COMPLEMENTARY TREATMENTS

Some studies have suggested that the supplements Glucosamine and Chondroitin can help with pain, but most did not confirm this finding. As a result, the American College of Rheumatology does not recommend using this combination of supplements to treat OA.



Figure 2. Left knee X-ray showing OA progression in the medial compartment

Some studies have shown that acupuncture can be useful, especially for Osteoarthritis of the knee.

Knee braces may be helpful when managing Osteoarthritis of the knee, but studies have been inconclusive.

Finally, changes in diet (e.g., gluten-free diets) have not been shown to affect pain or progression of osteoarthritis.

Holidays...Ouch!

BY ANNE WELLINGTON-GOLDSMITH, MPT
EXECUTIVE DIRECTOR OF REHABILITATION, ARA



It's that time of the year! The holidays are upon us and many find themselves very busy making preparations for spending time with family and friends. We are running around shopping, cleaning and preparing the house for guests, or cooking for large gatherings. This is a wonderful time of the year to enjoy our loved ones. However, for those dealing with rheumatologic conditions (arthritis, autoimmune diseases, osteoporosis, fibromyalgia, etc.), it can be a time of increased pain and discomfort. Here are some helpful hints for managing this holiday season:

- Break up your tasks, such as cooking, cleaning and shopping, over the course of the week and throughout each day. Do not wait for the last minute to do anything as this causes increased stress on your body.
- Use proper posture and body mechanics, and avoid repetitive activities. You should try to bend your knees and use solid core muscles with activities that require bending, lifting and carrying items.
- Ask for help when needed! Some of us have trouble saying

“NO” and obligate ourselves on more physical activity than their body can truly handle. Take cooking as an example: If you are accustomed to preparing meals for one or two people and you have been recruited to make the Thanksgiving meal, you will need to use heavy pots and pans filled with larger amounts of food. Repeatedly picking up, carrying and moving pots and pans can increase pain at the neck, shoulder, back or other areas. Be realistic with yourself and your family about what you can and cannot do. If you choose to accept the challenge, recruit others to help you with food preparation and other tasks such as removing the turkey from the oven! Remember, many conditions may worsen under atypical physical stress that increase force on the joints, or strain to the muscles.

- Take care of YOU first, and make sure that you get enough downtime, sleep and proper nutrition. Also, continue to exercise! When we get very busy in our lives, one of the first things that we tend to neglect is our exercise program. If your body is accustomed to regular exercise, then try to find time to maintain your routine so that your body remains as strong and flexible as possible.

FUN RHEUM:

B	W	S	Q	F	A	L	H	Q	H	M	R	T	W	A	O	N	K	N	C	U
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Find these words:

- ANKYLOSING SPONDYLITIS
- BODY MECHANICS
- BURSITIS
- CARTILAGE
- CHILI SOUP
- DMARDS
- EXERCISE
- GOUT
- IDEAL
- JOINTS
- MUSCULOSKELETAL
- NSAIDS
- OSTEOARTHRITIS
- OVERUSE
- PHYSICAL THERAPY
- RHEUMATOID ARTHRITIS
- STEROIDS
- TEAR
- TENDONITIS
- ULTRASOUND
- WEAR
- WEIGHT

Tendonitis and Bursitis

BY DANIEL EL-BOGDADI, MD, FACR



TENDONITIS

Tendons are the cords that attach muscle to bone. When tendons get inflamed or irritated, this is commonly referred to as tendonitis. Most of the time, overuse or repetitive movement of a limb causes the tendon to get inflamed or irritated. Other conditions such as autoimmune disease or infections may cause this sort of inflammation as well. The sites that are most commonly affected are the Achilles tendon (attaches the calf muscle to the heel bone), the shoulder (rotator cuff tendons or biceps tendons), the knee (quadriceps or patellar tendon), elbow (the triceps tendon), and wrist (deQuervain's tenosynovitis).

The best way to treat tendonitis is to rest the tendon so it can heal. Bracing or splinting may be helpful to prevent overuse and promote warmth in the area to improve blood flow for healing. Tendons are slower than bone to heal and this healing process sometimes may take up to six months. Tendons do however respond well to stimulation, such as massage and stretching, which promotes increased blood flow and strengthens the fibers of the tendon cord. Strengthening the supporting muscle groups also helps to stabilize the tendon and has been shown to reduce pain. A good physical therapy program to assist in stretching and strengthening is helpful as it often is not easy for patients to effectively passively stretch the tendon themselves. Other adjunctive therapies, such as anti-inflammatory medications and injection around the tendon (usually done by ultrasound guidance to avoid tendon rupture that may be caused by directly injecting the medicine in the tendon itself), can aid in decreasing inflammation. If not cared for in a timely manner, tendonitis may progress to tendinosis, which results in chronic degenerative changes of the tendon with disruption and scar tissue that may cause chronic pain and make the tendon easily susceptible to rupturing.

BURSITIS

A bursa is a fluid-filled sac that helps musculoskeletal structures glide against each other smoothly. When this very thin fluid-filled sac gets swollen and inflamed, it is commonly referred to as bursitis. There are several causes of bursitis including trauma or direct injury, prolonged pressure (such as leaning on one's elbow or sitting too long), overuse, inflammatory arthritis (such as rheumatoid arthritis, spondyloarthropathy, gout), or more serious infections. Bursitis may happen quickly, such as infection or trauma, or more slowly with prolonged pressure and overuse.

Bursitis usually presents with pain upon range of motion (if the bursa lies near a joint) or with applied pressure. If the bursa is close to the skin, redness may be noted, such as in the elbow or knee. If the bursa is a deep structure only, pain is noted such as in the shoulder or hip. Sometimes the bursa swells so much that fluid may be removed and sent for analysis.

Bursitis is treated by resting and joint protection, ice or heat depending on chronicity (chronic or lasting on a long-term basis), and anti-inflammatories such as NSAIDs. If that does not help, physical therapy and bursa corticosteroid injections often are helpful.

The Most Common Types of Bursitis

SHOULDER (SUBACROMIAL BURSITIS): Shoulder bursitis causes pain in the shoulder and outside of the upper arm. Pain often is present at rest and increases with movement of the arm. Rotator cuff tendonitis may present with similar symptoms so imaging of the shoulder may be helpful to diagnose the underlying process.

ELBOW (OLECRANON BURSITIS): Elbow bursitis usually causes a visible swelling at the tip of the elbow. Gout, trauma, rheumatoid arthritis, and infection are the most common causes. Olecranon bursitis causes pain when the elbow is flexed and applied pressure is made to the tip of the elbow.

HIP (TROCHANTERIC BURSITIS): The greater trochanteric bursa is located on the lateral side of the hip joint (the outside of the hip) and may cause pain while lying or sleeping on the affected side.

KNEE (PREPATELLAR AND INFRAPATELLAR BURSITIS): The prepatellar bursa is located at the front of the knee (on top of the patella or kneecap) and the infrapatellar bursa is located below the knee. Bursitis of these areas may occur as a result of consistently applying pressure to the knee such as kneeling for too long. It also may occur in other conditions such as gout, infection, or rheumatoid arthritis. It is important to note that swelling occurs within the bursa outside the knee, not in the knee joint itself.



RHEUMINATION:

Ankylosing Spondylitis (AS)

BY DAVID G. BORENSTEIN, MD, MACP, MACR

Ankylosing spondylitis (AS) is an autoimmune-related chronic inflammation of the structures of the spine that can destroy tissues and, in the setting of spondyloarthritis, ultimately results in the calcification of spinal structures and spinal fusion.

WHAT ARE THE SYMPTOMS OF ANKYLOSING SPONDYLITIS?

Symptoms related to ankylosing spondylitis include:

- Prolonged morning stiffness of the spine lasting hours
- Spine stiffness associated with sitting for variable lengths of time
- Back pain that improves with exercise
- Eye inflammation – iritis
- Radiating leg pain – pseudosciatica

General symptoms include:

- Fatigue
- Sleep disorder
- Mild weight loss
- Fever

The typical ankylosing spondylitis patient initially has a moderate degree of intermittent aching pain localized to the lower back. The muscles on the side of the spine can magnify discomfort if they go into spasm. The lower back becomes more difficult to move. Breathing may be affected if movement of the ribs becomes painful. In a majority of patients, the initial symptoms are lower back pain and stiffness. Another common location for inflammation is the Achilles tendon and plantar fascia on the bottom of the foot.

Ankylosing spondylitis is more than a skeletal disease. Iritis is a form of eye inflammation characterized by discomfort looking at light and occurs in about 25% of ankylosing spondylitis patients.

HOW IS ANKYLOSING SPONDYLITIS DIAGNOSED?

The diagnosis of ankylosing spondylitis is based upon a spectrum of typical findings noted in the patient's medical history, upon physical examination, and through radiographic images. Physicians refer to back pain as inflammatory in nature when the pain persists for longer than 3 months in association with an early age of onset (under 40 years), does not improve with rest, worsens at night and shows improvement with exercise. In the AS patient, plain x-ray films of the lower spine will show definite signs of arthritis in the sacroiliac joints. Laboratory findings of the HLA-B27 genotype and blood test signs of inflammation (such as elevated C reactive protein or erythrocyte sedimentation rate) are compatible with, but not specific for, ankylosing spondylitis.

HOW IS ANKYLOSING SPONDYLITIS TREATED?

The goals of therapy for ankylosing spondylitis are to control inflammation, decrease pain, maintain function, and prevent deformity through a therapeutic program that includes non-drug and drug components.



WHAT ARE NON-DRUG THERAPIES FOR ANKYLOSING SPONDYLITIS?

Maintenance of maximum motion of the skeleton, particularly of the entire spine, is a main focus of non-drug therapy for ankylosing spondylitis. Physical therapy with range of motion exercises to maintain function are essential for a good outcome. Supervised exercises are better than unsupervised exercises in reducing pain and stiffness while increasing spinal mobility and overall well-being in ankylosing spondylitis patients.

WHAT ARE DRUG THERAPIES FOR ANKYLOSING SPONDYLITIS?

A wide variety of drug therapies are available for the treatment of ankylosing spondylitis. The key to success is matching the degree of illness with the correct drug.

NSAIDs are aspirin-like drugs that can decrease pain, fever, and inflammation. They have anti-inflammatory and pain-relieving properties when given in larger doses, long term. In ankylosing spondylitis, NSAIDs decrease spine stiffness and pain.

Spasms in spinal muscles in ankylosing spondylitis patients cause pain and limitation of motion. The addition of a muscle relaxant to an NSAID helps decrease muscle pain and tightness.

DMARDs (disease modifying anti-rheumatic drugs) are drugs that work more slowly than NSAIDs but have the ability to modify the progression of the disease. DMARDs do not have a beneficial effect on spinal disease but some benefit may exist for arthritis of peripheral joints like the shoulders and hips.

Tumor necrosis factor (TNF) is associated with the clinical manifestations of ankylosing spondylitis, including fatigue, joint swelling, stiffness, and pain. A decrease in TNF production or complete removal of TNF from the bloodstream can result in a decrease in disease-associated complaints. However, the total removal of TNF also can be associated with an increased risk of infection. The goal of therapy is to obtain a normal level of tumor necrosis factor, not to completely eliminate it.

Toxicities associated with the use of TNF inhibitors include an increased risk of viral and bacterial infections. An increased risk of malignancy has been reported. However, the degree of this increase, believed to be small, is still undergoing evaluation.

The rheumatologists at Arthritis and Rheumatism Associates are experts at the diagnosis and treatment of inflammatory arthritis, including ankylosing spondylitis. They have expertise in non-drug treatments including physical therapy, and drug therapies, including tumor necrosis antibody inhibitors.

Chili Pumpkin Soup

INGREDIENTS

- 3 tablespoons cooking oil*
- 2 medium onions, peeled and chopped*
- 3 leeks, white part only, rinsed and chopped*
- 2 cloves garlic, minced*
- 1 jalapeno pepper, seeded and minced*
- 1 tablespoon chili powder*
- 5 cups raw pumpkin, cut in cubes*
- 5 cups water*
- 1 ½ cups milk or half-and-half*
- Salt to taste*
- 1 tablespoon freshly chopped fresh coriander leaves*



Heat the oil in a large, heavy saucepan. Add the onions and leeks and saute over low heat until they are tender but not brown, about 10 minutes. Stir in the garlic and the jalapeno pepper.

Stir in the chili powder and cook briefly, then add the pumpkin and water. Cover and simmer until the pumpkin is very tender, about 40 minutes. Allow to cool briefly, then puree the mixture in a food processor. You will probably have to do this in two batches.

Return the puree to the saucepan, add the milk or half-and-half and salt to taste. Serve with a sprinkling of coriander on each serving.

NUTRITIONAL INFORMATION: Nutritional analysis per serving (8 servings) 119 calories; 7 grams fat; 1 gram saturated fat; 0 grams trans fat; 3 grams monounsaturated fat; 1 gram polyunsaturated fat; 12 grams carbohydrates; 1 gram dietary fiber; 6 grams sugars; 2 grams protein; 4 milligrams cholesterol; 350 milligrams sodium

Pumpkins are an excellent source of beta-cryptoxanthin, a powerful anti-inflammatory. This antioxidant is absorbed best when paired with a fat, making the butter and oil in this recipe important for more than just flavor. Pumpkin skins are edible, which makes preparing this soup very easy! Serve this soup with a mixed green salad for a healthy lunch or as the first course of a holiday dinner.

Practice News:

- Dr. Angus Worthing takes over as chairman of the American College of Rheumatology's Government Affairs Committee, he serves as the lead advocate for rheumatology on Capitol Hill and at federal agencies like Medicare and the FDA. He also chairs the Public Policy Education Committee of the Rheumatism Society of the District of Columbia. This interest in public policy allows him to advocate for all of our patients and for the field of rheumatology.

► **ARA hosts an international educational day covering current topics in rheumatology for 20 visiting rheumatologists from Denmark. (Photo, Right)**

- Dr. Evan Siegel was one of only 3 rheumatologists appointed to the Medical Board of the National Psoriasis Foundation. Dr. Siegel also has been named to the American College of Rheumatology Psoriatic Arthritis Guidelines Committee tasked with creating national guidelines for the treatment of this disorder.



RHEUMORS

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When Rheumatologists Use Corticosteroids in Rheumatoid Arthritis

BY PAUL DEMARCO, MD, FACP, FACR

The use of corticosteroids in the management of rheumatoid arthritis dates back to 1948 when Philip Hench, MD, first used them at the Mayo Clinic. Dr. Hench received the Nobel Prize in Medicine for his work in 1950. His patients included the famous French Impressionist and Fauvist painter Raoul Dufy, who achieved a renewal of his physical dexterity from the treatments and had a renaissance in his artistic career. Rheumatologists have since been enamored with the use of corticosteroids for treating rheumatoid arthritis.

Corticosteroids are a group of medicines that control inflammation and regulate many of the human body's normal functions. For the management of rheumatoid arthritis, this group of medications can be given intravenously (in a vein), intramuscularly (in a muscle), intra-articularly (injected in a joint) or orally (by mouth). Although they can be given topically, topical administration is primarily for skin disorders. Prednisone, Medrol, Depo-Medrol, Solu-Medrol, Kenalog, Celestone, methylprednisolone, hydrocortisone, triamcinolone, dexamethasone and others are all different types of corticosteroids used to treat a host of illnesses. Your doctor will pick the type of steroid and the method of administration according to your personal needs at the time of his or her assessment of your situation.

Corticosteroids are used in many ways. The goal in any of these treatments is to resolve the joint swelling, pain and limitation caused by rheumatoid arthritis. One way of using corticosteroids is a high dose, followed by a decreasing dose program to lower the dose gradually, eventually stopping the medication. This is called a "burst-and-taper." Taper schedules are used when a high dose

is continued for more than 5 days. Most patients can take a high dose for less than 5 days and stop or return to a low dose of steroid without a dose taper; this would be just a steroid "burst." When a rheumatologist gives an intramuscular injection of steroid in the office, it is quite similar to a 5-day "burst" to provide relief immediately. Corticosteroids can be injected into a joint to relieve inflammation of rheumatoid arthritis; it will also act like a "burst," but it will act locally, in the joint. Some patients will use a low dose for a longer period of time, until other medications start to control the disease. This is known as "bridge" therapy.

On rare occasions, some patients with rheumatoid arthritis continue a low dose of steroid for much longer, and even more rarely will remain on low doses of a corticosteroid as part of the regular therapy for rheumatoid arthritis. Interestingly enough, there are some medical journal publications that suggest this is an alternate strategy for controlling the erosion or damage of rheumatoid arthritis.

Corticosteroids can be of great benefit to patients with rheumatoid arthritis but can have significant long-term side effects. These include but are not limited to skin thinning, easy skin bruising, purple skin streaking or striae, weight gain with increased abdominal girth ("belly" fat), progression to diabetes and bone loss that can lead to osteoporosis. Therefore, rheumatologists (and all physicians) make every effort to balance these risks against the benefits to health when prescribing or continuing corticosteroids for rheumatoid arthritis. For more information on corticosteroid use, please see the American College of Rheumatologist's website, www.rheumatology.org in the patient information section of the site, or talk to your treating rheumatologist about corticosteroids.