

ARA WELCOMES ASHLEY D. BEALL, M.D.

By Cindy Niemiec



Ashley D Beall, M.D. is a native of Atlanta, Georgia. She is a graduate of the University of Georgia, where she

was a member of the honors college. She earned a Bachelor of Arts degree in English Literature, as well as a Bachelor of Science degree in cellular biology in 1998. She earned her medical degree in 2003 from the Medical College of Georgia, where she was awarded

membership into the Alpha Omega Alpha honor society and was a Merck Medical Scholar. She then moved to Charleston, South Carolina, where she completed an internship and residency in internal medicine in 2006.

Following completion of her internal medicine training, Dr. Beall completed a clinical and research fellowship in rheumatology at the Medical University of South Carolina. Her research focus was in the areas of systemic lupus and systemic sclerosis. She joined Arthritis and Rheumatism Associates in July,

2008. Her clinical areas of interest include Systemic Lupus, Rheumatic Arthritis, Osteoporosis and Systemic Sclerosis. Her research findings have been published in various scientific journals, and she has spoken at local, national, and international rheumatologic meetings.

When asked why she chose the field of rheumatology she stated there are many opportunities to give her patients a better quality of life through treatment. Her goal is to help patients understand their

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ARA WELCOMES ANGUS B. WORTHING, M.D.

By Debra Mendoza-Rodney



Arthritis And Rheumatism Associates, P.C. welcomes Angus Brennan Worthing, M.D., to our team of rheumatology

specialists. Dr. Worthing joined us in July, 2008 and is currently treating patients at the Chevy Chase and Washington, DC locations. He is a native of Minneapolis, Minnesota and obtained his bachelors degree from Princeton University in New Jersey and his medical degree from the University of Minnesota Medical School. He completed his internal medicine internship and residency

and his rheumatology fellowship at Georgetown University Hospital in Washington, DC.

After graduating from Princeton, Dr. Worthing worked as a research assistant in Lima, Peru performing PCR testing for outbreaks of Bartonella bacilliformis which is a disease known to occur in native Peru. While completing his residency, he also spent some time working in the internal medicine department at Virginia Hospital Center. During his fellowship, Dr. Worthing co-authored a chapter on "The Rheumatic Causes of Elbow Instability" for the Hand Clinics.

Dr. Worthing is a fellow of the American College of Rheumatology (ACR). He is the

Vice President of the Rheumatism Society of the District of Columbia and also represents the District on the ACR's Affiliate Society Council. He is currently directing the preparedness of ARA in the prevention of the H1N1 (swine flu) virus.

When asked why he chose a career in rheumatology, Dr. Worthing says "It was the very first clinical rotation I chose to do during medical school. I knew I would love rheumatology from the very start. I was fascinated by patients, their illnesses, and the variety of information from x-rays, labs, and other studies." He enjoys getting to know his patients by asking how

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WHAT DID BENJAMIN FRANKLIN, KARL MARX AND DICK CHENEY ALL HAVE IN COMMON? GOUT!

By Herbert S. B. Baraf, M.D.

Gout, a form of arthritis caused by deposits of uric acid crystals in the tissues, was first described by Hippocrates 2500 years ago. The relationship of uric acid to gout was suspected in the 17th century. By the mid 19th century it was confirmed that patients with gout had excessive amounts of uric acid in their blood. Curiously, most forms of arthritis were thought to be variations of the gout as recently as 160 years ago.

I like to think of gout as two separate diseases. The first is the elevated blood level of uric acid that eventually leads to a build up of crystals. The second disease is the arthritis that is caused by this build up. Thinking of gout in this way helps physicians and patients to best understand how it should be managed.

Gouty arthritis is an extremely painful, episodic disease of the joints. Episodes or attacks of gout begin in a single joint quite suddenly causing the joint to become swollen, reddened and tender. About half of patients' first attacks occur in the big toe. At their peak, gout sufferers cannot put on a shoe or even tolerate the weight of their bed sheet on the foot. With treatment these attacks come under control in a few days. Once the first attack resolves, it may not occur again for weeks, months or even a few years. In time though, a pattern of recurrence develops usually involving a toe, ankle or knee – but sometimes the hands or elbows. Attacks eventually become more frequent and if not treated, a chronic and disabling arthritis develops.

At the root of all of these attacks is the accumulation of crystals derived from uric acid that deposit in the tissues. These deposits occur because the blood levels of uric acid are too high to remain dissolved in the blood. Much like a packet of sugar emptied into a glass of ice tea will sweeten the tea but form crystals at the bottom of the glass, patients with elevated uric acid levels will see uric acid-derived crystals deposit in the joints. Factors favoring crystallization of uric acid include poor circulation, cold temperatures and acidic environments. Since the feet are 5 degrees cooler than the hips and shoulders (which are closer to the heart), it is no wonder that the feet are usually the first to feel the brunt of these deposits.

So, in managing gout we must manage the arthritis when attacks occur; but more importantly, in patients who have established a pattern of recurrence, we must manage the high blood levels of uric acid. Once uric acid is removed from the tissues, the risk of gouty attacks is completely eliminated.

Treating attacks of gout and the resulting pain can be accomplished in a number of different ways. Our goal is to control the inflammation at the root of the attack. We use a variety of different medications that fall into three categories: colchicine, NSAIDs or cortisone derivatives. Colchicine, derived from the autumn crocus, has been used to treat gout for centuries and remains a mainstay of gout treatment. NSAIDs as naproxen, indomethacin and Celebrex are often effective. Cortisone

derivatives can be given by mouth, by intramuscular injection or by injection into the inflamed joint. The side effect profile of these drugs determines which is the best choice for a specific patient. Most importantly, treatment for an attack should begin as soon as possible after the first signs of gouty inflammation.

Over time, if the serum uric acid level is not controlled, chronic involvement of the joints may occur. Deposits of uric acid form in and around the joints and may form lumps. These lumps called tophi may become disfiguring and crippling. Patients with gout of this severity need to be on medications to control the inflammation and also need to have their serum levels of uric acid lowered. Uric acid lowering medications will eventually wash away the deposits, cause the tophi to regress, control the arthritis and eliminate attacks completely. The most commonly prescribed uric acid lowering drug is allopurinol.

There are three things to remember about being on uric acid lowering medication. First, when a drug like allopurinol is started, it may increase the short-term risk for additional attacks of gout. Therefore patients must be on concurrent medication for at least 6 months. Colchicine is most commonly used for this purpose. Second, patients need to be reminded that uric acid lowering medications should never be started during an acute attack; nor should they be stopped. Stopping or starting medication of this sort during an

see GOUT continued on page 3

NEW TREATMENTS APPROVED FOR RA

By Shari B. Diamond, MD

Ever since the anti-TNF agents exploded onto the scene about a decade ago, the treatment and the lives of patients with rheumatoid arthritis (RA) have been revolutionized. The management strategies for rheumatoid arthritis have continued to evolve as new information emerges, and so, the number of therapeutic options has expanded even more. As recently as this spring, yet another medication has been approved for the treatment of rheumatoid arthritis.

Infliximab (Remicade), Etanercept (Enbrel), and Adalimumab (Humira) are the three original biologic medications. These agents treat RA by attacking a molecule called tumor necrosis factor (TNF), crucial in causing the inflammation of rheumatoid arthritis. Inflammation and joint destruction in RA occur via communication of white blood cells with each other. They communicate by releasing messengers called cytokines which

stimulate other white blood cells to become activated and cause inflammation. TNF is one such cytokine and the above three medications work by intercepting that TNF signal before it can reach the next cell. In addition to those three agents, there are currently four more biologic agents approved for the treatment of RA: Abatacept (Orencia), Rituximab (Rituxan), Golimumab (Simponi), and Certolizumab (Cimzia). These agents attack different essential components in the cascade of inflammation which occurs in RA. They work either by interfering with cytokine function, inhibiting a “second signal” required for white blood cell activation, or depleting B cells, another kind of white blood cell.

Abatacept is given as a once monthly thirty minute intravenous infusion. It prevents the communication of white blood cells by inhibiting a second signal required for white blood cell activation. That second signal is a

molecule called CD28 and its counter-receptor, CD80/CD86. Rituximab is also given as an intravenous infusion but it is given every 6 months. Rituxan acts by depleting B cells, another type of white blood cell important in the inflammatory cascade of RA. Certolizumab and Golimumab are both subcutaneous injections which inhibit the TNF molecule but are dosed less frequently than the original anti-TNF medications. Golimumab is administered only once per month and Certolizumab is twice monthly, similar to adalimumab.

In summary, as our knowledge of the intricate details of the molecular basis of rheumatoid arthritis increases, our therapeutic options continue to expand. Disease control with minimal or no pain is now a realistic goal for many patients who previously were debilitated by the inflammation of rheumatoid arthritis. *

GOUT *continued from page 2*

Third, starting uric acid lowering medication is a lifelong commitment.

This year we saw the first new drug approved for gout in 46 years, and a second is likely to gain approval by the first half of next year. We are pleased to report that the research arm of our practice, the Center for Rheumatology and Bone Research, played a significant role in evaluating the safety and effectiveness of these drugs for gout. Uloric is a new uric acid lowering medication that works much like allopurinol and gives patients who are sensitive to

allopurinol a viable treatment alternative.

Pegloticase (to be named Krystexxa) is a new potent uric acid lowering drug which is expected to be approved next year and will provide much needed help to our most severely afflicted patients with gout. Pegloticase is an enzyme that works by converting uric acid to allantoin, a more soluble substance. It is for severe forms of gout and may dramatically shrink tophi and restore function in chronic disabling gout.

We are currently studying two different medications for acute

flare-ups of gout. If your gout is unstable and you are experiencing frequent episodes of joint pain and swelling discuss with your doctor whether one of these programs might be appropriate for you.

Gout is an old and venerable disease. After decades we are finally seeing significant new advances in managing gout. We are proud to have had the opportunity to contribute to the success of several clinical research projects focused on new treatments for gout, and are grateful to our patients who have participated in these trials. *

CLINICAL TRIALS CONTINUE AT CRBR

By Theresa Bass-Goldman

The Center for Rheumatology and Bone Research continues its mission to provide cutting-edge therapies for patients with various rheumatic diseases. Our physicians are considered experts in the field of clinical research both nationally and internationally. We are participating in many studies with new biologic agents for the treatment of rheumatoid arthritis and psoriatic arthritis. We have also continued our success in conducting trials for patients with osteoarthritis and gout. Located in Wheaton, MD, our research facility continues to take on new and interesting trials.

Our physicians and staff are, as always, dedicated to providing specialized care as we guide our research patients through their participation in trials. Participating in a clinical trial is an invaluable experience and The Center for Rheumatology and Bone Research feels privileged to offer you this unique opportunity. Patients who participate in clinical trials have early access to life-changing therapies. These patients are courageous contributors to furthering the knowledge of the field of Rheumatology so others may benefit. Through their courage, new roads to treatment are paved. The research participants are our modern day unsung heroes, and we invite to you to learn what that experience is like with the finest research staff you will ever meet. If you have ever considered participating in a clinical trial, we encourage you to contact us. Our staff will determine which one of our numerous trials may be suitable for you. The following are brief summaries of currently

enrolling trials we have for various indications:

RHEUMATOID ARTHRITIS: We currently have several trials enrolling for patients with rheumatoid arthritis. We offer rheumatoid arthritis trials for TNF inhibitor, Jak3 and other biologics for patients who may have had at treatment with a DMARD (i.e MTX, Arava) or least one previous dose of a biologic (i.e. Enbrel, Humira, Remicade). One of our most exciting and important trials of the year is a three year trial evaluating the cardiac safety of celecoxib compared to ibuprofen or naproxen. Patients with either osteoarthritis or rheumatoid arthritis and who are at risk for cardiovascular disease are eligible.

OSTEOARTHRITIS: We have three studies for patients with osteoarthritis. One study is an oral agent that may change the course of osteoarthritis and is in the unique class of agents called Disease-Modifying OsteoArthritis Drugs, or DMOADs. This may be first agent available to build cartilage, the smooth surface of bone in the joint space. It is open to patients with knee osteoarthritis. The second trial available for patients with osteoarthritis of the hip and/or knee is assessing the effectiveness of taking an injection every 4weeks for the relief of Osteoarthritis pain or flares. The third, the three year cardiac safety trial for the use of celecoxib compared to ibuprofen or naproxen, has been previously discussed in the rheumatoid arthritis section. Osteoarthritis studies are always being presented to us for enrollment. Even while

you read this, other trials for the management of osteoarthritis are being added as opportunities for our patients.

GOUT: We have been very involved in the gout community, having the opportunity to enroll patients with active gout in a trial to test a medication that dramatically reduces the serum uric acid level. Additionally, we have two new trials which could potentially help prevent gout flares and also treat acute flares when they occur.

Please check with your physician to see if there is a clinical trial opportunity appropriate for your disease. Many of the approved medications patients are prescribed today have been approved via the clinical trials process here at The Center for Rheumatology and Bone Research. We thank all our current and past patients for their participation in our trials. We look forward to meeting many new patients in the future. *

RHEUMORS

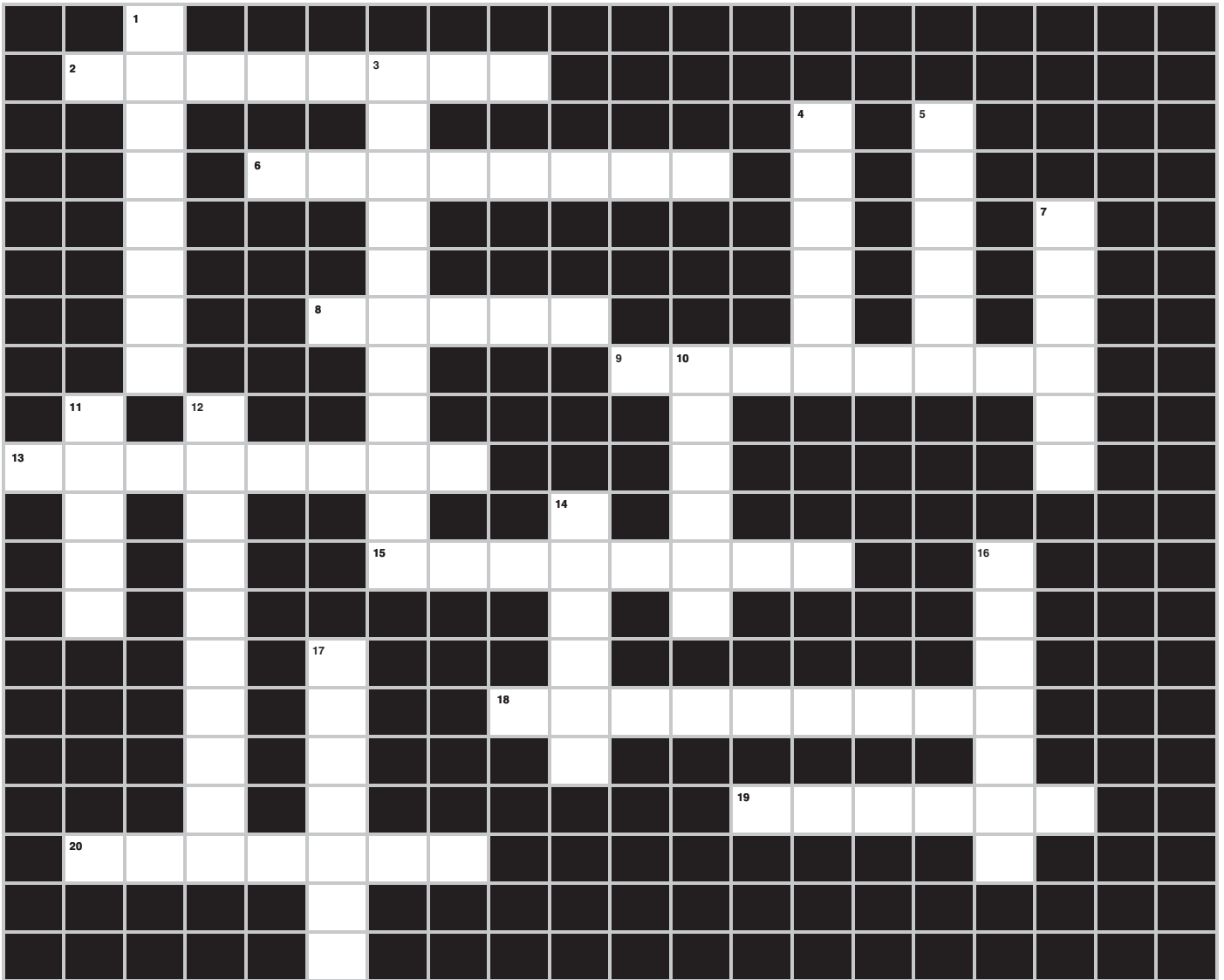
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A NEWSLETTER FOR PATIENTS

A publication brought to you by
Arthritis & Rheumatism Associates, P.C.

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FUN RHEUM By Paul J. DeMarco, M.D.
(answers on pg 7)

Across

- 2. 8th US president reported to have gouty arthritis (8)
- 6. 15th US president who is felt to have gouty arthritis (8)
- 8. British singer and actress diagnosed with systemic lupus erythematosus (5)
- 9. Kite flying colonial Philadelphian who was felt to have gouty arthritis (8)
- 13. "Demon Violinist" whose playing prowess was felt to be related to Ehlers-Danios Syndrome, not his Italian heritage (8)
- 15. This nutritional supplement makes for strong bones and muscles (8)
- 18. 3rd US president; he had rheumatoid arthritis (9)
- 19. Former Phillipines president reported to have had systemic lupus erythematosus (6)
- 20. 16th US president considered to have had Marfan's syndrome (7)

Down

- 1. Painter known to have scleroderma (8)
- 3. Eastern European Classical pianist whose keyboard reach was attributed to the diagnosis of Marfan's syndrome (11)
- 4. Academy Award winning actor for his role in the movie "Affliction" diagnosed with rheumatoid arthritis (6)
- 5. Gold medal figure skater known to have osteoarthritis (6)
- 7. Actress from "Romancing the Stone" known to have rheumatoid arthritis (6)
- 10. Late 19th century-early 20th century painter with rheumatoid arthritis (6)
- 11. Senior partner of Arthritis and Rheumatism Associates, P.C. (5)
- 12. "My Favorite Martian" star who died from complications of Lupus (10)
- 14. Paraoth who released Moses who had ankylosing spondylitis (6)
- 16. Catholic novelist who had lupus (7)
- 17. Ankylosing spondylitis gave this Frankenstein actor his stiff walk (7)

Arthritis and Rheumatism Physicians Go Paperless

By Alan K. Matsumoto, M.D.

If you have been to see your ARA physician over the past 18 months, it would have been near impossible for you not to notice a big change in how information about your visit is collected and stored. Gone are the paper charts with the loose pages of typewritten and hand scrawled notes. In its place are tablet computers running an electronic health record (EHR) that does everything from sending prescriptions, to keeping a record of your visit, to sending notes, to storing test results. You may have also noticed some growing pains as we converted from paper to computer. Hopefully, your doctor's quizzical stares at the computer screen are now things of the past and we thank you for your patience. Here are some answers to a few of the frequently asked questions about our EHR.

Why spend the time and money on an EHR?

We are certain that it will improve the quality of care we provide. Entering information with organized and standard templates greatly reduces the chance of errors such as misplaced test results or missed problems. Writing prescriptions electronically avoids misinterpreted hand writing and the computer can double check doses and check for harmful drug interactions. Your chart is easily available to all members of the ARA team including physical therapy, Xray, bone density center, other ARA doctors, infusion nurses, triage nurses and medical assistants. All laboratory tests at ARA are automatically entered into the EHR and your doctor is notified to review them.



Although only about 15% of medical practices have an EHR, health policy research groups such as the Institute of Medicine have strongly recommended that all practices move to an EHR in the next 5 years.

What happened to my old paper chart?

When we converted to the EHR, 4 years of past notes were automatically transferred to your new electronic chart. Your physician also selected additional important information to be scanned into the EHR. Finally your old paper chart is still filed in the office should the need arise.

Is my information in the EHR safe?

All information is backed up several times daily and transferred to a secure computer server off site in the event of a catastrophe such as a fire. Our EHR is fully HIPPA compliant, the government standard for health information privacy.

How does my physician get messages?

The call center or triage nurses will electronically send your physician the message. Your physician can review your electronic chart and either call you or ask the nurse to call you.

Does my primary physician receive notes?

Notes from your visit are usually completed by the end of the day and faxed to your primary physician. It is important that you keep us up to date with any changes in your primary care physicians.

What if I have tests or see doctors outside of ARA?

After your doctor reviews the results, the reports are scanned into the EHR.

What about the future?

We continue to improve our system. We are looking at ways to monitor your health with reminders to your physician about making sure you are up to date with routine testing. We are now using information from the questionnaires you fill out at each visit to help your physician make decisions about your treatment and to identify new problems. If the hurdles of maintaining privacy and security can be solved, we hope to someday be able to communicate electronically with our patients. There are great challenges for health care in the coming years and we are confident that our EHR will help us efficiently deliver the highest possible care. ✱

WORTHING *continued from page 1*

their rheumatologic conditions affect their lives, hobbies and jobs. “Knowing what makes someone ‘tick’ makes it all the more gratifying to help them get back to work and to the things they enjoy.”

This outstanding, well mannered and considerate physician has marked his successes and accomplishments with many awards and achievements. He was an elected member of the Alpha Omega Alpha Honor society and the recipient of the Medical Humanities Award from Georgetown University Department of Medicine. He was nominated for the String of Pearls Teaching Award at Georgetown and was the recipient of the Medical Student Achievement Award from the Minnesota Medical Foundation in his former hometown of Minneapolis.

Dr. Worthing is married, has one daughter, and lives in Washington, DC. He speaks Spanish fluently which is an asset to both the practice and his patients. His outside interests include attending baseball games, camping, swimming and participating in fun activities with his family. *

BEALL *continued from page 1*

disease and empower them to make themselves better through the use of medication and lifestyle changes. She finds it very gratifying to help her patients return to enjoying their lives like they did before developing arthritis.

When she is not seeing patients, Dr. Beall is an avid traveler. She has recently traveled to Spain, Italy, and Costa Rica. Other interests include reading, photography, and exploring the sites in her new hometown of Washington, DC. Dr. Beall’s parents have been married 39 years and split their residence

between Atlanta and Jacksonville. Her mother is an elementary school educator and her father is an attorney. She has a brother, Allen, living outside Atlanta with his wife Angela and a sister, Arianne, living in Dublin, Ireland.

Dr. Beall is a member of the American College of Rheumatology, the American Society of Ultrasound Medicine, and the American College of Physicians. She is Board Certified in Internal Medicine and Rheumatology. She is seeing patients in our Wheaton and Rockville office locations. *

ANSWERS TO PUZZLE

**If you or someone you know would like to learn more about our clinical trials program, call our study department at (301) 942-6610 or return this card to:
The Center for Rheumatology and Bone Research
2730 University Blvd. West, Suite 306, Wheaton, MD 20902**

I am interested in learning more about participating in a clinical trial.

Name: _____ Phone #: _____
 Address: _____ Best time to reach you: _____
 _____ Your Physician _____

Diagnosis and/or symptoms? _____
 ___ Check here if you are interested in receiving a free pamphlet on clinical trials.

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Digital X-ray

By David P. Wolfe, M.D.

Arthritis and Rheumatism Associates, P.C. has recently adopted a digital x-ray system at our Wheaton, Rockville, and Washington, DC locations. Implementation has been delayed at our Chevy Chase office.

Our conversion to digital x-ray represents our commitment to the latest and most efficient technology for the benefit of patient care. While the process and experience of x-rays from a patient's vantage point will be identical, the development time of films is considerably faster, allowing

physicians to receive and review images in high resolution much more quickly. This in turn decreases patient waiting time for x-rays.

Once completed, digital x-ray images can be easily enhanced and enlarged by our physicians in order to increase their ability to rapidly and accurately make a diagnosis. In addition, these images can be imported into the electronic record or burned to a disk to allow the images to be easily shared with other providers.

If you have any questions about our new digital x-ray system, please ask your physician.

RHEUMATORS

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