ARTHRITIS AND RHEUMATISM ASSOCIATES

RHEUMORS

A NEWSLETTER FOR PATIENTS

VOL. 9, NO. 1 • SUMMER, 1998

DC OFFICE ADDS THIRD PHYSICIAN

Margaret Dieckhoner, Administrator

Arthritis & Rheumatism Associates, P.C. (ARA) now numbers eight Board Certified heumatologists. The newest addition to our practice, John L. Lawson, M.D., joined the group in January and practices at our K Street N.W., Washington, D.C., location.

Dr. Lawson is a native Washingtonian. He attended The Landon School and the proceeded to the University of Virginia, Charlottsville, (UVA) where he earned his Bachelors degree. He also earned recognition as an outstanding student by being selected to the Echols Scholar Program (tapped as the most promising student his freshman year), Phi Beta Kappa and graduated with "highest distinction" (second in his class) , Summa Cum Laude.

Dr. Lawson says his mother tells him he always wanted to be a physician. He is not entirely convinced that is the case because his senior year he found himself in a personal debate between going to Law School or Medical School. Medical School won out primarily because as a high school and college student Dr. Lawson had spent summers doing research - at Children Hospital, Georgetown University Hospital, The George Washington University Hospital and NIH.

After receiving his medical degree from the University of Chicago, Dr. Lawson went to New England Deaconess Hospital, Boston, MA. (which is part of the Harvard Hospital system) for his residency. At that point, he still believed he'd go into research. Dr. Lawson selected Rheumatology as his area of interest and continued his training in a three year Fellowship at the Hospital for Special Surgery in N.Y., N.Y. (part of the Cornell University Hospital system). By the end of his fellowship, Dr. Lawson was finding himself less and less fulfilled in the lab. He was regarded as an excellent clinician, so he decided to "come home to D.C." and practice medicine.

Dr. Lawson began his medical career in Washington, D.C. by putting together a Rheumatology department at Group Health Association (which became Humana and the Kaiser). He then went into group practice with an Internist in D.C. where he practiced both internal medicine and rheumatology. Dr. Lawson describes those 6 years as "fruitful and wonderful."

January, 1998, brought Dr. Lawson to ARA. He already had a long-

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P O I N T S O N J O I N T S

Emma DiIorio, M.D.

FIBROMYALGIA

Fibromyalgia is a common musculoskeletal syndrome characterized by generalized pain, fatigue and a variety of other symptoms. This condition is also known as fibromyositis and muscular rheumatism. Considerable overlap exists with chronic fatigue syndrome and myofascial pain, in fact these may represent facets of the same underlying disorder. It is a common and sometimes disabling disorder affecting 2 to 4 percent of the population. Women more often than men will be found to have the condition and most patients are between the ages of 20 to 50.

Clinical Features

Widespread pain and tenderness are the cardinal symptoms. Patients will not have any swelling on exam. Most patients will also complain of fatigue and insomnia. Other associated symptoms and conditions include tension and migraine headaches, numbness or tingling which is fleeting, difficulty with concentration and short term memory, irritable bowel syndrome, allergic symptoms such as rhinitis or multiple chemical hypersensitivity, urinary frequency and urgency, psychiatric disorders including major depression, higher incidence of mitral valve prolapse.

Diagnosis

There are no diagnostic lab or x-ray abnormalities. However, in 1990 the American College of Rheumatology introduced criteria for fibromyalgia which includes history of widespread pain of at least three months duration and present in the central skeleton as well as all four quadrants of the body.. In addition, the patient must feel pain in at least 11 out of 18 specific tender points when 4 kilograms of pressure are applied to these areas. These areas include the base of the skull, midway between neck and shoulders, mus-

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A N S W E R S To Your Questions

Evan Siegel, M.D.

Q: I can't take anti-inflammatory medications because they upset my stomach, and acetaminophen hasn't been enough to control the pain in my knees. Is there anything new to help my arthritis?

A: This is a very exciting time with respect to the treatment of various types of arthritis, and in the near future a full issue of "Rheumors" will be devoted to the variety of new therapies currently in the pipeline.

If you have **Osteoarthritis (degenerative arthritis)** of the knees, there is something new on the market that may help. Recently a new form of therapy called "viscosupplementation" has become available. Two types have been developed and are sold under the trade names "Hyalgan" and "Synvisc". Both are forms of Hyaluronic acid, a natural component of normal joint fluid and cartilage. They are administered as a series of injections, 5 or 3 injections respectively for Hyalgan or Synvisc. While these medications actually remain in the joint for only 1 to 3 days, relief of pain and improved function may last for as much as 6 months or longer in some patients. It is thought that these drugs may stimulate the joint to produce more of its' own naturally lubricating Hyaluronic acid. Since they are injected locally there are no systemic side effects such as stomach upset, and no medication interactions. Some patients will experience pain at the injection site, and as with any injection there is a small risk of infection, but these drugs have otherwise been well tolerated. Allergic reactions have rarely been reported. Cost was a major issue initially and these treatments remain expensive, but viscosupplementation is now covered by many insurance plans. For now, it is indicated only for Osteoarthritis of the knee.

A new type of medicine for the treatment of **Rheumatoid Arthritis, Osteoarthritis, and other forms of arthritis** will likely soon be available to the general public. These will be known as the "Cox II inhibitors". These drugs appear to be an improvement on the current non-steroidal anti inflammatory drugs (NSAID's) such as aspirin and naproxen, which are the first line of defense against the inflammation present in many types of arthritis. "Cox" is an abbreviation for "Cyclooxygenase" which is an enzyme responsible for the production of a chemical called prostaglandins. Prostaglandins promote inflammation in joints and elsewhere, but are also responsible for a number of "housekeeping" functions in the body. These include maintenance of the stomach lining and keeping the kidneys supplied with adequate blood flow. NSAIDs block the production of prostaglandins. This is helpful in decreasing inflammation and pain. However, diminishing the production of these "housekeeping" prostaglandins is what is responsible for the majority of the side effects of these medications such as stomach upset or ulceration. Recently it was discovered that different enzymes are responsible for these two different functions. The new "Cox II" inhibitors decrease the level of the pro-inflammatory prostaglandins, without significantly affecting the "housekeeping" prostaglandins. Theoretically this should significantly decrease the number of problems associated with these drugs. Data released so far is very promising in this regard.

A variety of other new and innovative medications will soon be added to our arsenal against arthritis. Ask your doctor to keep you posted.*

RHEUMORS

Rheumors Volume 9, Number 1
Summer, 1998
A NEWSLETTER FOR PATIENTS
A quarterly publication brought to you by Arthritis & Rheumatism Associates, P.C.

T H E F U N R H E U M

Robert Rosenberg, M.D.

Drugs used in the prevention and treatment of osteoporosis

MATCH THE BRAND NAME WITH THE GENERIC NAME:

1. PREMARIN	a. CALTRATE CITRACAL
2. FOSAMAX	b. ESTROGEN
3. MIALCACIN	c. RALOXIFENE
4. DIDRONEL	d. CALDEROL
5. EVISTA	e. CALCITONIN
6. CALCIUM	f. ALENDRONATE
7. VITAMIN D	g. ETIDRONATE

Answers: 1-b, 2-f, 3-e, 4-g, 5-c, 6-a, 7-d.

Emma DiIorio, M.D.

FIBROMYALGIA *continued from page 1*

cle between spine and shoulder blades, 2 cms. Below elbow, upper outer buttock, hip bone, just above knee on inside, lower neck in front and edge of upper breast bone. In many cases a triggering event can be identified such as physical or emotional trauma or infection. Fribromyalgia often runs in families suggesting an inherited predisposition.

What causes it

No conclusive evidence of an underlying cause although many mechanisms have been proposed. Current hypothesis suggests low levels of serotonin. Low levels of serotonin also found or hypothesized to cause migraine headaches, irritable bowel syndrome and affective disorders. Others have suggested abnormality of deep sleep, low levels of growth hormone. Again none of these theories have been substantiated.

Management

Taking medication alone has relatively little effect on symptoms. Successful treatment requires active involvement of the patient in his or her care including:
Medication to improve deep sleep
Regular sleep hours and an adequate amount of sleep
Avoidance of undue emotional and physical stress
Patient education
Daily gentle aerobic Exercise! Exercise! Exercise! And yes Exercise!!!!

A number of medications have been used to improve sleep, amitriptyline (Elavil), cyclobenzaprine (Flexeril) and trazodone (Desyrel) being the most commonly prescribed. Medication is started at a low dose and gradually increased until you sleep well at night and feel good during the day. Patients begin to improve in 2 to 4 weeks. Side effects include dry mouth, weight gain and a fuzzy feeling in the morning. It often takes trying different medications and in different doses to find the right combination for a particular patient. It is important to avoid prescription tranquilizers and sleeping medications like Valium because they suppress deep sleep and make symptoms worse the following day. Alcohol and narcotic medications have the same effect and should also be avoided. Antidepressants like Prozac, Paxil, Zoloftt or Effexor may benefit patients with concurrent depression. Patients with fibromyalgia must get to bed by the same time and get enough sleep. Stress also worsens fibromyalgia symptoms. If a patient has ongoing problems with depression or anxiety, they should consider seeking professional help. Patients who make the effort to learn as much as possible about the disorder usually do better. Remember, this condition although painful does not cause any tissue or organ damage.

Exercise

Daily gentle aerobic exercise is vital to improvement. Exercise seems not to work through conditioning of muscles but rather through a direct, possibly hormonal effect on pain and sleep. Daily exercise is essential. Patients who have been regularly exercising and then miss a day usually find their fibromyalgia symptoms are worse for the next day or two. While many patients insist they get plenty of exercise at work, doing housework, or in the yard, it is rarely the right kind. Fibromyalgia patients need to set time aside for aerobic exercise. Appropriate exercise includes aquatic aerobics, low impact aerobics, stationary bicycle, stretching. Patients should begin at a level of exercise that results in mild muscle tenderness the following day, then gradually increase the level and duration of exercise. It may take several months to see a benefit. People who are out of shape may want to start at just 3 to 5 minutes of exercise and increase gradually. Virtually all fibromyalgia patients experience some pain following exercise and are reluctant to continue thus leading to further deconditioning. Physical therapy, biofeedback, acupuncture, trigger point injections, massage therapy are other modalities which may be helpful in your treatment. Not all treatments are effective for every person so patient and physician will need to work together see what works best. Remember, although this condition has no cure prompt recognition and management may lead to substantial symptomatic improvement.❋

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term relationship with Drs. Borenstein and Star who practice at our K Street location. He felt the exchange of ideas generated by a large Rheumatology practice would be more fulfilling to him.

Asked if he ever regrets giving up his long-term plan of going into research, Dr. Lawson answered, “I like the clinical side. The beauty is the long-term relationship with patients where you can significantly impact a person’s quality of life” Dr. Lawson also describes rheumatology as “one of the few specialties where basic science still has a major impact; a fascinating field that keeps me close to research as well as a practicing clinician.”

ARA welcomes Dr. John Lawson. Our D.C. office is located at 2021 K Street, N.W., 202-293-1470. We are open Monday through Friday from 8am to 5pm and offer a full-service facility which includes lab, x-ray, DEXA testing and a Clinical Research Program.❋

CLINICAL TRIALS 1998

Herbert S. B. Baraf, M.D.

Clinical Research has been an integral part of Arthritis & Rheumatism Associates' medical practice since 1982. Clinical trials have given our physicians the opportunity to be at the vanguard of therapeutics in arthritis care and have afforded our patients with unique access to new therapies that would otherwise be unavailable. The growth of our clinical trials program has been so dramatic in recent years that we have made it a separate division of the practice with its own name, The Center for Rheumatology and Bone Research.

This year the Center has been busier than ever. The Center's headquarters in our Wheaton office will be tripling in size as we undergo a renovation. The D.C. office will be increasing its involvement in the clinical trials program and for the first time, patients will be able to participate in clinical trials out of the Shady Grove Office.

A number of new medicines are actively under study by our physicians with the help of our clinical research team, June Carter, Betsy Shepard, April Bower, Susan Chandler, Joyce Jones, and Sonni Vann. The Center's research involves treatments with newly developed medicines for Rheumatoid Arthritis, Osteoporosis and Sjogren's Syndrome that have not yet received FDA approval and are only available to patients through research protocols.

For patients interested in participating in clinical research we have a number of new protocols:

RHEUMATOID ARTHRITIS (RA): We are currently recruiting patients with RA for participation in a study that evaluates a new drug that is believed to preserve cartilage and maintain function in patients with less than 10 years of disease who are currently on a stable dose of Methotrexate.

In a second clinical trial we are enrolling patients with RA to evaluate the usefulness of an oral chicken-cartilage derivative in inhibiting inflammation and controlling disease progression. This trial is available only at our DC location.

OSTEOARTHRITIS OF THE KNEE OR HIP: We have number of different programs that are actively enrolling. Three of these protocols are designed to evaluate new NSAID drugs that are anticipated to be free of gastro-intestinal side effects (COX-2 NSIADS). One study, scheduled to start in September, evaluates a cartilage-stabilizing drug that may slow the progression of disease. A fifth project will involve a non-NSAID pain medication for osteoarthritis of the knee.

A novel program is available to patients with osteoarthritis of the knee using an electronic device that generates electromagnetic waves to decrease knee pain. This program is also only available at the D.C. office.

SJOGREN'S SYNDROME: Patients with dry eyes and dry mouth caused by this condition may be eligible to participate in one of two clinical trials evaluating a drug that is expected to enhance salivation and tearing.

In all of these programs diagnostic testing, medication and physician visits are free of charge. We would be delighted to review the specifics of these programs with you. Please feel free to discuss these programs with your physician on your next visit to the office. If you know someone who is not a patient of our practice who might be interested in learning more, please refer him or her to one of our study coordinators at 301-942 7600 extension 124 for additional details.

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

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