ARTHRITIS AND RHEUMATISM ASSOCIATES

RHEUMORS

A NEWSLETTER FOR PATIENTS

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NINTH PHYSICIAN JOINS ARA

Margaret Dieckhoner, Administrator

The physicians and staff of Arthritis and Rheumatism Associates, P.C. (ARA) enthusiastically welcomed Dr. Sheila Kelly to our practice in early September. Dr. Kelly is a Board Certified Rheumatologist who comes to us from Albany Medical College in Albany, New York.

Dr. Kelly was awarded her undergraduate degree from Dartmouth College, in Hanover, New Hampshire. She earned her medical degree from Albany Medical College where she was a member of Alpha Omega Alpha, a medical honor society. Dr. Kelly completed her residency at Albany Medical Center Hospital and received her fellowship training in Rheumatic Diseases at Albany Medical College. After completing her fellowship training, Dr. Kelly remained at Albany Medical College where she was an Assistant Professor of Medicine in the Division of Rheumatology until joining our group.

Dr. Kelly is a native New Yorker. She was born in the Bronx, but her family moved to Westchester County when she was eight years old. Her family still resides in New York.

When asked at what stage of her life she developed an interest in medicine, Dr. Kelly recalls a desire to become a physician as far back as age six. She notes two major influences in her decisions to both enter medicine, and subsequently to specialize in rheumatology.

As a child, Dr. Kelly came down with a routine illness that remained misdiagnosed until her pediatrician, whom she fondly describes as "an old-fashioned clinician", took charge and set things straight. His knowledge and style of practice reinforced her interest in medicine into her adult life.

Later, as a resident, Dr. Kelly decided to change her focus from OB GYN to medicine. At that point, she did a rotation with Dr. Joel Kremer, a highly respected rheumatologist. It was this mentor's influence that ignited a special interest in Dr. Kelly, and led her to seek additional training to become a Rheumatologist.

see **PHYSICIAN** *continued on page 5*

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

CORTISONE – CURE-ALL OR POISON?

Norman S. Koval, M.D.

Glucocorticoids (also known as cortisone or "steroids") have been extremely important agents in treating diseases that are characterized by inflammation and exaggerated immune responses. Cortisone, the parent compound, was first isolated from the adrenal gland tissue in the 1930's, but interest in glucocorticoids really soared with the research of Philip Showalter Hench and his colleagues in the late 1940's. Hench began to use this hormone compound in the late 40's and received the Nobel Prize for it in 1950. The enthusiasm for the pharmacologic use of glucocorticoid steroids in the treatment of inflammatory diseases was soon dampened by the recognition of serious side effects that accompanied "high dose" therapy. The challenge of glucocorticoid steroid therapy continues to be the counterbalancing of desirable anti-inflammatory and immunosuppressive actions versus the undesirable pharmacologic activities. The decision to institute glucocorticoid steroid therapy must be derived from an understanding of these agents and the adverse reactions that may accompany their use. The minimal dose of glucocorticoid steroids that are necessary to suppress the disease process being treated should be used. These goals generally can be at least partially attained by using short acting glucocorticoid steroids at the lowest possible dose and for the shortest period of time.

see **CORTISONE** *continued on page 5*

A N S W E R S
To
Your
Questions

Evan L. Siegel, M.D.
Herbert S. B. Baraf, M.D.
David G. Borenstein, M.D.

Q. If I have arthritis, can I exercise?

A. The answer to this question is an emphatic YES! Not only can patients with arthritis exercise, but it is extremely important that they do so. Studies have shown that patients with osteoarthritis who exercise have improved muscle tone which can prevent or delay further joint deterioration. Some of the many benefits of exercise in people with all types of arthritis include improvement in joint pain and mobility, reversal of muscular atrophy and improvement in bone mineral density. This latter effect is of special importance to post menopausal women and patients on corticosteroid therapies who are already at great risk of osteoporosis. Inactivity specifically increases the risk of osteoporosis, as well as the risk of bone, joint and muscle injury. Nonspecific benefits of exercise, of course, abound. People who exercise are healthier and live longer. Cardiovascular status is improved, the risk of falling is reduced, weight control becomes easier, the risk of colon cancer and diabetes diminish and symptoms of depression and anxiety are relieved by regular exercise. Sleep patterns improve and even smoking cessation is easier with exercise.

While the benefits of exercise are clear, several restrictions and caveats apply to patients with arthritis. First, it is wise to discuss the parameters of a new exercise program with your physician or physical therapist. Physical activity in those who have been inactive should be started slowly and gradually increased. Cardiovascular testing may be appropriate for some patients before starting vigorous exercise training. Low impact aerobic type exercises such as walking, swimming, water exercise, or bicycling are helpful in maintaining muscle tone and strength without much stress on the joints. Tai Chi and Yoga are good ways to maintain flexibility and muscle tone. Gentle, but progressive, resistance and weight training have been shown to be of significant benefit to patients with arthritis. Joints that are acutely inflamed should not be vigorously exercised, but can benefit immensely from isometric and range of motion exercise. Significant pain should always be respected. Finally, stretching before all forms of exercise is important to prevent local injuries.

In many forms of arthritis and other musculoskeletal disorders, a prescription for exercise can be just as important as a prescription for medicine. Discuss this with your doctor soon.

Q. Is acupuncture helpful as a therapy for pain?

A. Acupuncture is based upon the Chinese theory that energy pathways, called meridians, carry the body's energy, called chi. Illness causes an imbalance in the flow of chi in these meridians. Stimulation of specific points along the meridians can correct the flow of chi to optimize health, or block pain.

Traditional acupuncture uses thin needles at specific points along the meridians to rebalance the flow of energy. Between 5 to 15 thin, flexible, solid, sterile needles are inserted from a fraction to 4 inches deep. As the needles are inserted, the recipient feels a range of sensations from normal to tingling, warmth, or pinching. The needles are left in place from 5 to 60 minutes (20 minutes is usual). A course of 10 treatments may be required to obtain maximum benefit. Follow-up treatments every few months may be necessary to maintain normal energy balance.

The mechanism that makes acupuncture work to relieve pain is related to the release of endorphins (the body's own pain reliever) and the stimulation of the large sensory fibers that block the transmission of pain signals from small pain fibers. Pain relief from acupuncture can be reversed by naloxone, a medication that reverses endorphin effects.

Acupuncture fits the role of a complementary therapy. Complementary therapies supplement the efficacy of other therapies including drug and physical therapy for the treatment of chronic pain. The frequency of a positive

response to treatments is unknown. Acupuncture is worth the effort if all other therapies have been tried and are not fully effective. Acupuncture should also be considered if toxicities prevent the use of first-line treatments. Acupuncture is a passive, time-consuming procedure. It is also relatively expensive since insurance coverage for this therapy is not universal.

Q. I have been asked to participate as a subject in a clinical trial. Why should I participate?

A. Over the years, hundreds of patients have participated in clinical trials at our Center for Rheumatology and Bone Research. Our research is nationally respected by the pharmaceutical research industry for the quality of our work. Our patients and highly qualified clinical research coordinators are primarily responsible for this reputation. Together with the pharmaceutical industry and the FDA, they have helped bring about some of the most significant advances in arthritis therapy in our lifetime. Many of our patients have enjoyed, or benefited from, the experience so much that they have volunteered to enter additional study programs.

People have various reasons for participating in clinical research. No one would argue that the knowledge gained from the clinical research process brings rewards to society as a whole. This is evident in the recent spectacular advances in arthritis therapies. Many study patients feel a need to do their part in advancing medical knowledge, which in turn, helps all arthritis patients find relief from the pain and disability caused by their illness. We are proud to have assisted in the endeavor, while always keeping patient safety as our utmost concern. Some patients become involved in the process to find treatments which may help when standard therapies have failed. Other patients are pleased to be involved in our research program because costly drug treatment is free to participants. Finally, many participants learn more about the nature of their arthritis, and its response to treatment, in the clinical trial process.

We respect whatever motivation you may, or may not, have to be a part of this program. Participation is voluntary and consent can be withdrawn at any time, for any reason. If you are interested, or have any questions, speak to your doctor or fill out the enclosed form and mail it in.❄

CLINICAL TRIALS QUESTIONNAIRE

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 form 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.

In the spirit of "Who Wants to be a Rheumatologist?" here are 10 questions to test your knowledge of Rheumatology. While there are no monetary rewards, you'll probably be interested in some of the tidbits surrounding what we do here at Arthritis & Rheumatism Associates.

Please choose the best correct answer.

1. Rheumatologists deal with diseases of the:
A. Joints
B. Bones
C. Muscles
D. All of the above

2. By the year 2010 the number of practicing Rheumatologists will be:
A. More than we need
B. Half the number required
C. Just right
D. None. All arthritis will be cured

3. Rheumatologists have ____ years of additional training after completing medical school:
A. 2
B. 5
C. 6
D. 10

4. Arthritis can effect:
A. The very young
B. The very old
C. Only the middle aged
D. All age groups

5. In addition to arthritis, Rheumatologists also treat:
A. Osteoporosis
B. Back Pain
C. Bursitis and Tendonitis
D. All of the above

6. Rheumatoid Arthritis probably first occurred in:
A. New World Indians 3,000-5,000 years ago
B. Europeans during Middle Ages
C. Chinese
D. Egyptians during the reign of Ramses

7. Rheumatoid Arthritis is best treated with:
A. The old tried and true medicines
B. New potent and safer medicines
C. Over the counter medicines
D. "Natural Products"

8. Arthritis treatments proven effective include:
A. Anti-inflammatory medications
B. Dietary supplements
C. Magnets
D. Copper bracelets

9. Arthritis can be caused by:
A. Infection
B. Immune disease
C. Injury
D. All of the above

10. Arthritis medications can adversely affect the:
A. Blood
B. Stomach
C. Kidneys
D. All of the above

Answers on page 6

CORTISONE *continued from page 1*

Several side effects of glucocorticoid therapy are characteristic early in therapy, including insomnia, emotional lability, enhanced appetite or weight gain or both. Common in patients with underlying risk factors or other drug toxicities are hypertension, diabetes, peptic ulcer disease and acne.

Other side effects are anticipated with use of sustained and intense treatment. Risk can be minimized by conservative dose regimens and other medications known as steroid-sparing agents when possible. Cushingoid habitus (moon face, buffalo hump, obesity of the trunk), pituitary and adrenal gland suppression, infection, osteonecrosis (sudden severe bone pain), muscle abnormalities, or impaired wound healing are all possible in these patients.

Insidious and delayed side effects which are likely dependent on cumulative doses include osteoporosis, thinning of the skin, cataracts, atherosclerosis, growth retardation in children or fatty liver.

Rare and unpredictable problems include psychosis, pseudo tumor cerebri, glaucoma and inflammation of the pancreas.

Alternative forms of corticosteroid dosing and delivery will help reduce the side effect profile. There are topical corticosteroids provided as lotions, creams or ointments.

Specific local injections of corticosteroids are of great value in selected patients and clinical settings. These are used in the treatment of arthritis, tendinitis or bursitis. Most studies confirm minimal long-term adverse effects when corticosteroids are administered in this fashion. It has been estimated that approximately one patient in 50,000 to 60,000 injections will develop an infection. Our patients who receive injections are always directed to call the office immediately if swelling develops at the site of injection, or if there is fever.

Low dose daily oral therapy at the lowest possible dose (generally less than 5 to 7.5 mg of prednisone by mouth per day) appears to be the safest route of systemic corticosteroid treatment.

Alternate day therapy is associated with fewer side effects than high dose daily therapy. Alternative day therapy is attempted when the primary disease has been brought under control by the daily dose regimen. There are groups of patients that will need to stay on daily corticosteroid therapy.

Your rheumatologist has been trained to use these drugs and is knowledgeable about the side effect profile. Most patients who are at risk for the development of GIOP (glucocorticoid induced osteoporosis) will be started on concomitant medicine to prevent this side effect.

Dr. Hench's pioneering work in glucocorticoid therapy has provided literally millions of patients the opportunity to survive severe diseases and reduce pain states. As with all drugs, corticosteroids should be treated with respect and reverence, but not with fear. They are neither cure-alls nor poison.❄

PHYSICIAN *continued from page 1*

In addition to her enthusiasm for her profession, Dr. Kelly pursues many other interests. She is a voracious reader—usually reading two to three books (on a wide range of subjects) simultaneously. She also enjoys running, skiing, hiking and going to the movies.

If you ask Dr. Kelly what brought her to the D.C. area, she will tell you she had decided to leave academic medicine, but was only interested in joining a progressive, well-run, cutting-edge group. Her extensive search and interview process ended, she states, when she found our practice.

We are pleased to welcome Dr. Kelly as the ninth member of our physician team. She will see patients in our Laurel and Wheaton offices.❄

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PRACTICE NOTES

- On November 1, 2000, at the Annual Conference of the American College of Rheumatology, and in the presence of thousands of his colleagues, Dr. Werner F. Barth was awarded the prestigious title of *Master* of the American College of Rheumatology. Please join us in congratulating Dr. Barth on his significant accomplishment.

- Dr. Robert L. Rosenberg was interviewed along with other national osteoporosis experts on the National Public Radio (NPR) show "All Things Considered" in August. He appeared on WRC News with Doreen Gentzler in April and in July he was a guest on a Voice of America call-in show about osteoporosis.

- Dr. David G. Borenstein was a guest on NPR's "All Things Considered" last spring where he discussed the new Cox-2 drugs Celebrex and Vioxx.

Congratulations!

To Our Enbrel Patients

Since its introduction 2 years ago, demand for Enbrel has grown rapidly. So rapidly in fact, that demand could soon, temporarily, exceed supply. Because of this, Wyeth and Immunex have created the Enbrel *Enrollment* Program. This program will ensure that your Enbrel therapy will not be interrupted. If you do not enroll, you may experience delays in getting your Enbrel prescriptions filled. To enroll call toll-free 1-888-4 ENBREL (436-2735). *PLEASE* call now to ensure your enrollment by December 31, 2000. If you have questions, please feel free to call our office.

ANSWER KEY: 1-D, 2-B, 3-B, 4-D, 5-D, 6-A, 7-B, 8-A, 9-D, 10-D

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