

**Rheumors**  
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## **RHEUMINATIONS**

### **A NURSE'S VIEW**

By Sylvia Dupre', R.N.

"Oh, I'm so glad to know someone else has felt that way too!" "I think the exercises are already beginning to decrease my morning stiffness." "It's good to be able to talk to others about my problems."

These are a few of the comments heard during the three session Health, Exercise and Living Program (abbreviated H.E.L.P.) course of The Arthritis Foundation held in April at our Shady Grove office. I was privileged to co-lead these sessions with another volunteer from the Foundation.

An office nurse assumes many roles in her work. Most apparent to patients is her role as technician as she takes blood pressure and medication history, draws blood, and sets up outside testing appointments. The nurse is also a facilitator who aids in the transfer and reinforcement of information or instructions between doctor and patient. She may also serve as a liaison between patients and outside agencies such as physical therapy or home health care programs. One of the greatest benefits to patients, however, comes from her role as a resource person and teacher. To improve my skills, I attended the Arthritis Foundation sessions to learn more about resources available to arthritis sufferers. I was introduced to the many available resources and was instructed in the three session H.E.L.P. course which I am now qualified to teach.

During the H.E.L.P. session held at our Shady Grove office, the group participants and leaders focused on several areas. The first session dealt with the physiology of arthritis and the how and when of exercise and its benefits. In session two, we explored practical techniques of coping with pain, how to identify and minimize stress, relaxation activities and further exercise. The final session addressed simple methods of protecting joints through body mechanics, energy conservation and the use of self-help devices.

Having had these learning and teaching experiences, I now feel more adept at conveying H.E.L.P. information to patients at the office. My co-leader and I both feel we learned as much from the course participants (novel techniques to cope with arthritis and the stresses in our daily lives) as we did from the curriculum. In all, much satisfaction was derived from enabling other individuals to help themselves - truly the essence of teaching - as evidenced in these closing comments. "It taught me self management and how the family can help." "It gave me a better understanding of what I could do to help myself!"

## **WHAT DO YOU DO WITH ALL THAT BLOOD, DOCTOR?**

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

Part two of a two-part series -

In the last issue of Rheumors, I discussed why laboratory studies are frequently required for the proper evaluation and management of the patient with arthritis, and how they are used to help confirm or establish a diagnosis. This article will discuss how laboratory studies help monitor how your medication is affecting your rheumatic condition, as well as how they help monitor medication side effects.

### **TESTS USED TO MONITOR EFFECTS OF TREATMENT ON DISEASE**

Both the sedimentation rate (ESR) and the C-reactive protein (CRP) are valuable in monitoring a patient's response to treatment. As a patient's illness improves their ESR and CRP values decrease.

The Complete Blood Count (CBC) consists of measures of the cellular components of the blood. These components consist of the red blood cells, the white blood cells and the platelets. Anemia is said to be present if there are too few red blood cells. Anemia is frequently seen when Rheumatoid Arthritis or Lupus is active. Anemia accompanies many of the other rheumatic diseases such as Polymyalgia Rheumatica or Psoriatic Arthritis. Anemia is also present in patients with severe infections. When these conditions improve, the anemia shows improvement too.

White blood cells may increase in number with certain infections, usually falling back to normal as the infection comes under control. In a Lupus flare the white blood cell count may be very low and improves when the Lupus flare resolves. Platelets, too may follow this pattern.

### **TESTS USED TO MONITOR FOR SIDE EFFECTS**

Every medication, both prescription and over-the-counter, has the ability to cause side effects. The medications used to treat the different kinds of arthritis have a wide spectrum of potential toxicity. These side effects can be obvious, such as a stomach ache or a rash, or they may be silent such as an effect on liver or kidney function.

Non-steroidal Anti-inflammatory Drugs (NSAID's) are the medicines most commonly prescribed for arthritis, no matter what the type. Aspirin and Ibuprofen are available over the counter. The others, including Naprosyn, Feldene, Voltaren, Indocin, Meclomen, Clinoril (to name but a few), all require a prescription. They ALL have the potential to upset the stomach and rarely to cause bleeding. Bleeding can be acute or gradual going undetected until a check of a blood count shows the development of anemia. Patients on these drugs must have periodic assessments of their blood counts to assure the safety of continued treatment.

NSAID's may less commonly cause inflammation of the liver, or malfunction in the kidney. These effects may not cause the patient any discomfort until they become quite severe. The elderly are more susceptible to kidney and liver damage from NSAID's but younger patients are not free of some, albeit small, risk. Therefore, periodic determinations of the blood urea nitrogen, serum creatinine and liver enzymes are recommended for all patients with a need to remain on these medicines for long time periods.

Medicines such as gold, methotrexate and azathioprine (Imuran), all used in the treatment of active Rheumatoid Arthritis, can all suppress bone marrow function and require close monitoring of the CBC. Methotrexate may adversely effect the liver as may azathioprine. Gold can alter kidney function necessitating testing of the urine for protein.

CONCLUSION.

The use of laboratory tests may allow for accurate diagnosis and effective monitoring of disease under therapy. The laboratory can also provide us with early clues of unwanted side effects. Proper use of the laboratory permits safer administration of medicines that ultimately can help to keep the arthritis patient comfortable, active and productive.

## **WE'RE EXPANDING !!**

We are bursting at the seams in our current Shady Grove Road (Rockville) office, so come fall, we will be moving to a new location, right around the corner on Research Boulevard (next to the Marriott Courtyard Hotel).

Our new facility will enable us to offer our patients expanded hours and services. We will extend our office hours from three mornings to five, and we will provide our own x-ray services. Perhaps the greatest advantage will be our easy access first floor location and improved parking conditions.

We are hoping for an early fall move. Please watch for more details as the summer progresses.

## **CLINICAL RESEARCH**

The practice is currently evaluating two new medications in clinical trials. If you are interested in participating and you have an established diagnosis of Osteoarthritis of the knee or hip, or of Rheumatoid Arthritis, please contact your physician. All costs are covered.

## LEAD ARTICLE

### **PSORIASIS/ARTHRITIS**

By Norman S. Koval, M.D.

Psoriasis is a very common skin disease which is characterized by the presence of well-defined dry, raised, red scaly patches which do not itch and are frequently found on the extensor surfaces of the knees, elbows and on the scalp. The incidence of psoriasis is equal in both the male and female populations. The usual age of onset is between 20 and 50 years of age. Ten percent (10%) of patient's with psoriasis will develop a form of arthritis. The psoriasis may be minimal or absent and usually precedes the arthritis, often by many years. Rarely, arthritis precedes the skin disease. Activation of the psoriasis and arthritis will occasionally coincide. Thirty percent (30%) of patients with psoriatic arthritis have a family history of psoriasis. The cause of psoriasis and the arthritis is unknown. Rheumatologists categorize this disorder as being a serologically negative (rheumatoid factor negative) arthritis.

Five clinical patterns of psoriatic arthritis have been recognized: 1) classic psoriatic arthritis with predominate involvement of the joints just behind the nails with nail lesions, 2) arthritis mutilans, a rare presentation where bone is reabsorbed and there is often an association with inflammation of the sacroiliac joints, 3) a symmetrical polyarthritis resembling rheumatoid arthritis, 4) oligoarticular arthritis (affecting a few joints) which characteristically has asymmetrical involvement affecting scattered joints of the hands and classic "sausage digits" (this is the most common presentation involving 70% of all cases) and 5) ankylosing spondylitis, presentation having both sacroiliitis and/or spondylitis (inflammation of the back).

Extra-articular associations have been noted, the eye being the most commonly involved. There have been inter-relationships with other disease processes such as ankylosing spondylitis, Crohn's disease, Reiter's disease, and Behcet's syndrome. Hence, there may be a shared genetic background. Intensive immunologic studies are being performed to determine the relationships.

Most patients with psoriatic arthritis have mild disease affecting only a few joints and following a rather episodic course. The patients generally suffer less pain and disability than those with rheumatoid arthritis. Approximately 5% of patients will develop a deforming arthritis that may lead to disability.

Psoriasis itself is considered a socially difficult disease for those afflicted, and the prospect of disability from arthritis is even more difficult to bear. It is important for the rheumatologist to stress that most cases follow a relatively benign course and that serious systemic complications are rare.

The initial drug treatment includes nonsteroidal anti-inflammatory drugs such as Indocin or Naprosyn. All of these agents have been observed to have beneficial effects. Some patients with severe joint disease need additional measures such as injections into the inflamed joints. Gold therapy may help the arthritis, but does not improve the skin condition. Methotrexate, however, has been recognized to be effective in treating both the arthritic manifestations and the skin involvement of psoriasis. It has been the drug of choice in patients with both active arthritis and severe skin disease.

No specific regimen is correct in every situation. The rheumatologist will thus often work closely with the dermatologist in developing a therapeutic program individualized for the given patient.

## POINTS ON JOINTS

### **GOLD AND ARTHRITIS**

By Evan L. Siegel, M.D.

The use of gold in the treatment of arthritis engenders many questions of varying types from patients to their rheumatologist. Many are surprised that the same metal that they have been wearing on their fingers and around their necks for years could be helpful in ameliorating their symptoms of painful and swollen joints. Some wonder whether all types of arthritis are helped by gold therapy. Others question the effectiveness and potential toxicities of this medication. Recently there has been a flurry of coverage in the press and lay journals with respect to these issues.

Of course, just wearing gold is of no use (nor is the wearing of other metals, such as copper, as previously discussed in Rheumors). However, the injection, and more recently oral ingestion of gold salts in the treatment of specific types of arthritis, has been in use for more than fifty years. In general, gold is recommended in the treatment of Rheumatoid Arthritis, although it can be used in Psoriatic Arthritis and has been tried in other forms of arthritis. It is not recommended for Osteoarthritis or "Degenerative" Arthritis, soft tissue rheumatism, and most forms of Lupus.

Multiple published trials documenting the effectiveness of gold in Rheumatoid Arthritis have been performed between the 1940's and today. Most show partial to significant improvement in several parameters used to measure disease activity. Remission of symptoms may or may not be long lasting, but many patients will experience improvement for meaningful periods of time. It has been thought by some that injectable gold is the standard by which all new therapies for Rheumatoid Arthritis should be measured.

A recent study, widely quoted by the lay press, has challenged this conventional wisdom, but should be interpreted cautiously and thoughtfully. The study, done by Dr. W. Epstein in San Francisco, questions the long term effectiveness of gold injections. It was not a blinded and controlled trial, lost many patients to follow-up, and relied heavily on statistical adjustments. While it gives rheumatologists a reason to pause and reflect upon the effectiveness of our therapies, it does not negate previous studies or our experience that there are many patients who respond beautifully to sustained injectable gold.

Gold is in no way a panacea or a cure. Therapy is frequently associated with side effects ranging from mild to severe, and these should be discussed in detail by each patient with his physician prior to embarking on a course of injectable or oral gold. With careful monitoring, many of the more severe toxicities can be avoided.

In summary, gold continues to be an important and effective mode of treatment in the therapy of Rheumatoid Arthritis and certain other rheumatic conditions. Specific indications should be discussed individually with a rheumatologist.

## **Q & A SECTION**

Q.

What are the risks of using steroids?

A.

Steroids (Prednisone, corticosteroids, Cortisone) are used in the management of inflammatory arthritis and rheumatic diseases. While they are very effective anti-inflammatory agents, they have many potential side effects. Possible side effects include increased appetite with weight gain, thinning of the skin, redistribution of body fat, elevated blood sugar, elevated blood pressure, glaucoma, cataracts, osteoporosis, aseptic necrosis (loss of blood supply) of bone, mood changes, and sleep disturbance. The risks may increase with higher dosage levels and longer use.

Steroids can be very effective in controlling severe inflammatory disorders but, as with all medication, benefits should be weighed against potential side effects.

Robert L. Rosenberg, M.D.

Q.

I have heard that arthritis can affect the eyes. Are there any precautions that I should take to protect my eyes?

A.

Several types of arthritis may affect the eyes, each injuring different parts of the eye. Rheumatoid arthritis might affect the sclerae (covering of the eyeball); SLE may affect the retina (light sensitive portion); Sjogren's syndrome (the cornea and tear glands); and ankylosing spondylitis of the anterior portion of the eyeball. Juvenile arthritis patients may experience a severe eye inflammation resulting in scarring. Certain drugs (Plaquenil) used in the treatment of arthritis may cause eye damage.

It is very important to discuss with your doctor whether you have any risk of eye damage related to arthritis. Problems are usually responsive to treatment and complications can be prevented.

Robert L. Rosenberg, M.D.

Q.

Can food poisoning cause arthritis?

A.

An unusual, but not rare, type of arthritis may occur after an inflammatory reaction in the gastrointestinal (GI) tract. This "reactive arthritis" may follow a GI infection even though the bacteria has been eradicated by medication. Bacteria such as Salmonella, Shigella, Yersinia, and others have been implicated. In some patient's these bacteria trigger an immune response resulting in chronic persistent arthritis even after the acute infection has cleared. Patients positive for HLAB-27 (a genetic marker) are more susceptible to these problems. Reactive arthritis can involve both large and small joints as well as the low back. Involvement of the

sacroiliac joints is common. Joint symptoms may be accompanied by skin involvement, eye inflammation, and occasionally sores in the mouth and genital region. Treatment is aimed at reducing the pain and inflammation of the arthritis.

Robert L. Rosenberg, M.D.

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Arthritis & Rheumatism Associates, P.C.  
Norman S. Koval, M.D.  
Herbert S. B. Baraf, M.D.  
Robert L. Rosenberg, M.D.  
Evan L. Siegel, M.D.  
Emma DiIorio, M.D.  
Margaret Dieckhoner, Editor  
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