Rheumors
Volume 6, Number 1
Winter, 1995

NEW ROCKVILLE OFFICE OPENS!
9707 Shady Grove Road - Suite 100 - Rockville, MD 20850

After several years of planning, and a full year of construction, Arthritis & Rheumatism Associates, P.C. proudly opened the doors to our beautiful new Rockville office on November 1, 1994. We remain on the campus of the Shady Grove Adventist Hospital, but have moved into our long-awaited permanent home.

We are especially excited about our new facility because it offers us the opportunity to better meet the needs of our growing patient population. We are now able to expand the number of hours we see patients at that location, and for the first time in Rockville, we are able to provide in-house X-ray services. These additions make us more efficient and enable us to provide more convenient service to our patients.

While Dr. Baraf's and Dr. Rosenberg's Rockville office schedules will remain the same, Dr. Siegel's and Dr. DiIorio's schedules will be expanded. Therefore, if you are a patient of Drs. Siegel or DiIorio and live or work in the Rockville area, but currently see them for treatment in our Silver Spring location, you might wish to consider transferring your care to our Rockville office. The new, expanded hours in that location may offer greater appointment flexibility and the opportunity to be scheduled more quickly.

As we all embark upon the fast moving, and to a large degree yet-unknown, changes in health care delivery systems, we hope that our vision, expansion and continued commitment to providing the highest quality of medical care, will carry our patients and our practice, successfully into the next century.

GUEST COLUMN

In an on-going effort to keep Rheumors a timely and informative patient newsletter, we have decided to introduce a "Guest Column" to our publication. Its purpose is to present topics of interest and relevance to our patients which are written by a variety of physicians, representing numerours specialties, from the Washington Metropolitan Area.

This is our introduction issue. We hope you will find our guest columnists interesting and informative. We welcome your feedback.

TOTAL JOINTS
WHERE ARE WE?
by Jerry S. Farber, M.D.

Total joint replacement has become almost a household word in the past ten years. For most orthopaedic surgeons, and the lay public, this means replacement of the knee and hip joints. While joint replacement can be done at several other joints in the body, such as the elbow, ankle, finger joints, great toe and wrist, these are not as common and, of course, not as dramatic as the large weight bearing joints that allow us locomotion.

Are these safe procedures? How well do they hold up? Will they have to be revised?

How hard will one have to work after surgery to regain strength and the ability to walk? How does one know when to have the operation?

No doctor can guarantee the results of an operation. The physician must educate the patient as to the potential risks, and benefits and the alternative procedures to any given operative procedure. The patient must then decide, given the available information, whether or not to have joint replacement surgery.
Total joints *do* hold up. While there have been changes in the construction of the components used, most components are metal but depend upon a plastic (Polyethylene) gliding surface. There has been a period of progressive experience and learning to improve the quality and longevity of the plastic portion of the joint. Some components are routinely cemented in place to fix them. Others use special surfaces and chemicals to help them bind to the surrounding bone. These special surfaces are still evolving and only time will determine if they will continue to be used.

If you are the patient, *you* will decide when to have the operation. The decision should be based on quality of life issues and not on changes, or lack of them, on x-ray studies.

When pain or limited motion significantly affects the lifestyle of the individual, and the situation is no longer acceptable, it is time to consider moving forward with joint replacement. There must be "a joint" (pun) decision by all of the patient's doctors that the non-operative therapies have failed and that the patient's medical condition does not pose an unacceptable risk for the procedure.

How much effort does the patient have to put in to ensure the success of the procedure? A great deal! The more effort the patient is willing to put forth after the procedure, the more likely the procedure will be successful. Appropriate supervised physical therapy and home care programs make the operation work. The patient who expects the physician and the therapist to do all the work for them will not achieve the maximum potential from the operation. Use of a walker or crutches after the operation will be determined by the joint replaced, the types of components used and the surgeon's assessment of the patient's abilities. The amount of weight borne on the operated leg will also vary depending on the joint and the components. In non-cemented hip replacements, partial weight bearing may be necessary for up to three months.

Revision of a total joint will depend on many factors. The age of the patient and the weight and level of activity of the individual will influence how well the components will "wear." The ability of a person's bone to accept and bind to the components will also have an effect on the longevity of the joint. Some problems recently have come to our attention regarding debris, or wear from the plastic or metal components, that can cause earlier failure of the hip joint. As this technology continues to evolve, we shall find unexpected successes and failures. In general, revision surgery is not quite as effective as the original procedure, but can still be quite helpful in relieving symptoms related to replacement joints that have worn poorly over time.

Total joint replacement is a well developed and well designed procedure that is economically reasonable, and extremely satisfying, for the vast majority of individuals who make a well informed decision to undergo this surgery.

POINTS ON JOINTS

AUTOIMMUNE DISEASE AND PREGNANCY

by Emma DiIorio, M.D.

As physicians, rheumatologists have always been interested in the effect of autoimmune diseases on pregnancy. Since I am currently pregnant, my interest in the topic has increased and prompted me to author this article. Because autoimmune diseases show a peak in the childbearing years, and generally occur more frequently in women, they are seen with some regularity in association with pregnancy. In 1890,

Sir Archibald Garrod wrote, "It is curious to observe the occurrence of pregnancy during the course of the disease (arthritis) appears to exert opposite influences in different cases, in some accelerating the process of the malady, and in others acting as a temporary check on its development."

Rheumatoid arthritis (RA) affects one of every 1000-2000 pregnancies. Women with RA often have remissions or improvement of their arthritis during pregnancy. The majority will be able to stop their medication. The reason for remission is unclear. Cortisol, a naturally occurring steroid, increases steadily during pregnancy and, by the third trimester, is doubled that of a nonpregnant female. Hormonal changes likely play a role. Recently, there is evidence to suggest that remision during pregnancy may be related to a maternal immune response to the fetal genes inherited from the father.

Unfortunately, the remission is not long lasting and it is quite common to suffer exacerbations in the first three months after delivery. Patients who experience remission during one pregnancy may generally expect to have further remissions during subsequent pregnancies. Also, the initial onset of RA occurs more frequently than expected in the first twelve months following delivery.

Fertility and fetal outcome are not affected by RA. There is an increased risk of RA among nulliparous women (women who have never given birth). The reason for this is unclear. It also appears that a large number of pregnancies and younger age at first pregnancy may offer a protective effect against the development of RA.

Systemic lupus erythematosus (SLE) female to male ratio during childbearing years is 15:1 and there is a 9:1 overall incidence. SLE has multiple effects on pregnancy and vice versa. Whether pregnancy places the patient with SLE at an increased risk of exacerbation remains controversial. However, numerous studies have shown that disease activity at the time of conception and throughout the pregnancy is detrimental.

Therefore, it is strongly recommended that SLE patients try to conceive during times of disease remission. Active lupus kidney disease is associated with a greater frequency of maternal deaths and postpartum exacerbations.

Patients with SLE are also at an increased risk of miscarriages, fetal demise, and premature labor. This is especially true in the setting of certain maternal antibodies, as will be discussed below, and in women with active disease.

Neonatal lupus erythematosus is an uncommon type of lupus seen in infants born to mothers with SLE. It is associated with the presence of particular antibodies in the mother. These antibodies are called anti-Ro and anti-La. Infants with this syndrome will manifest skin changes and cardiac manifestations, namely heartblock. These infants will require permanent pacemakers. Luckily, most women with these antibodies will have healthy babies, and only a small percentage will have babies born with neonatal lupus. Also, thanks to modern technology, infants with heartblock can be detected in utero by fetal echocardiogram and treatment to prevent permanent heartblock given before they are born.

SLE patients and patients without SLE may also make another unique set of antibodies called anti-phospholipid antibodies. Patients with these antibodies are prone to blood clots. In addition, patients with these antibodies may be prone to recurrent miscarriages secondary to the formation of blood clots in the placenta, which is the fetus' lifeline. Not all females who carry these antibodies will experience recurrent fetal loss. However, for those who do, treatment options do exist and healthy infants have been born to these mothers.

The pregnant SLE patient is monitored closely throughout pregnancy both clinically and by laboratory studies.

Miscellaneous - Other autoimmune diseases like systemic scleroderma, dermatomyositis, and mixed connective tissue diseases are rare in the reproductive years and so their effects on pregnancy are not well studied. There does appear to be an increased risk for both mother and fetus. Also, there is a documented increased risk of renal crisis in patients with early diffuse scleroderma and these patients are discouraged from becoming pregnant.

Carpal tunnel syndrome, although not an autoimmune disease, is seen more frequently with pregnancy. Carpal tunnel syndrome is caused by compression of the median nerve at the wrist, resulting in tingling and numbness in the first four fingers in the palm side of the hand. Symptoms commonly occur at night. Its increased frequency with pregnancy is secondary to the hand swelling seen in the last trimester.

Wrist splints and local injections are very successful in relieving the symptoms, as is delivery of the infant.

Treatment - How do we treat the pregnant female with active autoimmune disease?

Steroid medications appear to be very safe during pregnancy, without consequence to the fetus. Patients with active disease may require steroids during the pregnancy to control symptoms and protect maternal organs. In addition, steroids are found only in low concentrations in breast milk, and hence, can be used by breast feeding mothers. Azathioprine (Imuran) and anti-malarials like Plaquenil usually will be discontinued during pregnancy unless absolutely necessary. Salicylates, non-steroidal anti-inflammatory drugs, Gold, Methotrexate, and D-Penicillamine are absolutely contraindicated in pregnancy. They are associated with fetal defects and fetal mortality. Male patients on Methotrexate are advised to discontinue the drug three months prior to attempting conception and females are advised to wait one ovulatory cycle prior to attempting conception. Breast feeding is contraindicated with all of these medications. Very few medications are permissable during pregnancy, so before taking any medications, either prescription or over-the-counter, please ask your physician.

In summary, every pregnancy and every patient's disease is unique. It is highly advised that, prior to planning a conception, you discuss it with your doctor. This will enable you and your physician to take the appropriate steps to allow for the most successful pregnancy outcome.

Since writing this article for Rheumors, Dr. DiIorio has become the proud mother of a healthy and beautiful baby boy!

QUESTIONS & ANSWERS
by Herbert S.B. Baraf, M.D.

Q: I heard recently that Tylenol can cause serious damage to the liver and kidneys. Should I be concerned?

A: Tylenol is the most commonly sold brand name of acetaminophen and has been available for the treatment of pain for over 30 years. Although commonly regarded as a very safe medication, it , like all medications, can be associated with adverse effects in some people. A recent study published in the New England Journal of Medicine indicated that patients taking Tylenol on a regular basis were twice as likely to develop kidney failure as those who did not take the medication. It has long been suspected that chronic use of simple analgesics might be associated with kidney damage. The present study is considered by many experts to be flawed in several ways. Also, the reported risk in absolute numbers is small, making the risk to an individual minimal when taking the medication properly.

A second concern about Tylenol is related to abnormal liver functions. It is known that overdosing on Tylenol (more than 4,000 mg daily), can be associated with liver function disturbance. The risks are further enhanced by prolonged periods of fasting as well as by excessive use of alcohol. No patients who followed the dosing recommendations on the label (maximum of 4000 mg/day-ie 2 tablets 4 times/day) developed liver abnormalities.

In a practice such as ours, where the majority of our patients are on pain medications, many of whom are on Tylenol, the type of kidney or liver failure described in the recent reports has not been seen. Over the years, the practice has seen in excess of 20,000 individuals with arthritis. Overall, the use of Tylenol for control of pain or fever, particularly in aspirin or anti-inflammatory sensitive persons, is probably significantly safer than the alternatives.

Tylenol (acetaminophen) remains a safe and effective drug, however, it is important to remember that all drug therapy is associated with some risk. The lesson to be learned from these studies is twofold. First, dosing recommendations must be adhered to even on presumably safe over-the-counter medications, and secondly a frank discussion with your doctor should be held before starting **ANY** chronic medication.

THE FUN RHEUM
by Robert L. Rosenberg, M.D.

THE MATCH GAME

1. Gout
2. Osteoarthritis
3. Fish Oil
4. Fibromyalgia Syndrome
5. Ibuprofen
6. Osteoporosis
7. Juvenile Rheumatoid Arthritis
8. Acetaminophen
9. Propoxyphene
10. Lupus
11. Calcium and Vitamin D
12. Psoriatic Arthritis

A. Generic name for Darvocet

B. Associated with sleep disorder, soft tissue pain

C. Usually associated with a skin condition

D. Affects women 10 times more frequently than men, may have associated kidney problems

E. Generic name for Tylenol

F. Generic name for Advil, Motrin & Nuprin

G. Necessary for good bone formation

H. Most common form of arthritis

I. Often associated with acute attacks of severe arthritis involving the great toe

J. Affects over 300,000 children

K. Currently being investigated as a treatment for inflammatory arthritis

L. Fragile bone that are more prone to fracture

Answers: 1-I, 2-H, 3-K, 4-B, 5-F, 6-L, 7-J, 8-E, 9-A, 10-D, 11-G, 12-C.

STUDY UPDATE
by Evan L. Siegel, M.D.

The drug study section of Arthritis and Rheumatism Associates has been very active

recent months. This section of the practice allows access by our patients to new and exciting drugs that are under investigation for the treatment of rheumatic diseases. Participants in these studies not only get the rare opportunity to use medications not yet available to the general population, but also undergo intensive evaluation/ re-evaluation of their ailment, careful documentation of their progress, and the opportunity to learn about the intricacies of how a new drug makes its way to the marketplace. Participation in these investigations is cost free. Our physicians and study coordinators are constantly reviewing new protocols to determine which ones would be best to offer our particular patient population. The following is a partial listing of the study protocols currently available to patients meeting entry criteria.

Osteoarthritis (degenerative arthritis) of the knee: Patients with osteoarthritis of one or both knees may qualify to participate in a study of a new topical cream applied directly to the painful joint. Earlier formulations of this product have already been proven effective in controlling pain and improving mobility, with a minimum of side effects.

Osteoporosis: We are currently enrolling post-menopausal women with osteoporosis with or without previous fractures in a protocol to evaluate Raloxifene, a new drug with estrogen and anti-estrogen like properties. We expect this drug to be effective in stabilizing or improving bone mass and decreasing fracture risk. We continue to evaluate, but have completed enrollment of patients in the Tiludrinate and Risedronate osteoporosis protocols.

Tennis Elbow: Patients with as yet untreated tennis elbow (lateral epicondylitis) of less than 28 days duration may qualify for enrollment into a study to evaluate the efficiency of a skin patch impregnated with anti-inflammatory medication placed directly over the elbow. This patch has already met with great success in Japan, and is being introduced in this country.

Rheumatoid Arthritis: Patients with established Rheumatoid Arthritis may qualify for entry into one of two protocols involving new disease modifying agents for which we expect to begin enrollment in Spring of 1995.

A quarterly publication brought to you by
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