ARTHRITIS AND RHEUMATISM ASSOCIATES

RHEUMORS

A NEWSLETTER FOR PATIENTS

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DIET, NUTRITION AND ARTHRITIS: FREQUENTLY ASKED QUESTIONS

By Alan K. Matsumoto, M.D., F.A.C.R.

If you believe in the time honored adage you learned in grade school, "you are what you eat", then it stands to reason that diet and nutrition should play an important role in the treatment of patients with arthritis. Despite the appeal of a dietary approach to therapy, there is little scientific evidence that dietary manipulation can affect the course of arthritis. Since diet is governed by a lifetime of choices and cultural considerations, it is very difficult to conduct a controlled clinical trial with dietary manipulation. Use of diaries to document dietary intake is also cumbersome and difficult even for the most motivated patient. Although there is very little scientific information from which to make definite recommendations, patients frequently have questions on diet. Here is a sampling.

Can diet cause gout?

Gout is the only type of arthritis where diet clearly plays a role. Gout is caused by uric acid crystals that deposit in the joint causing inflammation. Although 80% of the uric acid is made by the normal digestion of proteins, the other 20% comes from foods high in purines. Purines are metabolized into uric acid. Foods high in purines include: organ meats (liver, kidneys), herring, trout, sardines, wild fowl (geese, turkey, pheasant), scallops and mussels. Red meat is an oft-mentioned culprit but is only moderately high in purines. Elimination of these foods may help but since few patients eat a significant quantity of purine–rich foods, the benefit of diet is usually minor.

Are there foods that trigger arthritis?

There are no foods that reproducibly trigger arthritis attacks. However, there are <u>rare</u> patients who may have an "allergic arthritis". There have been convincing case reports of dairy products, nitrates, shrimp and tomatoes triggering arthritis attacks in patients. Despite these case reports, avoidance of these foods is not recommended for all patients.

My grandmother says cod liver oil is the cure?

N-3 fatty acids (eicosapentaenoic acid, docosahexaenoic acid) found in fish and other seafood has been shown to reduce joint inflammation in both animal models and in human studies of rheumatoid arthritis. Interestingly, wild animals have a much higher level of n-3 fatty acids than domesticated livestock and medical historians have postulated that the dietary changes associated with the switch from a hunter-gatherer culture to farming has given rise to chronic medical illnesses such as arthritis. N-3 fatty acids inter-

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D I D Y O U K N O W . . . . . .

All nine of our physicians were included in the November, 2002, **<u>Washingtonian Magazine</u>** ***"Best Doctors"*** list.

John L. Lawson, M.D. is the new President of the Medical Society of the District of Columbia.

David G. Borenstein, M.D. is the Chairman of the Government Affairs Committee of the American College of Rheumatology. He is also the author of several books. His most recent, *Back in Control! A Conventional and Complimentary Prescription for Eliminating Back Pain* is currently available in book stores. Dr. Borenstein is also quoted in an article "*Get Back at Back Pain*", by Mary Anne Dunkin in the current issue of *Arthritis* Today.

Herbert S.B. Baraf, M.D. was a featured speaker at the annual meeting of the American College of Rheumatology in New Orleans, LA. His talk was titled *"The Challenge of Managing a Rheumatology Practice: A New Mission for the Rheumatologist in the 21st Century."*

ASSISTIVE AIDS AND ACCOMMODATIONS FOR ARTHRITIS - MAKING DAILY ACTIVITIES EASIER

by, Nava Shlesinger, P.T.

Editor's note: Although there are over 100 types of arthritis, the common thread amongst them all is joint pain and stiffness with a subsequent inability to perform activities of daily living with ease. It is a major goal of Physical and Occupational Therapists to restore function. This is done in part through exercise and manipulation of affected areas and the use of modalities to ease pain. Just as important, however, is the instruction in principles and techniques that both help protect joints from further destruction and allow for the completion of routine tasks without pain and frustration. What follows is a set of general recommendations for people with many forms of arthritis from the Director of Arthritis and Rehabilitation Therapy Services, our physical therapy division. (ELS)

General Joint Protection Principles:

Keep your joints moving and warm. Use heating pads, hot shower or paraffin bath prior to exercise. Avoid prolonged periods of maintaining the same joint position. Move every 30 minutes. Use the strongest or largest joint possible to accomplish a task. Support your joint when appropriate (according to the physical and medical condition of the joint) with pillows, splints, and braces. Splints, orthotics, and braces will support and stabilize a joint in a functional position and will decrease the pain. Stop activities that cause pain, and remember to alternate periods of activity with periods of rest. Break up long activities and walks. Sit instead of standing. Use proper body mechanics and correct posture. Use comfortable sleeping positions, either on your back with pillows under the head and knees or on your side with pillows under the head and between the knees. Avoid lifting heavy objects, slide or push, instead of pulling. Hold or carry objects close to your body. Do not bend over from the waist. Bend your knees and hips instead. Always face your work and turn by first pivoting. Do not twist your back. Avoid reaching, and sudden or jerky movements. Use each joint in its most stable functional alignment position.

Adaptive Aids:

Use adaptive aides to reduce pain, fatigue and to improve function in your back, neck, upper and lower extremities. Some specific suggestions follow.

Kitchen

Always avoid using a tight grasp and use the following assistive devices in case of pain, muscle weakness or joint stiffness or limitations. Use suction cups for pots, plates, and mugs to stabilize dishes and to prevent sliding. Ergonomic tableware will cut down on spills and will ease grasping of handles. The high rim will prevent the food from sliding off the plate, and the light weight makes dishes easy to balance and hold. Customized eating utensils decrease pain and discomfort and will improve associated fine motor functions. Use an easy peeler for fruits and vegetables. Light weight scissors and an electric can opener should be used for cases of limited strength or joint mobility. Use a faucet handle turner to help with finger and wrist limitations. Arrange the necessary dishes and equipment at waist level to prevent frequent bending, reaching and lifting. Use a high reach step stool and safety step stools to avoid accidents.

Bathroom

Safety is the main concern around the bathroom area. Use long handle reachers for bathing and personal hygiene. Use a transfer board in the bathtub and a chair in the bathtub and shower. Non-sliding adhesive mats outside and inside the tub and shower prevent slipping. Have grab bars in the tub, shower and next to the toilet. Use an elevated toilet seat when you have hip problems or difficulties in sitting down or getting up.

Ambulation Devices

Use canes, walkers, or crutches to reduce weight bearing on joints after fractures, surgeries, and in situations of weakness, paralysis or painful joints. Use ambulation devices according to your doctor's orders or therapist's advice. Types of canes include a simple standard cane, light weight folded cane, ergonomic cane, folded seat cane, quad cane, crutches, standard and wheeled walkers, and folded wheeled walkers with a seat. Light weight telescopic ramps can be used when ambulating with a cane or wheel chair. There are many different wheel chairs and accessories to ease transportation and reduce stress and pain on the upper extremities. If there are difficulties to transferring in and out of the bed, use a bed pull up and bed transfer handle. A lifter

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THE HRT CONTROVERSY
A REVIEW OF THE WOMEN'S HEALTH INITIATIVE REPORT

By Norman S. Koval, M.D., F.A.C.P., F.A.C.R., C.C.D. and Alan K. Matsumoto, M.D., F.A.C.R.

Introduction

On July 9, 2002, the National Institutes of Health announced that it had cancelled a part of the Women's Health Initiative (WHI), the largest women's health research study on post-menopausal hormone therapies ever undertaken. Unfortunately, the results were presented in a sensationalistic fashion by the news media and have created a great deal of confusion and fear among postmenopausal women, both on and off hormone replacement therapy. I would like to highlight some of the important issues regarding this new information.

Background

The WHI is a large and complex clinical investigation of a variety of prevention strategies for cancer, cardiovascular disease, and osteoporotic fractures. The study involves almost 165,000 postmenopausal women between the ages of 50-79. It was initiated in 1992 with a planned completion date of 2007. The clinical trial section of the study enrolled 64,500 women into three groups comparing different treatments:

Group 1: Low fat diet versus self-selected dietary behavior (48,000 patients).

Group 2: Hormone replacement therapy versus placebo. (27,000 patients). Patients received either estrogen/progesterone (HRT) if they had intact uterus or estrogen alone (ERT) if they had a hysterectomy. HRT consisted of conjugated equine estrogen 0.625 mg and medroxyprogesterone 2.5 mg daily (Prempro®. Wyeth-Ayerst)

Group 3: Calcium plus Vitamin D (CaD) versus placebo (45,000 patients).

Women are being followed for the incidence of cardiovascular disease, stroke, venous thrombosis (blood clots), fractures, breast cancer, endometrial cancer and colorectal cancer. The recent controversy involves women in group 2. Women receiving estrogen/progesterone (HRT) were stopped early because of an increase in breast cancer and cardiovascular disease. Only this section of the study was stopped. Women taking estrogen without the progesterone (ERT) and women in groups 1 and 3 continue in the study.

HRT was associated with a 29% increase in coronary heart disease events, 41% increase in stroke, 111% increase in venous thrombotic episodes, 22% increase in total cardiovascular disease and a 26% increase in invasive cancer. On the positive side, HRT was associated with a 37% decrease in colorectal cancer, and a 34% decrease in hip and vertebral fractures. However, the weight of the negative findings prompted the WHI investigators to terminate the HRT section of the study and to publish their findings before completion of the study.

The negative findings associated with the HRT group came as a surprise to the WHI investigators and to practicing physicians. Short term hormone replacement therapy to combat hot flashes, night sweats, and vaginal dryness has been used by women for more than 60 years. Previous smaller studies and retrospective studies suggested benefits of hormonal therapy for the prevention of cardiovascular disease, osteoporosis, fractures, colorectal cancer and other infirmities associated with aging. The size of the WHI study together with its prospective, placebo controlled study design, make the WHI findings powerful and credible. However, I would like to discuss these findings more closely to help patients to make a more informed decision about the risks and benefits of hormonal therapy.

Specific Issues:

1. Breast Cancer – The single greatest concern of women considering either estrogen replacement therapy (ERT) or estrogen/progesterone replacement therapy (HRT) is the association of this treatment with a small increased risk of breast cancer. The WHI confirmed the findings of prior studies. A 26% increase in invasive breast cancer was noted. The breast cancer risk in the WHI became statistically significant compared to placebo treatment during the fourth year of hormone therapy suggesting that there is no safe period of time for the use of HRT since cancer may take four to five years to be detected. Patients with a strong family history of breast cancer should be cautioned against using HRT.

2. Cardiovascular disease, heart attacks, strokes and blood

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clots – The main reason for the undertaking of the WHI was to determine whether long-term hormone replacement therapy could reduce the risk of cardiovascular disease in women with no demonstrated pre-existing cardiovascular disease. The initial rationale for this undertaking was suggested by the incontrovertible evidence that women have a significantly lower risk of heart disease than men at all ages up to and including menopause. After menopause, women rapidly catch up to the risk levels of men especially by their early to mid 60s. The WHI showed a statistically significant increase of 22% increase in total cardiovascular disease. There was no duration of HRT that was completely safe from these increases with the increase in cardiovascular risk apparent within the first year. While the association of HRT with cardiovascular disease is new information, the association between estrogen replacement therapy or hormone therapy and blood clots has been known for more than 30 years.

3. Osteoporosis and Fractures – It is well known and clearly documented that long-term estrogen or hormone replacement therapy prevents bone loss after menopause. Such bone loss can be documented by high quality bone mineral density testing (BMD), sometimes called DXA scan. What had not been well documented prior to the outcome of the WHI was whether or not long-term estrogen or hormone replacement therapy could prevent osteoporotic fractures, in particular hip fractures, a relatively uncommon type of fracture in the younger menopausal woman. The WHI showed that long-term use of hormone replacement therapy reduces the risk of fracture by 34%.

4. Colorectal Cancer – Several studies have demonstrated that both estrogen replacement therapy and hormone replacement therapy can reduce the risk of colorectal cancer and the risk of death from that cancer. The WHI confirmed a significant reduction in the number of colorectal cancers in women using hormone replacement therapy.

Weighing the Risk

Relative to placebo group, HRT showed a significant increase in risk of cardiovascular disease, stroke, pulmonary embolus and invasive breast cancer. However, it must be noted that the absolute risk to an individual woman is small. For every 10,000 women treated with HRT for 1 year, there are 7 more coronary events, 8 more strokes, 8 more pulmonary emboli and 8 more occurrences of breast cancer. On the positive side, there are 6 fewer occurrences of colorectal cancer and 5 fewer hip fractures. Using these numbers, for every 100 women treated with HRT for 5 years, 1 additional women will suffer an adverse event.

While the news media made it sound as if the NIH had called off the entire study, this is not true. In fact, the majority of participants in the WHI are continuing. Still ongoing in the investigation whether estrogen replacement therapy alone (without any progesterone medications) has an impact on all of the above issues. The fact the NIH did not halt the other important segments of this study suggests that the findings thus far may be different from the ones noted above. Women who have been taking estrogen alone should be reassured by this, although we will not know the final results of the estrogen part of the WHI until such time as the NIH releases them or until the anticipated end of the WHI study in 2005.

Another area that is being addressed by the WHI is whether or not women using other types, dosages, or routes of administration, i.e., patches of either estrogen and/or progesterone-like drugs have the same risk and benefits as the pharmaceutical agents used in the WHI. Another important missing piece of information not contained in the WHI report is whether the results apply to early menopausal women on HRT or ERT immediately after menopause. This issue is extremely important since most women start their hormone therapy when they begin to experience symptoms like hot flashes and night sweats at the onset of menopause. An area of importance to be investigated is quality life data – energy level, sexual interest, skin tone, hair quality, etc. As this information is gathered, one will surely see more front page news. Patients interested in further information on this topic can go to the Journal of the American Medical Association web site at www.jama.com. Click on "past issues" and then go to "July 17, 2002".

As with any therapy, patients must weigh the risks and benefits of HRT. The small increased risk of breast cancer and heart disease must be weighed against the benefit of quality of life, as well

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CLINICAL TRIALS

by Herbert S.B. Baraf, M.D., F.A.C.P., F.A.C.R.

Arthritis & Rheumatism Associates' participation in clinical trials is entering its twenty second year. As our reputation has grown around the country among researchers in the pharmaceutical industry, we have been granted wonderful opportunities to be involved with a large number of developing therapies. Perhaps most rewarding of all, we, together wit our patients, have contributed significantly to the development of a number of revolutionary new and effective treatments that have improved the lives of many people, in the United States and abroad.

We are now entering an exceptionally busy time for our clinical trials program. We are currently enrolling more than 20 trial programs collaborating with such reputable companies as Merck, Pfizer, Novartis, Johnson & Johnson, Wyeth and Roche. Each year we have the opportunity to work in new areas with new companies. Listed below are some of the types of projects that are currently seeking volunteers.

GOUT:

Although as rheumatologists we are the experts on gout management, there has been a significant lack of research about new treatments for this disease. We are excited to participate in a trial of the first new medicine to be evaluated for long term management of gout in nearly three decades. We have two projects related to gout which are actively seeking patients. Patients will be paid a stipend to participate.

- The first is evaluating a new medication to lower the blood uric acid level. It is a high uric acid level in the blood that causes gout. The new medication is being compared to allopurinol (Zyloprim) in a one year program. Patients already on uric acid lowering drugs, or those that need them are prime candidates for this study.

- The second is for patients with an acute attack of gout. If you have gout that suddenly flares, you may want to call us immediately to see if you qualify.

OSTEOARTHRITIS (DJD):

- Arthritis of the knee in individuals whose ancestors come from Asia or India are invited to participate in a 12 week trial comparing Celebrex to Naproxen or placebo. Patients are paid a stipend to participate.

- Osteoporosis of the neck, low back, hand, knee or hip is the subject of three large year-long clinical trials comparing a new COX-2 anti-inflammatory to standard anti-inflammatory agents. The advantage of these trials is that there is no placebo. Treatment lasts for one year and qualifying patients are provided with their arthritis medication and in some instances with stomach-protecting medications with no cost to them. This may represent a significant savings for patients. Patients are also paid a stipend to participate.

OSTEOPOROSIS:

- Women over 50 years of age and post-menopausal, currently on no treatment for osteoporosis who have either had a vertebral fracture or severe bone loss may enroll for a two year project evaluating a new treatment. You can be screened for osteoporosis at no cost to see if you qualify.

- Men or women with a recent (within past 6 weeks) hip fracture may qualify for a once a year infusion treatment for osteoporosis.

RHEUMATOID ARTHRITIS:

- Patients on Enbrel who still have stiffness and joint swelling are being sought for a trial evaluating a new biologic treatment taken in addition to Enbrel for this disease. This new medication is being developed by the same manufacturer as Enbrel. The trial will last 6 weeks and there may be an extension with 'open-label' treatment.

- Patients on Methotrexate or Arava with continued joint pain, swelling and stiffness may qualify for a six week double-blind project with a monoclonal antibody for Rheumatoid Arthritis. Patients who complete the project will qualify for an open-label extension program.

- Diabetics on medication or individuals with recurring respiratory or urinary infections may qualify for participation in a placebo-controlled trial with Enbrel for their arthritis.

- Patients on a stable regimen for their arthritis may participate in a one year trial comparing two

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different anti-inflammatory medicines, a new COX-2 drug that is currently approved for use in Great Britain and Voltaren, a standard and widely used NSAID. The advantage of these trials is that there is no placebo. Treatment lasts for one year and qualifying patients are provided with their arthritis medication and in some instances with stomach-protecting medications with no cost to them. This may represent a significant savings to patients. Patients are also paid a stipend to participate.

• A three month evaluation of an NSAID in three different doses versus placebo.

PSORIATIC ARTHRITIS:

• A placebo-controlled double-blind trial evaluating the benefits of Remicade (infliximab) infusions in patients with active disease. Remicade is already widely used to treat rheumatoid arthritis.

• A comparison of Celebrex to Naproxen to placebo in the treatment of psoriatic arthritis. This is a three month trial.

ANKYLOSING SPONDYLITIS:

• A placebo-controlled, double-blind comparison of Celebrex to Naproxen to placebo to control pain and inflammation. This is a three month trial.

CHRONIC PAIN:

• Patients currently using a Duragesic patch for chronic arthritis pain may qualify for an open-label trial of a new version of this patch.

• No changes in the dose of the patch will be made. The trial will last one month.

As you can see, it has been a busy time for our clinical trials program. If you are interested in being part of any of our projects, please feel free to discuss it with your Doctor, or with our head of patient recruitment, Linda Gargiulo at 301-942-6610.

A N S W E R S To Your Questions

By Werner F. Barth, M.D., F.A.C.P., M.A.C.R.

Q: Are either Actonel or Fosamax adequate therapy for osteoporosis?

A: Both agents inhibit bone resorption and will gradually promote better bone density. Neither will be adequate by itself without supplemental calcium in the diet. Calcium absorption tends to decrease with age and is improved by Vitamin D. The recommendations are for calcium 1.0-1.5 grams per day along with Vitamin D 400-800 i.u. per day.

Q: Should I use Vioxx or Celebrex given the controversy about the increased risk of cardiac problems?

A: Vioxx, Celebrex and the other COX-2 inhibitors currently available are analgesic and anti-inflammatory drugs that offer distinct advantages over the drugs we've used in the past. They can provide these effects given as a once a day tablet and overall, have less tendency for gastric irritation, GI bleeding or ulcer formation. They differ from other NSAID's like Aspirin, Ibuprofen or Aleve in that they don't inhibit platelet aggregation. Platelets are blood elements that cause blood to clot by causing a thrombus to form. Aspirin is used as a drug to protect the blood flow to the heart because it keep the platelets from clumping and clotting within the blood vessels when given at low doses like baby aspirin (81mg).

There is some data, as yet inconclusive, that high doses of COX-2 inhibitors such as 50mg of Vioxx daily may be associated with increased cardiac thrombotic events particularly in patients at higher risk such as those with diabetes, hypertension, high cholesterol, or prior heart attack. It is my practice to give patients at increased risk of heart disease enteric coated baby aspirin either daily or every other day along with a COX-2 inhibitor. There may be a higher incidence of gastric problems with concomitant use of baby aspirin but not as high as if we were using the old regimens (i.e.: Naprosyn or Ibuprofen alone).

This is one of those areas in medicine where there is room for difference of opinion. It is hoped that studies currently in progress will clarify this situation further.

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fere with the production of prostaglandins (inflammatory molecules) in a way that is similar to the effect of NSAIDs (aspirin, ibuprofen, etc.). However you may need to take a lot of fish oil (as much as 3-4 grams of EPA daily) to see even a modest effect. Many people have a difficult time tolerating the high dose.

How about the antioxidant group vitamins A, C and E?
There has been considerable interest in these vitamins as prevention for cardiovascular disease or dementia. Immune system cells, particularly lymphocytes, are sensitive to oxidative damage and thus these vitamins may be protective of the immune system. Vitamin C is essential for collagen synthesis. Some studies have shown a decrease of vitamin C in rheumatoid arthritis patients and a decrease in A, C and E in patients with osteoarthritis. However, there is no study showing a beneficial effect of supplementation with these vitamins.

What about osteoporosis?
Adequate intake of calcium and vitamin D is essential to prevent osteoporosis. Arthritis patients have increased osteoporosis from lack of exercise or in the case of rheumatoid arthritis, from inflammation itself. Prednisone, used to treat certain types of arthritis increases osteoporosis. Current recommendations for calcium and vitamin D are: premenopausal women-1000 mg calcium/800 IU vitamin D daily; postmenopausal women 1500 mg calcium/800 IU vitamin D (can be reduced to 1000 mg calcium if taking other therapy for osteoporosis).

I heard trace elements zinc and selenium are good?
Zinc and selenium are critical to several key enzymes necessary for normal immune function. Both zinc and selenium exhibit anti-inflammatory properties in animal models of inflammation. Zinc is important in collagen synthesis. Rheumatoid arthritis patients have been shown to be deficient in zinc. Unfortunately trials of zinc and selenium supplementation have shown mixed results.

Are plant seed oils effective?
N-6 fatty acids found in soybean, safflower, sunflower oil and sold as evening primrose oil supplement have been of considerable interest to investigators. N-6 fatty acids are the most common fatty acids in the Western diet. Some studies in rheumatoid arthritis with gammalinolenic acid (GLA) in the form of evening primrose oil have shown minor benefits, however others have failed to show improvements.

Animal studies and limited human investigations have shown that dietary and nutritional approaches to arthritis therapy is a very promising area of research. Most rheumatologists would agree and recommend that low calorie diets be used to promote weight reduction which can have a significant effect on the pain and progression of osteoarthritis. Much work needs to be done however, before more specific dietary therapies can be recommended.

Despite the lack of definitive dietary treatments, we have known about the effects of arthritis on nutrition. Arthritis, through lack of exercise, can cause weight gain and thus exacerbate underlying conditions such as cardiovascular disease, hypercholesterolemia, hypertension and diabetes. In the case of inflammatory arthritis such as rheumatoid arthritis, inflammation causes metabolic derangements resulting in increased body fat and diminished lean body mass resulting in protein malnutrition. Therefore, attention to a proper, well-balanced diet is an important part of the treatment plan for anyone with arthritis.

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seat will ease getting up and sitting down from regular chairs or recliners. An electric elevator seat for those who cannot go up or down stairs is available. The hydraulic lifter can be operated when maximum assistance in transfer from chair to bed is required.

Dressing

Dressing assistive devices are used with muscle weakness of the hand and wrist and joint stiffness and joint deformities. If buttoning a shirt is difficult, use the one-hand button hook and when appropriate use the ring zipper pull. When difficult to reach, use a stocking device to put on stockings or socks and use the long shoe horn for shoes. Elastic shoelaces can also be used. There are different long handled combs and brushes to overcome elbow and shoulder limitations.

House Assistive Devices

House assistive devices are designed to ease daily activities and function, to increase safety and reduce pain and increase the independence level of the individual. There are many different designs of pillows and mattresses. Use the ones that are most comfortable for you after trying them first. Use the extender to the doorknob with the upward and downward push. Long handled dusters and reachers will help grab objects. A keyholder will ease locking and unlocking a door or car ignition. A light weight sweeper and ergonomic hammer and other tools should be used. Many types of tools with corrective accommodations for arthritic hands are available or can be fashioned. Some assistive devices for use in leisure activities are book and cardholders, amongst many others. Customized large grip pens and pencils can facilitate writing.

Computer

The repetitive movements when using the computer can cause pain, weakness, and reduce functional abilities. One should seek ergonomic computer accessories such as arm support for wrist positioning, a rollout keyboard tray, an ergonomic keyboard to reduce shoulder, arm and wrist tension, and wrist support gloves.

For further information and answers to your questions, please talk with your doctor, or call Nava Shlesinger, P.T. at (301) 942-2520.

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as the decrease in osteoporosis. Patients risk factors such as family history, other medical problems (eg. Diabetes, hypertension), smoking history need to be incorporated into the decision making process. Further information will continue to be forthcoming. The U.S. Prevented Services Task Force Is now working hard to formulate guidance in reference to hormone replacement therapy. There will also be a position statement from the North American Menopausal Society.

We strongly urge patients on ERT or HRT to speak with their primary care physicians and/or gynecologists to review why they are taking HRT, discuss alternatives and assess their individual risk of continuing HRT in light of these important findings.

The Center for Rheumatology and Bone Research, A division of Arthritis & Rheumatism Associates, P.C., has a number of ongoing and enrolling studies related to SERMs (selective estrogen receptor modulators) that have positive effect on bone, but no adverse effects on breast or uterus. There are other anti-osteoporosis medications also being looked at by our research facility. For further information contact our research division at 301-942-6610.

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