ARTHRITIS
AND
RHEUMATISM
ASSOCIATES

RHEUMORS

A NEWSLETTER FOR PATIENTS

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TWO PHYSICIANS JOIN ARA

By Margaret Dieckhoner

Joseph D. Croft, Jr., MD is a cum laude graduate of Princeton University, Princeton, NJ. He received his medical degree from Cornell University, New York, NY. He completed his internship and residency at Strong Memorial Hospital in Rochester, NY where he was Chief Resident in Medicine and a fellow in Rheumatology. He then spent two years as a Clinical Associate at the Dermatology Branch of the National Cancer Institute. Dr. Croft is currently a Clinical Professor of Medicine at Georgetown University School of Medicine and prior to joining Arthritis and Rheumatism Associates, P.C. had been practicing Rheumatology in Chevy Chase, MD since 1969.

Dr. Croft's professional career has included service to many organizations and has resulted in his being the recipient of numerous awards. He has been the President of the American College of Rheumatology and was honored by the College in 1990 when he was presented with the Paulding Phelps award for outstanding service. He is a Past President of the Rheumatism Society of the District of Columbia and has served on

see **JOSEPH CROFT** *continued on page 2*

Robert J. Lloyd, MD is a graduate of Providence College, Providence, RI and Georgetown University School of Medicine, Washington, DC where he was elected to Alpha Omega Alpha honor society. He completed his internship and residency in Internal Medicine and his fellowship training in Rheumatology at Georgetown University Medical Center. He is currently a Clinical Associate Professor of Medicine at Georgetown and has been

see **ROBERT LLOYD** *continued on page 2*

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

THE UNKNOWN RHEUMATOLOGIST

By Evan L. Siegel, M.D.

Rheumatology is a specialty which focuses on autoimmune disorders, those in which the immune system mistakenly turns on it's own host. In these disorders the immune system loses the ability to differentiate foreign from self, creating a civil war in which organs as well as joints are the ultimate victims. When we think about a Rheumatologist, autoimmune problems such as Rheumatoid Arthritis and Systemic Lupus come to mind. This is because Rheumatologists have special knowledge and tools to make a tremendous difference in the outcome of these troubling and disabling disorders.

But Rheumatologists are specialists who care for many diseases. These include, of course, Osteoarthritis (OA) which is the most common form of arthritis. It is caused primarily by wear and tear of the cartilage in the joints over time, and here, too, much can be added by the Rheumatologist to decrease the pain and disability experienced by such patients. It is frustrating to hear patients or physicians trivialize OA as "just a little arthritis-there is nothing that can be done" when often there are numerous interventions that can at least ameliorate the daily discomfort.

What is unfortunately even more frequently overlooked is the expertise of the Rheumatologist in treating problems such as back pain and what is often called "soft tissue rheumatism". This includes problems such as bursitis and tendonitis as well as

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other painful musculoskeletal conditions.

Back pain is the most common medical complaint second only to the common cold. This problem generates more visits to the doctor than almost any other medical condition. More than 90% of adults will experience back pain at some point in their lives. Because of its incredibly common nature, a primary care physician should be the first stop for evaluation and treatment. If pain is not improving a specialist's help is often sought.

It is here again that the Rheumatologist can add special insight. As non-surgical specialists the Rheumatologist takes a careful history and performs a physical exam to rule out all of the more serious causes of back pain, such as arthritic or inflammatory disorders, osteoporotic fractures and malignancy. Unusual causes of back pain might be considered such as an aortic aneurysm. All available imaging modalities are available to the Rheumatologist, who is adept at their interpretation and implications. A panoply of non-surgical modalities are part of the armamentarium used by the Rheumatologist to improve pain and function in those suffering from back pain, and return them to a more normal active lifestyle. Trained initially in Internal Medicine, Rheumatologists pride themselves in considering the patient's entire medical history when making recommendations for specific therapeutic interventions, whether that be a new medicine or the appropriateness of anything from physical therapy to surgery in a person with multiple medical problems.

While the back is an area easily identified as a source of pain, other areas cause more confusion. It is not uncommon in a Rheumatology office for a patient to present for evaluation of "arthritis" when in fact they are suffering from "soft tissue rheumatism", ie. inflammation of the tissues around or near the joint. Arthritis by definition involves a joint such as the knee, hip or hand. Bursitis, Tendonitis and other inflammatory problems outside the joint can often cause pain and limitations which are every bit as troublesome. Rheumatologists specialize in differentiating these issues and instituting appropriate therapy which might include medications, injections, splinting and physical therapy.

In summary, it is appropriate to think of a Rheumatologist for nearly any musculoskeletal condition. This has not necessarily been the case in the past, and as Rheumatologists we are occasionally amused to find that a patient we have been treating for osteoarthritis of the knee or osteoporosis has been sent to an Orthopedist for treatment of rotator cuff tendonitis or new onset back pain. Rheumatologists are specialists in Musculoskeletal Medicine, and we stand ready and able to help with all such problems.❀

JOSEPH CROFT *continued from page 1*

committees for the Medical Society of the District of Columbia, the FDA, the Arthritis Foundation and the Georgetown University School of Medicine. Included among his many awards is Georgetown University's Outstanding Visit Award for Excellence in Teaching Medical House Officers in the Art and Science of Medicine and the American College of Physicians Preceptorship of the Year for Community Based Teaching.

Dr. Croft joined ARA in June of 2003 and sees patients in our Chevy Chase office, which is located in the Chevy Chase Building, 5530 Wisconsin Avenue (across from Saks Fifth Avenue) 240-497-0230.*

ROBERT LLOYD *continued from page 1*

engaged in the private practice of Rheumatology in the Washington, DC area since 1976.

Dr. Lloyd is a past recipient of the Clinical Faculty Award from the Department of Medicine at Georgetown University and the Vicennial Medal. He has served on numerous committees of the Medical Society of the District of Columbia and the American College of Rheumatology (ACR). In 2002, the ACR honored Dr. Lloyd with the Paulding Phelps award for outstanding service.

Dr. Lloyd joined Arthritis and Rheumatism Associates, PC in June 2003 and sees patients daily in our Chevy Chase office, which is located in the Chevy Chase Building, 5530 Wisconsin Avenue (across from Saks) 240-497-0230.❀

CLINICAL TRIALS UPDATE

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

Why would anyone want to be a patient in a clinical trial? That is a question many people ask themselves. In 23 years of operation, our Center for Rheumatology and Bone Research has treated more than 3000 patients in clinical trials. Study patients have expressed appreciation for the special attention they receive in the study setting, the opportunity to learn more about their rheumatic disease process, the chance to receive treatments not otherwise available, and the ability to help in the development of safer and more effective therapies.

There have been some recent reports in the news of mishaps, improper physician conduct and institutional abuses. Yet, more frequently these same media sources trumpet the benefits of new advances in therapy for a variety of different diseases. In fact, there have been astonishing therapeutic advances recently in virtually every field of medicine. How do these advances come about? Through the clinical trials process, of course! And for every successful drug studied, there are hundreds of patients who have benefited early on in the course of drug development. Indeed, many of you reading this article have profited greatly from these advances, either by participating in one of our studies or by receiving a new drug proven to be effective in trials conducted at our facility.

A prostate cancer patient, writing to the Washington Post in February, decried the press negativism and reflected on his experience with clinical trials. He wrote, "...First, I got a much more accurate diagnosis (than I did in my HMO.). ...Second, they offered me treatment in a clinical trial of a refinement of a standard technique that was known to be effective against my type of cancer. ...Third, they gave me outstanding attention and care. ...The therapies they used ...were expertly applied by highly ...trained medical professionals who were handling small numbers of patients with large numbers of staff and ample amounts of time. ...Finally, they did all of this for free. There was no payment, no co-pay, no insurance premium, or charges for records." Noting that his research physician was having difficulty recruiting enough patients for this trial, the writer lamented, "apparently the great majority of people in the Washington area would prefer to wrestle with their insurers, accept assembly line medicine, wait long weeks for doctors appointments, receive care from low paid staff and low bidder medical labs, and pay for the privilege."

At the Center for Rheumatology and Bone Research, we are very proud of the work we have done to help bring new and important therapies to our patients. With our patients' involvement, we remain at the spearhead of the successful development of dozens of important, life-altering, new arthritis therapies, including: Enbrel, Remicade, Humira, Kineret, Vioxx, Celebrex, Bextra, Evoxac, Fosamax, Actonel and Evista.

At present, we are recruiting patients for participation in a diverse group of programs.

Current Clinical Trials

GOUT:

We have two projects actively seeking patients.

- The first evaluates a new medication to lower the blood uric acid level. A high uric acid level in the blood causes gout. The new medication will be tested in patients with severe chronic gout who are unsuccessfully controlled with, or unable to tolerate, available uric acid lowering drugs. Patients will receive a stipend to participate.

- The second is for patients with an acute attack of gout. If you have gout that suddenly flares, please consider calling us immediately to see if you qualify. Patients will receive a stipend to participate.

RHEUMATOID ARTHRITIS:

Several trials for patients with RA are under way.

- We are seeking patients for an evaluation of a Chinese herbal therapy for rheumatoid arthritis. Chinese Thundergod Vine is being compared to Azulfidine for disease modifying effectiveness.

- We are beginning a trial comparing standard therapies for early rheumatoid arthritis. This is an outstanding opportu-

see **CLINICAL TRIALS** *continued on page 4*

CLINICAL TRIALS *continued from page 5*

nity for patients who have not yet been started on methotrexate. We are comparing methotrexate alone to two other combinations of disease modifying drugs, all of which are currently FDA approved. Costs of medicines are all covered.

- Patients with arthritis that is active in spite of full dose methotrexate therapy are candidates for participation in one of two trials evaluating antibodies directed against lymphocytes.

- Patients with anemia related to their rheumatoid arthritis may be candidates to participate in a trial of a hormone that stimulates red blood cell production.

OSTEOARTHRITIS (Degenerative Joint Disease):

- Osteoarthritis of the knee or hip is the subject of five clinical trials. These trials all differ from one another. Patients will receive a stipend to participate.

ANKYLOSING SPONDYLITIS:

- We are evaluating the effect of Humira - a TNF inhibitor approved for patients with rheumatoid arthritis - in the management of Ankylosing Spondylitis.

SYSTEMIC LUPUS ERYTHEMATOSUS:

- Patients with active lupus may be appropriate for a trial of an inhibitor of lymphocyte function.

OSTEOPOROSIS:

- We are currently screening patients for several new osteoporosis treatments.

If you are interested in participating in our clinical trials program, please speak with your physician or contact the Center for Rheumatology and Bone Research directly at 301-942-6610. Our patient recruiter, Linda Gargiulo, will be pleased to provide you with information and the opportunity to answer any questions you may have.

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 card 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? _____

_____

_____

_____

UPDATE ON THE NEW MEDICARE LAW

By David Borensein, MD

In December, 2003, the Congress passed and the President signed a bill that included the greatest number of modifications to the Medicare system since its inception. The 1400 page law included a wide array of changes to the system that affected both patients and physicians. In addition, some of the provisions of the bill started immediately, while others were phased in over time. The most significant change to the bill is the prescription drug benefit for Medicare patients. All Medicare patients are eligible for prescriptions but the rules for receiving the benefit are complicated.

Medicare Prescription Drug Benefit

The full prescription drug benefit does not start until 2006. In the interim for 2004 and 2005, a drug benefit will be offered in the form of a 15% discount card for drugs. The cards are to be delivered in April and are to be used at local pharmacies that have agreed to participate in the program. Low income seniors will receive a further drug subsidy of $600.

Starting in 2006, the drug benefit will be a stand-alone plan or will be part of a private insurance plan separate from Medicare. Monthly premiums will be $35. The annual deductible for the plan will be $250. Patients will be responsible for 25% of the cost of drugs up to an amount of $2,250. Beneficiaries will be responsible for the full cost of drugs between $2,250 and $5,100. Above the $5,100 level, patients will be responsible for 5% of the bill with a co-payment of $2 for generics and $5 for brand-name medications. Individuals with limited resources may be eligible for smaller co-payments and reduced premiums.

How this program will be implemented remains to be determined. Will private plans offer a better deal than the Federal Government? Will the current levels of premiums and co-payments remain the same or be increased? The current bill has been underestimated in cost by over 100 billion dollars. Whether the benefit plan can remain in its current form with this size in deficit is debatable.

Self-Injectable Medications

Currently, Medicare will pay only for medications that are administered by a physician. These medications include those that are infused intravenously (by vein) or injected into muscles or joints. Injected medicines (insulin) given by a patient to themselves are not paid by Medicare. A new demonstration project for self-injectable drugs has been included as part of the new Medicare bill. The demonstration project will be available for 50,000 patients or 500 million dollars. The medicines and patients to be included in this project need to be identified by the Center for Medicare and Medicaid Services (CMS) within the next few weeks. Rheumatoid arthritis patients who would be eligible for Remicade (infliximab) infusions would be able to substitute with etanercept (Enbrel) or adulimimab (Humira) if arthritis patients are included. The American College of Rheumatology and the Arthritis Foundation are actively advocating for the inclusion of RA patients in this program. We will inform patients about eligibility for this benefit once the parameters for inclusion are published by CMS.

Physician Office Visits

The Medicare bill also changed the premiums that patients will owe in the future. The yearly deductible for Medicare Part B (doctor's visits) has been fixed at a level of $100. In 2005, the yearly deductible will increase annually with inflation. Also, for the first-time, high-income beneficiaries (with $80,000 or more in income per year) will have to pay higher premiums for doctor's visits.

The new Medicare bill will have a significant impact on patients and their physicians. The final form of the bill remains to be determined. ARA will keep you informed about the changes in Medicare as they become final.❀

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 went into affect on April 14, 2003. It gave the federal government the ability to mandate how healthcare plans, providers and clearinghouses store and transmit individuals' personal healthcare information. The passage of HIPAA occurred, in part, to improve the efficiency and effectiveness of the healthcare system by standardizing the transmission of certain administrative and financial information and by protecting the privacy and security of personal health information.

The Privacy Rule portion of the Act essentially controls the use and disclosure of what is known as protected health information (PHI). It also affords the patient greater knowledge of the content of their medical records and how that content is used. In addition, the Rule enables patients to control the disclosure of their PHI in certain circumstances.

It is the policy of our practice to preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. This is not simply a result of the Privacy Rule-preserving patient confidentiality is an integral part of who we are.

When you visit any of our office locations for the first time, you will receive our Notice of Privacy Practices (NPP) and be asked to sign a receipt stating that you received it. The NPP outlines in very great detail, the specifics of the law and how ARA plans to meet all of its requirements. You will also find our NPP posted in each of our offices and on our website at www.washingtonarthritis.com.

Our Privacy Officer is Margaret Dieckhoner. If you have any questions, she can be reached at 301-942-7600. Our staff is committed to patient confidentiality and receives HIPAA training on an on-going basis.❀

MAMSI
ARA Once Again Participates

Our practice is happy to announce that we once again participate with all MAMSI products. This includes MDIPA, Optimum Choice, MDIPA Preferred, Optimum Choice Preferred, MAMSI Life and Health and Alliance.

These plans cover services provided in all of our locations and in each of our divisions including our Osteoporosis Assessment Centers and our rehab centers Arthritis and Rehabilitation Therapy Services.

The Fun Rheum

Know your bones and joints

Match the medical name for the bone or joint in the left column, with the part of the body in which it can be found in the right column.

1. acetabulum	a. wrist
2. patella	b. heel
3. acromion	c. hip
4. olecranon	d. jaw
5. calcaneus	e. shoulder
6. carpals	f. mid foot
7. tarsus	g. elbow
8. mandible	h. kneecap

Answers: 1c, 2h, 3e, 4g, 5b, 6a, 7f, 8d.

A N S W E R S To Your Questions

By Robert J. Lloyd, M.D.
and
Joseph D. Croft, M.D.

Q. I have psoriasis and lately I've been having a lot of joint pain and stiffness. My dermatologist tells me it may be related to my psoriasis. Is this possible?

A. Your dermatologist may very well be correct. Up to 30 % of patients with psoriasis may develop associated musculoskeletal problems. Psoriatic arthritis is quite variable in its presentation and severity. The most common form of psoriatic arthritis tends to affect only a relatively few joints. In many patients, involvement is limited to the tips of the fingers or the toes. In addition, the entire finger or toe may become painful and swollen. This is referred to as a "sausage digit." Approximately 5% of patients, with psoriatic arthritis will have involvement limited to the spine. This causes pain and restriction of motion in the buttocks, lower back and neck. Some patients with psoriatic arthritis will develop a symmetrical pattern of joint involvement with inflammation of multiple joints quite similar to rheumatoid arthritis.

Fortunately, for many patients, the disease is only intermittently active. In some cases, control of the skin disease can be helpful in managing the arthritis. The treatment of psoriatic arthritis is very similar to the treatment of rheumatoid arthritis. The first line of defense is anti-inflammatory agents to minimize joint pain, stiffness and swelling. There are several effective disease modifying anti-rheumatic drugs that are available for long term suppression and control of psoriatic arthritis. I would suggest that you consider seeing a rheumatologist in consultation to determine if indeed you do have psoriatic arthritis or perhaps another unrelated musculoskeletal problem.

Q. Several friends of mine are taking glucosamine and chondroitin for arthritis. Do they really help?

A. Studies indicate that at least some people with osteoarthritis do benefit from taking these supplements. By way of background, veterinarians have been using them to treat osteoarthritis in horses and dogs for many years. They have been in use in Europe for treating osteoarthritis patients since the 1980s. European studies suggest that a substantial proportion of patients with osteoarthritis do get pain relief equivalent to that obtained with anti-inflammatory agents such as ibuprofen and naproxen. Both glucosamine and chondroitin are substances naturally found in the body. They are both constituents of joint cartilage. Cartilage is the firm rubbery material that covers the surface of bones within joints. It provides a low friction surface for smooth joint motion and also has shock absorbing capacity. In osteoarthritis, the joint cartilage wears, loses its resiliency, and tends to become brittle and roughened. Both glucosamine and chondroitin are building blocks of cartilage. The theory is that providing these nutrients in adequate amounts, will help the body to slow cartilage loss in osteoarthritis. These supplements are generally safe and well tolerated. They are not recommended for children, pregnant women or women who may become pregnant. Patients with diabetes or patients taking blood thinners should consult with their physician prior to starting these supplements.

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RHEUMORS

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Q. I have Been taking over-the-counter Ibuprofen fairly regularly. Is this safe?

A. Most over the counter medications have a fairly good safety profile when carefully used according to the directions. It is the inappropriate or injudicious use of some of these medicines which can get patients into serious trouble.

Ibuprofen falls into the category of nonsteroidal anti-inflammatory medications (NSAID's). The use of this type of medication is widespread among our patients with the expectation of reducing pain and inflammation. Such extensive use began with aspirin, which was the original NSAID. Aspirin was introduced in the 1890's but has been used in various forms for more than 3,500 years. Worldwide use is now estimated at 120 billion standard tablets annually. Ibuprofen was introduced in the 1960's as a prescription medication, but is now available over the counter. A variety of other drugs with similar mechanisms of action are currently available, mostly by prescription. These include medicines such as Naprosyn, Voltaren (Diclofenac), Celebrex and Vioxx.

It is surprising that 75% of regular NSAID users are not aware or concerned about the possibility of NSAID-related gastrointestinal complications, a common and serious problem associated with these medications. Unfortunately, 40% of individuals use a combination of OTC and prescription NSAID's. These people are engaging in particularly dangerous behavior, with high risk of gastrointestinal ulceration and bleeding, or even perforation. It appears that the general public does not realize that OTC NSAID's carry a significant risk, not very different from their prescription counterparts.

In reality, NSAID related complications are responsible for 16,500 deaths annually in the U.S. and are associated with 107,000 hospitalizations per year for GI bleeds. Risk factors related to NSAID gastrointestinal (GI) toxicity include:

- Advanced age (over 65)
- History of peptic ulcer disease
- Use of multiple NSAID's (including baby aspirin)
- Concomitant corticosteroid use
- Concomitant anticoagulant therapy

There are special potential toxicity issues for patients using NSAID's who have other disorders including chronic renal disease, hypertension, congestive heart failure and chronic daily aspirin use.

In an effort to minimize some of the potential complications noted above, please advise your Arthritis and Rheumatism Associates, P.C. physician and/or your family physician, on every visit, of the following: 1) any adverse reaction to any medication; 2) all medications being taken including alternative and over the counter agents; 3) any history of peptic ulcer, renal or cardiovascular disease.

PRACTICE NOTES

Werner F. Barth, M.D. was honored by the American College of Physicians at their meeting in April, when they presented him with the title Master of the American College of Physicians (MACP)

The 3rd edition of *Low Back and Neck Pain: Comprehensive Diagnosis and Management; Elsevier* by **D Borenstein, S Wiesel, S Boden** is about to be published. This is a book for physicians. The second edition was considered one of the 200 books to be included in a medical library.

John L. Lawson, M.D. is Chairman of the Board of the Medical Society of the District of Columbia.

RHEUMORS

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