

RHEUMATISM

Practice Newsletter

FALL 2015

EDITOR: Evan Siegel, MD, FACR

Meet the Newest Physicians at ARA



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Daniel El-Bogdadi
MD FACR

Grace Ahn
MD



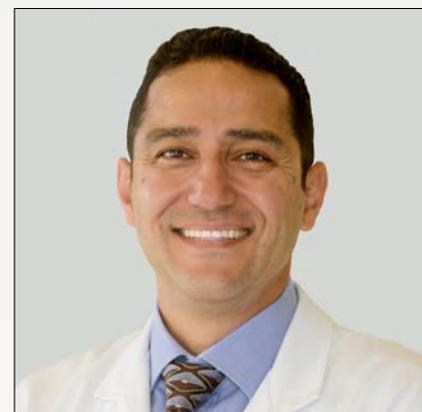
DR. GRACE AHN, MD

Dr. Ahn was born in Korea and is fluent in the Korean language. She came to the U.S. in her early teens and grew up in Virginia. She attended the University of Virginia as an Echols Scholar, majoring in music with a pre-med focus, earning her B.A. degree with Distinction in 2001. She wanted to be a doctor and her volunteer experience in college, especially a year working with a rescue squad, reinforced this goal.

After graduation, Dr. Ahn spent a year participating in basic research at the National Cancer Institute before enrolling at Virginia Commonwealth University School of Medicine and receiving her medical degree in 2006. She completed her internship at Drexel/Hahnemann University in Philadelphia and her internal medicine residency at Northwestern University in Evanston, IL, serving as Chief Resident. She remained at Northwestern for her rheumatology fellowship in Chicago. "In my second-year of medical school, while shadowing different doctors, I was matched with a rheumatologist whose character and interesting way of teaching the rare autoimmune diseases started me on my path to rheumatology."

Dr. Ahn received multiple scholarships and

continued on inside back page



DR. DANIEL EL-BOGDADI, MD FACR

Dr. El-Bogdadi was born and raised in Southern California. He graduated *cum laude* from the University of California, Irvine in 1997 with a B.S. degree in Biological Studies and earned his medical degree in 2001 from The George Washington University School of Medicine in Washington, DC.

He completed his internship and residency in internal medicine in 2004 and his rheumatology fellowship in 2007 at Emory University in Atlanta. He chose rheumatology because of wonderful mentors and his fascination with the immune system. "It is supposed to be our protector against infections," says Dr. El-Bogdadi, "but it also has the potential to turn against us, like our best friend becoming our foe. The treatments are also fascinating," he continues. "We need to suppress our immune system to treat these conditions. When we approach treatment it is best to think of the immune system as an orchestra, where a few bad players can throw off the whole symphony. Our treatments are focused on suppressing these bad players without suppressing the good players so good music can still be appreciated."

From 2004-2005, Dr. El-Bogdadi was an Instructor of Medicine at Emory. He then practiced Rheumatology for seven years

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Going, Going Gluten Free

MARIETTA AMATANGELO, MS, RDN/LDN, RM
NUTRITIONIST

Athletes are doing it, Hollywood stars are doing it, and maybe even you are doing it! Going gluten free (GF) that is. It's all the rage right now. At least 2 million Americans are doing it for medical reasons, such as celiac disease, an autoimmune disorder with symptoms triggered by a sticky protein, gluten, found in some grains. When a person with celiac disease ingests gluten, it causes severe damage to the digestive tract and the immune system. A large number of non-celiac individuals are avoiding gluten, because they seem to have problems digesting it properly, or it causes some physical symptom in the body. This is the gray area that I fall into. Unfortunately, my daughter and my niece both have Celiac, so I've had a lot of practice being creative with a GF lifestyle.

You can find gluten in the common flours of wheat, rye, barley and spelt (ancient cousin to wheat). There are some less common flours that contain gluten such as: triticale, kamut, einkorn, and farro. These last four are ancient grains and not used much today.

Symptoms involving gluten sensitivity are not always isolated to the GI system. Many of the symptoms are neurological and involve the brain. Hence, the new book by Dr. David Perlmutter, "Grain Brain." Other possible symptoms from gluten sensitivity are vertigo, migraine headaches, anxiety, depression, tingling in the fingertips, numbness in the legs, foggy brain, insomnia, constipation, ringing in the ears, gas, bloating, diarrhea, fatigue, balance problems and dizziness, to name a few. These are some of the symptoms that I have encountered in my practice over the years. Studies strongly suggest that gluten sensitivity is separate and distinct from celiac disease.

A common method used by individuals to test for gluten sensitivity is an elimination diet, where the gluten is removed from the diet for several weeks, then reintroduced to discover what physical symptoms (if any) arise from the reintroduction of gluten. This is always best when done in cooperation with a qualified nutritionist.

Whatever the reason for going GF, the increased awareness in the diagnosis of celiac disease and the large numbers of individuals who are going sans gluten have pushed the food manufacturers to get creative and provide an abundance of new, tantalizing GF products in the marketplace. Sales of GF foods have tripled since 2004. It makes going GF much more enjoyable. Some tips for a happy GF life are:

- Think about what you can have, instead of what you cannot have. When you concentrate on the positive choices, there is quite a bit from which to choose.
- The big 3 to avoid are wheat, rye and barley and any food or product that contains them.
- Any baked goods, pastas, cereals, crackers, cookies, and snack foods that are made from grains other than the big 3 are okay to eat.
- Be sure to check all labels. In this country wheat or gluten is in almost everything. I was astonished to find out it is even in some gelato.
- Become familiar with all the many names of wheat.
- Make the foundation of your GF diet organic produce, peas, beans, lentils, organic meats and poultry, wild-caught fish, nuts, seeds, hormone-free dairy products, and gluten-free whole grains.
- Non GMO corn and GF oats are good alternatives along with quinoa, millet, buckwheat, wild rice, amaranth, almond flour, rice flour, cashew flour, coconut flour, buckwheat flour, chickpea and lentil flour, mashed beans, wild rice, arrowroot, flax, and tapioca flour/pearls.

If you are following a GF diet, here are some great websites with useful information:

Celiac Central.org - <http://www.celiaccentral.org/>
Shelley Case - <http://www.glutenfreediet.ca/>
Gluten Intolerance Group - www.gluten.net
Elana's Gluten Free Pantry - <http://www.elanapantry.com/>
GFree Foodie - <http://www.gfreefoodie.com/>



The infusion center is happy to announce expanded hours in our OLNEY location.

We have added Friday appointments in an effort to meet the needs of our patients.

Did you know?

Did you know that ARA speaks out on behalf of patients and their healthcare? “Angus Worthing, MD, is one of the D.C. physicians backing a bill proposed by Council members Mary Cheh and Anita Bonds to limit the coinsurance a patient would have to pay to \$150 for a 30-day supply of medication. The idea is to curb the increases in cost-sharing insurers have begun requiring for some of the most expensive drugs on the market.”

To read more about this initiative please visit our website:

<http://www.arapc.com/rheumors-newsletter/our-doctors-in-the-news/>

FUN RHEUM:

Y B P T I V D C W R D H R
O S U U H B W A N Y W O E
L R S G L U T E N Q T Z G
U W K T J T J O R A F V W
N E E D L I N G R H J N T
Y J E K W W I T N S A I D
B N Z Z E Q S F I S Z G X
J F N K N I F S I N N E T
R P N J N I N J M L P I Y
E M J I W Y Z M V H I Z W
U Z M L Y E N D I K A L F
I D H R V R B V L G N T E
A H S A V O C A D O O Q D

CLUES:

1. Retirement of Margaret Dieckhoner from this practice position has changed ARA
2. This will add some zest to your burger recipe
3. Common medical abbreviation for anti-inflammatory medications
4. Pesky and troublesome nutrient for some people
5. Dr. Ahn can serenade you with this instrument
6. Anti-inflammatory meds can cause problems with this organ
7. A physical therapy procedure that uses the same instruments but is not the same as acupuncture
8. Dr. El Bogdadi loves this sport



Fall Prevention – Not Just a Season

JOSHUA COSTA, PT, DPT, DIRECTOR OF REHABILITATION, ARTHRITIS AND REHABILITATION THERAPY SERVICES

Fall prevention has progressively become an important topic and concern as the population ages. The cost of health care associated with falls in the elderly has been estimated at \$30 billion annually. Fall prevention programs and education can be provided by physical therapists and can be most effective before a fall has occurred. Fall prevention should be considered by the at-risk individual, their family and their medical provider. In an article titled *What Works to Prevent Falls in Community Dwelling Older Adults* published in a recent issue of *The Journal of the American Physical Therapy Association*, the authors assert that there is “consistent evidence to suggest that exercise is associated with a reduction in the rate, risk, and odds of falling (including falls resulting in injury), thus affirming physical therapists’ central position to lead in international efforts to prevent falls.” Consequently, physical therapy should be an essential part of the correction of any balance/gait abnormality.

The physical therapists at Arthritis and Rehabilitation Therapy Services (ARTS) perform a comprehensive evaluation addressing strength deficits, mobility deficits, postural abnormalities, ergonomics and home safety. They understand that it is of utmost importance not only to rehabilitate the individual but to also give them the education and tools to prevent further falls. It is very important to integrate an exercise program into each person’s daily routine. A critical factor in maintaining health as we age is simply staying active. This can be achieved in a variety of ways including getting started with a physical therapy program, joining a gym or joining a wellness program in your community. We provide wellness programs at ARTS, that include classes in yoga, osteoporosis, fibromyalgia education and exercise classes, back school, hip/knee osteoarthritis programs and massage therapy. If you are interested in further information please, ask your doctor or therapist, or look on our website at www.washingtonarthritis.com. These classes are very popular and registration is required.

In summary, preventing falls prevents pain, loss of independence, high medical costs and personal and family stress. Physical therapy evaluation and management can play a big role in avoiding these traumatic consequences.

Dry Needling - Treatment for Reducing Pain

Arthritis and Rehabilitation Therapy Services (ARTS) has expanded our services to include myofascial trigger point dry needling or intramuscular manual therapy (IMT) at three of our offices: Rockville, Chevy Chase and Washington DC.

Although IMT utilizes a solid monofilament needle, it is important to note that IMT is not acupuncture. IMT is an advanced technique based on the Western medical model. *IMT is a useful technique to decrease acute and chronic pain and facilitate the use of other physical therapy interventions, such as therapeutic exercise.*

WHAT IS DRY NEEDLING AND HOW DOES IT WORK?

Dry needling is an invasive procedure that can be used to reduce or eliminate



myofascial trigger points and the pain and stiffness associated with these areas in muscle tissue that are often referred to as “knots.” A myofascial trigger point consists of multiple contractions or taut bands of tissue within a muscle

and can develop when muscle tissue is stressed or overloaded, leading to pain, weakness, or loss of flexibility. Over time, myofascial trigger points can actually perpetuate an ongoing pain cycle. When performing dry needling, we insert a solid filament needle into the skin and muscle, specifically at the myofascial trigger point. While the exact therapeutic mechanisms of dry needling are still not completely understood, we do know that effects of dry needling are both mechanical and biochemical in nature. Insertion of a needle directly into a myofascial trigger point is intended to elicit what is called the local twitch response, a spinal cord reflex, to “release” the restrictive contracture within the muscle and improve the muscle tissue’s flex-

ibility and function. Additionally, studies by Dr. Jay Shah and colleagues at the National Institutes of Health have shown that inserting a needle into a myofascial trigger point can elicit desirable biochemical changes that can reduce pain. While we commonly use therapeutic exercises and other manual treatment techniques in conjunction with dry needling to reduce pain and restore function of the muscle, dry needling can be an effective tool to initiate this process.

— Matthew Reed, MPT, CMTPT

HOW DID DRY NEEDLING ORIGINATE?

Dr. Janet Travell is credited with the identification



of myofascial trigger points (taut bands of skeletal muscle) as a source of referred musculoskeletal pain. Dr. Travell, who served as a White House physician under President John F. Kennedy, mapped out the referral pattern of the skeletal muscles

in the body. Utilizing this information, she injected trigger points with medication to reduce the former president’s musculoskeletal pain.

Although these trigger point injections were very successful, many believed relief came from the medication injected, not the needle itself. In 1979, Karel Lewit, a neurologist from the Czech Republic who has contributed significantly to movement science, hypothesized that mechanical deformation secondary to the penetration of the needle into the musculature resulted in pain relief and that it was not solely the medication. Over time, most practitioners switched from using hypodermic needles and transitioned to monofilament needles (e.g., acupuncture needles) and hence dry needling was born.

— Powell Bernhardt, MS, DPT, CMTPT, COMT

HOW LONG DOES IT TAKE FOR THE PROCEDURE TO WORK?

In general, it takes several visits to see a therapeutic response. We are trying to cause both a local and systemic change. This is achieved by decreasing the local tissue restrictions and creating biochemical changes. The goal is to alter the sensitivity and painful cycles to improve overall functional mobility.

— Josh Costa, DPT, CMTPT

HOW IS DRY NEEDLING USED IN PHYSICAL THERAPY?

Although dry needling is an effective tool for facilitating decreased pain and the overall achievement of a patient’s return to function, it is not used in isolation from other physical therapy treatment techniques. When treating a patient, we use dry needling to reduce or eliminate pain, weakness, and restricted mobility associated with myofascial trigger points. Once the myofascial trigger points have been released, we use a host of manual therapy, therapeutic exercise, and neuromuscular re-education techniques to maintain the normal length of the muscle. Once the normal length has been restored, it is important to improve stability and strength of the musculature involved to ensure that the trigger points do not return. For example, people often have pain in the upper trapezius muscle of the neck. After dry needling, the upper trapezius and associated musculature to restore proper length, it is important to ensure that the patient has adequate strength of the muscles that stabilize the neck, shoulder, upper back, and trunk to prevent return of the initial symptoms.

— Powell Bernhardt, MS, DPT, CMTPT, COMT

New Olney Office Finds Its Permanent Home

The office is located at 18111 Prince Philip Drive, Suite 323, on MedStar Montgomery Medical Center’s campus. The Olney office offers physician appointments, onsite radiology and laboratory services as well as an infusion suite. Paul DeMarco, MD; Guada Respicio, MD; Dan El-Bogdadi, MD; Grace Ahn, MD; are accepting patients at this location.



POINTS ON JOINTS:

Osteoarthritis and Exercise

BY GRACE AHN, MD

Osteoarthritis is one of the most common conditions treated by a rheumatologist. It is a natural process, with more and more people developing joint symptoms as they age which is why it is often referred to as “degenerative arthritis.” However other risk factors besides age often come into play, including genetics and environment, which may lead to early osteoarthritis in certain people.

For example, 100% of professional football players will develop osteoarthritis, typically earlier than others, due to repetitive trauma. People who are obese may have early arthritis in weight-bearing joints such as hips and knees. Osteoarthritis typically affects the

hands, feet, knees, and spine, and also can affect the shoulders and hips. Pain is the most common symptom. Swelling or deformity may be seen in these areas, or there may be few or no symptoms at all. Many patients feel that weather changes, such as impending rain or snow, may make their pain worse though studies have been inconclusive about a weather-related link. The diagnosis of osteoarthritis can be confirmed through physical examination or x-rays ordered by a physician.

Treatments vary depending on the degree of arthritis, and may include medications, physical therapy or even surgery. Exercise is one of the core supportive elements of osteoarthritis treatment. Exercises can facilitate weight loss, preserve joint range of motion, improve strength, improve physical function and reduce symptoms such as pain. Public health organizations recommend at least 150 minutes of exercises a week, typically defined as vigorous- intensity aerobic physical activity. Studies have found that people with arthritis often do not meet these public health guidelines, mostly due to limitations from their condition. We encourage our patients to participate in exercise even if they cannot do so for the recommended duration. Low-impact aerobic exercises such as walking or biking can benefit your health as can aquatic exercise programs. Water based exercise may in fact, be preferable, due to the reduced effects of gravity on weight-bearing joints. We encourage our patients to start slow and progressively build up activity levels to the point where they can eventually maintain a healthy active lifestyle. It is also helpful to focus on strengthening exercises for muscles surrounding problem areas such as the knees or back. A physical therapist can be helpful in creating an exercise program.

In summary, for each patient with osteoarthritis, physical well-being will be promoted by finding some form of physical activity that is enjoyable and the time to pursue that activity on a regular basis.



Farewell - Arrivederici - Ciao - Aloha

BY HERBERT S.B. BARAF, MD, FACP, MACR



Margaret Dieckhoner recently retired after 28 years as the practice administrator of Arthritis and Rheumatism Associates. With Margaret's background in social work, her mission, like that of the physicians, was to make the patient the highest priority for everyone who worked here. She accomplished this by hiring and training top-notch staff and setting the highest standards for them to follow. Her ability to identify caring and compassionate staff and to imbue them with a passion for serving the patients has been at the core of our success.

As the managing director, I have worked by Margaret's side for the duration of her 28 years at ARA. From the first time I interviewed her for the job of practice administrator to the countless conversations that followed I have marveled at her unflinching grace, prodigious wisdom, clarity of thought, class, style, integrity, dignity, decency, effectiveness, charm, goodwill and generosity of spirit. Her qualities and her presence will be missed here at ARA. Margaret established a foundation and left a legacy that will benefit us for years to come. The outstanding, well-directed staff she developed and the high standards to which they adhere are Margaret's chief accomplishments and will benefit our patients for years to come.

Margaret, we wish you well in retirement. You will be missed by all of us. You have given outstanding service to the physicians, staff and patients of ARA and we are all in your debt! Thank you!

RHEUMINATIONS:

The Untold NSAID Story

DANIEL EL-BOGDADI, MD, FACR

I remember it like no other night. I admitted a patient to the hospital who was taking over-the-counter ibuprofen, meloxicam prescribed by her primary care physician and Celebrex prescribed by her orthopedic physician. Her kidney function was severely decreased and, as a result, her legs and thighs were severely swollen. Her potassium level was high enough to cause cardiac arrest. I gave her medication to try to lower her life-threatening potassium level, but to no avail. I had no choice but to order dialysis to clean her blood.

My patient never knew that all three medications she was taking were nonsteroidal anti-inflammatory drugs (NSAIDs) that, in combination or sometimes alone, may significantly decrease kidney function. I spent a great deal of time thinking about how I could try to prevent this dangerous situation from happening again to any of our patients, and that is why I chose to write this article.

Aspirin, first produced in 1897 by the Bayer company, was the first NSAID. Others were later introduced. At the time, the mechanism of the action of these medications was unknown. Eventually, it was discovered that these medications work by inhibiting the production of prostaglandins, which promote inflammation and pain. After that discovery, the pharmaceutical industry was able to produce similar agents such as ibuprofen and naproxen, which we now know inhibit the enzyme cyclooxygenase (COX).

After recognizing that COX was the target enzyme, numerous NSAIDs were introduced since the early 1970s. In response to side effects from steroids (prednisone and cortisone), the pharmaceutical industry coined the term "nonsteroidal" because these NSAIDs were not prednisone or cortisone. However, these NSAIDs which were formulated to have a lower side effect potential than steroids, actually had their own potential severe adverse effects. One of the first NSAIDs, phenylbutazone,

was eventually removed from the market when a number of cases were reported in which it caused aplastic anemia.

NSAIDs increase the risk of stomach ulcerations and bleeding, which prompted the development of specific medications that selectively target the COX-2 enzyme. Theoretically, this would reduce the risk of stomach ulcers and bleeding. Celebrex, among other COX-2 inhibitors, received FDA approval in 1998. These drugs did cause less bleeding but were noted to cause an increased risk of clotting which, in turn, caused a slight increase of heart attacks and strokes in at-risk patients. On July 9, 2015, the FDA strengthened its existing label warning that NSAIDs could increase the chance of heart attack or stroke. For more information on the FDA rulings visit: <http://www.fda.gov/Drugs/DrugSafety/ucm451800.htm>

All NSAIDs, however, cause a decrease in kidney function by limiting blood flow to the kidney. It is important to note that when normal, healthy individuals take an NSAID, their kidney function mildly decreases for a short period of time and most of those patients are able to recover. But in the presence of dehydration, certain blood pressure medications, older age, lower blood pressure states (i.e., heart failure or cirrhosis) or baseline low kidney function, the addition of an NSAID may reduce kidney function by almost 100%. Certainly baseline blood work to estimate kidney function should be done before NSAIDs are started, and regular monitoring should occur if they are taken on a consistent basis.

As noted in my story, patients need to be cautious about what they are taking and understand that combinations of various NSAIDs should be avoided. This is especially true of a patient who may be taking an over-the-counter NSAID and a prescription NSAID at the same time! Always be sure to review all your medications carefully with your doctor. This problem is not uncom-



mon considering that NSAIDs accounting for 70 million prescriptions, and 30 billion over-the-counter doses sold each year in the United States.

List of NSAIDs:

- **Aspirin**
(may be taken at low dose (81 mg) with other NSAIDs)
- **Celebrex**
- **Diclofenac**
(Common brand name: Voltaren)
- **Diflunisal**
- **Etodolac**
(Common brand name: Lodine)
- **Flurbiprofen**
(Common brand name: Ocufen)
- **Ibuprofen**
(Common brand names: Advil, Motrin)
- **Indomethacin**
(Common brand name: Indocin)
- **Ketoprofen**
(Common brand name: Orudis)
- **Ketorolac**
(Common brand names: Toradol, Sprix, Acuvail, Acular)
- **Meclofenamate**
- **Mefenamic acid**
(Common brand name: Ponstel)
- **Meloxicam**
(Common brand name: Mobic)
- **Nabumetone**
(Common brand name: Relafen)
- **Naproxen sodium**
(Common brand names: Aleve)
- **Oxaprozin**
(Common brand name: Daypro)
- **Piroxicam**
(Common brand name: Feldene)
- **Salsalate**
(Common brand name: Disalcid)
- **Sulindac**
(Common brand name: Clinoril)
- **Trisalcylate**

FUN RHEUM ANSWERS:

1. Administrator

2. Avocado

3. NSAID

4. Gluten

5. Piano

6. Kidney

7. Needling

8. Tennis

Sun Dried Burgers with Avocado Smear

1 pound lean grass-fed ground beef
1/2 cup sun-dried tomatoes,
chopped small
1/2 tsp finely chopped garlic
1/2 tbsp tablespoon black pepper
2 teaspoons sea salt (makes it salty
depending on your sun-dried tomatoes)
1 avocados, ripe
Juice of 1/2 a lemon
1/4 tsp cumin and garlic powder

INSTRUCTIONS

Put your ground beef in a large mixing bowl and add black pepper, 1 teaspoon of sea salt, chopped sun-dried toma-

toes, chopped garlic. Mix well and form into burger patties.

In another mixing bowl, mash the avocado, combine with lemon juice, 1 tsp salt, cumin and garlic powder. Mix ingredients well to get as smooth as you like.

Grill, broil or pan cook to your liking.

Smear avocado mixture on a plate and place patty on top.

Serve with your favorite salad and vegetable. Enjoy!

Meet the Newest Physicians at ARA *(continued from pg1)*

DR. GRACE AHN, MD CONTINUED...

awards throughout her academic and medical careers, including Intern of the Month during her residency and teaching awards during her fellowship. She is first- and co-author of scientific articles and abstracts and has presented research at regional, national and international conferences, including the American College of Physicians, the American College of Rheumatology, and Osteoarthritis Research Society International. Her article on physical activity and systemic lupus erythematosus was published recently in the journal *Arthritis Care & Research*.

Dr. Ahn is board certified in internal medicine and rheumatology. Her clinical areas of interest include systemic lupus erythematosus, rheumatoid arthritis, osteoarthritis and gout. She states: "A rheumatologist is not just a joint doctor. Often-times, autoimmune diseases involve multiple organ systems, and we sometimes have to put that together. It's important for me to listen to and communicate well with my patients, their caregivers and their other physicians." She notes that, while rheumatologists are looking at scientific findings, they have to figure out what's really going on and find the best treatment for individual patients. "Many of my patients feel they constantly have to explain themselves to describe how they hurt, and that creates stress," Dr. Ahn says. "Depression, anxiety and situational stress affect their physical health. For a healthy well-being, I emphasize that their minds and bodies go together. I tell them that together, we will work to improve both."

Dr. Ahn is married to a colon and rectal surgeon and has two children. She enjoys playing the piano, traveling and spending time with her family. She sees patients at our Olney and Wheaton offices.

DR. DANIEL EL-BOGDADI, MD FACR CONTINUED...

in Virginia's Shenandoah Valley area at Augusta Health Medical Center and Sentara Rockingham Memorial Hospital. He served on the Augusta Medical Group board of directors.

He has received numerous awards and honors including induction into the William Beaumont Research Honor Society and received the Lakewood Regional Medical Center Foundation Scholarship Award and Recognition of Excellence in the Field of Medicine. He earned patient choice awards, including the Sentara Patient's Choice Award in 2012. An accomplished researcher, he has published and given presentations on topics including lupus, sarcoidosis, osteoporosis and giant cell arteritis.

As Dr. El-Bogdadi develops long-term relationships with his patients, he settles into the roles of supporter, guide, advocate and collaborator. "With autoimmune disease, it's important that my patients understand that they didn't do anything to cause it," says Dr. El-Bogdadi. He also talks with patients about alternative ways to control autoimmune disease such as nutrition and stress management. "Stress is a major trigger of arthritis flares. We are not in control of everything, but if we change our approach and attitude to stress, we can certainly modify the course of the disease a great deal."

Dr. El-Bogdadi is board certified in internal medicine and rheumatology and a fellow of the American College of Rheumatology. "What is so unique about doctoring is, the longer you practice, the more you learn to see the bigger picture and how diseases affect patients' lives at any age: socially, emotionally and physically," says Dr. El-Bogdadi. "You can't apply the same principles and rules for all patients. This forces me to practice the art of medicine, not just the science, and that's most gratifying."

Dr. El-Bogdadi enjoys running 5k to 10k races and full marathons, reading, and playing/watching soccer and tennis. Rupturing his Achilles tendon playing tennis in 2001 was a humbling and valuable experience for him as a doctor, teaching him how to better support his patients. "I learned to understand and overcome the difficult setbacks we encounter in our lives. It taught me what being a 'patient' really means because healing is a process that requires great patience and sometimes simply cannot be done on our own."

Dr. El-Bogdadi sees patients at our Rockville and Olney locations.

RHEUMORS

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RHEUMORS

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Psoriatic Arthritis - More Than Skin Deep

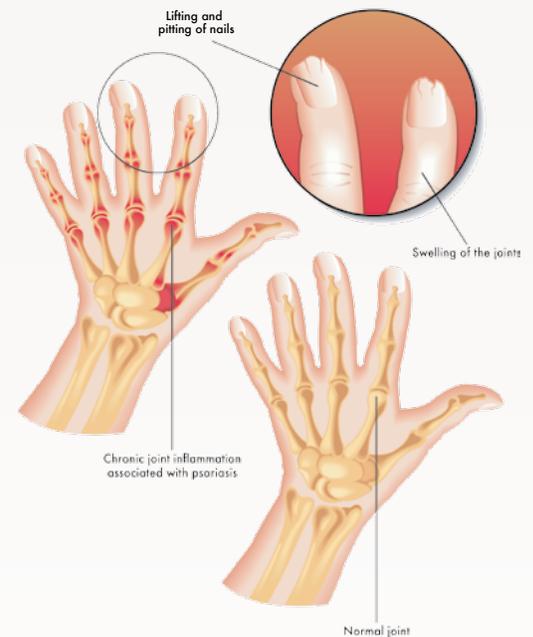
EVAN SIEGEL, MD, FACR

Psoriasis is a common skin condition that affects 1-2% of the population, causing chronic well-defined red and sometimes itchy patches on the skin with a superimposed silvery scale. Approximately one third of patients with psoriasis will develop psoriatic arthritis, a painful disease that can affect the peripheral joints including the hands, feet, elbows shoulders and knees as well as the spine, tendons and hips. Psoriatic arthritis generally occurs on average about 9-10 years after the onset of psoriasis. Often the diagnosis is delayed because patients with psoriasis are not aware that arthritis can complicate their skin disease. Even some health care professionals are not aware of all the potential skeletal complications that can occur in patients with psoriasis. The delay in diagnosis is problematic because studies have shown that damage to the joints can occur in some patients when appropriate treatment is not started promptly.

Psoriatic arthritis is an autoimmune disorder unlike osteoarthritis, which develops primarily secondary to wear and tear of the joints. This means that, like rheumatoid arthritis (RA), the immune system erroneously attacks the joints causing inflammation and damage. However, psoriatic

arthritis falls into a group of disorders that is distinct from RA, known as the “seronegative spondyloarthropathies” or SPA, which is a group of disorders that share similar or overlapping features. This group includes; psoriatic arthritis; ankylosing spondylitis; arthritis associated with inflammatory bowel disease such as ulcerative colitis; or Crohn’s disease, and reactive arthritis (arthritis that occurs secondary to an infection such as food poisoning or venereal disease). These disorders share some genetic and clinical features, and may share some biologic characteristics that lead to their development.

The diagnosis of psoriatic arthritis is based on typical symptoms and findings in the musculoskeletal system in a patient with current or past psoriasis or a family history of psoriasis. Joint symptoms typically include swelling, redness and warmth of a few or many joints often in an asymmetric fashion. What is often different about psoriatic arthritis when compared to RA is prominent involvement of tendons and “enthuses,” the area where a tendon or ligament attaches to bone. “Enthesitis” is present in many common conditions such as tennis elbow,



plantar fasciitis and Achilles tendonitis. When these problems are occurring repetitively or in a chronic nonhealing fashion in a patient with psoriasis, the diagnosis of psoriatic arthritis should be considered.

In summary, psoriatic arthritis is a potentially progressive disorder that can affect skin, joints, tendons and spine and also can increase the risk of heart attack and stroke. Early recognition of the disorder to allow appropriate treatment is essential to avoid both ongoing symptoms and to prevent future damage and disability.