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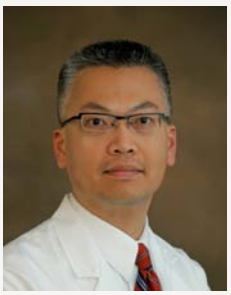
RHEUMORS

Practice Newsletter SPRING 2018

ARA Welcomes Dr. Grant Louie & Dr. Adey Berhanu

GRANT H. LOUIE, MD MHS FACR



Dr. Grant Louie earned his B.A. degree in molecular and cell biology at the University of California at Berkeley. He graduated from medical school at Drexel University (formerly known as MCP Hahnemann University) in Philadelphia and completed his internship and residency in internal medicine at California Pacific Medical Center in San Francisco. He subsequently completed a fellowship in rheumatology at the National Institutes of Health in Bethesda. Additional training in clinical investigation at Duke University School of Medicine earned him a Masters in Health Sciences degree.

Dr. Louie served as Assistant Professor of Medicine in the Division of Rheumatology at Johns Hopkins University School of Medicine for six years. There, he relished his role as a preceptor for trainees in the classroom, ambulatory and inpatient settings. Dr. Louie has published numerous articles in peer reviewed medical journals and has presented at local and national scientific meetings. He also has served as principal investigator and co-investigator in various clinical trials of new arthritis therapies.

After leaving Hopkins, Dr. Louie worked in private practice before joining ARA.

continued on back inside cover...

ADEY BERHANU, MD FACR RHMSUS

Dr. Adey Berhanu was born and raised in Denver, Colorado. She attended Stanford University where she earned a B.A. degree in human biology. She earned her medical degree from the University of Illinois School of Medicine and completed her residency in internal medicine at Loyola University in Chicago. She completed her fellowship in rheumatology at New York University's Langone Medical Center, where she served as chief fellow in her final year.

Following her fellowship, Dr. Berhanu joined the medical faculty at George Washington University as Assistant Professor of Rheumatology, where she had an active clinical practice and trained new physicians.

Dr. Berhanu has a clinical interest in musculoskeletal ultrasound for which she received specialized training from USSONAR and obtained RhMSUS certification from the American College of Rheumatology. She applies her expertise with musculoskeletal ultrasound to her clinical interest in gout and has authored and co-authored several articles on the therapeutic management of gout. In addition to her research interests, Dr. Berhanu has

continued on back inside cover...

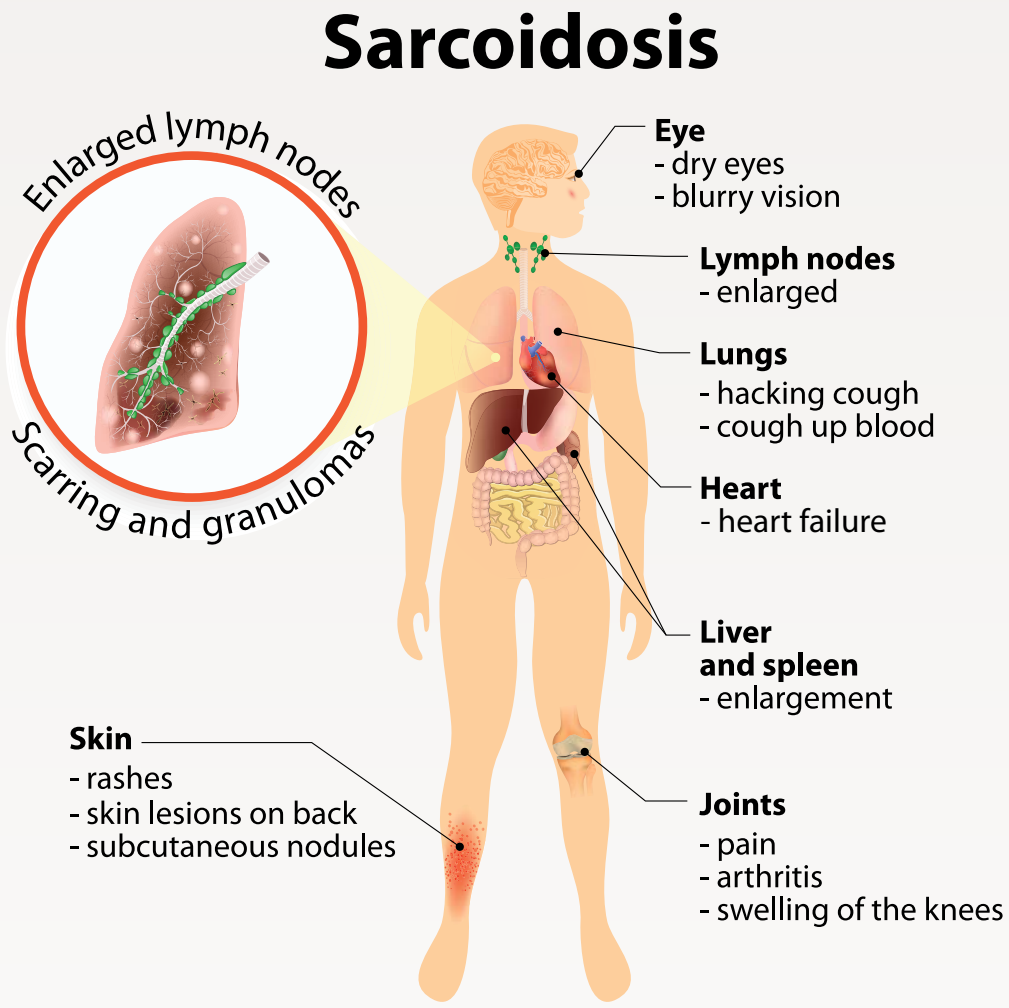
Understanding Sarcoidosis

NICOLE THOMAS, MD FACR

A 40-year-old gentleman came to me complaining of fevers, night sweats, 10 pounds unintentional weight loss, and swollen ankles. He had high calcium levels and very high levels of inflammation noted on his blood tests. There were no clear-cut infections to account for the inflammation. To investigate further, I obtained x-rays, which revealed many swollen lymph nodes in his chest. I was concerned about malignant cancer and consulted with hematology/oncology colleagues who shared my concern. We arranged a lymph node biopsy and, fortunately, there was no cancer found. What the lymph node biopsy report did reveal was "sarcoidosis."

Sarcoidosis is an autoimmune condition that causes the body to form nodules consisting of inflamed tissue, called granulomas, in the body's organs. Sarcoidosis can affect almost any organ in the body. It usually involves the lungs, but the skin, eyes, nose, muscles, heart, liver, spleen, gut, kidney, nerves, lymph nodes, joints, and brain can all be involved.

We do not know the exact cause of sarcoidosis. The prevailing theory is that there is an environmental trigger in a genetically susceptible person that leads to the development of



Practice News

ARA supports the Arthritis Foundation's annual "Walk to Cure Arthritis." On Sunday, May 20th, ARA physicians and staff participated in the Walk to Cure Arthritis as part of Arthritis Month activities. The ARA Team raised over $5,700 to help this worthy cause.

the disease. Sarcoidosis is not contagious and is more common in African-American, German, Irish, Scandinavian, Asian and Puerto Rican patients. Sarcoidosis generally occurs between the ages of 20 and 40 but can be diagnosed at any age.

Because sarcoidosis can affect so many different organs, it can be challenging to diagnose. The symptoms also may vary depending on the organs involved. Some people may have no symptoms and sarcoidosis only becomes apparent when a routine chest X-ray comes back as abnormal, showing evidence of lymph node swelling from sarcoid involvement. Other patients may experience weight loss, fatigue and fevers. If the lungs are involved, coughing, breathlessness or chest pain may occur. Patients may experience painful, red eyes or vision loss if sarcoidosis involves the eyes. Skin nodules, ulcers or flat areas of discolored skin can develop in sarcoidosis patients, usually near the nose or eyes, or on the back, arms, legs and scalp. Tender bumps also may appear on the ankles and shins. Sarcoidosis can cause swollen cheeks and dry mouth. It also can cause swollen lymph nodes, sometimes occurring within the chest, but also may occur under the chin, in the armpit area or in the groin. Sarcoidosis also may cause elevated calcium levels or abnormal blood cell counts. Rarely, sarcoidosis may interfere with the heart's electrical system and cause irregular heart rhythms or affect the brain or nerves causing neurological dysfunction.

There is no single test to diagnose sarcoidosis and its diagnosis generally depends on the organ system involved. Imaging studies, especially a chest x-ray, can be helpful. A blood test called an ACE (angiotensin converting enzyme) level is used to determine elevated levels related to sarcoidosis. However, it is possible to have sarcoidosis with a normal ACE test and ACE levels also can be elevated due to other conditions, so it's not a perfect test. If possible, a biopsy of the swollen area is ideal to confirm a diagnosis of sarcoidosis and rule out other causes of swelling such as infections, cancers or other medical conditions.

Some people with sarcoidosis require no treatment. If the inflammation is leading to organ damage, corticosteroid medications and sometimes further immunosuppressant medications are needed. Your rheumatologist can help you test for sarcoidosis and determine the best course for you.

Lung Involvement in Autoimmune Diseases

BY JEFFREY A. POTTER, MD FACR

Autoimmune disorders are conditions characterized by abnormal functioning of the immune system, the body's system for protecting against bacteria, viruses and cancers. Patients with autoimmune disorders experience symptoms when their immune system turns these protective mechanisms inward and causes damage to organs including joints, kidneys, liver, lungs, nerves, and heart tissue. Many autoimmune diseases affect multiple organs at the same time, while others are limited to involvement of one or two organ systems. Lung involvement is commonly found in many of these conditions and can manifest itself in many ways.

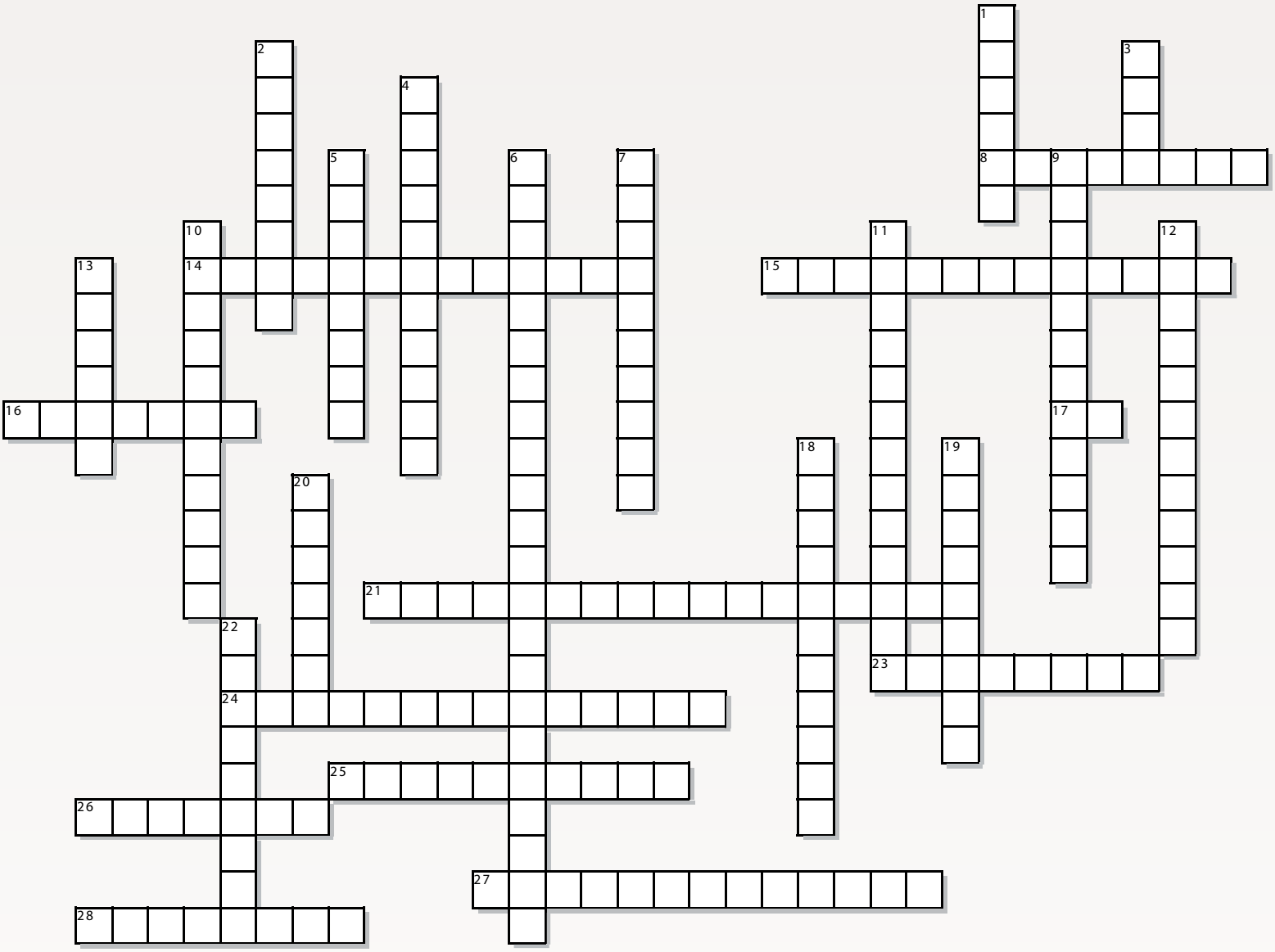
Lung abnormalities in rheumatic diseases can be due to inflammation and damage to the lung itself, involvement of the muscle and connective tissue supporting the lung, or injury to the blood vessels supplying the lung and those allowing gas exchange. Autoimmune myositis is characterized by inflammation and damage to muscle groups responsible for moving air in and out of the lungs as well as inflammation of the lung tissue itself, making breathing difficult and less effective.

Scleroderma is characterized by increased numbers of fibroblasts, which are cells responsible for wound healing in their natural state but cause thickening and scarring of previously healthy tissue in the disease state. This can lead to dysfunction of the lung itself and limit its ability to expand fully, in addition to causing blood alterations in the pressure of the vessel responsible for pumping blood through the lungs. Patients with systemic lupus can experience inflammation of the lung lining, which can result in accumulation of fluid and associated difficulty breathing as well as chest discomfort.

Vasculitis is characterized by inflammation of the small blood vessels in the lung. In severe cases, this causes bleeding into the lung, which can be life-threatening if not recognized early. Blood clotting disorders can develop in many different autoimmune disorders, interrupting blood flow in the lungs and causing a lack of oxygen and associated tissue damage.

Discussing symptoms suggestive of lung disease with your rheumatologist is important and will help to determine whether additional testing is necessary to establish whether lung involvement from rheumatic disease is present. Many forms of lung disease are treatable and, therefore, early recognition and institution of appropriate therapy is necessary to prevent permanent damage. Your rheumatologist and pulmonologist (lung specialist) will work together to determine the best treatment for lung disease.

FUN RHEUM:



ACROSS

8 An infection called herpes zoster.
14 Process between patients and physicians.
15 A therapy used to control Ankylosing Spondylitis.
16 Center where triage is located.
17 Associated with prolonged morning stiffness.
21 Disease with dry eyes and mouth
23 Name of a new vaccine being given at ARA.
24 Doctor who treats autoimmune diseases.
25 Individuals who screen office calls.
26 Side effect of a vaccine.
27 Lung specialist.
28 Another word for conditions.

DOWN

1 Diagnostic test done with Sarcoidosis.
2 Presents with a disease or condition.
3 An organ that can be affected by autoimmune disease.
4 Disease that affects so many different organs.
5 A service located in Frederick facility.
6 A complication of Sjörgren's Syndrome (mystery - answer not found in newsletter).
7 Nodules consisting of inflamed tissue.
9 Causes damage to the lung itself.
10 Hardening of the skin.
11 The triage will help a patient with filling.
12 Characterized by chronic widespread pain.
13 Lack of this can cause lung damage.
18 Chronic inflammation of the structures of the spine.
19 Where is ARA's new office?
20 A live virus given as a treatment.
22 Virus that causes chickenpox.

A New Office Now Open in Frederick, Maryland

Arthritis and Rheumatism Associates is pleased to announce the opening of our newest office at 71 Thomas Johnson Drive in Frederick, Maryland.

ARA'S physicians and staff are excited about establishing new relationships with the local community and for the opportunity to provide the most advanced medical care available for those living with autoimmune and rheumatologic conditions. Our move to Frederick is also an opportunity for established patients of our practice to have more convenient access to their favorite ARA physicians without the long drive to the DC suburbs. We welcome new patients referrals and look forward to becoming a vital resource for specialists and primary care physicians who have long entrusted us with the care of their patients.

Onsite services include:

- Physician appointments
- Infusion services by ARISE infusion
- X-rays and DEXA diagnostics
- Lab tests
- Ultrasound

Meet the Triage Team

Arthritis and Rheumatism Associates strives to provide excellent medical care to patients even when we are communicating with them by telephone! That is why we made the decision in 2008 to establish the Triage Team. Our Triage Team is home to some of our most experienced and friendly clinical specialists – many of whom spent years working side by side with the physicians seeing patients in our six clinics.

The Triage Team's primary objective is to facilitate your quick access to care and get answers to your medical questions. Team members answer patient inquiries about medical matters and serve as a liaison between the patient and their physician. Need a prescription refilled? Chances are that one of our operators will refer you to a member of the Triage Team who will get authorization from the physician and call the prescription in to the pharmacy. Wondering if your symptoms are concerning enough that your physician thinks you should come in for an appointment today? A Triage Team member will ask you questions and then bring the information to the physician for assessment.

The Triage specialists follow protocols established by the physicians and they communicate with them about your needs and concerns throughout the day. They are available by phone Monday through Friday from 8:00 am until 4:45 pm and, even though most patients never get to meet them in person, they appreciate the specialists' compassionate approach to assisting our physicians with their care.

TRIAGE TEAM RESPONSIBILITIES

- **Listens to patient concerns and find the appropriate resources to help**
- **Communicates important details about the patient's condition to the physician**
- **Communicates medical results/findings and physician instructions back to patients**
- **Assists with scheduling urgent (same-day) appointments**
- **Processes prescription requests and refills**
- **Provides clarification of prescription instructions**
- **Provides immediate, compassionate and accurate assistance**

RHEUMINATION:

Fibromyalgia and Ankylosing Spondylitis

BY DAVID G. BORENSTEIN, MD MACP MACR

Having one illness is more than any patient wants to bear, but, often, patients may have more than one medical problem affecting their musculoskeletal system. In those circumstances, treating only one of those problems may explain why patients are not improving as much as they desire. This situation may occur in individuals who, for example, have both fibromyalgia and ankylosing spondylitis.

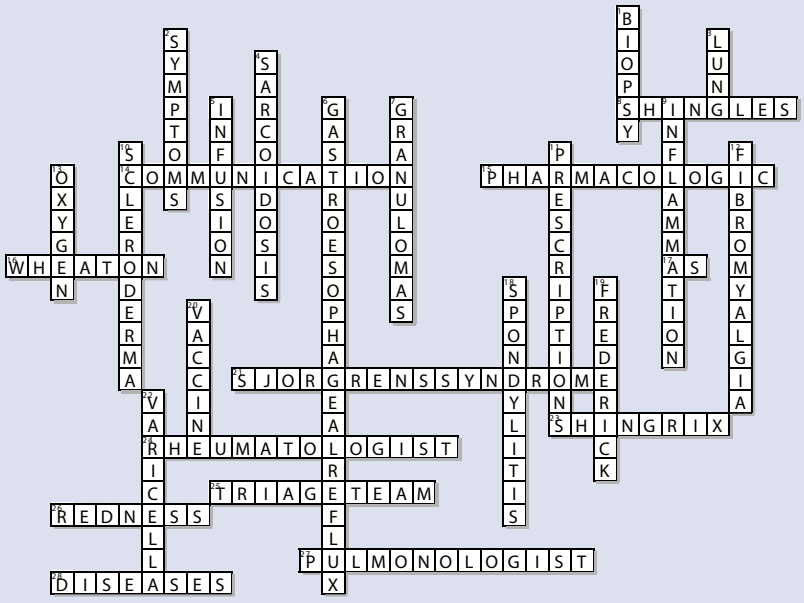
Fibromyalgia is a condition characterized by chronic widespread pain in the upper and lower parts of the body and frequently is associated with symptoms including fatigue, restless sleep, mental fogginess, irritable bowel syndrome, interstitial cystitis, and unstable blood pressure. Optimal treatment for fibromyalgia requires a multidisciplinary approach including both pharmacologic and non-pharmacologic interventions such as patient education, aerobic exercise, and cognitive behavioral therapy. Pharmacologic therapy includes nonnarcotic analgesics that increase neurochemicals like serotonin and norepinephrine, which affect the pain inhibitory pathway that travels from the brain to structures throughout the body. Up to 8% of people in the United States have fibromyalgia.

Ankylosing spondylitis is an autoimmune-related chronic inflammation of the structures of the spine that can destroy tissues and, in the setting of spondyloarthritis, ultimately results in the calcification of spinal structures and spinal fusion. Ankylosing spondylitis is associated with prolonged morning stiffness that is exacerbated by sitting for variable lengths of time and is improved by exercising. The goals of therapy for ankylosing spondylitis are to control inflammation, decrease pain, maintain function, and prevent deformity with non-pharmacologic (exercise and physical therapy) and pharmacologic (nonsteroidal anti-inflammatory drugs, disease-modifying anti-rheumatic drugs, and biologics) interventions. It is estimated that 4% of the U.S. population lives with ankylosing spondylitis and other inflammatory spinal disorders.

The question arises as to how many individuals have both fibromyalgia and ankylosing spondylitis. A recent survey reviewed medical literature to determine the frequency of individuals with both conditions. The prevalence of fibromyalgia in ankylosing spondylitis patients is reported to be 4-25%, with more women being affected than men. These individuals tend to have more subjective complaints of pain in the spine and other areas than those who have ankylosing spondylitis without fibromyalgia. The clinical importance of this fact is that the usual therapies effective for ankylosing spondylitis may not be adequate to control pain in these individuals. The addition of effective therapy for fibromyalgia will be required to fully treat these individuals.

For more information about these conditions, please go to thespinecommunity.com where the author is executive editor.

FUN RHEUM ANSWERS:



AIP Orange Chicken Teriyaki Meatballs

Serves 20

Asian flavors tend to be rich in anti-inflammatory ingredients, like these meatballs, which incorporate orange zest, ginger, and garlic.

MEATBALLS

2 pounds ground chicken
1/2 cup finely chopped green onions
2 tsp orange zest (2 oranges worth)
big pinch salt

SAUCE

2/3 cup fresh orange juice (juice of 2 navel oranges)
2 tsp grated ginger
1/4 cup coconut aminos
1 tbls apple cider vinegar
1 clove crushed garlic
1 tbls honey

INSTRUCTIONS

In a bowl, mix ground chicken (you can use any kind; breast or a blend), orange zest, pinch of salt and green onions. On a parchment lined cookie sheet, form 2 1/2 inch sized meatballs. Bake at 350 until internal temperature reaches 170 degrees. Mine took about 30 minutes.

In a saucepan, add coconut aminos, grated ginger, garlic, honey, vinegar and fresh orange juice. Bring to a simmer and reduce until sauce coats the back of a spoon. It will simmer for about 10 minutes; then start to watch it closely. It will start to bubble as it is reducing and almost ready. You want the sauce to be the consistency of maple syrup.

When meatballs are cooked, place in a bowl and drizzle with the sauce. Gently toss to coat all the meatballs.

Recipe by Jessica Flanigan

continued from front cover...

Welcome Dr. Louie & Dr. Berhanhu

GRANT H. LOUIE, MD MHS FACR

Though he treats all manner of rheumatological conditions, Dr. Louie has particular interest and expertise in inflammatory arthritis, including axial spondyloarthritis, psoriatic arthritis, and rheumatoid arthritis. Dr. Louie is an active member of SPARTAN, a professional organization of North American experts in spondyloarthritis, and has lectured on the topic.

Dr. Louie is board certified in rheumatology and internal medicine, and is a Fellow of the American College of Rheumatology. He brings his expertise, compassion, and dedication to ARA. He is seeing patients at the Frederick and Wheaton offices.

ADEY BERHANHU, MD FACR RHMSUS

long been dedicated to community service -- both locally and abroad. She is serving as the 2018 Arthritis Foundation "Walk to Cure Arthritis" Medical Honoree and is particularly proud to have worked with the rheumatology program at the teaching hospital in Addis Ababa, Ethiopia.

Dr. Berhanu is board certified in rheumatology and internal medicine and is a Fellow of the American College of Rheumatology. Besides gout, her areas of clinical interest include rheumatoid arthritis, systemic lupus erythematosus, inflammatory eye disease, Sjögren's syndrome, and osteoarthritis. In addition to English, she is fluent in Amharic (Ethiopian dialect) and is proficient in Spanish.

RHEUMORS
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New Vaccine for Shingles

GRACE E. AHN, MD FACR

Shingles is an infection caused by a virus called varicella. This is the same virus that causes chickenpox. Once the virus enters your body, it can stay dormant in your nerves and reactivate at a later time, causing an infection called herpes zoster, more commonly known as shingles. Patients can develop a painful, raised, and sometimes fluid-filled rash in the same area in which the patient felt pain preceding the rash. The rash and pain often are treated with antiviral and pain medications, depending on the severity of the symptoms. Often, those infected can go on to have post-herpetic neuralgia, characterized by lasting chronic pain in the regions where they had the infection.

For the past 12 years, Zostavax, a drug originally approved in 2006, was the only available vaccine. Zostavax is a live virus vaccine approved for those above age 50. In October, 2017, the FDA approved a new vaccine called Shingrix. This is a recombinant (genetically engineered) vaccine that is non-live. According to the CDC, Shingrix reduced the incidence of shingles by 97% in those aged 60 to 69, and 91% in those above age 70. In comparison, Zostavax showed reduced incidence of shingles by 64% in those aged 60 to 69, and 41% in those above age 70. Shingrix also has been shown to reduce the incidence of post-herpetic neuralgia by 89% for those above 70. Zostavax is a live vaccine and cannot be given to patients on immunosuppressive therapy. Shingrix is non-live and appears to be safe for that population of patients.

Compared to Zostavax, Shingrix has been shown to cause more local injection site reactions. Common side effects are pain, redness, and swelling at the injection site, as well as muscle pain, tiredness, headache, shivering, fever, and upset stomach. It is important to note that Shingrix is given in a two-dose series, with the second dose given two to six months after the first vaccine.

If you have a question about whether you should get the Shingrix vaccine, please talk to your doctor. Shingrix is available at each of our six office locations.