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RHEUMORS

Practice Newsletter FALL 2020

ARA Welcomes Two New Physicians to the Practice

RAMI R. ElTARABOULSI, MD, FACR

Dr. ElTaraboulsi was born and raised in Raleigh, North Carolina. He graduated as the valedictorian from North Carolina State University with a Bachelor of Science in biochemistry. He earned his medical degree from East Carolina University and completed a combined internal medicine-pediatrics program at Georgetown University Hospital. He completed his rheumatology fellowship training at the University of North Carolina at Chapel Hill.

During training Dr. ElTaraboulsi participated in clinical research and has published scholarly articles on scleroderma and osteoarthritis. He has presented his work at several conferences including the DC Rheumatism Society, American College of Rheumatology, and Osteoarthritis Research Society International. He co-authored a textbook chapter on pseudogout and gout. He is trained in musculoskeletal ultrasound, and utilizes it for diagnostic and interventional purposes. He has special interest in transitional care for adolescents with chronic rheumatic conditions.

Dr. ElTaraboulsi is board certified in internal medicine and board eligible for rheumatology. He is a member of the American College of Rheumatology and participates in advocacy initiatives for rheumatology patients. He lives with his wife, Heba, a speech therapist, and their two sons. Dr. ElTaraboulsi is accepting patients ages 12 and up at the Olney and Shady Grove offices.

NITASHA KUMAR, MD, FACR, CCD

Dr. Kumar is a native of DC metro area and earned her undergraduate degree in neurobiology and physiology from the University of Maryland. She completed her medical degree at St. George's University, where she was a member of the Iota Epsilon Alpha medical honor society. She completed her internal medicine residency at Rutgers New Jersey School of Medicine and her fellowship training in rheumatology at the Ochsner Clinic Foundation in New Orleans, Louisiana.

continued on back inside cover...

Navigating COVID-19 for the Rheumatology Patient

BY LOUISA ZIGLAR, MD, FACR

Stay-at-home orders, social distancing from friends and family and sometimes having to take on new or increased care for family members can be very stressful. For patients with rheumatologic conditions, there is also additional concern about increased risk for a severe infection requiring hospitalization. I am asked frequently during my office visits, "Am I likely to become sicker than others if I catch the Coronavirus?"

To help provide some clarity, these are the studies I often quote during my office visits. Please note that this should not be used to replace individual physician assessments of risk since each individual medical case is slightly different from another.

DATA FROM NEW YORK CITY[1]:
In a case series published in *The New England Journal of Medicine*, patients in New York with rheumatic disease (specifically rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, psoriasis, inflammatory bowel disease) on immunomodulatory therapies with confirmed or suspected Covid-19 infections were studied. As background to what medications these patients were taking, 72% of the patients were on biologics or receiving Janus kinase inhibitors, 20% were on methotrexate, and 9% were on hydroxychloroquine.

The data revealed that, of the people who were infected with Covid-19, if matched for age and other medical histories, the proportion of patients with rheumatic conditions who were hospitalized was similar to the proportion of patients without rheumatic disease in the general population hospitalized in New York City.

The incidence of hospitalization was 16% in the patients with rheumatic disease, and these patients tended to have other health characteristics in the general

population that are associated with increased risk. These include older age, history of hypertension, diabetes or chronic obstructive pulmonary disease. This is a very small study (86 patients) and caution needs to be taken with interpretation given that the limited sample size can lead to significant changes in conclusions with a change of just a few cases. Doses also were not discussed and the dosing (especially with steroids) can show considerable differences in suppression of the immune system.

DATA FROM AN INTERNATIONAL PERSPECTIVE[2]:
The Covid-19 Global Rheumatology Alliance registry published data on 600 patients with Covid-19 and rheumatic diseases. Of the patients who were infected with Covid-19, 46% were hospitalized. Prednisone use of greater than 10mg per day was associated with higher risk of hospitalization than those on lower doses or on no prednisone at all. On the contrary, use of TNF inhibitors (such as Humira, Enbrel, Remicade) was associated with a lower risk of hospitalization rate compared with patients not on those. The use of methotrexate or sulfasalazine alone or with a biologic/Janus kinase inhibitor was not associated with increased hospitalization compared to patients not on those medications. The use of non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen) was not associated with increased risk of hospitalization compared to patients not on those medications.

To help patients with rheumatic conditions navigate through the Covid Pandemic, here is some general advice:

- Treatments of stable patients in the absence of infection or Covid-19 exposure should be continued. Do NOT stop your treatment unless you are infected or are concerned you are infected with Covid-19.[3]
- If infection is suspected, decisions whether to continue treatment with immunosuppressive therapy should be evaluated on a case-by-case basis by your rheumatologist. Your rheumatologist will know which treatments are still considered safe to continue or treatments that will need to be decreased or discontinued temporarily.[4]
- Treatments with TNF inhibitors seem to confer lower risk of hospitalization than those not on this class of medication. General preventive measures such as social distancing and hand hygiene still should be practiced.[4]
- Despite known increased risk for a more severe response to infections among people with rheumatic disease, most patients with rheumatic diseases do not seem to be at an increased risk of hospitalization, even when taking medication for their rheumatic disease.[5]

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[1] Haberman R, Axelrad J, Chen A, et al. Covid-19 in Immune-Mediated Inflammatory Diseases - Case Series from New York. N Engl J Med 2020; 383:85.

[2] Gianfrancesco M, Hyrich KL, Al-Adely S, et al. Characteristics associated with hospitalization for COVID-19 in people with rheumatic disease: data from the COVID-19 Global Rheumatology Alliance physician-reported registry. Ann Rheum Dis 2020.

[3] Mikuls TR, Johnson SR, Fraenkel L, Arasaratnam RJ, Baden LR, Bermas BL, et al. American College of Rheumatology guidance for the management of adult patients with rheumatic disease during the COVID-19 pandemic. Arthritis Rheumatol doi: https://onlinelibrary.wiley.com/doi/abs/10.1002/art.41301. E-pub ahead of print.

[4] Gianfrancesco M, Hyrich KL, Al-Adely S, et al. Characteristics associated with hospitalization for COVID-19 in people with rheumatic disease: data from the COVID-19 Global Rheumatology Alliance physician-reported registry. Ann Rheum Dis 2020.

[5] Conticini E, Bargagli E, Bardelli M, et al. COVID-19 pneumonia in a large cohort of patients treated with biological and targeted synthetic antirheumatic drugs. Ann Rheum Dis 2020.

FUN RHEUM:

MYURAEGOOLHT

TAEHELHELT

MEIDIACONT

NISFUINO PRAYHTE

PICYSHAL RAHTEYP

TIMNAOMUEU SASEDESI

SESUULAL TOMLEKC NOISDNOITC

CISTAORIP RISHITRTA

HERTODIMAU SIRHIARTT

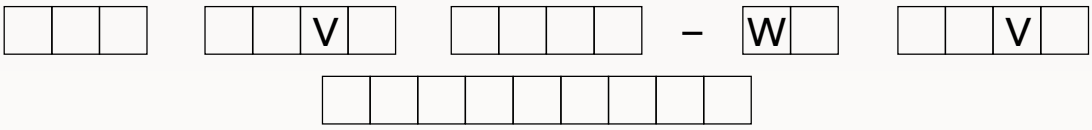
SLPUU

SOOTIORSPOES

TOUG

SINSAD

AOTETHTSRRIOSI



Unscramble each of the clue words.

Take the letters that appear in ◯ boxes and unscramble them for the final message.

ARA Changes in Leadership

There have been some exciting changes in the leadership of the practice! **ANNE WELLINGTON-GOLDSMITH, MPT**, currently our Executive Director of Rehabilitation, is transitioning to her new role of Chief Operating Officer (COO) for ARA this September. Anne has been with the practice since 2006 during which time she has demonstrated outstanding skills in leadership, administration and staff management. She drove the successful development and expansion of our excellent rehabilitation and wellness department. We look forward to the growth Anne will bring to ARA in her expanded leadership role.

JOSHUA COSTA, our Rockville office ARTS Director, and Matthew Reed, our D.C. office ARTS Director have both accepted the position of Co-Executive Directors for the ARTS team.

Congratulations to all!

Don't Say the F Word

BY DANIEL EL-BOGDADI, MD, FACR

"Fibromyalgia is a diagnosis used by doctors when they don't know what is going on with you." I have heard that statement thousands of times. Truth be told, doctors really do not understand fibromyalgia. That's because fibromyalgia is not actually a disease like strep throat or rheumatoid arthritis. Fibromyalgia is a syndrome and hence we use the term "fibromyalgia syndrome." A syndrome is when we have a collection of symptoms that is recurrent in patients and in which there is poor understanding of what causes the disease. For fibromyalgia, the collection of symptoms is widespread pain for greater than three months, which may be accompanied by headaches, numbness/tingling, irritable bowel syndrome, lack of ability to think clearly (brain fog), depression, and interstitial cystitis.

The pain of fibromyalgia is real in every way, but many doctors remain uncomfortable with the diagnosis of fibromyalgia. This is because the pain may be attributed to mental distress or somatization of underlying stress, depression, or anxiety. However, this concept often is avoided in an office visit. CS Lewis best describes this phenomenon when he writes that "mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say 'My tooth is aching' than to say 'My heart is broken'."

But not all fibromyalgia, of course, is due to mental stress. Autoimmune diseases such as Sjögren's syndrome and Lupus may present with fibromyalgia symptoms as one of the musculoskeletal manifestations. Rheumatoid arthritis patients may have diffuse pain and stiffness that may be consistent with fibromyalgia symptoms. It also was once thought that ankylosing spondylitis was primarily a male disease, but it recently was learned that female patients with ankylosing spondylitis may present with fibromyalgia symptoms! This certainly offered hope to a group of patients

continued on back cover...

POINTS ON JOINTS:

Understanding The Drugs We Use: An Insight into Methotrexate

BY NITASHA KUMAR, MD, FACR, CCD

WHAT IS METHOTREXATE? Methotrexate has been used widely by rheumatologists to treat a variety of inflammatory conditions, most notably rheumatoid arthritis. It was developed in 1947 and initially was used to treat cancer. In the mid-1980s, studies emerged that showed that it was highly effective in treating rheumatoid arthritis with long-term sustainability. These insights led to the evolution of methotrexate into its present status as the dominant drug to treat patients with rheumatoid arthritis. It also continues to be used as a chemotherapy drug but at much higher doses.

HOW DOES METHOTREXATE WORK FOR MY TYPE OF ARTHRITIS? Methotrexate works by reducing inflammation and damage to joints. By reducing inflammation, it also reduces pain. It works at a cellular level to help decrease the instigators of inflammation.

HOW IS METHOTREXATE TAKEN? Methotrexate is taken one time a week. The pills are 2.5 mg each and the usual dose ranges from three pills (7.5 mg) to 10 pills (25 mg). Most rheumatologists will dose methotrexate between 15 mg and 25 mg. It can also be given as an injection.

HOW LONG DOES METHOTREXATE TAKE TO WORK? Many RA patients will start to experience an improvement in symptoms after six to eight weeks on methotrexate, but it can take up to six months before they will reach the full benefits of taking the drug.

WHY DO I NEED TO TAKE FOLIC ACID? Folic acid is a type of B vitamin. It's currently recommended that all patients on low-dose methotrexate take folic acid (1 mg a day) to help offset potential side effects that come with taking methotrexate.

IS METHOTREXATE SAFE IN PREGNANCY? Methotrexate is not safe in pregnancy. Both men and women should be off of methotrexate for at least 3 months prior to conceiving. Contraception is strongly encouraged for all women of child-bearing age while on methotrexate. Mothers should not nurse if on methotrexate as it can enter the breast milk.

WHAT HAPPENS IF I MISS A DOSE OF METHOTREXATE? If you miss your dose, you can take it safely the next day and then resume your normal weekly dose. Try to avoid missing too many doses as this could cause your symptoms to return.

CAN I SAFELY STOP METHOTREXATE? Yes, it is safe to just stop methotrexate; you do not need to slowly reduce the dose.

WHAT ARE THE SIDE EFFECTS OF METHOTREXATE AND WHAT ARE THE WAYS TO REDUCE THEM?

Nausea, Gastrointestinal upset	• Consider splitting your dose. Take half the pills in the morning and the other half 12 hours later, preferably with food. • You may get some relief with a histamine H2 blocker (eg, ranitidine 150 to 300 mg orally) or a proton pump inhibitor (eg, omeprazole 20 to 40 mg orally). These drugs usually are cycled in a weekly manner with methotrexate (MTX), being used the evening before, the day of, and the morning after the weekly MTX dose. • Consider increasing the dose of daily folic acid up to 3 to 5 mg or adding Leucovorin (folinic acid) 8 to 10 hours after the weekly MTX dose. • Consider taking it on a non-work day. • Try taking it at night, so the effects may be gone by morning. • Consider subcutaneous injections, which may be more tolerable than tablets.
Mouth sores	• Consider increasing folic acid dose from 1 mg daily up to 2 mg or higher (to a maximum of 5 mg daily) by 1 mg increments until sores resolve.

RARE SIDE EFFECTS

Decrease in blood counts	• Make sure to go to all of your scheduled lab appointments so that your blood counts can be monitored regularly. • Depending on severity, your rheumatologist may consider lowering your MTX dose or discontinuing it altogether. • Make sure not to miss your daily folic acid.
Abnormal liver tests	• Make sure to go to all of your scheduled lab appointments so that your liver tests can be monitored regularly. • Minimize your alcohol intake, as both alcohol and MTX can irritate your liver. For most people, 1-2 drinks/week is still safe. • Make sure to let your rheumatologist know if you have any liver problems prior to starting MTX. • Depending on severity, your rheumatologist may consider lowering your MTX dose or discontinuing it altogether.
Infections	• MTX rarely is associated with increased infection risk unless you're also taking other medications at the same time, such as glucocorticoids, immunosuppressive disease-modifying antirheumatic drugs (DMARDs), or biologics.
Effect on kidneys	• At the low doses used to treat inflammatory arthritis, MTX usually does not harm the kidneys. • If your kidneys are not working properly, your rheumatologist may need to decrease or stop MTX.

Overall, methotrexate has been safely used for many years. For more information about methotrexate, or for questions that are specific to your situation, always consult your physician.

What to Expect with the Pandemic: *We Are Here for You!*

BY BRENDA BROUILLETTE, RN, BS

Whether you require care that can be rendered only in our offices, or have a non-urgent problem that can be addressed through a telemedicine "virtual visit," Arthritis and Rheumatism Associates (ARA) wants to assure you that we are ready to meet your needs in the safest possible manner.

ARA is strictly adhering to current public health recommendations for implementing enhanced infection control measures and other safeguards to reduce the risk of contracting COVID-19. This includes daily screening of our patients and staff for infection prior to coming into our offices, maintaining social distancing in our offices and infusion suites, and mandatory universal use of personal protective equipment (PPE) for all employees and visitors.

WHAT TO EXPECT WHEN VISITING ARA

Appointment Scheduling & Screening: You will be triaged over the phone or electronically via our Phreesia check-in platform prior to your visit to ensure that you do not have any signs or symptoms or infection or other risk factors for COVID-19. If after screening you are determined to have an elevated risk of infection, you will be offered a virtual visit with your doctor instead of coming into the office. Even if you do not have an increased risk of COVID-19, we can facilitate a virtual visit for you if you feel more comfortable having your visit from home with your doctor or physical therapist. To maintain physical distancing in our offices, we have arranged our waiting rooms and infusion suites with limited chairs spaced at least six feet apart. Magazines, sign-in sheets, pens and other high touch items have been removed.

Office Visit Tips:

- We ask that you please enter the office within 10 minutes of your scheduled appointment time to prevent crowding in our waiting rooms. We have decreased the number of appointments each day to minimize your wait time and the total amount of time you are in the office.
- Please come to your appointments alone unless you have a disability that requires an attendant to be with you.
- When you arrive, you will be greeted by our check-in staff who will take your temperature using a touchless thermometer and ensure you are wearing a mask over your nose and mouth. If your mask does not meet CDC recommended standards, our check-in staff will provide one for you.

If you cannot wear a mask or face shield for your office visit, we ask that you choose a telehealth visit with your provider. We will reschedule your visit if you are found to have a fever upon arrival in our suites.

- We have installed protective plexiglass shields throughout our offices for staff and visitor protection.

GENERAL OFFICE PROTOCOLS:

- **Surface Disinfection:** Our practice follows CDC recommendations for cleaning and disinfecting all areas of our facility. Cleaning procedures are done frequently throughout the day and every evening.
- **Provider/Staff Exposure:** We screen our personnel daily for symptoms of illness and contacts relevant to COVID-19.
- **Staff Training:** ARA has trained and educated our staff extensively on screening and triage protocols, patient management, and appropriate use of PPE. We monitor recommendations from public health experts and continue to adjust our protocols to meet changing standards.

The physicians and staff of ARA are committed to making your visit safe and as comfortable as possible. We look forward to welcoming you back to our offices soon.

Turkey & Quinoa Stuffed Peppers

INGREDIENTS
3 large yellow peppers
1.25lb extra lean ground turkey
1 C diced mushrooms
1/4 C diced sweet onion
1 C chopped fresh spinach
2 teaspoons minced garlic
1 C (1 8oz can) tomato sauce
1 C chicken broth
1 C dry quinoa
**optional – cheese of choice. Try using pepper jack on those for the adults and an Italian cheese blend for the kids.*

DIRECTIONS

In a small saucepan, start the quinoa and cook according to package directions (usually about 15 minutes).

While the quinoa cooks, saute the vegetables in a pan with a little butter or olive oil.

After about 5 minutes or so, add the ground turkey and garlic to the vegetables. Cook over medium heat. Once the turkey is almost cooked through, add in the tomato sauce and about half of the chicken broth. Let simmer until the turkey is fully cooked and some of the excess liquid has cooked off.

Preheat the oven to 400.

While the turkey mixture simmers, prep your bell peppers.

Wash the peppers, cut them in half, and remove the stem & seeds. Spray a 9×13 baking pan with cooking spray and place the cut bell peppers in the pan (open side up).

Once the quinoa is cooked, put it into the pan with the turkey & vegetables. Stir together. Then, stuff each bell pepper with the mixture. Make sure they are nice & full! If you're opting for cheese, top with just enough cheese to barely cover the mixture (if you put too much on, it will get super messy in the oven!). Pour the rest of the chicken broth into the base of the pan (go around the peppers, not over them).

Cover with foil and bake at 400 for about 30-35 minutes. Serve warm & eat up! They are sooooo good!

ARA Welcomes Two New Physicians to the Practice

...continued from front cover

During her fellowship Dr. Kumar participated in a wide range of clinical and translational research projects that have been recognized by the American College of Rheumatology, Rheumatology Alliance of Louisiana, Congress of Clinical Rheumatology, and the North American Young Rheumatology Investigator Forum. Her work has been published in journals such as *The Rheumatologist* and *Healio Rheumatology*. Dr. Kumar treats all types of rheumatologic conditions and has a particular interest in Sjögren's syndrome, scleroderma, and osteoporosis. She believes in a comprehensive and collaborative approach to patient care.

Dr. Kumar is board certified in internal medicine and rheumatology. She is also a certified clinical densitometrist. She is a member of several professional organizations including the American College of Rheumatology, American Medical Association, the International Society for Clinical Densitometry, and the Association of Women in Rheumatology. She lives with her husband, Hiten, in Rockville, Maryland, and is fluent in the Hindi language. Dr. Kumar is accepting new patients ages 16 and up at both our Wheaton and Olney office locations.

RHEUMORS
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RHEUMORS
PRACTICE NEWSLETTER
Fall 2020
A publication brought to you by:
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Don't Say the F Word

...continued from fron inside page 4.

frequently visiting pain clinics without relief as effective treatments are available now for ankylosing spondylitis. Lastly, I cannot forget about multiple sclerosis (MS), a degenerative autoimmune neurologic disease that may have features that mimic fibromyalgia and chronic fatigue syndrome.

Another very common condition that may present with fibromyalgia symptoms is having too little or too much thyroid hormone (hypothyroidism or hyperthyroidism). Oftentimes a thyroid evaluation may be overlooked or "recently" the test was normal so this possibility is dismissed. Other hormone-related diseases besides thyroid disease (for example hyperparathyroidism or Addison's disease) also should be considered when making the diagnosis of fibromyalgia.

Other considerations include chronic viral infections such as chronic hepatitis B and hepatitis C, which are more common than you think! Most people do not know they are infected, nor do most people know how they were infected! Screening for viral etiologies should be a routine part of evaluating a patient with fibromyalgia.

Certain cancers may present with fibromyalgia syndrome. I recall a patient many years ago who presented with diffuse pain and ended up having multiple myeloma, or bone cancer. Also, some studies have indicated that those with diffuse body pain may be at increased risk for cancer—whether the cancer or fibromyalgia symptoms came first can be difficult to distinguish.

Finally, there are some cases for which an underlying etiology for fibromyalgia just simply cannot be found and continuing to reinvestigate the possible causes with your rheumatologist is essential. Remember, fibromyalgia is a symptom complex that may be caused by a lot of different things. That makes understanding it, at least for me, and hopefully for you, a little easier.