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RHEUMATORS

Practice Newsletter

SUMMER 2024

Meet Dr. Marc Phillpotts!



MARC PHILLPOTTS, MD, FACR, CCD, RHMSUS, earned his Bachelor of Science and medical degree from The University of the West Indies, Mona, Jamaica, W.I. He completed his Internship and Residency in Internal Medicine at Howard University Hospital in Washington, DC in 2016 and later pursued Rheumatology Fellowship training at The George Washington University Hospital, Washington, DC. After completing his fellowship, he became an Assistant Professor of Medicine in the Division of Rheumatology at George Washington University. In this position, he mentored medical students, residents, and rheumatology fellows,

while also maintaining an active clinical practice that involved providing inpatient rheumatology consultations. Additionally, he served on the MD Program Admissions Committee and acted as a Peer Reviewer for the Musculoskeletal Block at The George Washington University School of Medical and Health Sciences.

Dr. Phillpotts is Board Certified in both Internal Medicine and Rheumatology. He is a Fellow of the American College of Rheumatology (ACR) and is a current member of the ACR Workforce Solutions Committee. He is a member of the International Society of Clinical Densitometry (ISCD) and a Certified Clinical Densitometrist (CCD) by the ISCD. Dr. Phillpotts holds the Musculoskeletal Ultrasound Certification in Rheumatology (RhMSUS) from the American College of Rheumatology and received musculoskeletal ultrasound training from the Ultrasound School of North American Rheumatologists (USSONAR).

Dr. Phillpotts has experience in all areas of rheumatology and his areas of special clinical interest include rheumatoid arthritis, systemic lupus erythematosus, spondyloarthritis, inflammatory eye disease, vasculitis, systemic sclerosis, osteoporosis, gout, and musculoskeletal ultrasound. He applies his expertise with musculoskeletal ultrasound to diagnose and treat various conditions such as carpal tunnel syndrome, trigger finger, gout, and Baker's cyst.

Dr. Phillpotts has been recognized as a Top Doctor in Rheumatology by Washingtonian Magazine. In his spare time, he enjoys long-distance running, tennis, and swimming.

Dr. Phillpotts sees patients at our Washington, DC, and Fairfax office locations.

*To schedule an appointment with Dr. Phillpotts,
call 301.942.7600 or visit www.arapc.com.*

Spotlight on Uveitis

MARC PHILLPOTTS, MD

Uveitis is a condition that is characterized by inflammation (redness and swelling) of the middle layer of the eye. This layer, called the uvea, contains many blood vessels that nourish the eye. It also helps with several functions, including absorption of light and focusing. It is important to recognize and treat uveitis since it can damage eye tissue and lead to permanent vision loss.

The uvea is made up of three segments, which include the iris (the pigment-containing part of the eye that surrounds the pupil), the choroid (a vascular bed that supplies nutrients and oxygen), and the ciliary body (a ring of muscle behind the iris). Uveitis is sub-classified into different types based on which part of the uvea is involved.

Anterior uveitis (also known as iritis) affects the front part of the eye. Iridocyclitis is a form of anterior uveal tract inflammation with the involvement of the ciliary body. Posterior uveitis refers to inflammation affecting structures behind the lens of the eye and encompasses the terms vitritis, intermediate uveitis, pars planitis, chorioretinitis, and retinochoroiditis. Panuveitis is inflammation affecting all layers of the uvea. This type of uveitis can involve other parts of the eye such as the lens and optic nerve.

The symptoms and signs of uveitis vary but most commonly, patients present with a sudden onset of eye pain and redness. Visual changes may be noticed such as an abnormal sensitivity to light, blurred vision, and floaters (spots in the field of vision). An ophthalmologist will examine the inside of the eye to make the diagnosis. The inflammation may be confined to the eye, associated with an infectious disease, or associated with an autoimmune disease. In 34% of cases, uveitis is idiopathic (uveitis of unknown cause).



Autoimmune disease occurs due to a problem with the immune system and uveitis has been linked to several autoimmune disorders. Spondyloarthritis is the most common systemic immune disorder associated with uveitis. It is a group of diseases characterized by inflammation of the joints and/or spine. About 20-40% of patients have acute anterior uveitis (associated with the HLA-B27 gene). Uveitis may develop in 7% of patients with psoriatic arthritis and 2-9% of patients with inflammatory bowel disease (such as Crohn's disease and ulcerative colitis). Uveitis may be the initial manifestation of sarcoidosis, a rare inflammatory condition that affects the lungs, skin, and eyes. Other systemic rheumatic diseases that are linked to uveitis include juvenile idiopathic arthritis (JIA), tubulointerstitial nephritis and uveitis (TINU) syndrome, Behcet syndrome, Blau syndrome, and Vogt-Koyanagi-Harada syndrome.

Due to the number of potential underlying conditions that may cause uveitis, the ophthalmologist may refer a patient to a uveitis

specialist and/or rheumatologist for a comprehensive clinical evaluation and diagnosis of any underlying condition. Rheumatology consultation may also be considered for co-management of uveitis when topical steroid eye drops or local steroid eye injections have not adequately controlled the inflammation, and systemic immunosuppressive treatment is required.

Uveitis should be treated promptly to prevent any long-term complications. These complications may include cataracts, glaucoma and vision loss. The most common treatment for uveitis involves the use of steroid eye drops to help reduce inflammation. In resistant cases, injected steroids, corticosteroid implants, and oral steroids may be used. In some cases, immunosuppressive therapy may be needed to help reduce the abnormal immune system response. This often requires the specialized care of a rheumatologist for medication management and coordination of care with ophthalmology, to ensure patients have the best clinical outcome.

ARA Launches New Gout Center of Excellence



Arthritis and Rheumatism Associates has created a new Gout Center of Excellence (GCOE) to provide prompt relief of symptoms and create a treatment plan to prevent future flares.

WHAT IS GOUT?

Gout is a form of arthritis that develops in some people who have high uric acid. It can cause sudden pain, redness, warmth, and swelling in the joints. It most often affects the big toe, but can also affect other joints like the ankles, knees, wrists, elbows, and hands.

HOW SHOULD GOUT BE TREATED?

Gout is the most common form of inflammatory arthritis and is associated with other medical problems, like cardiometabolic disorders. It is best to see a rheumatologist for evaluation and treatment. Untreated gout can cause joint pain and damage. In severe cases, elevated uric acid can affect other organs including the kidneys, heart, and eyes.

The clinicians at Arthritis and Rheumatism Associates know the importance of seeing a patient who is experiencing a gout flare as soon as possible. Our commitment at the GCOE is to see patients experiencing a gout flare within three business days.

WHAT SHOULD I EXPECT FROM THE GCOE?

The rheumatologists at the GCOE will develop a personalized treatment plan, which may include additional diagnostics, medication, dietary and lifestyle changes, or therapeutic procedures.

To learn more about gout, check out the educational resources at www.arapc.com/gout.

HOW CAN I SCHEDULE AN APPOINTMENT?

We have made scheduling easy through the new ARA Gout hotline. **Call 240-908-GOUT (4688) or visit www.arapc.com/gout.** This service is available at all ARA office locations.

PA CORNER

The Benefit of the PA-Physician Relationship

LAURA ROBBINS, PA-C

You may be hesitant to see a physician assistant (PA) for the first time. A lot of people have never heard of physician assistants or aren't very familiar with the profession. You may have heard of a nurse practitioner (NP). PAs function in a very similar role, just with slightly different training [PAs are trained via a "medical model" and NPs are trained via a "nursing model."] Rest assured that ARA takes your health as the highest priority and ensures that the physician-PA team is beneficial in more ways than one. PAs are skilled clinicians who have graduate training in general medicine. Some PAs complete post-graduate training programs in specialties. PAs can diagnose, order, and interpret



tests, and prescribe medications. Your PA at ARA works very closely with your physician and your physician can see the visit notes generated by your PA to ensure transparency. As a PA, I spend a lot of time reading the latest rheumatology literature/research and engage with

physicians in the practice regularly for continued learning and professional development. Your health is in good hands in a team setting. One of the best outcomes of the addition of PAs to ARA is the idea of increased access to care. Often physicians are booked out months in advance. In rheumatology in particular, many diseases require treatment as soon as possible to prevent further joint damage. In that case, our patients must be seen in a timely fashion. With the help of a PA, new patients can be seen sooner and established patients can be seen more quickly if an urgent evaluation is needed. Your PA and physician team work together to ensure your care goes above and beyond expectations.

Using Ultrasound to Diagnose the Cause of Joint Pain

CHARLIE OSHINSKY, MD

Joint pain is so ubiquitous it is almost a fact of life. At some point, we will all twist an ankle, develop knee pain, or experience rotator cuff tendonitis. Making a diagnosis and treatment plan with your rheumatologist often relies on both the story of the joint pain and imaging technology. Over the years, improvements in imaging technology have enhanced our diagnostic abilities immensely. X-rays remain the imaging workhorse to evaluate the underlying bone. However, X-rays have limited ability to identify tendon damage or active inflammation. MRI, a highly sensitive modality, is expensive, time-consuming, and claustrophobia-inducing. Fortunately, with advances in musculoskeletal ultrasound technology, research, and experience, we now have an additional tool to accurately diagnose and treat many causes of pain.

WHY MUSCULOSKELETAL ULTRASOUND?

Musculoskeletal ultrasound can look at multiple parts of a joint, identifying abnormalities in bone, tendon, muscle, and nerve. Unlike other images, it can be performed in real-time, and dynamic assessment can be performed to look for changes with movement. It can reliably differentiate an inflamed joint from a joint with wear-and-tear arthritis. Musculoskeletal ultrasound is safe and effective and has a large body of research supporting its use.

USE CASES:

Evaluate for inflammation:

If a patient has an autoimmune form of joint pain, such as rheumatoid arthritis, sometimes he or she experiences pain that is not typical of rheumatoid arthritis. Perhaps they thought they sprained an ankle months ago but just has not healed. Or perhaps their knuckles hurt but their hands still appear normal, and we need to decide if there is inflammation that warrants medication. These are perfect situations to use ultrasound, which can identify tell-tale signs of inflammation such as increased blood flow and subtle joint swelling not visible to the naked eye.



Rotator cuff tendinopathy:

Shoulder pain is incredibly common and has several causes. Ultrasound can quickly identify rotator cuff tendinopathy, rotator cuff tears, joint inflammation, and joint swelling, reliably assisting in diagnosis and treatment planning.

Injection and aspiration accuracy:

Historically, choosing where to place a needle, either to remove fluid from a swollen joint or inject medicine into a painful joint, was based on an examination of the joint and an understanding of anatomy. Today, ultrasound allows rheumatologists to determine where the needle should travel before puncturing the skin, and then visualize the needle within tissue. We can pinpoint fluid to remove and inject medication safely and with a high degree of accuracy.

Rheumatologists have pushed the field of musculoskeletal ultrasound forward dramatically, helping providers accurately diagnose and effectively treat many different causes of joint pain.

ARA's MLK Day Community Service Event



This year, ARA's Annual MLK Day Community Service Event was a wonderful opportunity to honor Martin Luther King Jr. by serving the community through Shepherd's Table. Staff members had the chance to serve lunch, organize and clean the dining hall, greet guests, and wash dishes. Donations collected will support Shepherd's Table's mission to inspire hope and improve the quality of life for the most vulnerable. By coming together to help those facing food insecurity, homelessness, and poverty, ARA has shown the power of community and kindness. Let us continue to come together and create a more caring and compassionate world for everyone. Learn more about Shepherd's Table at www.shepherdstable.org.

History of Physical Therapy

ALLISON BERGER, PT, DPT

The practice of physical therapy began in the early 20th century during the First World War. Boston-born, British-educated Mary McMillan served as Director of Massage and Medical Gymnastics at the Children's Hospital of Portland, Maine before being sworn into the US Army in 1918, where she trained fellow young women as "reconstruction aides." These reconstruction aides were educated to perform duties that remain central to modern physical therapy practice, including anatomy and physiology, massage techniques, and rehabilitative exercises.

Physical therapy education grew from that initial training program, first to a bachelor's degree in science, then in 1991 to a master's level, and finally to a doctorate level. Since 2002, all entry-level physical therapists have graduated with a Doctorate in Physical Therapy, educated on those same topics as the first reconstruction aides as well as physics, statistics, exercise science, differential diagnosis, interpretation of imaging, specific techniques for manual therapy, cueing and handling, and education.

The progression from a technician level to a clinical doctorate level has driven many changes in the field, including the intensity of education and training, degree of clinical autonomy, and responsibility to treat in an evidence-based manner. Clinical research in the realm of rehabilitative science has progressed profoundly since the adoption of the doctorate level of education for physical therapists, with some recent research disproving long-held beliefs. For example, a physical therapy appointment for an ankle sprain in 1993 would very likely have included treatment with an ultrasound unit, with the therapist explaining that the sound waves can act to drive healing of the ligaments injured in the ankle sprain. Nowadays, physical therapists know that research has proven ultrasound treatment does not significantly impact the healing of an ankle sprain, so while a PT may still use ultrasound to treat another type of injury, they won't likely use it to treat a sprained ankle.

When Joshua Costa, one of our current Executive Directors of Rehabilitation, joined Arthritis and Rehabilitation Therapy Services (ARTS) in 2006, he was the lone physical therapist practicing out of the Rockville office, with one other PT practicing out of the Wheaton office. Shortly thereafter, Anne Wellington Goldsmith, current Chief Operating Officer, and former Executive Director of Rehabilitation, joined the team to direct the Wheaton PT office. Anne was instrumental in growing both the wellness and PT sides of ARTS, which has since expanded to four locations with multiple therapists in each clinic. ARTS physical therapists are prepared to evaluate and treat any number of neuromuscular, musculoskeletal, and autoimmune conditions. Our PT team boasts excellent outcomes, providing personalized plans and specific education to help our patients improve their pain, mobility, and quality of life.



Team ARA



Dr. Maher,
Medical
Honoree



Youth Honoree

Walk to Cure Arthritis – Frederick

Team ARA once again partnered with the Arthritis Foundation to support the Walk to Cure Arthritis in Frederick, MD, on Saturday, May 18, 2024. This walk is a major fundraiser for the Arthritis Foundation, helping to bring future and expanded arthritis programming to Western Maryland. It is crucial to advancing arthritis research, discovering new treatments, and finding a cure. We were honored that ARA's very own Dr. Katherine Maher was chosen by the Arthritis Foundation as the 2024 Medical Honoree for the event. Dr. Maher has been providing care for patients in the Frederick community since 2019.

Arthritis is the nation's leading cause of disability, with more than 100 types affecting joints and surrounding tissues, causing pain, swelling, stiffness, decreased range of motion, and diminished quality of life. The arthritis community showed great strength as this walk raised over \$23,000! Thank you to everyone who supported this event; your donations will help find a cure for the almost sixty million Americans battling arthritis.



ARA Honors Patients Through the Rheumatology Research Foundation

Rheumatologists have the special opportunity of building long-term relationships with their patients. When their patients pass away, they leave a lasting impact. ARA honors those patients by creating commemorative tributes to the Rheumatology Research Foundation. The Foundation sends a memorial tribute letter to the patient's family, informing them that a donation has been made in their name. These donations are significant because they contribute to rheumatology research, which aims to find cures and better therapies. The Foundation funds programs to increase further access to care, research, and accelerate discoveries of rheumatic care.

ARA collaborates with the Foundation to support its mission to advance research and training to improve the health of

patients living with rheumatic disease. If you or a loved one suffer from a rheumatic disease and you want to make a meaningful donation, below are reasons to consider supporting the Foundation:

- The Rheumatology Research Foundation is the largest private funder of rheumatic research in the country.
- The mission of the Rheumatology Research Foundation is to advance research and training to improve the health of patients living with rheumatic disease.
- Charity Navigator is the nation's largest charity evaluator and has given the Foundation its highest rating of 4 stars for 15 years in a row.

- The Foundation's high level of fiscal responsibility ranks them among the top 0.5% of charities in the nation and allows them to focus on what is most important: the health of patients living with rheumatic disease.
- Thanks to the support of a generous donor, 100% of all gifts made to the Foundation support the delivery of the mission, optimizing and accelerating the power of your philanthropic investment.

If you would like to learn more about how you can make an impact at the Rheumatology Research Foundation, please visit www.rheumresearch.org or contact them at foundation@rheumatology.org.



Rheumatology Research Foundation

Advancing Treatment | Finding Cures

ARA & Arise Take Steps with the Crohn's & Colitis Foundation



On a beautiful Saturday in June, Team ARA joined forces with the Crohn's & Colitis Foundation to Take Steps toward Mt. Remission and find cures for inflammatory bowel disease (IBD). This event aims to raise awareness and funds for IBD research and treatment and to support critical patient programs. Take Steps is the Crohn's & Colitis Foundation's largest fundraising event, bringing communities together to support IBD patients and their families.

Grace Cruz, RN, Arise Clinical Infusion Director, was recognized as the Healthcare Professional Honored Hero for the walk. This marked the first time that an Arise Infusion Therapy nurse had been named a Healthcare Honoree. We were delighted that Grace had the opportunity to represent the Arise nurses. Arise Infusion nurses administer medications for autoimmune conditions, including IBD such as ulcerative colitis and Crohn's Disease. These nurses spend a significant amount of time with infusion patients throughout their treatments and get to know them and their families as well.

Crohn's disease or ulcerative colitis, collectively known as IBD, affects 1 in 100 Americans. This walk was a huge success—over \$204,000 was raised towards finding a cure! We thank everyone who contributed.

Grace Cruz, RN

Quinoa, Black Bean, Arugula & Spinach Ragout

From the kitchen of Cleveland Clinic

INGREDIENTS:

- 3 Tbsp. extra virgin olive oil
- 4 cups onion, medium diced
- 1 Tbsp. fresh garlic, minced
- 3 cups fresh broccoli, cut into similar size florets
- 1 15-ounce can of black beans, low sodium, rinsed and drained
- ¼ tsp. black pepper, coarsely ground
- 2 each, 23- to 25-ounce jars of tomato pasta sauce, no added sugar
- 1 Tbsp. hot pepper sauce
- ½ cup arugula ½ cup spinach stems removed
- 2 cups, cooked (2/3 cup raw) red quinoa*, pre-rinsed, cooked as directed on package *White, black, or tricolored quinoa can be substituted for red.

DIRECTIONS:

1) In a large skillet over medium heat, heat the olive oil and sauté onion until light golden brown. Add the garlic and cook until aromatic, about one minute.

- 2) Add broccoli florets and black beans. Sauté three minutes while stirring.
- 3) Add the black pepper, tomato sauce, and hot sauce.
- 4) Add the spinach and arugula and stir until thoroughly heated and greens just begin to wilt.
- 5) Add the pre-cooked quinoa, bring to a simmer, mix, and serve.

CHEF'S NOTES:

- Be sure to buy pre-rinsed quinoa or rinse before cooking to remove its natural saponin coating and the bitter flavor associated with it.
- Easily modify this recipe with different types of beans, greens, or grains of your choice.
- Broccoli tastes best when it's al dente (crunchy). Scoring the stalk allows the stem to cook more evenly with the florets in a shorter time.
- Sautéing the onions until golden and caramelized adds sweetness to the ragout.

SERVES 6. SERVING SIZE: 1 1/3 CUP | NUTRITIONAL INFO - CALORIES: 320
 SODIUM: 220 MG | SUGARS: 15 G | CHOLESTEROL: 0 MG | SATURATED FAT: 1 G
 FIBER: 12 G | PROTEIN: 12 G | CARBOHYDRATES: 52 G



FUN RHEUM:

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

Find these words in the puzzle at left.
 Words can go in any direction.
 Words can share letters as they
 cross over each other.

- Phillpotts
- Uveitis
- Gout
- Excellence
- Flare
- Ultrasound
- Joint
- Arthritis
- Therapy
- Musculoskeletal
- Inflammation
- Colitis
- Physical
- Psoriasis
- Sjogren's

RHEUMORS

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RHEUMORS

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ARA in the Community

Arthritis and Rheumatism Associates is proud to take part in and collaborate with organizations that provide resources, awareness, education, and fundraising for many conditions and diseases that our clinicians treat.



Dr. Daniel El-Bogdadi was a Featured Expert during the Ask the Expert Q&A segment of the **2024 Mid-Atlantic & National Walk for Sjögren's** on Saturday, April 13, 2024. Dr. El-Bogdadi has been caring for Sjögren's disease patients for over 20 years. This year, the

Sjögren Foundation is also commemorating 40 years of Sjögren's progress. This walk raised more than \$25,000! These walks raise vital Sjögren's awareness and crucial funds to support education and research efforts. Sjögren's Syndrome is just one of the 100+ conditions that fall under the category of rheumatic disease. More than 50 million Americans currently live with these diseases.



Dr. Evan Siegel was honored by the National Psoriasis Foundation (NPF) at their Soirée & Play event in April for his dedicated years to psoriasis treatment. The NPF event raises awareness and critical funds to fuel the mission of the National Psoriasis Foundation.



While Dr. Siegel cares for all rheumatic diseases, he has a special interest in psoriatic arthritis and other spondyloarthropathies. He has served on the steering committee of the International Group for Research and Assessment of Psoriasis and Psoriatic Arthritis, authored treatment guidelines, and written academic papers on diagnosing and treating psoriatic arthritis. Dr. Siegel is a member of PPACMAN's steering committee, a group dedicated to combined clinics in rheumatology and dermatology. He also serves as a clinical consultant to the NIH, and has received the NPF's Most Outstanding Physician award.