

ARA GROWS IN PHYSICIAN AND LOCATION NUMBERS

In January 1997, we enthusiastically opened a new office at 2021 K Street NW, Suite 300, Washington, DC. Two Board Certified Rheumatologists, David G. Borenstein, M.D. and Vicki L. Star, M.D., previously members of the faculty of the Division of Rheumatology at the George Washington University School of Medicine, joined our practice and began seeing patients in our new K Street office. This brings the number of physicians in our group to seven Board Certified Rheumatologists practicing in four locations. Profiles of our new physicians appear elsewhere in this issue of Rheumors.

Our new office is conveniently located in a modern, handicapped-accessible building only two blocks from both the Farragut North and the Farragut West Metro Stations. For those who prefer to drive, there is ample parking available in a garage located adjacent to our building.

For our patients' convenience, we offer x-ray, lab and a select number of clinical research trials at our new location. In addition, we have opened our third Osteoporosis Assessment Center (OAC) to better serve our downtown patients. OAC is housed within Suite 300 and contains a state-of-the-art Lunar IQ DEXA machine. The same commitment to high quality imaging, reporting and patient education that has become synonymous with the other OAC locations remains our standard.

Please be sure to inform your family and friends of our additional location. We are striving to make visits to our physicians as convenient as possible for those who live or travel downtown.

WE'D LIKE YOU TO MEET.....

Vicki L. Star, M.D. is a native of the Washington, DC area who attended Walt Whitman High School. Her undergraduate degree was earned at Boston University and her Doctor of Medicine degree at Howard University in Washington, DC. Internship and Residency programs were completed at Sinai Hospital in Baltimore, MD and her fellowship training in Rheumatology was served at the University of Maryland Hospital in Baltimore. During her last year of training, Dr. Star was awarded the "Senior Rheumatology Scholar Award" by the American College of Rheumatology. This award is presented to fellows in their last year in recognition of superior achievements.

During her fellowship training, Dr. Star was greatly involved in both the treatment of patients with Osteoporosis and clinical research relating to the disease. This ignited an interest in the field which Dr. Star continues to pursue today. Her interest is now enhanced by the introduction of a third Osteoporosis Assessment Center (OAC) to the Washington Metropolitan Area which is located in our new office at 2021 K Street NW, Suite 300.

After completing her fellowship, Dr. Star returned to the DC area where she became an Assistant Professor of Medicine at The George Washington University Medical Center in the Division of Rheumatology. She remained there for 3 ½ years before joining Arthritis and Rheumatism Associates, P.C. (ARA) in private practice. Her attraction to the world of academics was related to the unique opportunity to combine clinic work with research and teaching.

Asked what excites her about private practice, Dr. Star replied, "I like the aspect of dealing with patients with long-term illnesses. I can really get to know my patients, follow them closely and have the satisfaction of seeing them improve and become more functional." Dr. Star is currently conducting a clinical research trial in the DC office involving a topical anti-inflammatory for osteoarthritis, so she is able to continue her interest in research as well.

The youngest of three daughters, Dr. Star became interested in the sub-specialty of Rheumatology because she, herself, suffers from Juvenile Chronic Arthritis. As a young woman, she participated in a research study involving Physical Therapy which piqued her interest in research and patient education.

Dr. Star is involved with many local organizations including the Lupus Foundation, the Arthritis Foundation, the Medical Society of DC, the Washington Bone Club (where she is Secretary), and the Rheumatism Society of DC (where she will be President). Dr. Star continues to teach at the G.W.U. on a part-time basis and lectures frequently. She has also had articles published in Gout and Rheumatoid Arthritis.

For enjoyment, Dr. Star cheers on the Redskins – she is a *BIG fan*, does volunteer work for The United Jewish Appeal, sews, fiddles with photography and computers and spends time with her young nieces and nephews. She looks forward to building a stimulating and successful career with ARA beginning with helping to develop our new NW Washington DC office.

LET US INTRODUCE US TO.....

David G. Borenstein, M.D. grew up in Miami Beach, Florida and his family still lives in the Ft. Lauderdale area. He traveled north to get his education beginning with undergraduate studies at Columbia University in New York followed by medical school, internship, residency and fellowship training at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital in Baltimore, Maryland.

Dr. Borenstein's interest in medicine was sparked by his brother who is eight years his senior and is a neurologist. His interest in rheumatology was inspired by two physicians at Johns Hopkins University who became his mentors and whom he decided to emulate. Dr. Borenstein came to Washington, DC after his fellowship was completed and took a position as part of the medical faculty, rising to the rank of Professor of Medicine, at The George Washington University Medical Center. He remained there for 18 years. What turned him on about academic medicine? "The combination of teaching, seeing patients and research. I trained at least 20 individuals who became Rheumatologists and now practice in areas all across the country." Now that Dr. Borenstein is in private practice, will he miss teaching on a full-time basis? "Teaching is in my blood," says Dr. Borenstein. "Doctors are teachers. Now I will teach the public."

After Dr. Borenstein left Johns Hopkins, he expected Lupus to be his area of specialization. But, in DC, he came to find out that low back pain was a prevalent disorder. He became very interested in the subject, and with much encouragement from the Orthopedic Surgeons at G.W., he began evaluating their patients. When he had enough experience and felt he had enough important information to share with others, he began to write about the topic. The result is a book, now in its second edition, entitled Low Back Pain Medical Diagnosis and Comprehensive Management. This book is on the *Selected List of Books and Journals for the Small Medical Library*. This list consists of books that experts Brandon and Hill feel every medical library should contain. There are only 14 books on Orthopedics on their list and Dr. Borenstein's is one of them.

Dr. Borenstein published a new book in 1996 entitled Neck Pain Medical Diagnosis and Comprehensive Management and in 1997; he authored the section on *Connective Tissue Disease* for Conn's Current Therapy.

Among Dr. Borenstein's distinguished achievements is his membership in the International Society for the Lumbar Spine. Society membership is limited to 250 active members throughout the world. One has to be elected to the Society and currently Dr. Borenstein is one only six Rheumatologists in the world to belong. Dr. Borenstein will travel to Singapore in June to present a paper to the Society.

Dr. Borenstein lectures regularly around the country both for the American College of Rheumatology and pharmaceutical companies.

In his spare time, Dr. Borenstein plays squash, skis, and listens to music. He is married to an attorney who practices Family Law and has three daughters ages 19, 16 and 14. He is now comfortably steered into private practice with ARA where he sees patients daily at our new NW Washington, DC office.

ANSWERS TO YOUR QUESTIONS

Q: Does an “arthritis cure” really exist?

A: Millions of patients with arthritis of all types have been looking for a cure. Those who are more realistic are looking for ways to supplement their response to more traditional medications. Recently, Dr. Jason Theodosakis published his remedy for arthritis in “The Arthritis Cure.” Despite the injudicious title, Dr. Theodosakis makes no wild claims for a cure. He does promote the use of glucosamine (GA) and chondroitin sulfate (CS) in combination with an eight-point program to treat osteoarthritis (OA). He does not claim that a cure for OA, or the over 100 other types of arthritis, exists. Rather, some patients may get some benefit using the recommended regimen.

GA and CS are both synthesized by the body and are important constituents of the cartilage that caps the end of our bones at the joint. GA, taken orally, does find its way to cartilage. European studies done in the early 1980’s suggested that GA could slow cartilage breakdown. Subsequent studies of the GA-CS combination suggest that OA symptoms may be reduced and cartilage production may be stimulated.

GA-CS is classified by the FDA as a food supplement, not a drug. Therefore, it is available over the counter (OTC) without a prescription. As a food supplement, it is not regulated by the FDA for purity, safety, or efficacy. Many people are surprised to hear that OTC “food supplements,” including vitamin and mineral supplements, are not subject to regulation and therefore are not standard preparations. Many of the GA-CS preparations contain little of the active compounds and are of dubious value. Thus far, safety of these preparations does not seem to be an issue.

Patients contemplating use of the GA-CS combination should know that this is not a cure for osteoarthritis or any other form of arthritis. Small studies have suggested modest benefit and only larger controlled studies will eventually determine if GA-CS offers real help in treating OA. Even Dr. Theodosakis’ program includes the American College of Rheumatology recommendations for weight reduction, muscle strengthening, and proper diet. Many patients will improve with these achievements alone. While we don’t have a cure for arthritis, the prospect for better management is always improving.

Q: Can antibiotics be used to treat arthritis?

A: Infectious arthritis is caused by the direct invasion of the joint by a bacteria or virus. Sometimes the body’s response to an infection elsewhere may result in an immune response that causes inflammation within the joint. Either way, infection can cause joint swelling, pain, and even joint damage. Lyme disease, post streptococcal arthritis, gonococcal arthritis, and the arthritis of measles are all examples of arthritis resulting from infection.

Antibiotics are essential in treating and curing arthritis caused by bacterial infection. However, the causes of most types of arthritis, including the most common types such as rheumatoid arthritis and osteoarthritis, are unknown. Bacteria and other infections have been postulated to play a role in the cause of many types of arthritis, but their role has been unsubstantiated. Despite this, antibiotics have been proposed as treatment for many types of arthritis.

Recent studies have evaluated the role of antibiotics in both rheumatoid arthritis and osteoarthritis. Although there is no evidence that either of these types of arthritis is caused by infections, the studies do suggest that the tetracycline class of antibiotics may offer some benefit. In these cases the antibiotics, minocycline and doxycycline help retard the activity of the metalloproteinase and collagenase enzymes that lead to joint damage.

In these situations, the tetracyclines are not acting as antibiotics, have relatively modest antiarthritis activity, and must be continued long-term for continued benefit. Only about 30% of patients will respond and most will need to continue on standard arthritis therapy. The tetracycline and antibiotic story is interesting enough to warrant more research. The NIH has on-going trials looking at the role of antibiotics in arthritis treatment.

Q: How are the dry eyes and dry mouth of Sjogren's Syndrome treated?

A: Sjogren's Syndrome (SS) is an autoimmune condition characterized by dry eyes, dry mouth and often arthritis. The dry eyes are best treated with eye drops that add moisture to the eyes. Eye drops are available as thin watery drops that moisten well, but need to be applied frequently. More viscous eye drops last longer, but may blur vision in some patients. These are best used at night. Tears may last longer if the tear drainage is blocked temporarily or permanently with punctual occlusion performed by an ophthalmologist. Goggles and humidification may also help keep eyes moist.

Salivary substitutes, frequent sips of water, and salivary lubricants all help keep the mouth moist. Products such as Glandosane and Salix SST can stimulate the production of normal saliva provided there is some residual salivary function. To prevent the complications of dry mouth good dental care is necessary. Frequent use of fluorinated toothpaste and mouthwash, as well as regular dental care, including fluoride applications, are necessary to prevent tooth decay. Sugarless mints and candies may help stimulates salivary flow. Sugar containing candies are to be avoided, as they will promote rapid tooth decay.

Oral pilocarpine (Salagen) is now available and often will help stimulate saliva and tear production.

Patients suffering from Sjogren's with dry eyes may be eligible to participate in a clinical trial of anew agent to treat dry eyes and mouth. Please ask your physician, or contact our Clinical Research Department, for details.

POINTS ON JOINTS

PREVENTION OF OSTEOPOROSIS: AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE

Vicki L. Star, M.D.

Normal bone is strong and resistant to fracture. Osteoporosis is a disease that weakens bones, causing them to become brittle and more likely to break. This is the result of a loss of calcium, which in its most severe form can make bones more susceptible to fracture with even minor trauma.

Osteoporosis is a major health problem in the United States. It is one of the most common bone diseases in developed countries. Osteoporosis affects an estimated 20 million people in the United States which results in 1.5 million fractures per year with 250,000 of these being hip fractures. By the year 2040, it is estimated that the number of hip fractures will more than double and will cost over \$240 billion in health care dollars.

Bone growth and loss is a continuous cycle that occurs throughout one's life. The strength of the bones is referred to as the bone "density" or the bone "mass." Bone density is built up until the end of adolescence, a time when bone gain is greater than bone loss. After adolescence, bone gain equals bone loss until the time of menopause. The balance of bone growth and loss is changed at the time of menopause primarily because of a decline in estrogen levels, a hormone which helps to preserve bone mass. Women may lose as much as 25% of their bone mass around the time of menopause.

While there are several causes of osteoporosis, the most common is menopause in women. Menopause may either occur naturally as part of the aging process, or at the time when the ovaries are surgically removed. Other causes of osteoporosis in men and women include corticosteroid (prednisone) therapy, thyroid supplementation (if given at too high of a dose), rheumatoid arthritis, systemic lupus erythematosus, parathyroid abnormalities, and vitamin D deficiency, among multiple others.

Bone loss occurs without any symptoms until a fracture occurs. Patients or their physicians may notice a decline in height or the onset of curving of the upper spine, sometimes called a dowager's hump. However, the patient is generally unaware that their bones are weakening. Once enough bone is lost, a minor fall, cough or sneeze may result in a fracture.

There are two main goals in the prevention of osteoporosis: 1] to attain maximum bone quantity during adolescence and 2] to maintain bone during adulthood and prevent bone loss at menopause.

There are several ways to attain maximum bone mass during childhood. Genetics plays an important part in the bone mass achieved, along with several other factors. Adequate nutrition, activity and weight are all crucial to reaching the goal of maximum bone. Calcium during childhood is essential for the development of bones. Children should consume between 800-1200 mg. of calcium per day (see table 1) while participating in regular exercise. Calcium may be taken in the form of food products or supplements.

Recommendations to prevent bone loss in the adult are similar to those in the child and adolescent, with the addition of estrogens after menopause if the patient is able. Calcium supplementation still remains important in maintaining adult bone, however, the requirements

may differ (see table 1). In addition, regular weight bearing activities, such as walking or low impact aerobics may increase bone strength. Cigarette smoking and excessive alcohol intake should be avoided. Unfortunately, the above measures, if used alone, are often inadequate to stop the rapid bone loss experienced at the time of menopause. Estrogens are effective in controlling the rapid bone loss that occurs around this time. For patients who are not able to take estrogens, Alendronate (Fosamax) has recently been approved by the Food and Drug Administration for the prevention of osteoporosis.

Finally, an ounce of prevention is worth a pound of cure. Preventing osteoporosis by using the guidelines mentioned is the most effective way to diminish bone loss and to decrease the risk of fracturing a bone. It is much easier to prevent bone loss before it occurs, than to treat osteoporosis after a significant amount of bone has already been lost. Preventive measures should begin in childhood and should be maintained throughout one's life.

Table 1 – Optimal Calcium Requirements		
<i>Age</i>		<i>Daily Intake (Mg Calcium)</i>
1-5 years old		800
6-10 years old		800-1200
11-24 years old		1200-1500
Men	25-65 years old	1000
	Over 65 years old	1500
Women	25-50 years old	1000
	Postmenopausal Not taking hormones	1500
	Postmenopausal Taking hormones	1000
	Over 65 years old	1500

RHEUMINATIONS

CLINICAL TRIALS 1996-1997

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

The Center for Rheumatology and Bone Research is the new name for our clinical research unit. Research studies have been conducted in this practice for the past 15 years, allowing our physicians to be at the vanguard of therapeutics in Rheumatology and giving our patients unique access to new treatments that would otherwise be unavailable.

This spring the Center has been busier than ever. A number of new medicines are actively under study by our physicians and our Clinical Research Coordinators, June Carter, Maureen Montgomery, Jennifer Rocca, and Debbie Schley. Some of the Center's research involves treatments with newly developed medicines for Osteoporosis, Rheumatoid Arthritis, Osteoarthritis and Sjogren's Syndrome that have not yet received FDA approval and are only available to patients through research protocols. We have participated in many nationwide trials that, over the years, have led to the release of a number of new arthritis medications. We have assisted such companies as Pfizer, Eli Lilly, Proctor & Gamble, Searle, Merck, Immunex, Schering Plough, Upjohn and Wyeth-Ayerst.

For patients interested in participating in clinical research we have a number of new protocols:

RHEUMATOID ARTHRITIS (RA):

We are currently recruiting patients with early RA for participation in a study that compares a new biologic agent to methotrexate. This agent inhibits communication between the white blood cells which promote inflammation in rheumatoid arthritis. Exciting reports about this agent first made it into the national media last fall when extraordinary results were reported at the meetings of the American College of Rheumatology.

In a second clinical trial, we are enrolling patients with RA for less than six years who have had an incomplete response to methotrexate therapy. These patients may be eligible to enroll in a program comparing Methotrexate alone to Methotrexate in a combination with a second immuno-suppressive agent.

Finally, we have been asked to participate in a trial of a genetically engineered copy of a substance produced naturally by white blood cells in humans, which can help turn off the chronic inflammation seen in Rheumatoid Arthritis. To be eligible, a patient must have Rheumatoid Arthritis and have failed to respond to one or more disease modifying drugs.

OSTEOARTHRITIS OF THE KNEE OR HIP:

We are looking for patients currently on stable treatment with anti-inflammatory agent (NSAIDS). We have three different programs that are actively enrolling. These protocols are designed to evaluate new NSAID drugs that are anticipated to be free of gastro-intestinal side effects (COX-2 NSAIDS)

SJOGREN'S SYNDROME:

Patients with dry eyes and dry mouth caused by this condition may be eligible to participate in one of two clinical trials evaluating a drug that is expected to enhance salivation and tearing. In all of these programs diagnostic testing, medication and physical visits are free of charge. We would be delighted to review the specifics of these program with you. Please feel free to discuss your interest with your physician during your next visit to the office.

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ACROSS	DOWN
3 Brittle in osteoporosis	1 Inflammation of skin, sometimes allergic reaction to drugs
6 People with disabling arthritis may need for daily activities	2 Chronic inflammation of skin, red patches with scales
7 Type of arthritis that causes symmetric inflammation and may be progressive	4 Body fluid most often tested to monitor arthritis and its therapy
10 Another name for I	5 Some people say arthritis worse just before
11 Often first body part affected in Gout	8 Back of foot, unthoughtful person
12 Butterfly rash on face, arthritis, kidney problems	9 Ben Franklin's arthritis, was thought to be associated with rich food
<i>See page 6 for answers</i>	13 Most common direction of body weight while on steroids (Prednisone)

PRACTICE NOTES

- Dr. David G. Borenstein will present a paper entitled “Mexiletine Therapy for Persistent Neuropathic Radicular Pain; An Open Trial of 11 Patients” to the International Society for the Lumbar Spine when they meet in Singapore in June.
- Dr. Norman S. Koval and Dr. Herbert S.B. Baraf have been appointed Clinical Associate Professors of Medicine, Department of Rheumatology, at the University of Maryland School of Medicine.
- Dr. Robert L. Rosenberg is the immediate past president of the Rheumatism Society of D.C.
- Dr. Vicki L. Star is the incoming president of the Rheumatism Society of D.C.
- Dr. Evan L. Siegel is featured in a discussion of Arthritis as part of the variety show “Tacoma Coffeehouse,” seen on The Montgomery County Channel (49/22) and the Tacoma Park Channel (54/14) on Cable TV.
- Dr. Herbert S.B. Baraf and Dr. Emma DiIorio were interviewed for local news channels 8 and 9 regarding exciting new arthritis medications currently being evaluated as part of our drug study program

Answers:

1-Rash, 2-Psoriasis,
3-Bone, 4-Blood, 5-Storm,
6-Help, 7-Rheumatoid, 8-Heel,
9-Gout, 10-Me, 11-Toe,
12-Lupus, 13-Up