LABORED Breathing

Strategies to diagnose and manage dyspnea in the scleroderma patient

By Richard M. Silver, MD

Scleroderma (systemic sclerosis or SSc) is one of the more challenging conditions for rheumatologists to diagnose and manage. Diagnosis may be difficult early in the course of the disease when signs and symptoms (e.g., arthralgia, fatigue, stiffness, and puffy hands) are nonspecific. Once the diagnosis has been established, more challenges confront the rheumatologist, who must investigate and manage a myriad of complaints referable to the multiple organ systems affected by scleroderma. A particularly important aspect of management involves the patient with dyspnea.

In this review I will provide my personal approach—one based on evidence from the medical literature and more than 25 years of experience caring for SSc patients. continued on page 16

MEDICARE'S Part D prescription drug benefit provides coverage to those who otherwise might not be covered, but the design of the system creates barriers to prescribing some medications commonly used to treat RA.

Thus concludes a representative sample of rheumatologists completing the first year of working with the new Part D prescription benefit. Granted, any new program—particularly a large one initiated and administered by the national government—is going to experience initial glitches that require time to surface and to reveal their effect on the overall functioning of the program.

Nevertheless, because of factors inherent to the field of rheumatology and to serving an aging population, rheumatologists are finding that the Centers for Medicare and Medicaid Services (CMS) has some work to do before Part D becomes a smoothly functioning, comprehensive prescription drug program for patients with rheumatic diseases. continued on page 22

Who Will Treat Arthritis in 2025?

ACR study documents shortage of rheumatologists and predicts greater shortfalls to come

By Terry Hartnett

Results of the first rheumatology workforce study in the past 10 years were released last November, confirming concerns that the supply of rheumatologists may not meet demand in the near future. The extensive report, commissioned by the ACR, lays out the hard facts about this medical specialty that its practitioners had long anticipated were true—the number of practicing rheumatologists does not meet the current or future needs of the patient population, patients are waiting longer for appointments, and practices must be redesigned to preserve and improve the quality of the profession. Article on page 12

medicare d-lemmas

Rheumatologists and patients report mixed experiences with the new prescription drug benefit

By Ann Kepler

Medicare’s Part D prescription drug benefit provides coverage to those who otherwise might not be covered, but the design of the system creates barriers to prescribing some medications commonly used to treat RA.

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Ask any rheumatologist why he or she chose to pursue a career in rheumatology and the answers will be as unique as the individual. Dig deeper, though, and you tend to find that at the heart of this choice, rheumatologists are attracted to this field because of the challenging diseases we treat and caring for patients who have them. From that initial attraction, rheumatologists can choose to pursue a career in any number of settings, with the majority choosing private practice (although many in other settings still continue to see patients). At the end of the day, though, we are all rheumatologists trying to improve the lives of patients with rheumatic diseases. To that end, all practicing rheumatologists—regardless of workplace setting—should care about practice advocacy efforts for rheumatologists.

**Practice Advocacy Defined**

I’m often asked what, exactly, practice advocacy is. Practice advocacy is an umbrella term for organized activism related to issues that affect a physician’s practice. This can include representing the specialty for coding valuation, lobbying Congress for favorable legislation, working with CMS to address reimbursement issues, advocating policy change with an insurance company, assisting members with coding compliance issues, and developing and delivering quality education on practice management issues—just to name a few examples.

The ACR does all this and more for all practicing rheumatologists in the United States. Through volunteer groups such as the Committees on Rheumatologic Care and Government Affairs and the Regional Advisory Council, as well as through advocacy and professional coding staff, we assiduously work on issues that directly affect your professional practice life.

**ACR Advocacy Activities**

Private practitioners face a myriad of little questions that can have a big impact on practice. How do you know you’re accurately coding a procedure and receiving appropriate reimbursement? How is pending or recently enacted legislation going to affect you and your patients? What’s the latest information on electronic health records? Do you have the tools you need to assess the Medicare fee schedule and Part B versus Part D, and their effects on your practice? Are your documentation aids up to date? It is easy to get caught up in the routine of our day-to-day professional lives, but when you have an issue in your practice, do you know where to turn?

Turn to the ACR. We offer a wide range of resources and tools to help you run a successful practice. Here’s just a glimpse of our offerings:

**Coding compliance:** The ACR employs two certified professional coders, Melesia Collins and Resaee Freeman, who are available to answer coding questions and address insurance problems. If you have a problem receiving reimbursement for imaging studies or medications, contact our coders. Sometimes the problem can be handled by adjusting your coding; other times, a letter may need to be sent from the ACR requesting that the insurance company change their policy. The coders have assisted hundreds of mem-
The Regional Advisory Committee is made up of regional advisors who are available to discuss insurance and practice management issues related to a specific region or state. If you feel your issue is broader in scope, feel free to contact any member of the ACR Committee on Rheumatologic Care (CORC). During the past year, the ACR CORC and regional advisors have successfully changed some insurance company policies to assist practicing physicians. Selected achievements include:

• Convincing an insurance company to change its policy that patients on anti-TNF medications must also be on methotrexate.
• Changing a non-reimbursement decision by an insurance committee that would not allow patients to receive IV hydrocortisone sodium if they were unable to take the oral version.
• Reopening a comment period for an insurance company trying to restrict the number of c-reactive proteins that can be reimbursed during a year.
• Convincing an insurance company to change its policy requesting additional documentation when reporting modifier -25.

The regional advisors also attend state and local rheumatology meetings to review relevant ACR activities, discuss the issues faced by members in your area, and gather feedback on what services and resources the ACR can offer to better assist you in your practice.

Practice tools: At www.rheumatology.org, we offer nearly two dozen practice management tools for use with documentation (including academic tools for teaching physicians and pediatric-specific tools), HIPAA compliance, and fee schedule and coding assistance. In our “Patients & Public” section we offer more than 50 complimentary patient education pieces examining a wide range of diseases and related issues, medications, and lifestyle issues. If you are interested in subscribing, visit the ACR Web site at www.rheumatology.org and follow the links. Encourage your staff to sign up for the coding and practice management list serve.

Legislative advocacy: The ACR Government Affairs Committee undertakes activities regarding pending and proposed legislation that may have an effect on our members and their patients. We issue legislative alerts, facilitate and conduct Hill visits between ACR leaders and members and key Congressional leaders and their staffs, host legislative receptions, and initiate letter-writing campaigns to influence the outcome of legislation. We have an outstanding online Legislative Action Center where you can learn more about the pending issues affecting our profession, locate and communicate with your House and Senate representatives, and learn more about how you can become involved in legislative advocacy efforts.

Courses: The Committee on Rheumatologic Care develops educational sessions for the ACR State-of-the-Art meeting in April and the annual meeting each year. These sessions focus on coding, compliance, electronic medical records and more. Interested in seeing a specific topic? Let us know.

Let Us Know What You Think
If you want to see additional services, or if you have suggestions for how to improve our efforts, please contact us. We are constantly looking at ways to improve the practice environment for every one of our practicing members. Additionally, if something has worked well for you—a particular letter or program in your office—let the staff know or post it on the list serve. As rheumatologists, our best outcomes will occur when we work together to improve the practice environment of rheumatology.

Dr. Birnbaum is president of ACR. Contact him via e-mail at birnbaum@rheumatology.org.

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The World is Round

How to stay grounded when communications and information fly

By David S. Pisetsky, MD, PhD

The 2006 meeting of the American College of Rheumatology was the biggest in history and most certainly the best. The clinical and basic research was spectacular. The attendance topped 12,000 people. Importantly, attendees journeyed from all over the world to Washington, D.C., to speak and to learn. In its spirit and variety, this conclave attested to the globalization of rheumatology and its vibrancy on every continent.

Adding to the excitement of the meeting was the striking new Washington Convention Center. The building is beautiful—if not cavernous—and sits at the center of an area that had once been one of the most rundown and dangerous places in the district. At a museum I visited, a pleasant and solicitous docent politely described the area as having been “seedy.” Economic growth and visionary civic leadership have transformed a site of desolation and decay to a modern nexus of commerce and culture.

While I can marvel at all the whiz-bang and information fly off the presses and you grasp it in your hands, pride, delight, and relief surge simultaneously. That first issue is a milestone and a cause of celebration but, as the bubbles of champagne stream joyously to the top of the glass, reality hits home as the deadline for the next issue looms and two articles are already late.

In any artistic endeavor, like editing a magazine, there is a bit of a Sisyphusian travail. The difference is that, with art, pushing the stone to the top of the mountain is as exhilarating as it is exhausting and, once at the summit, the view is great. Until the stone plunges back to the bottom of the slope, you can savor the smart writing and brilliant color shining on every glossy page.

Another difference between the work of an editor and Sisyphus is that the editor should not be alone on the ascent and that is the main point that I wish to make in this column. TR is a publication both for and by the membership of the ACR. It will succeed best as a team effort. TR needs ideas for articles that will stir interest because they engage the heart and soul of today’s rheumatology practice.

TR is the voice of the members of ACR and ARHP and, as described by Peggy Crow in her thoughtful and eloquent presidential speech, an essential venue for communication for our organization. Given the diversity of the ACR and its division, the ARHP, there will be a multitude of voices. I urge everyone to contribute your ideas and join what should be an entertaining and absorbing conversation about the state of rheumatology as well as its future.

Over-Wired Lives

While I was in Washington, I was struck by both the power and paradoxes of modern communication. Like many of my colleagues, each morning I strapped onto my belt my Blackberry and cell phone, making sure that my cell phone was on the vibrate mode. (To the person whose cell phone blasted “Moonlit Haze” during a session in Ballroom B/C, please learn to use the controls of your miraculous little gizmo I am no techie but I have mastered the buttons. If I can do it, so can you.)

Stoked electronically, I was ready to receive calls and missives from the deep reaches of cyberspace. In the midst of a crowded lecture room bathed in the radiant glow of PowerPoint, the buzz from one of these electronic contraptions is actually kind of nice. There is excitement as the email is opened and I look expectantly at the little screen for some piece of good news, like a paper accepted or an invitation to a chic new bistro.

Alas, the content of most of the 240 emails I received in Washington was trivial. As I learn with grim regularity, Olga in Russia is still looking for a man to transcend national boundaries. To Friedman, the flat world is a good world.

I am as dependent on the flat world as anyone else is, but I miss the round world. At the ACR meeting, I missed seeing many of my friends. I exchanged far too few handshakes, kisses, and hugs, and my desire to finish a conversation with a close friend and say a proper farewell went astray as I became lost in the overwhelming expanse of the convention center.

While Friedman uses flat to signify closeness and proximity, the word has other more less positive meanings. Among its slew of definitions in Webster’s dictionary, flat can mean dull, lifeless, and insipid. Friedman doesn’t emphasize that danger of a flat world but it is omnipresent and lurking.

As a vehicle for communication, TR is old fashioned. It is a product of a bumptier and more variegated world and it will overflow with images, feelings, and personality. To enliven its pages and put a picture in the beautiful frame that Wiley has fashioned, TR needs you. It needs your ideas, opinions, advice, recollections, remembrances, questions, answers, cogitations, proclamations, and yes, even your shrinks and your rants.

Our lives are too flat.

Write for TR.

Keep the world round.}

More than 13,000 rheumatologists, health professionals, and other guests of the globe attended the 2006 ACR Annual Meeting in the Washington Convention Center.

The Renaissance Lobby, however, is a dark and gloomy place and many a rendezvous could be completed only with the coda of a cell phone conversation. “It’s 1:15.” “Where are you?” “In the lobby. I’ve been waiting for you.” “I can’t see you.” “I’m near the front desk. Turn around.” “Oh, I see you. You’re behind a plant.”

Reconnect the Map

Thomas Friedman, in his best-selling book entitled The World Is Flat, elevated the title into a mantra for our modern era of electronic communication. In this conceptualization, the flat world, linked instantly and immediately by myriad fiber optic networks, reorganizes life and work to promote unprecedented communication and cooperation that transcend national boundaries. To Friedman, the flat world is a good world.

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Write for TR.

Keep the world round.
Abstract

Study design: A retrospective, follow-up cohort study.

Objective: To evaluate the 25-year (or longer) outcome of discectomy for lumbar disc herniations by validated instruments.

Summary of background data: A comprehensive patient-oriented evaluation should include measurements of pain and disability along with a reliable evaluation of the general health status. There is a paucity of data from validated measuring instruments on the very long-term outcome of lumbar discectomy.

Methods: The authors conducted a follow-up study of 201 patients an average of 27.8 years (range 25-32) after lumbar discectomy. The patient-oriented assessment included a Short Form-36 Health Survey questionnaire, Oswestry Disability Index, Cumulative Illness Rating Scale, and a study specific questionnaire dealing with daily life activities and satisfaction with the surgery.

Results: The Short Form-36 Health Survey physical scales and summary scores were similar to the normative values for healthy subjects and were better than the scores of patients with untreated sciatica with respect to reported pain. The mean Oswestry disability score was 17.5. Satisfaction with surgery was expressed by 181 of 201 patients (90%).

Conclusions: Patients who had undergone lumbar discectomy a minimum of 25 years earlier have a satisfactory self-reported health-related quality of life and less pain than non-surgically treated subjects.

Commentary

An important concern for patients with radiculopathy associated with intervertebral disc herniation involves the better short-term and long-term outcomes associated with surgical discectomy versus medical therapy. Patients need to balance the possibility of rapid resolution of back and leg pain against the potential risks of advanced spinal degeneration caused by surgical intervention. Prior studies have reported a benefit for surgical patients early in the post-operative period. In a prospective study of 126 patients randomized to surgical discectomy versus conservative therapy, the difference in early surgical benefits tends to equalize over a 10-year follow-up period as reported by Weber. However, the effects of surgery on clinical symptoms and advancement of spinal degeneration over a longer period than a decade were unknown.

I was reassured by the overall results of this long-term, 25-year follow-up study reported by Mariconda and colleagues demonstrating the satisfaction of surgical patients with their operations as documented by validated outcome measures. A majority of patients undergoing surgery can be pain-free and functional without progressive spinal disorders. I was concerned, however, about several aspects of the study. For example, a significant number of individuals from the initial cohort have been lost to follow-up. Also, a small but significant proportion of study enrollees required additional spinal surgeries and were disabled. (See Table 1, top right)

Another of my concerns with the authors’ conclusions regards the unfavorable comparison of normative data of pain score...
outcomes for medically treated patients reported in the Italian medical literature with the surgical patients in this study. First, the characteristics of these historical medical patients are unknown and the duration of their follow-up is unspecified. Second, while pain scores were lower in surgical patients versus the historical controls, physical function measures were comparable in both groups. Therefore, I would not consider the current study definitive in assessing the relative long-term benefits of medical versus surgical therapy.

Patients with herniated discs are interested in practical outcomes. They are concerned with pain relief, the preservation of function, and limiting future episodes of disc herniation and progressive spinal disease. A recent study by Weinstein et al. reports the equally favorable outcomes of medical and surgical therapy for herniated discs at two years.2 The study by Mariconda et al. demonstrates the potential of those individuals who choose surgery to have a continued good outcome a quarter of a century later.

## References


### Lymphoma Risk in Patients with Ankylosing Spondylitis

#### Methods

The association between ankylosing spondylitis and malignant lymphomas overall (and separately for non–Hodgkin’s lymphoma, Hodgkin’s lymphoma, and chronic lymphocytic leukemia) was assessed in a nationwide, population-based, case-control study of 50,615 cases of lymphoma and 92,928 matched controls by using prospectively recorded data on lymphomas from the Swedish Cancer Register (1964–2000) and data on pre-lymphoma hospitalizations for ankylosing spondylitis from the Swedish Inpatient Register (1964–2000). The odds ratios (ORs) associated with pre-lymphoma hospitalization for ankylosing spondylitis were calculated using conditional logistic regression.

#### Results

Twenty-three (0.05%) patients with lymphoma and 41 (0.05%) controls had a pre-lymphoma hospitalization listing ankylosing spondylitis, relative risk=1.0 (95% confidence interval [CI] 0.6 to 1.7). The number of discharges and the mean latency between ankylosing spondylitis and lymphoma were similar in patients and controls. Analyses restricted to lymphomas diagnosed during the 1990s showed similar results (OR=1.3, 95% CI 0.6 to 2.5, number of exposed cases/controls=14/21).

#### Conclusion

On average and in the absence of TNF inhibitors, patients hospitalized with ankylosing spondylitis do not show an appreciable increased risk of lymphoma.

### Commentary

In a time when there is significant discussion in the medical community and press regarding the risk of lymphoma in patients treated with anti-TNF agents, Askling and colleagues’ article is an important and welcome addition to the current state of knowledge.

To date, there has been little published regarding risks of malignancies in patients with AS or other spondyloarthropathies—with the exception of those who received radiation treatment in past decades. Of the two prior publications found on Medline, the first is from the same authors examining a Swedish population-based cohort prior to the use of anti-TNFs. They reported a standardized incidence ratio of 1.34 (CI 0.93–1.89) for all hematopoietic cancers. The second is an abstract that’s not easily available for review.

There are limitations to this study—particularly with the use of an inpatient discharge registry to identify patients with a diagnosis of AS, which may limit generalizability. Conversely, the patients who require hospitalization may represent a sicker population. In light of the recent studies suggesting that chronic inflammation may be a contributing factor to lymphoma origin in RA, studying a sicker population may be appropriate. Additional potential limitations include the lack of disease severity measurements and the overall small numbers despite using an entire country’s registry. However, these limitations should not overshadow the fact that this is a well-designed and executed study that highlights the strengths of an organized data collection system.

The published data suggest that there is not a significant increase in lymphoma risk—certainly not of the magnitude seen with RA. (See Table 2, below.) The distinct disease pathophysiology may contribute to the differences in lymphoma rates. Or perhaps it may be simply the differences in levels of chronic inflammation, which are generally lower in the AS patient.

In summary, this article draws attention to the need estimate lymphoma risk in patients with AS and other spondyloarthropathies prior to the use of anti-TNF agents from other populations. In future studies addressing this knowledge gap, authors should gather information on measures of disease severity, cumulative disease activity, and disease duration in patients to allow us to explore the potential contribution of inflammation in an epidemiological fashion. Similar questions regarding the potential increased risk of lymphoma in the setting of anti-TNF agents are bound to arise, and without background data, the true answer will never be realized or understood.

### References


### Preempting Fractures in Patients with RA

#### Objectives

To examine whether treatment with anti-TNF alpha prevents loss of bone mineral density (BMD) at the spine and hip (generalized) and in the hands (local) of patients with RA, and to study the changes in markers of bone metabolism, including receptor activator of the NFkappaB ligand serum levels during treatment with infliximab in patients with rheumatoid arthritis. Ann Rheum Disease. 2006;65:1495-1499.

#### Abstract

Patients and methods: One hundred two patients with active RA who were treated with infliximab during one year were included in this open cohort study. The BMD of the spine and hip (dual X-ray absorptiometry) and hands dual X-ray radiogrammetry was measured before the start of treatment and after one year. Changes in osteocalcin formation, beta-isomserised carboxy terminal telopeptide of type 1 collagen (beta-CTX; sorption), RANKL, and OPG were determined at 0, 14, 30, and 46 weeks.

#### Results

The BMD of the spine and hip was unchanged during treatment with infliximab, whereas BMD of the hand decreased significantly by 0.8% (p<0.01). The BMD

### TABLE 1: 25-Year Follow-Up of Disc Herniation Surgery

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Study Group</td>
<td>348</td>
<td>100</td>
</tr>
<tr>
<td>Individuals lost to follow-up (Died–55) (Moved–92)</td>
<td>147</td>
<td>42</td>
</tr>
<tr>
<td>Men/Women</td>
<td>118/83</td>
<td>58.7/41.3</td>
</tr>
<tr>
<td>Individuals with re-operation</td>
<td>21</td>
<td>10.4</td>
</tr>
<tr>
<td>Within 11 years of first procedure</td>
<td>10</td>
<td>48</td>
</tr>
<tr>
<td>Oswestry Disability Score</td>
<td>139</td>
<td>69.2</td>
</tr>
<tr>
<td>None/minimal</td>
<td>29</td>
<td>14.4</td>
</tr>
<tr>
<td>Moderate</td>
<td>33</td>
<td>16.4</td>
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</table>

### TABLE 2: Number of cases and controls with personal history of AS, including corresponding odds ratios

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Outcome</th>
<th>All lymphomas (ca = 50,615/case = 92,928)</th>
<th>NHL (ca = 32,773/ca = 60,202)</th>
<th>CLL (ca = 10,982/ca = 20,141)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>(ca = 32,773/ca = 60,202)</td>
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<td>ca co</td>
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<td>OR (95% CI)</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>41</td>
<td>1.0 (0.6 to 1.7)</td>
<td>15</td>
</tr>
</tbody>
</table>

Despite Clinical Remission, Inflammation Marches on in RA

**Commentary**

The bone abnormalities associated with RA include juxtaarticular osteopenia, focal bone erosion, and diffuse bone loss that extends far beyond the region of the joint. Osteoporosis and the associated fractures appear increase in some groups with RA compared with controls. While our understanding of the pathophysiology of bone loss in RA is incomplete, many studies suggest that receptor activator of NFκB ligand (RANKL) and osteoprotegerine (OPG) play important roles in regulating bone metabolism. In turn, TNFα regulates RANKL and OPG, suggesting that the TNFα antagonists may retard not only focal bone erosions but also generalized osteoporosis among patients with RA.

This study by Vis and colleagues builds on several preliminary investigations that suggest a relationship between TNFα antagonist use and improved BMD. In this multicenter study, consecutive patients treated with infliximab for at least one year were included. These patients had all undergone dual energy X-ray absorptiometry (DEXA) measurements at baseline and at follow-up. All patients had DAS28 scores of at least 3.2 and had previously failed at least two DMARDs. Thirty-four patients dropped out because of an inadequate response or side effects to infliximab; they were not included in the analyses.

The study produced several notable findings. First, the spine, hip, and total body BMD was lower at baseline in patients with erosive disease than in those without. Second, there were no significant changes in BMD at the hip or spine over the year follow-up in patients taking infliximab. Third, the soluble RANKL decreased during the follow-up period, whereas OPG remained stable, resulting in a reduced RANKL/OPG ratio. Fourth, patients with a good response to infliximab according to EULAR criteria had a statistically significant improvement in hip BMD compared with those with less than a good response. The same trend was observed with spine and hand BMD, but these were not statistically significant. (See Table 3, left.)

**Reference**

Results of the first rheumatology workforce study in the past 10 years were released last November, confirming concerns that the supply of rheumatologists may not meet demand in the near future. The extensive report, commissioned by the ACR, lays out the hard facts about this medical specialty that its practitioners had long anticipated were true—the number of practicing rheumatologists does not meet the current or future needs of the patient population, patients are waiting longer for appointments, and practices must be redesigned to preserve and improve the quality of the profession.

In a response to the 2006 Rheumatology Workforce Study, President Neal S. Birnbaum, MD, told attendees at the ACR Annual Meeting in Washington, D.C., last November that the workforce report—and the professional specialty—are a study in contrast. “Never has there been such a rich period of opportunity for rheumatologists to improve the lives of their patients,” says Dr. Birnbaum. “Yet the American College of Rheumatology knows that our members confront significant challenges in a rapidly changing environment: declining reimbursements, increasing paperwork, and complex, confusing, and at times inexplicable demands from insurance companies and government.” In addition, Dr. Birnbaum says, “Practitioners face increasing demand for services at a time when our aging rheumatology workforce might typically intend to reduce its workload.”

Supply and Demand Snapshot

Dr. Birnbaum’s remarks echo the findings in the workforce study. The genesis of the study was an advisory group formed by the chairman of the ACR Committee on Training and Workforce Issues, Walter Barr, MD, and led by Chad Deal, MD. ACR members informally had discussed perceptions of a shortage among rheumatologists and knowledge of longer wait times for patients as well as difficulty in recruiting practice partners. The study, says Dr. Barr, allowed the ACR to validate and reinforce these general impressions and outline potential solutions and formal goals. The advisory group first met in early 2005 and immediately sought the expertise of The
The purpose of the study was to better understand the factors affecting the supply of and demand for rheumatologists, to quantify factors where possible, to project likely paths for the evolution of the workforce, and to assess its implications. As part of this study, The Lewin Group conducted a survey of practicing rheumatologists between November 2005 and February 2006. The analysis also included a literature review and guidance and input from advisory group members.

The study results cover the following areas:
- Adult versus pediatric rheumatologists;
- Demographics of current rheumatologists;
- Retirement trends;
- Changes in practice efficiency;
- Supply and demand;
- Adult versus pediatric rheumatologists;
- Earnings and job satisfaction; and Distribution of work hours.

The workforce study projects that the number of rheumatologists in adult practice will increase only 1.2% between 2005 and 2025. However, the demand for rheumatologists to treat patients in that time period will rise 46%. Analysts say the increase in demand will come from several factors: an overall increase in the population, an increase in the number of elderly patients, and a general rise in per capita income.

What can the profession do to meet this demand? The workforce study recommends increasing fellowship positions, increasing the work effort of rheumatologists, improving practice efficiency, and using more allied health professionals including trained rheumatology nurse practitioners and physician assistants. Two professionals who played a significant role in identifying these possible solutions are Tim Harrington, MD, a rheumatologist in practice at the University of Wisconsin who has studied and developed alternative practice designs, and Rod Hooker, PhD, PA, a physician assistant in a rheumatology practice at the University of Texas Southwest in Dallas.

Literature Overview

The backdrop for the study results is a review of the literature on the prevalence and costs of musculoskeletal diseases, technological advances in the treatment of RA and lupus, practice efficiency, and changes in Medicare coverage and payment policies.

The review found that arthritis and musculoskeletal disorders are among the most frequently occurring chronic conditions in the U.S. Approximately 42 million Americans had rheumatoid arthritis in 2005; juvenile rheumatoid arthritis cases in the U.S. number between 30,000 and 50,000, with half of the cases being inactive. The prevalence of RA is estimated to rise to 2.8 million by 2025. Osteoarthritis is the most common type of arthritis. Estimates are that 20.7 million Americans had osteoarthritis in 2005 and that the prevalence will rise to 28.1 million by 2025. Studies show that women are nearly eight times more likely to develop osteoarthritis than men.

Medicare and other payment policies have changed in the past few years in ways that affect the demand for rheumatology services. The Medicare Replacement Drug Demonstration allowed a limited number of beneficiaries with rheumatoid or psoriatic arthritis to receive coverage for self-injecting biologics. Medicare Part D now covers this therapy. Medicare payments for rheumatology services have decreased, which may require rheumatologists to reduce the number of infusion sites and the size of staff to cover costs.

Current and Future Workforce

Researchers used AMA files supplemented with the ACR membership list to identify 4,946 current adult rheumatologists and 218 pediatric rheumatologists in the U.S. The vast majority (94% adult rheumatologists and 92% pediatric rheumatologists) treat patients. The median age for adult specialists is 51; for pediatric rheumatologists, it’s 47. Approximately 70% of adult rheumatologists are male; 51% of pediatric rheumatologists are female.

The number and geographic location of rheumatology practices in the United States varies significantly. Boston has both the highest number of adult and pediatric rheumatologists. Areas with the highest concentration of adult rheumatologists are New England and the Mid-Atlantic. The central and mountain states, Hawaii, and Alaska, have the lowest concentration.

A secondary factor that affects the future workforce is the number of rheumatologists who plan to retire in the near future. This number may be offset by the number of medical school graduates who will fill a rheumatology fellowship. The study predicts that the number of fellowship positions is not likely to increase but will remain constant, as will the number of international medical school graduates. There is also likely to be an increase in the demand for both adult and pediatric rheumatologists, based on increases in the U.S. population as a whole and an increase in real personal income per capita.

Dr. Birnbaum says in his response to the study that it is highly unlikely that the number of fellowship positions will increase in 2006, and he recommends adding rheumatologists to practice as a key way to address workforce shortages. The study challenges us to consider the impact on the practice of our members and how to prepare our members to continue to offer the highest quality rheumatology care.

The study found that the majority of pediatric rheumatologists were unwilling to treat a patient over age 18 (44.9%) or age 21 (33.3%). Among adult rheumatologists, 27.7% says the youngest they would want to treat a patient would be 16 to 17 years, and another 22.4% says they would be reluctant to treat a patient age 12 to 15.

The ACR is confident that the 2006 Rheumatology Workforce Study will meet the needs of the profession into the future. It includes a computer modeling tool that allows for periodic reassessment of the projections made in the study. “Perhaps the real value to any workforce study is that it forces us to evaluate our profession,” says Dr. Birnbaum. “The study challenges us to communicate the practice of our members and how to prepare our members to continue to offer the highest quality rheumatology care.”

Terry Hartnett is writing the workforce study series.

Only a small percentage of practices currently employ a nurse practitioner (15.5%) or a physician’s assistant (7.2%). This finding is important since the study recommends adding these professionals to a practice as a way to address workforce shortages.

Family status was shown to have a dramatic impact on the number of hours worked by female versus male rheumatologists. The overwhelming majority (88%) of female rheumatologists are married and of that number 26% have preschool-aged children. Married women rheumatologists report working 440 fewer hours per year and women with children under six work 660 hours less per year than their single counterparts. In contrast, married men who are rheumatologists work 330 more hours a year than single men but those with children under age 18 work 100 less hours annually.

Male and female adult and pediatric rheumatologists are all pretty satisfied with their work. Only 6% to 10% reported any level of dissatisfaction. However, the need for more colleagues in a practice is evident. More than 30% are in practices that are currently looking to hire another rheumatologist and more than half are in practices that plan to hire additional partners within the next five years. Income levels reported in the survey show that the median income for a rheumatologist is between $185,000 and $193,000. More than half (57%) of full-time rheumatologists receive an income between $100,000 and $250,000.

The workforce study also points to reported wait times for patients as a strong indication of excess demand. The mean wait time for a non-urgent patient is 37 days and almost half of the rheumatologists surveyed said that their non-urgent patients waited more than four weeks for an appointment. The wait time for new rheumatology patients is higher than for general medicine and other specialty referrals such as cardiology and gastroenterology. These data point to the need for practice redesign, an area of concern that the ACR is already beginning to address.

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As I recently told a new member, there is something special about the ACR that I have found lacking in other groups. I have been a member since 1987, and the nice part of having a 20-year history is that one can look back and review the road traveled and the quality of the trip. As Mark Twain noted, “Broad, wholesome, charitable views of men and things cannot be acquired by vegetating in one little corner of the earth all one's lifetime.”

Over the past two decades, it has been my privilege to work on many ACR committees, serve as the ARHP president, and contribute to the ACR Research and Education Foundation. Drawing from my travels through the ACR structure, I would like to share some of our most interesting trips, talk about the benefits of having the ARHP in the car, and look at what's down the road.

Small Beginnings
When I started in the ACR, the entire annual meeting had roughly one-tenth the number of its current participants. If you didn’t know everyone at the onset, by the end of the opening reception you had a good sense of where your colleagues came from—and were on a first-name basis with many.

The rheumatology world then felt like a small town where several roads led to a common destination. The townpeople had a common interest in rheumatology care but many personal interests as well. ACR gave us a professional arena to learn, change, and interact for the common good. It was easy to maintain community ties in our regions and with our patients. It was easy to encourage our fellow ACR members to expand their own careers and share their knowledge and experience.

The ARHP involvement in rheumatology goes back at least a few generations. As a professional group, it started in 1966 as a section of the Arthritis Foundation, which has been focusing energy and resources on fighting rheumatic diseases since 1948. In 1985, the ACR was formed from the physician group within the Arthritis Foundation. Similarly, in 1994 the health professionals formed the ARHP as a division of the ACR.

Synergistic Society
ARHP and ACR have a synergistic relationship, mirrored in the clinical and research communities. We bring together physician, researcher, and health professionals to enhance education, research, and advocacy efforts for patients with rheumatic diseases. As with any multifaceted group, there are benefits and challenges. One challenge for the ARHP is having a minority voice in ACR. It can be difficult for health professionals to be heard, have their needs recognized as important, and obtain the majority vote in favor of a minority position.

On most days, though, physicians and health professionals work together to provide patients with the best care, and the greatest continuity of care. When the ARHP brings this to ACR is diversity of expertise. Members include RNs, clinical trial nurses, doctorally prepared nurses, advanced practice nurses, OTs, PTs, psychologists, social workers, epidemiologists, and scientists—at all different levels of training and experience.

As an epidemiologist who is most comfortable looking at risk factors and disease patterns, I take great delight in speaking with my ACR/ARHP colleagues about scleroderma or pediatric physical therapy for juvenile RA or the possibility of foot deformities with certain diseases. Having access to varied expertise leads to better research and patient care, as well as encouraging collaborations for comprehensive studies.

Integrating multiple disciplines dissuades turf battles, as everyone works collectively toward the common goal of maximizing the wellbeing of patients with rheumatic diseases. Interprofessional collaborations have improved the understanding of rheumatic diseases and patient care, achievements demonstrated most notably by the advances presented at each annual scientific meeting.

By drawing on so many diverse and talented professionals, the ACR can speak knowledgeably from a provider team perspective on the best ways for patients to access care and for providers to integrate the latest innovations in rheumatology care into their practices. Also, the organization can help basic bench scientists effectively communicate their work to clinical investigators who may continue this work in patient populations, leading to medical interventions that benefit patients.

ARHP is fully integrated into ACR, with ARHP members on ACR committees and physician ACR members on the health professional committees, encouraging collaboration and integrated educational efforts. ACR has a seat at the table for generating policies and setting the future agenda for ACR. Benefits of this partnership include the combined clinical symposia and a combined abstracts session at each annual scientific meeting. The collaboration of physician, researcher, and health professional at these focused sessions enriches the educational experience and expands questions and debates beyond each individual’s usual way of thinking. The end result is greater than the sum of the parts and fosters further growth.

Growth of a Community
By almost any metric, ACR and ARHP have enjoyed tremendous growth in both clinical and research members, especially over the past few years. The ACR has an increasing number of international members representing more than 20 countries. The annual scientific meeting continues to have outstanding sessions and workshops, record-high attendance, and highly scored abstracts submissions. Each year, the most current research available is presented at our rheumatology meeting.

The editors of the ACR journals, Arthritis & Rheumatism and Arthritis Care & Research, deserve congratulations for their success and for encouraging important clinical work as well as basic scientific efforts. The ACR published its Clinical Care in the Rheumatic Diseases textbook in 1998, and the text is now used in more than 20 different training programs. The third edition of Clinical Care debuted at our annual meeting.
Both ARHP and ACR need to look to the future of the organization and of rheumatology. We are exploring educational teleconferencing and alternative media for educational opportunities; to support this we are developing our Web site and expanding hosting capabilities.

How do we create continuity and use the roadmap to get to our future destinations? We established a structure of committees that will ensure that the College survives and thrives and looks to the interprofessional future while still asserting our presence today. Another source of continuity and one of the major assets of ACR/ARHP is the annual meeting. In my experience, it is also a source of research ideas that get funded. The ACR must continue to provide superb patient education and care, expand research endeavors, and advocate for the best in rheumatologic patient care.

For the past 20 years I have seen our organization grow. Serving on many committees and in many roles has allowed me to look closely at the work of ACR and the division of ARHP—the research, training, spirit of our members, and most of all, the care given to our patients. It has been an extremely inspiring two decades. We inverted the pyramid, added biologics, encouraged exercise, collaborated in our treatment regimens, expanded our provider base, and whole is carving away at the isolation of the specialist, and we anticipate the interface between ARHP, ACR, and other organizations to become even more important.

The writer Miriam Beard said: “Certainly, travel is more than the seeing of sights; it is a change that goes on, deep and permanent, in the ideas of living.” My 20-year-old ARHP roadmap is very worn and wrinkled but the trip has given me a wealth of knowledge. The advice I’ve received (and have given out) has taken me into many side adventures. I look forward to my next two decades in ACR, with anticipation of continued roadside assistance.
LABORED BREATHING

Strategies to diagnose and manage dyspnea in the scleroderma patient

Since the introduction of angiotensin-converting enzyme inhibitors and their remarkable success in managing scleroderma renal crisis, pulmonary complications have assumed greater importance as a source of morbidity and mortality in this disease.

Prior to the use of captopril, renal failure was the leading cause of death in scleroderma. Now renal failure accounts for fewer than 10% of scleroderma-related deaths.

At present, the majority (nearly 80%) of deaths now are attributable to interstitial lung disease (ILD) and pulmonary arterial hypertension (PAH). Other pulmonary complications may occur, but ILD and PAH are the major complications experienced by our patients. (See Table 1, page 17.)

As pulmonary manifestations have assumed greater importance, new treatments now offer hope to SSc patients. Now that treatment is available, it is essential for the rheumatologist to screen patients for the presence of ILD and PAH, so that treatment can be instituted before the disease becomes irreversible. Similar to our current approach to patients with rheumatoid arthritis or lupus nephritis, there may be a window of opportunity to successfully intervene and treat ILD and PAH.

My approach to the evaluation and management of SSc patients with dyspnea is described below. First, I will describe the major clinical and laboratory investigations available for the evaluation of dyspnea.

Signs and Symptoms

Dyspnea is the most common complaint of patients with ILD or PAH. Like hunger or thirst, dyspnea can be characterized as a “synthetic sensation” in that it often arises from multiple sources of information rather than from stimulation of a single neural receptor. Severity of dyspnea as well as qualitative aspects of unpleasant breathing experiences vary widely among patients. Dyspnea usually signals the presence of lung or heart disease (or rarely, coexisting muscle disease). Standardized tools exist to quantify dyspnea, and these are often used in clinical trials; in the office it is more practical to assess dyspnea in terms of self-reported activities (e.g., walking, carrying, and climbing stairs).

Paul Klee, the famous 20th-century artist who suffered from scleroderma, described his symptoms while hiking in the mountains: “I inhale as deep as possible. My dyspnea depends on the trail, whether going up or going down. It also depends upon the weather … and it also depends on how much food I have in my stomach.” With progressive disease, even simple tasks may prove difficult. Near the end his life, Klee noted that the small incline to his house was difficult to traverse: “This is now my Matterhorn.”

Because the intensity of dyspnea associated with ambulatory activity depends on the rate of work performance (power output), patients may reduce the rate of work performance, thereby minimizing the intensity or distress of symptoms. Frequently, my patients tell me that they experience no breathlessness as long as they perform tasks slowly. Other patients find their activity limited by articular or neuromuscular complications—or simply by the overwhelming fatigue associated with SSc. The complaint of dyspnea is an important clue to the presence of underlying lung or cardiac disease; but the absence of dyspnea does not rule out significant pulmonary disease.

Usually, dyspnea associated with SSc is chronic. When a patient with this disease presents with acute dyspnea, the rheumatologist must consider pulmonary embolism, pneumothorax, infection, sepsis, and heart failure. Acute pulmonary edema may be a manifestation of volume overload secondary to scleroderma renal crisis, other causes of renal failure, or primary scleroderma heart disease.

Cough is another symptom of lung fibrosis and usually is nonproductive and made worse by exercise. Productive cough or hemoptysis requires evaluation to rule out aspiration pneumonia or neoplasm—each of which occurs with increased frequency in SSc.

Physical examination remains key when evaluating any rheumatic disease patient. Some argue cynically that the stethoscope is obsolete in this era of high-tech diagnostic studies. To others, “the stethoscope embodies the essence of doctoring: using science and technology in concert with the human skill of listening to determine what ails a patient.”

Laennec’s invention of the stethoscope initiated medicine’s irreversible trend toward physically separating the diagnosing physician from the patient. High-tech medicine has expanded the potential gap between patient and physician. For me, the hollow tube of the stethoscope is a connection to my patient and reinforces my need to listen.

Fine inspiratory (and sometimes expiratory) crackles are a finding heard in patients with ILD. Crackles may be audible at the lung bases and higher in more extensive disease; in early disease, however, crackles may not be audible. Accentuation of the pulmonic component of S2, a tricuspid regurgitation murmur, or right-sided S4 may be indicative of PAH. Right ventricular heave, jugular venous distension, and edema are later findings of PAH with right-sided heart failure. The presence of any of these physical findings requires further evaluation but, like dyspnea, their absence does not preclude ILD or PAH.

Pulmonary Function Testing

Perform pulmonary function tests (PFTs) at baseline and regular intervals in all patients. The characteristic PFT pattern of SSc-ILD is restriction, with reduced lung volumes (e.g., total lung capacity) and a proportionate reduction in diffusion capacity for carbon monoxide (DLCO). In the absence of significant obstructive airway disease, the forced vital capacity (FVC) serves as a surrogate for total lung capacity. If the FVC percent predicted is less than 75% and the ratio of the FVC percent predicted divided by the DLCO percent predicted is <1.4, the patient has a predominantly restrictive PFT pattern characteristic of ILD.

SSc patients with PAH have a disproportionate decline in DLCO relative to decline in FVC. A fall in
DLCO may be the first clue to the presence of SSc-PAH, and, if confirmed by serial testing, work-up for PAH is warranted. If the FVC percent predicted is greater than 75% and the ratio of the FVC percent predicted divided by the DLCO percent predicted is >1.4, the patient has predominantly pulmonary vascular disease. Of course, mixed patterns may occur in patients with both ILD and PAH.

Six-Minute Walk Test

The six-minute walk test (6MWT) is a sub-maximal exercise test that yields important information about exercise capacity of the patient and oxygen saturation. (See Figure 1, page 18.) This test is useful to obtain at baseline and, when performed serially, may be used to monitor response to therapy. In some pulmonary conditions, the 6MWT correlates with New York Heart Association functional classification and even predicts mortality. Such correlations have not been demonstrated in SSc, perhaps due to extra-pulmonary features of SSc (e.g., joint pain, muscle weakness, etc.) that often affect ambulation. Nevertheless, the distance walked can be monitored and compared with prior test results for the individual patient. In addition, if exercise-induced hypoxemia is present, supplemental oxygen should be prescribed.

Imaging Studies

Although the chest radiograph is not a sensitive test for detecting early ILD, it may detect lung infiltrates or nodules, pleural disease, lymphenphadenopathy, or cardiomegaly. High-resolution computed tomography (CT) is a much more sensitive test and should be part of the baseline assessment of all SSc patients. The earliest sign of ILD is a hazy-appearing opacification through which normal lung architecture can be seen (ground-glass opacification). (See Figure 2A, page 18.) With progression, more advanced signs of disease (e.g., honeycombing and traction bronchiectasis) may be seen. (See Figure 2B, page 18.) Patients with a normal CT scan have a good long-term prognosis, whereas those with CT abnormalities tend to worsen if not treated.

Pulmonary thromboembolism rarely occurs in SSc but is seen in any patient who experiences acute dyspnea or in the patient with risk factors for chronic thromboembolic disease (e.g., sedentary lifestyle or antiphospholipid antibody). Ventilation-perfusion lung scans and CT pulmonary angiography are indicated in such situations.

Bronchoalveolar Lavage

In years past, SSc-ILD was believed to result from a blinding fibrogenic process. My lab was among the first to employ bronchoscopy with lavage to obtain cells and proteins from the lower respiratory tract of SSc patients, and these studies provided new insight into the pathogenesis of SSc-ILD. Many patients have evidence of an inflammatory process characterized by increased numbers of neutrophils and eosinophils, activated alveolar macrophages, and increased levels of pro-inflammatory and profibrotic cytokines. Cells cultured from bronchoalveolar lavage fluid exhibit the phenotype of an activated myofibroblast with contractile and fibrotic cytokines. Of course, these cells are not certain, but these activated myofibroblasts are key players in the pathogenesis of SSc-ILD. Although bronchoalveolar lavage remains a valuable research tool, it may be less useful in the clinic. For technical reasons, the interpretation of bronchoalveolar lavage fluid can be difficult when performed in community-based laboratories. Another disadvantage of this test is the potential for sampling error because generally only one or two sites are lavaged. When performed in a standardized fashion in specialized laboratories, however, it does provide clues to the presence of active ILD.

Lung Biopsy

Open lung biopsy is rarely indicated unless there is clinical concern for other pulmonary conditions that might confound SSc (e.g., bronchiolitis obliterans with organizing pneumonia, sarcoidosis, or aspiration, among others). The predominant histologic pattern of SSc-ILD is a nonspecific interstitial pneumonitis. CT findings in SSc closely resemble those observed in patients with idiopathic nonspecific interstitial pneumonitis.

Echocardiography

Obtain echocardiogram with Doppler at baseline on all newly diagnosed patients, and perform serial studies at intervals, depending upon the patient’s clinical symptoms and the results of their other tests (e.g., DLCO). Echocardiography is an important tool to evaluate the complaint of dyspnea, particularly when PAH is suspected (e.g., in the patient found to have a low DLCO percent predicted with normal or only slightly reduced FVC percent predicted [vide supra]). In recent studies conducted in community-based rheumatology practices, the prevalence of PAH as defined by an estimated RV systolic pressure of >40 mm Hg was found to be approximately 25% in SSc and mixed connective tissue disease patients. Thus, one must have a high index of suspicion for PAH in this patient population.

Echocardiography provides important information about right atrial (RA) and right ventricular (RV) size and function—especially RV systolic pressure. (See Figure 3, page 18.) Congenital heart disease, valvular disease, pericardial effusion, and left-sided heart dysfunction may also be detected.

Right Heart Catherization

Because the Doppler echocardiogram may overestimate or underestimate RV systolic pressure, right heart catheterization is required whenever PAH is suspected. Right heart catheterization remains the gold standard for accurate diagnosis of PAH and also permits assessment of concomitant left ventricular disease by measuring pulmonary capillary wedge pressure or left ventricular end-diastolic pressure. PAH is defined as a mean pulmonary arterial artery pressure of >25 mm Hg at rest, or >30 mm Hg with exercise, and a normal pulmonary capillary wedge pressure (<15 mm Hg). Diastolic dysfunction is not an uncommon cause for dyspnea in SSc patients. Treatment of diastolic dysfunction differs significantly from that of PAH; therefore, cardiac catheterization is critical for accurate diagnosis and management of the SSc patient with suspected pulmonary vascular disease.

Diagnosis and Management

My recommended baseline cardiopulmonary evaluation for a newly diagnosed SSc patient is shown in Table 2. (See above right.) If baseline studies are normal, and the patient has no complaints of dyspnea, I recommend annual re-assessment (sooner if the patient develops symptoms). If PFTs are abnormal, further work-up is necessary and should be guided by the particular pattern of PFT abnormalities. For example, a restrictive PFT pattern suggests SSc-ILD, which should be confirmed by CT.

Other causes of restriction must be considered, especially if the CT is normal. If the PFT pattern suggests pulmonary vascular disease, then echocardiography is indicated. Obstructive airway disease is seen in some SSc patients—especially former or current smokers, those with asthma, chronic obstructive pulmonary disease, or bronchiolitis, or patients with secondary Sjogren syndrome. Manage dyspnea due to obstructive airway disease with bronchodilator drugs and measures to prevent gastroesophageal reflux disease (GERD). If the echocardiogram reveals evidence of PAH (e.g., right atrial enlargement, RV hypertrophy, asymmetric septal bowing, or elevated RV systolic pressure), perform a right heart catheterization to rule out PAH. In some SSc patients, dyspnea is the result of diastolic dysfunction and heart failure; in such cases the echocardiogram may reveal left atrial enlargement, left ventricular hypertrophy, abnormal E/A slope, or findings of left-sided diastolic dysfunction. It is essential to distinguish left-sided heart failure from PAH, since the management of pulmonary venous hypertension differs greatly from that of PAH.

Log on to www.TheRheumatologist.org for printable flowcharts on PFT and echocardiogram assessment.

Treatment of SSc-ILD

Once you establish a diagnosis of SSc-ILD, treatment is warranted—especially for those patients who have relatively early disease. The best and most current evidence for treatment of SSc-ILD derives from the Scleroderma Lung Study: a double-blind, randomized controlled trial to test the efficacy of cyclophosphamide for the treatment of SSc-ILD. Scleroderma Lung Study patients had dyspnea, restrictive lung physiology, and evidence of inflammatory ILD either by bronchoalveolar lavage, high-resolution computed tomography, or both. Treatment consisted of oral cyclophosphamide, 2 mg/kg daily or placebo for one year with an additional one year of follow-up. For the primary endpoint, FVC percent predicted at 12 months, there was a clinically modest and statistically significant difference in favor of cyclophosphamide (2.53%, 95% CI 0.28% to 4.79%, p<0.03). The difference in FVC was maintained at 24 months.

Interestingly, a significant interaction between baseline fibrosis on CT and treatment was seen: patients in the placebo group with high baseline fibrosis scores had the greatest decline in FVC at one year, whereas baseline degree of fibrosis had no significant influence on the change in FVC for the cyclophosphamide group.
Treatment of SSc-PAH

Current therapy is targeted to one or more of the major pathogenic mediators of PAH—endothelin-1, prostacyclin, and nitric oxide. Evidence supports the use of agents that block endothelin-1 (endothelin receptor antagonists), augment PGI2 (PGI2 and its analogues), or enhance nitric oxide (phosphodiesterase-5 inhibitors). Guidelines for treatment of PAH have been developed by the American College of Chest Physicians.3 (See Figure 4, below.) Several caveats apply to SSc-PAH. First, oral anticoagulation may not be feasible if GERD is severe. Also, SSc patients rarely display acute vasoactivity and are not likely to experience improvement in PAH with calcium channel blocker therapy. Finally, SSc-PAH patients do not fare as well with patients with ILD.

The ACCP PAH Treatment Algorithm. Quality of evidence: good = good randomization; moderate = no randomization; weak = non-randomized, case-control, or other observational studies; negative = no studies met criteria for inclusion. Net benefit to patients: substantial, intermediate, small/weak, none, conflicting, negative.

FIGURE 1: Six-Minute Walk Test. Perform this sub-maximal exercise test as part of the baseline assessment of dyspnea in the SSc patient and monitor senarily to assess progression or response to treatment. A forehead oximeter detects exercise-induced hypoxemia.

Clonazepam treatment group. Also of interest, clonazepam therapy was associated with statistically significant differences in dyspnea score, total lung capacity, skin score, and certain health-related measures of quality of life. Significantly more adverse effects were observed in the clonazepam treatment group than in the placebo group, so treated patients must be monitored carefully for signs or symptoms of drug toxicity. Less robust studies suggest a similar beneficial effect on PVC with other immunosuppressants (e.g., azathioprine and mycophenolate mofetil), but randomized controlled trials are needed to test the efficacy of these agents for SSc-ILD. For those patients who fail all therapy, lung transplantation is an option but only at selected transplant centers.

Sustained Response
Oral CCB [B for IPAH, E/B for other PAH]
Continue CCB
Yes
No
LABORED BREATHING

FIGURE 2A (top): High-Resolution Computed Tomography. High-resolution CT is a sensitive imaging technique for detecting signs of early interstitial lung disease such as ground-glass opacification. FIGURE 2B (bottom): Fibrosis and traction bronchiectasis are seen in later stages of SSc-ILD.

FIGURE 3: Echocardiogram. Apical four-chamber view of patient with SSc and PAH showing tricuspid valve regurgitation, dilatation of the right atrium and right ventricle, and bowing of the interventricular septum with compromise of the left ventricle.

Bosentan, an oral, dual ETA/ETB receptor antagonist, has been approved for the treatment of patients with class III or class IV PAH. It improves exercise capacity (6MWT) and hemodynamics, and reduces time to clinical worsening when used in doses of 125 mg bid after an initial month of treatment at 62.5 mg bid.

Recent reports suggest that first-line bosentan therapy, with the subsequent addition of other PAH treatments if required, is safe and may prolong survival.12 Bosentan treatment can be associated with unwanted effects—hypotension, anemia, micturition, and edema. Monitoring of liver tests is required prior to initiating bosentan therapy and monthly thereafter. Exclude pregnancy and encourage patients to prevent it by two forms of birth control.

Sildenafil is a phosphodiesterase-5 inhibitor approved for the treatment of patients with class II, III, or IV PAH. In doses of 20, 40, or 80 mg bid, sildenafil improves exercise capacity, hemodynamics, and functional class. More studies are needed before it can be determined

if sildenafil improves time to clinical worsening or improves survival. The recommended starting dose is 20 mg tid. Sildenafil is well tolerated but may cause headache, flushing, dyspepsia, and epistaxis. A clinical trial is underway to assess the efficacy and safety of bosentan and sildenafil combination therapy.

PGI2 and its analogues are approved for the treatment of patients with class III or IV PAH. Epoprostenol is administered by continuous intravenous infusion, whereas treprostinil can be administered by subcutaneous or intravenous infusion. Sudden interruption in drug delivery may be complicated by extreme elevation of pulmonary artery pressure. Administer lidoacetate by inhalation six to nine times daily. Combination therapy with bosentan and inhaled iloprost improves exercise capacity and time to clinical worsening.

Conclusion

Great strides have been made in understanding and managing the major pulmonary complications of SSC, and the prospect of even better treatment has never been greater. Management of SSc lung disease requires the combined skills of the rheumatologist, pulmonologist, radiologist, and cardiologist. The rheumatologist plays a vital role in this process, first by exercising a high index of suspicion to ensure early diagnosis, and then by coordinating the complex management of the SSc patient. Rheumatologists are in the unique position of seeing patients prior to the development of end-stage ILD or PAH. It is the responsibility to see that SSc patients undergo full evaluation for what are now treatable complications of their disease.

Dr. Silver is professor of medicine and pediatrics at the Medical University of South Carolina in Charleston. He would like to thank his colleagues in the Pulmonary Hypertension Center at the Medical University of South Carolina (MUSC) and the patients and staff of the MUSC Scleroderma Clinic.

References
From the COLLEGE
NEWS FROM THE ACR AND THE ARHP

CODING CORNER

Think you know all there is to know about coding? Here’s a chance to find out. Each month in “From the College,” we’ll present a coding scenario to test your knowledge. Tell us how you would answer the question by e-mailing the ACR coding/practice management list serve. Want to take part in this exercise but haven’t signed up for the list serve? It’s quick and easy to join! Go to http://lists.rheumatology.org/read/all_forums and follow the instructions.

January coding scenario: A 55-year-old man comes in for a scheduled visit of methotrexate injection and infliximab infusion. The patient also has an E/M visit that has a problem focused exam and the medical decision making is straightforward. The infusion lasts for two hours and 20 minutes using 580mg of infliximab. The patient was injected with 15mg of methotrexate. How should this be coded?

November’s coding answer: -96413, -96415 x 2, -J1745 x 60.

If you want to see your answer in a future issue, please include the scenario month and your name, practice, city, and state with your answer. If you have any questions, please contact the ACR coding specialists Antanya Chung, CPC, or Melesa Collins, CPC, at (404) 633-3777.

Look for the answer to January’s scenario in the February “From the College.”

PRACTICE UPDATES

Zero Stars for Star-based Physician Ranking

Several insurance companies have tried to share quality information with enrollees by developing “star” systems to rank physicians. While star rankings may be a good way to pick a movie or restaurant, the ACR feels this system may be too simple to serve as a tool for identifying quality healthcare. Consumers need quality information, and need to know the true costs of medical services so they can make informed decisions about their healthcare. This idea is reflected in an executive order President Bush signed in August 2006 requiring government agencies to work with the private sector to gather and share data on the quality and cost of healthcare.

Star-based ranking systems employed by insurance companies, such as United Health Care, Aetna, and Wellpoint, are designed to provide consumers with an effective tool to make better informed healthcare decisions and thereby improve the quality and cost efficiency of healthcare. While the ACR agrees that improved quality of care is a laudable goal—and has launched a comprehensive effort to develop measures and performance indicators that make sense from a rheumatologist’s standpoint—the ACR is concerned that the current star-based ranking system could have the unintended negative consequence of misleading patients.

The ACR believes that in order for the insurance companies’ star-based physician ranking systems to accurately provide better information to consumers, they must clearly delineate which stars are awarded based on quality measures and which are awarded based on cost efficiency. Otherwise, the system could lead patients to choose a provider based primarily on the number of stars awarded, without understanding what each star represents. The ACR believes this is not the intent of President Bush’s executive order on healthcare transparency.

To address this issue, the ACR sent a letter to insurance companies implementing star-based physician rankings and asked for more transparency in their ranking systems. The letter highlighted President Bush’s executive order and expressed the ACR’s concern that the star-based ranking system could be misleading to some patients. The ACR also requested that programs include a clear explanation of the difference between stars awarded for demonstrated quality of care versus stars awarded for cost efficiency or other criteria in order to give patients the opportunity to make truly better informed healthcare decisions.

The ACR will continue to monitor this issue and work with insurance companies that are using the star-based ranking system. Please contact Antanya Chung, senior practice management specialist at achung@rheumatology.org or (404) 633-3777, ext. 818, or your Regional Advisory Council representative if you learn of any insurance companies utilizing a star-based physician ranking system. If you are interested in learning more about the ACR’s efforts in developing quality indicators for the rheumatology community, please visit the quality-measures page on the ACR’s Web site at www.rheumatology.org.

CPC-saving advice and tips

Due to last year’s success, ACR’s coding specialists will be visiting state and local rheumatology societies to present coding tips again in 2007.

Last year, ACR’s two certified professional coders, Antanya Chung, CPC, and Melesa Collins, CPC, visited 15 state and local societies. Their coding presentations included information on documentation, consultation codes, modifiers 25 and 59, drug administration codes, new drugs available, denials and appeals, and compliance. Each presentation was eligible for 1 CME credit.

Save the Date!

CPC, at (404) 633-3777, ext. 818.

ONLINE RESOURCES

New and Updated Patient Education Materials Available

The ACR is continually updating and increasing its collection of patient education materials, or fact sheets. One of the newest fact sheets, “Pregnancy and Rheumatic Disease,” discusses the complex interactions of pregnancy and rheumatic diseases, acceptable medications to use during pregnancy and breastfeeding and helps to define what constitutes a high-risk pregnancy. The fact sheet offers links to additional resources and educational materials.

“So many autoimmune diseases disproportionately affect women, often in their childbearing years, says Kristine M. Lohr, MD, chair of the Patient Education Task Force. “The ACR can now offer patients and their healthcare providers a well-written, easily accessible patient fact sheet on this topic of importance.”

Key points to remember about treating or monitoring patients who are pregnant or may become pregnant include:

• With careful medical and obstetric management, many women with rheumatic disease can have successful pregnancies if they and their physicians are prepared to handle the possible complications.

• Rheumatic diseases with the potential to trigger antiphospholipid syndrome or affect the kidney are more likely to affect pregnancy outcome than others.

The ACR’s patient education materials are among the most popular on the College’s Web site, attracting approximately 70,000 visitors each month. The patient fact sheets provide a more detailed source of information about the pathogenesis and treatment of rheumatologic diseases that can supplement and reinforce information given to patients in the office. These printer-friendly online pieces can be printed and displayed in the waiting room or distributed to patients during a consultation, or physicians can direct patients to the ACR Web site to read information at their leisure.

Currently, the ACR has over 40 patient fact sheets available, including rheumatic disease-specific topics such as gout and psoriatic arthritis; information about drug therapies and medications such as NSAIDs and biologics; and other topics of interest including clinical trials and back and neck pain.

The complimentary patient education materials not only provide practice resources for members, but also serve as an unbiased source of information about rheumatic disease and new developments in research and treatment and emphasize the role of the rheumatologist and health professionals in the care of rheumatic diseases. For more detailed infor-
The ARHP is committed to advancing the knowledge and skills of health professionals in the area of rheumatology in order to improve health outcomes for people with or at risk for rheumatic disease and musculoskeletal conditions. In 2005, the ARHP Executive Committee developed a three-year, long-range plan, which identified the following priorities for our organization:

- Increase the supply of highly qualified health professionals;
- Increase research capacity for inter-professional research;
- Increase research productivity of rheumatology health professionals;
- Increase volunteer leadership skills and opportunities;
- Improve communication across ARHP members and ACR staff and members;
- Maintain outstanding health professionals and inter-professional educational services; and
- Market ARHP products and services.

The past year was a very successful one for ARHP and significant progress was made toward meeting these objectives. ARHP membership reached an all-time high, surpassing 1,100; ARHP members now make up over 13% of the total ACR membership. Other significant accomplishments included the premier of the Clinical Care in the Rheumatic Diseases 3rd edition, the expansion of Arthritis Care & Research to eight issues per year, the initiation of ARHP list serves, and the development of an aggressive new marketing plan to fortify ARHP’s position as the rheumatology resource for health professionals.

ARHP will continue to build on these successes as we meet new challenges and create new opportunities for growth and success in the coming year. The following are a few of ARHP’s key goals and initiatives for 2007:

Education

A major ACR/ARHP initiative is the NP and PA Post-Graduate Rheumatology Training Program, which is scheduled to debut in the fall of 2007. This comprehensive program consists of 19 Web-based modules and two skills training sessions designed to provide NPs and PAs with basic knowledge and clinical skills in the management of adults and children with rheumatic diseases. The 2007 Rheumatology Audioconference Series commences on January 17. The audioconferences are convenient, economic, one-hour educational programs that provide busy health professionals and physicians with up-to-date information on the management of rheumatology patients.

Research

ARHP will continue to collaborate with the ACR and Research and Education Foundation (REF) to advance an inter-professional perspective in research priorities and promote increased funding opportunities for health professional investigators. We are also working closely with the ACR to implement the College’s quality initiatives and ensure that the health professional perspective is integrated into these efforts. These quality initiatives aim to improve patient outcomes through the development of evidenced-based classification criteria, outcome measures, response criteria, treatment guidelines, and quality indicators.

Membership

The strength and essence of any professional organization is its members. One of ARHP’s greatest assets is the diversity of its membership. ARHP membership continues to grow and we are confident that we will increase our membership by 15% by the end of 2007. These are just a few of the many exciting opportunities and challenges ARHP will encounter this year. It is an honor and privilege to serve as the president of this great organization. The many ARHP and ACR colleagues and staff I have met over the years are some of the most talented, knowledgeable, compassionate, and committed individuals I have ever known. With such collective expertise, dedication, and enthusiasm, ARHP is well positioned for continued success in 2007 and beyond.

Karen Kerr is president, ARHP and a pediatric nurse practitioner at Children’s Hospital of Michigan in Detroit. Contact her via e-mail at arhp@rheumatology.org.
**ADVOCATING FOR YOU**

T he ACR Government Affairs Committee and ARHP Advocacy Subcommittee met in Washington, DC, on September 26 to discuss current legislative priorities and to participate in their annual legislative reception on Capitol Hill.

Committee members and staff exchanged ideas on ways to increase advocacy and political involvement from ACR/ARHP members. Increasing advocacy is a primary focus for the Government Affairs Committee (GAC) and Advocacy Subcommittee because it is essential that Congress be aware of the magnitude of our concerns.

Senator Johnny Isakson (R-GA) hosted the event Tuesday evening and spoke on a personal note on his battle with arthritis. Senator Isakson, a co-sponsor of the Arthritis Prevention, Control, and Cure Act of 2005 (S.424/H.R. 581), spent time talking with ACR/ARHP members and patients about their concerns with arthritis and how they can be addressed. A number of Congressional staff attended the reception to learn more about the ACR, physicians issues, and rheumatic diseases. Those attending the event had the opportunity to receive a fast DEXA screening compliments of ACR board of directors member David Borenstein, MD. The ACR’s legislative reception and Capitol Hill visits are valuable approaches to promote the needs of rheumatology and their patients.

Then ACR President Mary K. Crow, MD, GAC Chair Joseph Flood, MD, Senior Government Affairs Specialist Aaron Johnson, and ACR Washington representative Martie Kendrick met with Senator John Kyl’s (R-AZ) health staff to discuss the fact that physicians need a permanent fix to the current Medicare physician payment system. Senator Kyl is a strong advocate for physicians and is proactively working with his contemporaries in the Senate to develop a permanent solution. This group met with top House Ways and Means Committee health staff to discuss these issues as well.

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**FIVE MINUTE INTERVIEWS Dr. Leslie Crofford’s Balancing Act**

Leslie Crofford, MD, wears a lot of hats professionally. Her primary role as chief of the division of rheumatology and women’s health at the University of Kentucky is enough to keep her busy. But her work with clinical practice guidelines as program director of the General Clinical Research Center at the University of Kentucky Health Science Center and advisory board member of the ACR Research and Education Foundation, and you have one very busy woman.

“I have the greatest job in the world,” says Dr. Crofford. Rather than feeling overwhelmed by conflicting demands on her time, she draws satisfaction from them. “Having so many roles means that I don’t feel right or wrong, I can turn to another role for job satisfaction. I feel I’ve made a wonderful, very rewarding career choice because the clinical aspect is great because I’m able to try innovative therapies in patients who need them.”

She came to Kentucky two years ago because she got a call out of the blue from an old colleague from her residency at Washington University in St. Louis. Before that, Dr. Crofford had clinical and translational research, she says. “We need more young investigators that know how to do that.”

The work she’s doing now places an emphasis on that future focus. “Working with the REF as we develop an Annual Giving Campaign has been very exciting. We’re melding the REFiC, which I appreciate, with that role. We’re making a wonderful, very rewarding career choice. Even the clinician role means that no matter what is going right or wrong, I can turn to another role for job satisfaction.”

Send Us a Letter!

Do you have feedback on any of the articles you’ve read in The Rheumatologist? If so, send us a letter and share your thoughts.

E-mail your letter to us at dantzolin@wiley.com. Please include your full name, credentials/title, a daytime phone number, and an e-mail address in case we need to contact you. We reserve the right to edit correspondence for space and clarity.

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What is the future of inflammatory autoimmune diseases and how will current trials affect patient outcomes in the future? If you have ever asked yourself this question then you will want to make plans to attend the 2007 Innovative Therapeutics Conference. Daniel Furst, MD, conference co-chair. “This conference is unique in that it brings together clinical investigators, academicians, industry leaders, and regulatory authorities in an informal, interactive atmosphere to interchange ideas and collaboratively move forward in the field of rheumatology and their population-specific research for the specific benefit of therapeutic advancement,” says Dr. Furst. Topics at this year’s meeting include trial design, new safety issues and monitoring, drug development, and knowledge about the disease and new therapeutic entities in the rheumatic diseases.

New this year, a pre-conference course titled “Introduction to Clinical Therapeutics Research in Rheumatology” will be offered on Friday, March 2 from 8 a.m.-noon. This course has been designed for those who are new to clinical therapeutic research.

For specific program information and to register visit www.rheumatologist.org/meetings.
By Ann Kepler

Rheumatologists and patients report mixed experiences with the new prescription drug benefit
**Patient Perspectives**

Patients, even those who benefit from Part D prescription drug coverage, encounter many of the same frustrations that face their rheumatologists. Phyllis, a retired New York teacher with RA now living in California, has worked out a plan that combines Part D coverage with her New York retirement coverage to handle the financial costs, but she is frustrated with Part D’s restrictions on self-injections and infusions and the prior authorization required for oral medications. She considers herself fortunate to be in good health except for RA, but she thinks the administration of Part D is unnecessarily complicated.

Another patient, Chuck, turned to his state—Illinois—seeking prescription drug coverage and discovered that once he proved he qualified, state coverage was more comprehensive and less confusing than signing up for Part D, so he chose not to enroll. However, Chuck manages a support group for arthritis patients and tries to help his members navigate through Part D enrollment.

He reports that his members find Part D extremely confusing. Many, for example, do not understand that Part D is renewed each year and that, therefore, the doughnut hole (the gap in coverage during which all of the expensive rheumatic medications are paid for out-of-pocket) reappears annually—knowledge gaps are as widespread as doughnut hole gaps, he notes.

One of the most commonly mentioned concerns of rheumatologists is their perception that following Part D guidelines may interfere with the practice of medicine and their ability to provide optimal patient care using the most appropriate medications (within cost-containment guidelines) for each patient.

**Rheumatologists in particular use medications that don’t fall neatly into government guidelines. These drugs have more than one indication, are often expensive, and may be used on a long-term basis. Any or all of these factors may make prescribing a challenge—a drug may not be listed in a formulary or may require extra paperwork for coverage. Such problems begin with the questions of generic equivalents, cost-sharing requirements, and drug formularies in general.**

**Generic Drugs**

Many rheumatologists say their treatment choices are compromised when the plan coverage requires automatically switching to a generic form of a medication or a less expensive treatment option. “Forcing a drug choice to be a generic equivalent may be acceptable,” says Fredrica Smith, MD, “but it should be a medical decision, not a government mandate.”

Dr. Smith, who, with the aid of a nurse practitioner, maintains a solo practice that serves the entire northern half of New Mexico, believes the “system discriminates against those with chronic disease.” Because 40% of Dr. Smith’s practice load is eligible for coverage under Part D, she is familiar with the problems of an aging population with chronic disease.

Christopher Morris, MD, objects to using generic drugs simply to meet the coverage requirements. Dr. Morris is part of a practice that includes three physicians and five physician’s assistants, working out of Kingsport, Tenn., and covering a large area of southern Appalachia. He and his colleagues serve both an urban area and a more rural community.

Dr. Morris is dismayed that so many patients are asked to switch to a generic brand even though their current treatment is quite successful. “I am shocked by the number of patients requiring prior authorization for state-of-the-art medications that have been successfully treating their conditions all along,” says Dr. Morris.

John Goldman, MD, a solo practitioner in Atlanta, also takes a strong stand on the question of generic drugs. He questions the testing procedures for determining the equivalency of a generic drug. “Generic drugs are tested by normal, healthy volunteers—not patients,” claims Dr. Goldman. “The generic drug can’t automatically be assumed to be a satisfactory substitute.”

His opinion of generic equivalency can be summed up with the question in the title of his article in the ACR Practice View: “Generic Drugs: Should bioequivalence be equated with therapeutic equivalence?”

**Cost Sharing and Drug Formularies**

Rheumatologists must work with cost-sharing systems and utilization management tools daily, and working with the formularies can be a daunting task. In the first place, Medicare’s private, stand-alone plans vary significantly in regard to covered drugs, out-of-pocket copayments for certain medications, and restrictions on the use of certain medications.

Part D is designed to encourage competition among its approved benefit plans in order to foster cost-effectiveness, and so far this outcome is being met. However, the burden of sorting through all of the choices and selecting the best plan for an individual’s needs falls on the patient—and secondarily upon the doctor who must provide optimal medical care within the limits of the chosen plan.

Not only does the clinician need to work with a formulary of pre-approved drugs, but he must also consider the cost-sharing requirements for the given drugs. For example, the most common cost-sharing arrangement is a three-tier system of co-payments: the lowest copay for generics (tier 1), a higher copay for preferred brands (tier 2), and the highest copay for non-preferred brands (tier 3).

However, many plans use a “specialty tier” for biologic or injectable drugs—some of which are successfully used to treat RA. While the CMS guidelines recommend charging beneficiaries no more than 25% of the cost of these specialty tier drugs, several plans impose a specialty tier charge between 30% and 33%.

Jack Hoadley, PhD, a research professor at the Health Policy Institute of Georgetown University in Washington, D.C., has completed an in-depth study of formularies and Medicare plans. He includes a detailed explanation and table of the TNF inhibitors in his paper, “An In-depth Examination of Formularies and Other Features of Medicare Drug Plans.”

“Fourteen of the plans studied offered different levels of coverage so they have the flexibility to make things more or less expensive,” says Dr. Hoadley. “As one analyst put it, this plan is like a roller coaster—up and down and starting over every year.”

Further, utilization management tools—prior authorization, quantity limits, and step therapy—can also have a negative effect on drug costs for rheumatology patients. Again, in an effort to contain costs, some plans impose quantity limits and step therapy programs (requiring patients to take a less expensive drug before receiving a more expensive alternative). These cost-containment efforts impose yet another restriction on the prescribing rheumatologist.
Prior Authorization

By far the most common problem mentioned by the rheumatologists seems to be the need for prior authorization to use a drug not on a plan’s formulary. Some of these problems exist because of confusion between coverage from Medicare Part B and Medicare Part D. For example, a prescription may be refused under Part D because it is an injectable or infusion administered by a physician and therefore should be covered under Medicare Part B.

Another common problem is obtaining prior authorization for drugs used in rheumatology that are not on the list. For example, a patient with RA, diabetes, asthma, heart disease, and high blood pressure needs a carefully balanced drug regimen for effective treatment and safety. The choice of medication for any one problem, therefore, may not be an easy decision—nor can it be a decision dictated by an insurance drug formulary.

Logistical Questions Remain

In addition, the prior authorization process itself causes logistic problems. A patient can appeal a drug denied by his or her plan and can also request a reconsideration (level 2) appeal on a denied Part D claim. This is the point at which the patient can appoint the physician to represent him or her in the claim, which requires a form signed both by the physician and the patient that is good for one year.

One of the early complaints is that patients in rural areas, such as those in Dr. Denio’s Appalachian areas and Dr. Smith’s remote northern New Mexico region, have to travel long distances to sign the authorization form. In addition, the staff in the physician’s office have to complete the paperwork and follow up throughout the process—either by mail, fax, or telephone.

This erosion of staff time has become a cost factor for many practices. Herb Baraf, MD, who works in one of the largest practices in the country in the suburbs of Washington, D.C., puts it succinctly, “The ability to get through the day is degraded terribly.”

In Forz’s case, Dr. Baraf considers this problem so important to some practices that they are forced to close down for a day to week to balance costs. “This is not our motto in our practice,” ensures Dr. Baraf, “but it can be a problem for many practitioners.”

Dr. Smith in New Mexico, for example, estimates it takes 40 minutes per patient to obtain each authorization.

Also, everyone interviewed here wonders about the potentially biggest frustration of all. Will all the prior authorizations have to be resubmitted each new year when coverage begins anew or every time a patient changes a plan? Will the authorization ever follow the patient and not the plan?

Prior authorization, staff costs, and the frustrations of dealing with new regulations are only the beginning of the challenges presented by Medicare Part D. From the patient’s point of view, seeing the medication in his or her plan, changing medications to meet coverage requirements, and working with the physician to create the best treatment regimen under given circumstances can be demanding tasks.

Then there is the high cost of coverage during the doughnut hole. For example, Lois, an RA patient in Chicago, takes Humira. She is happy that Part D is sparing her from paying her total drug costs. Nevertheless, because of the expense of her medication, she is concerned about the doughnut hole.

These problems are also the rheumatologist’s problems. “We have to accommodate the regulation because our patients can’t afford to do otherwise,” says Dr. Denio.

Providers Needed Coverage

Without exception, the physicians interviewed agree that Medicare Part D, for all its flaws, provides coverage that otherwise would not be available. Dr. Denio calls it a “bargain compared to going without.” Dr. Morris sees it as a real bonus for those in his district who have never had medication coverage, and Dr. Fohrman thinks it provides a service for those who cannot afford medication at all.

On the other hand, “It can be problematic,” says Dr. Fohrman. Still, as Medicare Part D continues to be tweaked, and as clinicians and patients voice their concerns and demand changes, there are likely to be improvements. Many rheumatologists working with the plan now have ideas and, in the end, Medicare Part D may become a workable plan for the ever-aging population in the United States. (See “Meeting the Challenges of Part D,” page 23.)

Ann Kepler is a medical journalist based in Chicago.

References

A DAY IN THE LIFE OF NIVEDITHA MOHAN, MD

By Heather Lindsey

I wanted to see the world and felt that I would get the best possible training if I came abroad,” says Niveditha Mohan, MD, of her decision to leave Chennai, India—where she earned her medical degree at the University of Madras—and travel halfway around the world to complete a residency at the Brooklyn Hospital Center in New York City. She was in search of a more rounded perspective of the world and exposure to more aspects of training, such as research and clinical trials. However, sometimes the best medical training comes not in high-tech urban hospitals but in underserved communities where care has to accommodate small-town life and a shortage of services. For Dr. Mohan, working in an underserved South Dakota community offered lessons she didn’t learn in the classroom.

“It’s nice being in an academic setting because you have the luxury of bouncing ideas off other colleagues and can refer complicated patients for a second opinion,” says Dr. Mohan. “But my experience in Sioux Falls gave me the confidence to deliver care in a real-world setting.”

East Coast Adventure

“Moving from India to New York was like an adventure that you have always dreamed about coming true,” says Dr. Mohan. “[New York] was big, bold, brash, beautiful and exciting, especially since I had never been to the U.S. before and the first place I landed was NYC. … Yet in some ways, New York was also easy to get used to because it was so diverse, and anyone could live in New York and not feel out of place.”

She lived on the East Coast for the next 10 years, accepting a fellowship and then a faculty position at Georgetown University Medical Center in Washington, D.C., after finishing at Brooklyn Hospital Center.

In 2003 she relocated to Sioux Falls, S.D., because her husband, a hematologist-oncologist who is also from India, was able to get his visa requirements waived by working in an underserved area. Dr. Mohan was one of four practicing rheumatologists in a city of about 120,000 people. In addition to treating local residents, she cared for patients from surrounding towns and rural areas, including several from underserved Native American reservations.

Midwest Move

“Everything seemed different,” she says, “starting from the topography of the place, the weather, the people, pace of life, traffic, attitudes. … It made me realize how insular large parts of this country are, and it gave me a better understanding of some of the dichotomies that have puzzled me about American politics and policies.”

While in South Dakota, Dr. Mohan practiced at Avera-McKennan Hospital, where some patients had to drive several hours to see her. For example, Native American reservations such as Rosebud and Pine Ridge were 250 miles to 350 miles away, respectively. Patients there were referred to the city by their community hospital’s primary care physicians because subspecialists on the reservations were rare. The Indian Health System would usually arrange transportation, says Dr. Mohan.

These patients usually had much worse diseases than other patients Dr. Mohan and her colleagues saw. If they had rheumatoid arthritis (RA), it was usually advanced, she says. If they had lupus, they were much sicker than other patients. “This was partly due to a delayed referral or because they sought medical care too late,” she says. “These patients also had a much more stoic attitude toward their physical ailments.”

Coordinating ongoing care for Native Americans on reservations and other people living in rural communities was challenging, says Dr. Mohan. For example, patients taking methotrexate for RA should ideally undergo blood work every two months. “But we couldn’t follow algorithms by the book for practical reasons,” she says.

Rural Challenges

Farmers needing to drive to Sioux Falls had to overcome obstacles such as gas prices, icy roads during the winter, or missing a day of work during harvest season. “We had to find other ways to monitor their disease and medications,” says Dr. Mohan. “We would tell them, ‘If A, B, or C happens, call me right away so we can arrange care.’”

Unfortunately, some patients on the reservations did not have enough money to make a phone call or did not own a phone, notes Dr. Mohan. Additionally, medical care and compliance were compromised by issues such as substance abuse, alcoholism, and unemployment, she explains. Other problems were lack of education and lower socioeconomic status—the Pine Ridge Reservation is located in one of the poorest counties in the United States, according to the Bureau of Economic Analysis.

Dr. Mohan is currently assistant professor of medicine at the University of Pittsburgh Medical Center in a city she describes as “a midway point between the extremes of living in a big city on the east coast and a typical midwestern town in the heartland.” She still thinks about the challenges of delivering rheumatologic care in rural settings, though.

“One way to overcome some of the many hurdles associated with treating rheumatology patients in rural South Dakota is to establish an outreach program, says Dr. Mohan. “The problem is, there is a shortage of rheumatologists across the country and we tend to be concentrated in bigger towns and cities,” she says. “But even if rheumatologists could do a couple of outreach clinics in these communities just once or twice a month, it would help to improve care.”

Heather Lindsey is a medical journalist based in New York City.

ACR STATE-OF-THE-ART CLINICAL SYMPOSIUM

Friday, April 13, 2007
Renaissance Chicago Hotel • Chicago, Illinois

CORC Practice Management Course:
Making Your Office Run Like Clockwork

This course requires an additional registration fee.

TARGET AUDIENCE:
New and established private practice rheumatologists, practice administrators, office managers and Fellows in Training.

Upon completion of this program, participants should be able to:
• Identify practical strategies for rheumatology practice to enhance operational efficiency
• Explain how to code correctly using CPT codes
• Describe process for establishing a compliance program and the benefits
• Discuss how to buy malpractice insurance and crucial aspects of the insurance policies to review

8:00 AM – Noon
Session One
The morning session will focus on: Coding, running your practice more efficiently, Medicare do’s and dont’s and how to buy malpractice insurance.

Noon 1:00 PM
Lunch

1:00 – 1:02 PM
Session Two
The afternoon session will focus on: Keeping staff up-to-date, how to deal with difficult patients, training and using health professionals effectively and establishing a coding compliance program.

REGISTER NOW! Go to www.rheumatology.org
For additional information contact Antnya Ching, Sr. Specialist of Practice Management at (404) 673-3777 ext. 818.