the Rheumatologist

An official publication of the ACR and the ARHP serving rheumatologists and rheumatology health professionals

VOLUME 1 NUMBER 5
MAY 2007

page 16

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Have We Reached an Estrogen Comfort Zone?

A review of research on prescribing estrogens in systemic lupus erythematosus

>> By Jill P. Buyon, MD

Physicians caring for women with systemic lupus erythematosus (SLE) often face difficult decisions regarding the use of exogenous estrogens as part of the overall management plan. In certain circumstances the discussion is moot because a patient may have an unambiguous contraindication to estrogen therapy such as a thrombotic diathesis. In other cases, physician and patient must have a lengthy discussion, attempting to balance evidence for and against use. Three recently published randomized controlled trials offer new evidence to aid this discussion.

continued on page 16

PAC A PUNCH ON CAPITOL HILL

New political action committee will be a voice for rheumatology

>> By Elaine Zablocki

In February, the ACR board voted to form a political action committee (PAC) to represent members' interests in the political arena. The new committee will allow the ACR to contribute to candidates who promote the interest and needs of rheumatologists and their patients in the political process. The PAC is non-partisan; contributions are based the candidate's involvement in rheumatology issues, not party affiliation.

continued on page 22

SHUTTERSTOCK

On BOARD with BABY

Rheumatology programs make strides in work–life balance support

>> By Sheri Polley

This is the first of a series of articles on balancing parenthood with a rheumatology career.

Giving birth to triplets is daunting for any parent—even more so when you have to balance parenthood with a medical career that includes teaching and research responsibilities. This was the situation for Sujata Sarkar, MD, a clinical lecturer and research fellow at the University of Michigan (UM) in Ann Arbor, who was unable to work for nine months when she gave birth to her triplets three years ago. She says that her colleagues and coworkers were extremely supportive during this time. They pitched in and took over her on-call responsibilities, and her clinic patients were temporarily reassigned to other clinicians.

continued on page 20

The Rheumatologist
John Wiley & Sons
111 River Street
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Make Our Voice Heard

It's up to you to take rheumatology's case to Congress

>> By Neal S. Birnbaum, MD

It is the duty of every citizen according to his best capacities to give validity to his convictions in political affairs.—Albert Einstein

It is important for all ACR members—especially those who serve in leadership roles for the ACR—to make their voices heard to their elected officials. In this spirit, the ACR board of directors, standing committee chairs, and senior ACR staff headed to Capitol Hill on May 10. This unprecedented event, scheduled to coincide with the ACR's May board meeting, was a first for the leadership as a group, though many of us have individually met with members of Congress.

Congressman Frank Pallone, Jr. (D-NJ), spoke to the leadership before its visit to the Hill. Pallone serves as a senior member of the House Energy and Commerce Committee and chair of its powerful Subcommittee on Health. The subcommittee has sole jurisdiction over Medicaid, the Food and Drug Administration, the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC), and shares jurisdiction of Medicare with the Ways and Means Committee. It oversees public health, biomedical programs, food and drug safety, mental health and related research, hospital construction, and all healthcare homeland security-related concerns.

All told, some 40 volunteers and staff spent part of Thursday visiting more than 16 members of Congress from more than 22 states to advocate on behalf of rheumatology. We talked about four of the most important issues affecting rheumatology today, which I will summarize below.

Not all ACR members could join us in Washington, D.C., but you each can make sure the voice of rheumatology is heard. I encourage you to use this summary as a basis for a letter or phone call to your senators and representatives, or visit the ACR Legislative Action Center online at www.rheumatology.org for more details on each of these issues and assistance in contacting your member of Congress.

Fair Physician Reimbursement

The ACR strongly urges Congress to support legislation revising Medicare payment methodology to ensure appropriate reimbursement for specialists treating arthritis and rheumatic and musculoskeletal diseases.

In 2006, Congress again prevented what would have been a damaging 5% cut in the Medicare fee schedule for 2007 by including a 0% update in the Tax Relief and Healthcare Act of 2006. Unless Congress takes remedial action, rheumatologists and other physicians are expected to face Medicare reimbursement cuts of 10% or more in 2008 and in each year through at least 2012.

The Sustainable Growth Rate (SGR) is part of the formula used to calculate physician reimbursement for Medicare. Unfortunately, the basic premise of the formula is flawed. The SGR formula is linked to the performance of the overall economy, yet the medical needs of individual patients do not shrink whenever the economy slows. When overall spending on services in the SGR exceeds the per capita gross domestic product, cuts to physician reimbursement are triggered. The SGR also includes the costs of drugs covered under Medicare Part B, a cost over which physicians have no control. Notably, spending on these Part B drugs is increasing at a higher rate than spending on actual physician services. This skews the calculation of the SGR and triggers overly harsh reductions in physician reimbursement.

Congress should repeal the SGR formula and base payments on the growth of the Medical Economic Index, replacing the flawed payment methodology to avoid continually bandaging a broken system.

The ACR asks Congress to support a long-term fix to the Medicare physician reimbursement issue. Repairing the SGR formula is imperative to ensure that physicians will be fairly compensated and that patients will have access to appropriate care.

Enact Arthritis Act

The ACR exhorts Congress to enact the Arthritis Prevention, Control, and Cure Act of 2007 (S. 626/H.R.1283). This legislation would expand efforts to discover and implement new ways to prevent, treat, and care for patients with arthritis and related rheumatic diseases. See "Arthritis Act Provisions," above, to learn how the act would enhance rheumatic disease research and public awareness.

Revoke Imaging Cuts

Because of a provision in the Deficit Reduction Act of 2005, imaging studies such as flat films and duel-energy X-ray absorptiometry (DXA) have been reduced to the Hospital Outpatient Perspective Payment System rate. This reimbursement reduction negatively affects not only rheumatologists who perform vital and timely imaging studies in their offices but also patient care—especially women's access to treatment—and will increase cost for Medicare beneficiaries.

Additionally, the Centers for Medicare and Medicaid Services has made changes to the practice expense calculation for DXA, decreasing reimbursement for this vital service a staggering 75%. The ACR is concerned that if reimbursement continues to drop, patients will be unable to receive these important studies.

The ACR encourages members of Congress to revoke the imaging cuts in the "Deficit Reduction Act of 2005" so physicians can continue to perform these necessary studies.

Increase Research and Public Health Funding

The ACR supports increased funding to federal programs engaged in vital research to combat arthritis and related diseases. (See "Key Rheumatology Research Agencies," below.) These programs are essential for finding innovative treatments that can help millions of Americans live longer, healthier, and more productive lives, and they are critical to developing more effective treatments, decreasing costs, and improving the quality of life for patients suffering from rheumatic diseases.

While this leadership visit to the Hill is a first for us, we hope it won't be the last. I'll let you know how it went in my report of the ACR board meeting, which I'll send to all members later this month.

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

Arthritis Act Provisions

>Implementing a national arthritis action plan to enhance support for federal and state public health activities and outreach programs to prevent and manage arthritis;

>Developing a national education and outreach campaign to educate healthcare professionals and the public on successful self-management strategies for controlling arthritis;

>Establishing a coordinating committee to oversee all national research institutes conducting research on arthritis and rheumatic diseases;

>Ensuring greater coordination and intensification of federal research efforts by organizing a National Arthritis and Rheumatic Diseases Summit to examine challenges and opportunities related to basic, clinical, and translational research and development efforts;

>Increasing attention to juvenile arthritis research by creating planning grants for innovative and collaborative research specific to juvenile arthritis, with a focus on better understanding the prevalence, incidence, and outcomes associated with juvenile arthritis; and

>Creating incentives—education loan repayment and career development award programs—to encourage health professionals to enter the field of pediatric rheumatology.

Key Rheumatology Research Agencies

> **National Institutes of Health:** The NIH is a key agency for advancing the prevention, detection, diagnosis, and treatment of disease and disability, including arthritis and rheumatic diseases.

> **National Institute of Arthritis and Musculoskeletal and Skin Diseases:** The NIAMS leads the federal medical research effort in arthritis and rheumatic diseases and conducts research related to the causes, treatments, and prevention of diseases of the bone, joints, muscle, skin, and other connective tissues.

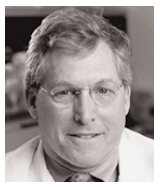
> **National Institute of Allergy and Infectious Diseases:** The NIAID conducts research that strives to understand, treat, and prevent a myriad of infectious, immunologic, and allergic diseases.

> **Centers for Disease Control and Prevention** The CDC conducts surveillance, epidemiology, and prevention research to reduce the occurrence of arthritis.

> **National Arthritis Action Plan:** The NAAP—a public health program developed by CDC and the Arthritis Foundation—works with state health departments to develop or enhance programs to address arthritis.

> **Agency for Healthcare Research and Quality:** The AHRQ provides evidence-based information on healthcare outcomes, quality, cost, use, and access.

> **Veterans Administration Medical and Prosthetic Research Program:** This program supports studies on many conditions, including arthritis.



Cost of a Free Lunch

Much is made of pharma's influence on CME—but do we really know what this educational funding buys?

>> By Bruce N. Cronstein, MD

The ACR's annual meeting serves many purposes. First and foremost, it is the premier scientific meeting in rheumatology—a chance for those of us in academia to come together in one place to exchange ideas, develop collaborations, and plant the seeds of new investigations. It is also a chance for us to see and be seen, hopefully impress our colleagues with our newest research, and gossip about who is doing what.

For clinicians (by far the largest group in attendance) the meeting is an opportunity to discover the cutting edge of research and review and consolidate their understanding and approaches to therapy of rheumatic diseases. For everybody who attends, the meeting is also a social occasion—a chance to see old friends who share an interest in rheumatology but who are geographically distant from you.

Influence for the Price of Chow Mein

Among the many old friends whom I saw in Washington last November was someone who had left academia for employment at a pharmaceutical company. We chatted in the halls of the convention center and had an opportunity to have lunch together at one of D.C.'s fine restaurants.

At this lunch, I did something that was highly unusual for me and certainly for the attendees of the ACR meeting: I picked up the check. It is not often that I have the opportunity to subsidize the pharmaceutical industry or influence an employee of major pharma, although I readily admit that lunch in D.C.'s Chinatown doesn't make much of a dent in anybody's budget. Nonetheless, by the logic of the people in charge of continuing medical education (CME), I could be exerting undue influence on this pharmaceutical employee because even the smallest gift (e.g., a pen) carries more than token influence. Fortunately for my friend in pharma, I didn't intend to fill out any disclosure forms or put up a slide disclosing our lunch at his next presentation to management.

Clearly, the bulk of the advertising and promotion funds spent by pharmaceutical companies is directed at physicians, and the industry must think that it is getting value for its money. Much of the pharmaceutical funding goes to supporting CME events for physicians, and the majority of outside speakers who visit any institution are funded, at least indirectly, by pharmaceutical company donations. Moreover, from the Frank Netter illustrations that were used widely when I was a medical student to the PowerPoint images used by many medical-school lecturers today, basic teaching materials have also emanated from the pharmaceutical industry. Thus, the continuing education of clinicians, evidence for which is a condition for licensing and renewal of hospital privileges, is highly subsidized by the pharmaceutical industry. Critics of this system often seem aghast because the continuing education system for physicians could be susceptible to disguised (and not-so-disguised) commercialism.

Regulatory Burden on CME

In response to the potential for abuse inherent in this system, the Accrediting Council for Continuing Medical Education (ACCME), the accrediting body for continuing medical education, has developed a series of regulatory requirements that govern the provision of CME. Not least of these requirements is that all presentations be vetted for undue pharmaceutical company influence. According to the ACCME, speakers must make a full disclosure of any potentially conflicting commercial interests prior to any presentation.

If the organizers of a CME activity believe, based on what the speaker has disclosed, that the speaker has a commercial interest that may conflict with the goal of giving an honest and unbiased interpretation of the data and clinical recommendations, they may take several approaches to resolve this problem, including prior review of the material to be presented and labeling or elimination of offending portions. Alternatively, the organizers may instruct speakers to "…reference the best available evidence," although why you would invite somebody to speak who does not do that is beyond me. Finally, the audience can be polled for their opinion on the objectivity of the presentation, an approach most commonly taken on an informal basis since most physicians seem to have fairly strong opinions on the subject. [To learn more about the ACCME's policies on resolving personal conflicts of interest, visit www.accme.org/index.cfm/fa/faq.detail/category_id/6a4a0ce7-1e62-4fc9-a437-1e6e7eedecb2.cfm.]

Needless to say, these regulations are often resented and compliance can be quite burdensome. As a director of a CME program, I have had to take a course in writing educational objectives—not something I would like to repeat and not something for which I see much value, either. Indeed, for a time, the NYU Division of Rheumatology dropped CME credits for rheumatology rounds because the regulatory burden seemed too great. I have yet to hear of or see a study documenting that all of these requirements add anything meaningful to medical education or (more to the point) influence the prescription of new or expensive drugs. Indeed, the studies, which suggest that undue commercial influence of CME leads to increased prescription of proprietary agents, never include an appropriate control (e.g., Is there a concomitant increase in diagnoses of a given condition following the presentation?).

Inherent in the proliferating regulations for CME is the view that the audience for CME talks is a mass of clinicians who uncritically receive information from speakers who themselves have uncritically received and then presented information from the pharmaceutical companies. An unscientific survey of people leaving medical lectures does not support this view. A more scientific examination of the written comments made by attendees at the NYU Course in Advanced Rheumatology also suggests a great deal of skepticism and strong basic knowledge of the subject matter on the part of people in practice in rheumatology.

> There have clearly been instances when the covert influence of the pharmaceutical industry on the content of CME has been documented and the clear implication has been that medical practice was negatively influenced. But if CME has as little effect on actual practice as Medicare seems to suggest, does the commercial influence matter so much?

Trading the Carrot for the Stick

More tellingly, Medicare must not believe that CME successfully indoctrinates physicians, either, because it now pays physicians to document adherence to standards of care.[1] For example, it has been known for years that individuals who have had a myocardial infarction should be administered beta blockers and aspirin, and lecturers throughout the country stress this information to residents and attending staff at CME events. Nevertheless, compliance with therapeutic guidelines by physicians remains limited unless a variety of other measures are taken (computerized automatic ordering and the like).

Similarly, handwashing in hospitals unfortunately does not seem to increase after lectures and discussions; increasing handwashing seems to require the prospect of penalties. Studies on the effect of CME on the practice of medicine indicate that CME exerts only minimal effects on medical practice.[2] More extensive programs and automated ordering systems have been put into place by hospitals to improve compliance with recommended guidelines for medical practice. Thus, the evidence suggests that not only are we impervious to brainwashing but that we don't seem to listen, either. So, Medicare will now pay physicians to document adherence to guidelines and it is likely that pay-for-performance is the future for many common conditions.

What *Does* CME Teach?

If CME does not change the way physicians practice, what is it good for? CME plays many roles. In some states, evidence for minimal attendance at CME events is a necessary condition for maintaining a license to practice. Many physicians also take home new ideas about treating specific difficult patients from CME events and can become familiar with new approaches to therapy. Moreover, CME is good for morale: knowing there is progress in the treatment

Continuing education is as much part of the fabric of our profession as the stethoscope; CME makes us more than just "healthcare providers."

of difficult diseases makes it easier to face the patients who come to us for help with those diseases. Finally, medicine and—in particular—rheumatology, are cognitive pursuits, and education is at the very center of how we perceive ourselves as professionals. Continuing education is as much part of the fabric of our profession as the stethoscope; CME makes us more than just "healthcare providers."

Traditionally, medical schools and hospitals were the main distributors of CME, but over the past few years CME has burgeoned into an industry with nearly $1 billion in revenues providing nearly 67,000 CME activities in 2003. That year there were 697 accredited providers of which 100 were for-profit organizations generally hired by pharmaceutical companies to arrange CME events.[3] What can we make of all of this educational activity that is regarded so lightly by Medicare, among others? And what are we to make of all of this economic activity in pursuit of such ephemera?

It is obvious that much of the funding that drives and supports CME comes from the pharmaceutical industry and—to many observers—pharma funding taints most CME. There have clearly been instances when the covert influence of the pharmaceutical industry on the content of CME has been documented and the clear implication has been that medical practice was negatively influenced. But if CME has as little effect on actual practice as Medicare seems to suggest, does the commercial influence matter so much?

Fortunately for my guest at lunch at the ACR meeting, I left my PowerPoint slides at the hotel. Not only did I not have the opportunity to bore him and ruin an otherwise pleasant meal, but I also did not have to bring anybody along to review what I had to say before I said it. I did not even have to offer a postprandial evaluation of my conversation.

Dr. Cronstein is Paul R. Esserman professor of medicine at NYU School of Medicine in New York.

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VOLUME 1 NUMBER 5 ▮ MAY 2007

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The Rheumatologist is published monthly by John Wiley & Sons on behalf of the American College of Rheumatology. Editorial, business, and production offices located at 111 River Street, Hoboken, NJ 07030; (201) 748-5813; (201) 748-6182 fax. Printed in the United States by Cadmus Specialty Publications, Easton, Pa.

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Make Peace with Complexity

Not even gout is simple these days >> By David S. Pisetsky, MD, PhD

Several years ago, at a venerable New York hotel, I attended a meeting that has made a lasting impression on my thinking. The purpose of the event was to bring together academic physicians of all levels for two days of lectures, dinners, and talk. On the first afternoon, we had breakout sessions to discuss topics of major, even pretentious-sounding, importance: the future of clinical research, the health of the Third World, the genetic revolution. The breakout groups comprised everyone from a post-doc to a professor and featured an eclectic mix of sub-specialties, all sitting around tables in darkened meeting rooms that were oppressively overheated.

The breakout groups were charged with reducing our deliberations into a key concept to guide future clinical or basic research, policymaking, or even a personal career choice. Although the groups focused on different subjects and had amazingly diverse memberships, we all came back with the same word. That key word was (drum roll, please) complexity.

You may find it ironic that complexity could be a simplifying concept but the unanimity of its selection shows how complicated medicine has become.

As Simple as Complexity

Everything about modern medicine is complicated. I love adjectives, so I suggest the following other descriptors of our current state: multifaceted, convoluted, intertwined, interdependent, interdigitated, intricate, thorny, and downright confusing. Nothing in research is simple anymore. Clinical trials can number 50,000 patients and—with mathematic and statistical analyses worthy of astrophysics—provide evidence for 1.1 relative risk of an adverse event that occurs in one in a thousand subjects. Genetic studies are similarly baroque, involving hundreds of SNPs distributed unevenly in the population but, in certain alignments (or phases of the moon), produce a suggestion that genes do matter after all. Microarray analyses are even worse because, in reality, each data point comprises myriad others.

Clinical medicine can be similarly dizzying in its practice. Each decision involves a measured and deliberate weighing of risks and benefits, which must be explained in a comprehensible way to the patient even though the physician might be clueless about the right choice. The problem is that the risks and benefits are often uncertain, shifting, or imprecise. While, as professionals, we pride ourselves for being evidence based, often the evidence simply does not exist.

Our breakout groups were correct. Complexity governs our work as physicians and providers.

No More Easy Decisions

As noted in "Sniff 101 and Other Lessons" (April 2007, pg. 6), I recently attended on general medicine and was amazed by the complexity of the medical problems I saw and the tortuous thought process necessary to devise even the most basic diagnostic or therapeutic plan. Modern medicine is now like a chess game; we have to plan for many moves in advance knowing that our opponent, sickness, is cagey, mean, and unpredictable. How do you play chess against a madman, knowing that erratic moves can beat even the cleverest strategy?

Consider a recent case that I saw. The diagnosis was unquestionably gout. A joint tap—deftly accomplished by a rheumatology fellow—produced several drops of cloudy albeit blood-tinged fluid. Using the marvelous optics of the polarizing microscope, the diagnosis was a slam dunk as yellow crystals glowed luminously on the slide. While the fluid was sent for gram stain and culture, the evidence was sufficient to start treatment. Treating gout should be simple except, for this patient and numerous others we see, it was limited by far more Scylla and Charybdis channels than I like to navigate.

The patient was 72 years old, looked 100, and was breathing oxygen frantically through a nasal cannula. He had heart failure and an ejection fraction of 20. His creatinine was 2.5; his blood urea nitrogen was 60 and rising as intermittent squirts of Lasix squeezed fluid from his tissues. As if that was not bad enough, he had a fever and an infiltrate on chest X-ray that could have been pneumonia, atelectasis, or pulmonary congestion; maybe two out of three or—if the patient was especially unlucky—all three together in a perverse trifecta of pulmonary misfortune. Oh, did I forget to mention that he was on coumadin because he recently had a pulmonary embolus that almost killed him? In the midst of all this trouble, the poor man now had gout that was scalding the skin off a knee that shined bright red.

In the old days, gout was a simple problem and colchicine was the morning-after pill for an evening of debauchery. Now gout is a therapeutic dilemma, with a chessboard of decision-making filled with seeming checks and checkmates as solutions are conjured. NSAIDs? No way. The creatinine and heart failure make them a bad choice. Systemic corticosteroids? Possible, but the infectious disease consultant tending to the pneumonia is worried about immunosuppression. Intraarticular steroids? With the INR near 3, an errant needlestick could flood the joint with blood.

What Would You Do?

I won't tell you what I recommended. Send your suggestion to me at piset001@mc.duke.edu—I'm curious what others would decide. The point is, as people have grown older and sicker, medical decision-making has escalated in complexity.

Dr. Jim Fries has written presciently and eloquently about the compression of morbidity. His hypothesis is, as medical care has improved and life expectancy has increased, the time a person suffers from disability diminishes and concentrates at the very end of life. The good part is that many people live longer, happier, and healthier lives, with the price of longevity paid mostly at life's denouement.

That is the optimistic version. The pessimistic view is that, when morbidity comes, it hits like a ton of bricks. While morbidity may be compressed in time, medical care then explodes in magnitude, complexity, and, of course, cost. Decision-making requires enormous thought and attention to detail when a patient suffers simultaneously with four or five major illnesses and has a 30 item med list. As medicine gets more and more complicated, doctors and patients can go down blind alleys as they make their choices, never knowing when some disaster will come out of the blue to inflict a terrible blow. Who would have predicted that gadolinium would cause menacing skin fibrosis if the kidneys do not work?

Attending on medicine should teach respect for how complicated patient care has become, especially as people live longer and their bodies fill with myriad drugs. In the next issue, I'll discuss why consultation and collaboration are important so that confronting complexity does not bewitch us and hurt doctor and patient alike. | THE RHEUMATOLOGIST |

Dr. Pisetsky is physician editor of *The Rheumatologist* and professor of medicine and immunology at Duke University Medical Center.

From the COLLEGE

NEWS FROM THE ACR AND THE ARHP

PRACTICE UPDATES

Maximize Reimbursement by Managing Denials

Could you use an additional $50,000 to $80,000 in revenue each year? If you are like most clinicians, you have superbills and well-trained office staff but you still receive frequent denials. Though some denials are appropriate, many can be corrected and the lost revenue recovered.

Most practices nationwide have a 5% to 8% denial rate, according to the April 2004 issue of *Physician Practices*. This means that in a practice with a $1 million revenue stream, denials potentially represent between $50,000 and $80,000 in lost revenue.

Reports show that 50% of denied claims are never refiled; this represents significant lost revenue—much of which doesn't have to be lost. According to the Healthcare Advisory Board, 90% of denials are preventable and 67% are recoverable. Given the magnitude of these numbers, a targeted denial management strategy should result in a significant revenue increase to the typical practice. The key to recovering additional income is managing denials.

Denial management requires time and resources—but can benefit your practice if the recovered reimbursements ultimately improve your bottom line. Here are some tips for creating a successful denial management program in their office:

1. **Make decisions in advance:** Analyze your denials to see if there are common patterns from individual payers. Determine which payers you will target, define denial reasons you'll investigate, and use your billing system to evaluate and follow up on over- and underpayments that might reflect negatively on accounts receivable.

2. **Prepare a detailed implementation plan:**

Sample Implementation Checklist:

- ✔ Make phone inquires to clarify what is needed if a claim is denied;
- ✔ Refile a corrected claim and send by certified mail; and
- ✔ Follow up with a phone inquiry to verify receipt of the corrected claim and confirm when the claim will be reprocessed.

3. **Gather relevant fee schedule information:** Confirm that your Medicare fee schedule information is up to date at www.cms.hhs.gov. Create charts with your private carriers, including contractual agreements for CPT code payments. Generate reports to monitor progress on denials and appeals to verify whether the current process is working or not. This is also a good way to distinguish "contractual adjustments" from "write-offs."

4. **Get all staff involved:** Communicate the importance of the project to all staff. Define process, benchmark performance targets, timetables, and performance standards for those employees charged with performing the daily charge entry, billing, follow-up, and reporting.

5. **Consider an incentive plan:** For example, one practice implemented a casual day for participants, offered a pizza lunch, and paid overtime for staff to work on denials on Saturdays. The office was able to clean up denials and retrieve significant lost revenue.

6. **Look at the big picture:** Anticipate and budget the additional staff and related expenses necessary for claim follow-up, management, and reporting duties.

If this all seems onerous, remember that lost revenue is likely to increase if you don't manage your denials. Physicians should understand their practice's current revenue cycle performance statistics. At a minimum, examine the following statistics:

ARHP Angle The Quest for Quality

>> By Karen L. Kerr, MSN, NP, CPNP, APRN-BC

The ARHP has an important role to play as the ACR addresses the emerging quality movement in healthcare. Most healthcare professionals are familiar with terms such as quality assurance, continuous quality improvement, and total quality management. In the late 1980s, healthcare organizations, following the lead of the manufacturing industry, began to implement quality-management programs as a way to improve the quality and cost efficiency of healthcare services and meet rising consumer expectations.

The Institute of Medicine's (IOM's) 1999 report, "To Err is Human: Building a Safer Health System," brought renewed attention to healthcare quality. The report estimated that between 44,000 and 98,000 people in the United States died every year as a result of medical errors, and that the total cost of medical errors was between $17 billion and $29 billion. According to a subsequent IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century," problems in the quality of healthcare persist because the healthcare system "frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately."

The IOM defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] Providing high-quality, evidence-based, patient-centered services is important to rheumatology health professionals in every practice environment.

ARHP and Outcomes

The ARHP works in a number of ways to advance the knowledge and skills of rheumatology health professionals in order to improve care. ARHP has a long history of encouraging and supporting outcomes research. In 1997, the December issue of *Arthritis Care & Research* was devoted to "Assessing the Quality and Outcomes of Care for Rheumatic Diseases." In October 2003, a compilation of rheumatology outcome measures was published as a supplement to *Arthritis & Rheumatism* titled "Patient Outcomes in Rheumatology: A Review of Measures."

Quality within the College

ARHP continues to focus on improving quality of care. We work closely with the ACR on a number of quality initiatives to help rheumatologists and rheumatology health professionals identify and implement evidence-based best practices. We have representatives on the ACR Quality Leadership Council and the Quality Measures Committee and subcommittees to ensure the integration of an interprofessional perspective into these quality activities.

To learn what the ACR is doing to assist members in the quality movement, visit the Quality Measures pages at www.rheumatology.org. There, you'll find an overview of the ACR's quality initiatives and links to more detailed information on each of these initiatives. The Quality Measures Resource Library provides information and tools to help members learn more about the quality movement and offers links to other quality-related Web sites and recommended readings, including the 2006 ACR Practice View, "The Quality Movement: Rheumatologists Need to be Prepared."

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

Reference:

1. National Roundtable on Healthcare Quality, Institute of Medicine. "Statement on quality of care: national roundtable on healthcare quality—the urgent need to improve healthcare quality," 1998. Washington, DC: National Academy of Sciences; p. 11.

- Days in accounts receivable;
- Net cash collections percentage; and
- Outstanding accounts receivable percentage by the age of the claims.

Denial management can be time and resource intensive to implement—especially for small solo practices—but recovered revenues make it worth the effort.

For more information or assistance, please contact Antanya Chung, senior specialist for practice management at (404) 633-3777 ext. 818 or achung@rheumatology.org.

MEDICARE TIPS

Prior Authorization Struggle Continues

Many Medicare Part D plans continue to request prior authorizations for several drugs commonly prescribed by rheumatologists. The ACR has been working diligently with Robert Bennett of the Physician Regulatory Issues Team (PRIT) to avoid the same problems many physicians had last year. PRIT advises all physicians to write "for Part D" along with the diagnosis on the prescription, to verify that the drugs are for Part D diagnoses and should not be paid under Part B. This way the administrators of the prescription drug plans (PDPs) can waive the need for a new prior authorization—saving time and money for physicians, pharmacists, and the PDPs.

Questions or concerns? Contact the ACR's Melesia Collins, CPC, or Resaee Freeman, CPC, at (404) 633-3777, or PRIT at PRIT@cms.hhs.gov.

BENCH & BEYOND

Apply for ARHP's Graduate Student Award

The deadline to apply for 2007 ARHP Graduate Student Recognition Awards is July 5. Last year, the ARHP successfully launched this new award campaign to recognize health professional students pursuing creative research or clinical projects that merge theory and clinical practice to assess or improve the lives of patients with rheumatic diseases.

The award is open to graduate students in health-related areas including, but not limited to, behavioral medicine, epidemiology, health services, psychology, nursing, nutrition, occupational therapy, physical therapy, bioengineering, and social work. The ARHP member serving as the student's mentor will need to assist students with submitting the award application.

Proposals will be evaluated based on scientific merit, rigor, and potential significance to the field. The two top-rated proposals will win a $500 award, registration to the 2007 Annual Scientific Meeting, and a year's ARHP membership.

For more information or to obtain an application, visit www.rheumatology.org/arhp or contact Julie Anderson, program services specialist, at janderson@rheumatology.org or (404) 633-3777.

continued on page 10

CODING CORNER

Starting this month, you'll see a change in Coding Corner. May's challenge is printed here; the answer is located on p. 25.

May's coding challenge:

A new 68-year-old female patient is referred for osteoporosis treatment. The rheumatologist does a comprehensive history and examination and makes medical decisions of moderate complexity. After deciding on a treatment course, the rheumatologist concludes that a DXA scan is needed. The patient had a bone-mass measurement procedure the previous year, ordered by her primary care physician, but the rheumatologist is unaware of this because he hasn't received all of her records. He sends the patient to the imaging room for the procedure and schedules her for a follow-up visit.

How can the physician be sure to receive payment for the DXA scan? **See p. 25 for the answer.**

 continued from page 9

REF AWARDS

REF Award Opens New Doors for Young Investigator

Do you know that old adage about the best-laid plans? If you ask Jon T. Giles, MD, about it, he'd agree that even the firmest plans change. "When I entered medical school at Vanderbilt University, I was convinced that I'd pursue subspecialty training in neurology," recalls Dr. Giles. "My plan was to specialize in movement disorders."

Though Dr. Giles held fast to that plan during his first three years at Vanderbilt, his fourth year held a few surprises. During that year, Dr. Giles elected to complete a rheumatology rotation. What he didn't elect was the career-changing experience he would have. "The rheumatology rotation made sense for me because I was interested in movement disorders," says Dr. Giles. "I knew that exposure to musculoskeletal disorders would provide an advantage to me as I went on to pursue neurology. What I didn't know is how fascinating these musculoskeletal and rheumatic disorders actually were in themselves."

His rheumatology rotation was such an interesting and enriching experience that Dr. Giles decided to switch gears and build his career around rheumatology. "Diagnosing and treating rheumatic disease involves creativity and finesse, and a future in rheumatology would present the kinds of exciting professional challenges I was seeking for my medical career," comments Dr. Giles.

He completed his residency at the University of California, San Diego (UCSD). "It was during my residency that I really defined my career plan," says Dr. Giles. "I had excellent interactions with the rheumatology faculty at UCSD, and decided to pursue fellowship training in rheumatology with a plan to focus on clinical research." Though sad to leave Southern California, Dr. Giles decided to pursue his fellowship training at Johns Hopkins University in Baltimore, Md., where he found a research mentor in Joan Bathon, MD, professor of medicine and director of the Johns Hopkins Arthritis Center.

During his fellowship, Dr. Giles worked closely with Dr. Bathon on a study focused on subclinical cardiovascular disease in patients with rheumatoid arthritis. As he neared the end of his fellowship, knowing that he wanted to continue with clinical rheumatology research, Dr. Giles looked for research funding.

Jon T. Giles, MD, received an ACR REF Clinical Investigator Fellowship Award in 2004.

"Figuring out how I wanted my career in rheumatology research to progress—that was the easy part. Figuring out how to fund my career in rheumatology research was not nearly as easy," shares Dr. Giles. "Research funding is hard to obtain, especially if you are a young investigator trying to get started. I wanted to stay on as faculty at Johns Hopkins and continue my research projects, but without adequate funding, I'd have to spend less time on research and more time in the clinic."

As a trainee ACR member, Dr. Giles received information about the ACR Research and Education Foundation (REF) Clinical Investigator Fellowship Award, a program designed for young rheumatologists interested in building careers in clinical research. He applied for and received the award in late 2004.

"I can't tell you how much better I slept at night knowing that I had secured funding for two years.," says Dr. Giles. "I was able to stay at Johns Hopkins as a faculty member and continue my research, mentored by Dr. Bathon."

With his REF funding, Dr. Giles began a study focusing on the relationship between body composition and accelerated cardiovascular disease in RA, related to his work with Dr. Bathon. Dr. Giles' study is one of the first to evaluate fat mass and muscle mass as separate components of overall body composition in patients with RA, and where fat mass is distributed in the body in connection with RA disease outcomes, such as disability and subclinical cardiovascular disease.

Data from this study have produced some interesting findings. The greater an RA patient's fat mass, the more severe the disability was. Further, of patients with high fat mass, the most severely disabled were those whose fat mass was heavily concentrated in the limbs. Study findings also indicated that a concentration of fat around the body's middle section may increase cardiovascular disease risk.

One of the most interesting results of Dr. Giles' study is what he learned about the effect of fat mass on C-reactive protein (CRP) levels in women. His results suggested that high body fat may be a major contributor to elevated CRP levels in women, perhaps even more than RA disease activity in some cases. The same did not hold true in male patients.

Dr. Giles is excited about his findings and their implications for patients. "It will be valuable for patients to understand how their body composition can affect their RA symptoms and severity, as well as predict their risk for cardiovascular disease," he says.

Dr. Giles is glad that he seized the opportunity during his rheumatology rotation at Vanderbilt University—it led him to the ACR REF Clinical Investigator Fellowship Award which has opened many new opportunities, including pursuing a Masters of Public Health degree and securing a NIH/NIAMS-funded K23 award to continue his clinical research.

"Truthfully, I would not have been so successful in securing a K23 without my REF funding. The award really was the perfect opportunity for me at that stage in my career. It was tailored to the young investigator, and other potential funding sources have taken notice of the fact that I received REF funding as a young investigator," reflects Dr. Giles. "Most importantly, REF funding helped make the transition from rheumatology fellow to rheumatology researcher smoother. And, it will continue to open new doors for me."

The ACR REF Clinical Investigator Fellowship Award is part of the REF's extensive awards and grants portfolio. This award supports a structured, formal clinical research training program for rheumatology fellows or young rheumatologists.

continued on page 12

 continued from page 11

BRIEFLY

Final Chance to Apply for 2008 ACR Committee Positions

All ACR members are invited to volunteer. Nominate yourself or a colleague by June 1 to be considered for a position beginning at the ACR Annual Meeting in November. Apply online at www.rheumatology.org/ACR/Volunteer.aspx.

"Within Our Reach" Update Online

Information about the REF's "Within Our Reach" campaign, the $30-million effort to support underfunded RA research, is within your grasp—it's just a click of the mouse away. Visit "Within Our Reach" online at www.rheumatology.org/ref/withinour reachcampaign.asp for up-to-date information about the campaign's progress.

REF Reviewing "Within Our Reach" RA Research Grant Applications

In March, the REF received more than 70 applications from leading RA researchers as part of the first "Within Our Reach" RA research grants cycle. The REF Scientific Advisory Council is completing a thorough review of each application and will select 15 applicants to receive a combined $6 million during the next two years to fund their research projects. Winners will be announced this month.

Calendar Correction

The 2007 ACR calendar has two errors. July 30 is repeated, and September is started a day early, on Friday. All deadlines in September are correct, though: the Fellows/Late-Breaking abstract deadline is September 7, the Legislative Reception is September 19, and the Annual Scientific Meeting advance housing and registration deadline is September 28.

HONORING OUR WINNERS

The ACR Research and Education Foundation (REF) maintains an extensive award and grant program with research, training, and education opportunities for medical students, fellows, clinicians, researchers, health professionals, and academic institutions. This month, the REF continues to recognize its latest group of award recipients, who will begin their award terms in July. Please join us in congratulating the second group of recipients:

Programs for Students

ACR REF/Abbott Medical/Graduate Student Achievement Award

- Sarah E. Eiser (formerly Booth), Penn State College of Medicine
- Yvonne Golightly, PT, MS, Department of Veterans Affairs Medical Center
- Jack Hutcheson, BS, Saint Louis University
- Jason M. Low, MS, Saint Louis University School of Medicine
- Maribeth R. Morral, BS, Hershey Medical Center
- Justin Neff, BS, BA, University of Oklahoma Health Sciences Center
- Grace S. Park, MPH, University of California, Los Angeles
- Sunitha Rao, University of Kansas Medical Center
- John C. Scatizzi, BS, Saint Louis University
- Deborah Smith, BA, University of California, Los Angeles
- Elaine Sunderlin, Jefferson Medical College
- Laura Tesmer, University of Michigan
- Muthiah Vaduganathan, BS, Northwestern University Feinberg School of Medicine
- Jason S. Weinstein, BS, University of Florida
- Jane Yaciuk, BS, MS, Oklahoma Medical Research Foundation, Oklahoma University Health Sciences Center

Programs for Residents

ACR REF/Amgen Pediatric Rheumatology Research Award

- Edward M. Behrens, MD, Children's Hospital of Philadelphia
- Neelufar Mozaffarian, MD, PhD, University of Washington Children's Hospital
- Eyal Muscal, MD, Baylor College of Medicine

ACR REF/Abbott Medical and Pediatric Resident Research Award

- Daniela S. Ardelean, MD, Hospital for Sick Children, University of Toronto
- Nazanin Firooz, MD, VA Greater Los Angeles Healthcare System

PATIENT FACT SHEET

Paget's Disease of Bone

Paget's disease generally affects people over 40, and while the disease is associated with heredity, the cause is unknown. The ACR has recently added a fact sheet about this condition to the patient education material online.

"Normally as people age their bones rebuild at a slower rate," according to fact sheet author Roy Altman, MD. "For those with Paget's disease, however, this process of rebuilding bones takes place at a faster rate. As a result, the rebuilt bone has an abnormal structure." The involved bone can be soft, leading to weakness and bending of the pelvis, back (spine), hips, thighs, head, and arms. The regrowth can also cause the bone to enlarge, making patients more susceptible to arthritis, hearing loss, fractures, and discomfort. Because Paget's disease occurs in those older than 40, its symptoms are often mistaken for changes associated with aging.

Dr. Altman also notes that, "Paget's disease does not seriously affect quality of life and, for most people, the outcome is good. In fact, most people with Paget's disease of bone have no complaints. Rather, it is fast bone rebuilding that leads to complications."

For more details on diagnosing, treating, and living with Paget's disease, or to download the fact sheet, visit www.rheumatology.org/public/factsheets.

MEMBER BENEFITS

Join an ACR/ARHP List Serve Community

Have you ever wanted peer input on a rheumatology-related problem? Thanks to the ACR and ARHP list serves, help is only an e-mail away. The list serves give you unlimited access to rheumatologists or health professional experts. The ACR offers list serves on coding and practice management, advocacy, and five for specific U.S. regions, while the ARHP offers clinical, pediatric, rehabilitation, and research lists. Members can join as many lists as they like.

Since their launch, these list serves have helped ACR members share information and advice on reimbursement challenges and successes, practice tools, research methods, physical therapists in a pediatric hospital setting, and many more topics.

You can choose to receive list updates as they are posted or as one digest message at the end of the day.

For questions on joining, changing your settings, or posting messages, contact Regina Adair at (404) 633-3777, ext. 817 or radair@rheumatology.org (for ACR lists), or Julie Anderson at ext. 802 or janderson@rheumatology.org (for ARHP lists).

REFER NEW MEMBERS FOR A CHANCE TO FLY

The ARHP is kicking the Member-Get-A-Member campaign up a notch. We know members want to make the ARHP the best it can be, but may be asking "What's in it for me?" The answer this year is: quite a lot! The ARHP member who sponsors the most new ARHP members for 2007 will receive a $500 airline gift certificate. Visit www.rheumatology.org/arhp for details and membership application forms.

MEMBER get a MEMBER 2007 ARHP

FOCUS ON EDUCATION

State and Local Society Coding Presentations

The ACR Practice Advocacy Department will give programs to assist physicians with coding and reimbursement again this year. Last year, ACR coders spoke at more than 15 state and local societies.

ACR certified professional coders are available to present a one-hour coding seminar at your next state or local rheumatology meeting. This year's program will help you identify the pitfalls of evaluation and management coding. A question-and-answer session will follow, so be sure to come prepared with questions.

Schedule your presentation today—contact the ACR coding and reimbursement specialists Melesia Tillman, CPC, or Resaee Freeman, CPC, at (404) 633-3777, ext. 820 or 819, respectively.

Become a Quality Improvement Tool Pilot Site

The ACR plans open enrollment for its new AIM (Assess Improve Measure) module, "AIM: Gout" during the 2007 annual meeting and is seeking clinicians to participate in the testing phase. For more information on pilot site requirements, contact Amy Beith at abeith@rheumatology.org, or (404) 633-3777.

AIM modules provide a tool for physicians seeking a quality-improvement program and a way to meet new ACGME competencies or the American Board of Internal Medicine's Maintenance of Certification Program requirements.

AIM is a Web-based self-evaluation tool that guides the user through medical chart abstraction of de-identified data. The questions, based on rheumatology measures and guidelines, generate a report that enables physicians to:

- Reflect on practice performance data;
- Identify strengths and areas for improvement;
- Develop and implement improvement plans;
- Assess the chart re-measurement effects; and
- Report changes.

The ACR released its first AIM practice improvement module, "AIM: Rheumatoid Arthritis," during the 2006 annual meeting.

FATIGUE MANAGEMENT

Fight Fatigue in Arthritis Patients—As a Team

It's like having the flu every day." That sentiment, voiced by a child with juvenile RA, offers a vivid description of what it can be like to cope with the fatigue brought on by rheumatic disease.

"Fatigue is a symptom reported by children with polyarticular arthritis, as well as adults with RA, fibromyalgia, osteoarthritis, systemic lupus erythematosus, ankylosing spondylitis, primary Sjögren's syndrome, and other rheumatic diseases," says Geri Neuberger, RN, EdD, professor of nursing at the University of Kansas School of Nursing in Lawrence. On the ARHP June 14 audioconference, Neuberger will present research evidence of clinical and psychosocial factors associated with fatigue and recommend research-backed interventions to reduce fatigue.

Fatigue can greatly affect a patient's quality of life, so it is important for health professionals and rheumatologists to learn more about how to help patients manage it. Neuberger has conducted clinical research on fatigue—one of the many sequelae of rheumatic disease that can be difficult to manage.

A key to coping with fatigue is managing—and maximizing—the energy you do have. A team approach is optimal. "The head member of the team is the individual with the rheumatic disease, who decides each day what actions she or he will take to control fatigue and other symptoms," says Neuberger.

Neuberger will review effective, research-supported interventions to managing fatigue. Beyond medical interventions, such as checking thyroid activity and treating the primary and co-morbid conditions, consulting a dietician can help a patient who is over- or underweight. A social worker, psychologist, nurse, occupational therapist, or physical therapist can help a patient adjust to life with a chronic illness, complete paperwork, get medications, balance rest and exercise, and manage other tasks.

Using these approaches to improve a patient's energy levels can have significant benefits. Neuberger believes that addressing fatigue can help foster treatment compliance—in part because patients can easily track this symptom. The audioconference offers participants a unique opportunity for a comprehensive summary of the research that has been done.

continued on page 25

REGISTER ONLINE!

Sign up for the June 14 audioconference by visiting www.rheumatology.org/arhp. The registration fee is $35 for members and $50 for non-members. Several people can listen in on the toll-free call for one registration fee. Paid registrants are eligible for CME credits or certificates of participation. If you are unable to participate, purchase a recording online and listen at a more convenient time.

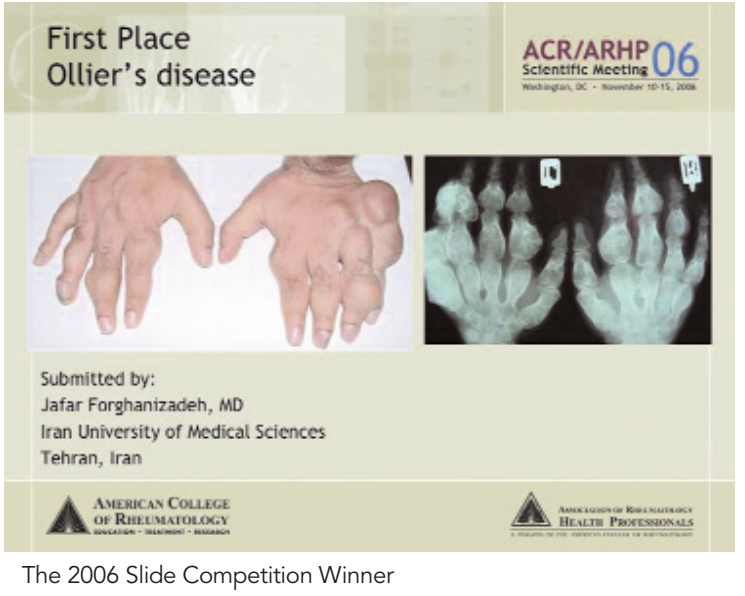
New Categories for the Annual Slide Competition

Three new submission categories have been added for the 2007 Annual Slide Competition. In addition to clinical medical images, radiographs, and pathology images, the ACR is now accepting submissions in the following categories:

- Case studies;
- Historical or archival images; and
- Procedural or dynamic submissions, such as joint injections or biopsies.

The winning images will be published in Arthritis & Rheumatism. The entrant with the best overall submission will receive registration to the 2008 ACR Annual Scientific Meeting in San Francisco, Calif., and four nights of hotel accommodations during the meeting. Additional prizes will be awarded to the top two submissions in each category. The submission deadline is September 1.

Visit www.rheumatology.org/educ/slidecompetition to review the updated rules and criteria for the new submission categories, download the submission forms, or review the image "wish list" complied by the Audiovisual Aids Subcommittee.



The 2006 Slide Competition Winner

RHEUMATOLOGY Goes to Washington

Volunteers converge on Capitol Hill for the ACR's annual Advocates for Arthritis Day

>> By Virginia Hughes

As a girl growing up in rural Montana, Larissa Norstebon remembers terrible pain in the joints of her feet. Reeling from this daily pain, and lacking the energy of a typical 11-year-old, she went to a general physician because then—as now—no rheumatologist practiced nearby. But the doctor "just kept treating my pain symptoms," Norstebon recalls, "never knowing that I actually had an underlying autoimmune disease."

That changed when Norstebon was 24. "I woke up one day—it was January of '98—and I just felt this terrible, all-over pain." She went to a rheumatologist in Missoula, Mont., who finally diagnosed her with RA. "It was a relief to know that, OK, there is something wrong with me, like those 15 years living with the disease had been validated."

On March 12 and 13, Norstebon joined 60 other patient advocates, rheumatologists, and rheumatology health professionals in Washington, D.C., for the ACR's Advocates for Arthritis Day. The advocates' top priority: to urge legislators to support the Arthritis Prevention, Control, and Cure Act of 2007 and three other legislative issues that affect the rheumatology field. (See "Make Our Voice Heard," p. 3, for more information.)

From left to right: Government Affairs Committee member Gary Bryant, MD; ACR Vice President Sherine Gabriel, MD; Sen. Amy Klobuchar (D-Minn.); and patient advocate Jan Henderson.

From left to right: Government Affairs Committee member Tim Laing, MD; ARHP President Karen Kerr, MSN, NP, CPNP, APRN-BC; Sen. Debbie Stabenow (D-Mich.); patient advocate Amanda Eubanks; and ACR president-elect David Fox, MD.

Strong Support from Rheumatology Community

"The event was very well received," says Aiken Hackett, specialist of government affairs at the ACR and head organizer of the conference. In the weeks since the event, she says, "members of Congress have contacted us for more information—and that means they're listening."

The Arthritis Prevention, Control, and Cure Act was first introduced in the 108th congress—and again in the 109th—by U.S. Senators Kit Bond, R-Mo., and Edward Kennedy, D-Mass. In both years, however, the bill never made it out of subcommittee deliberations.

Last time, the bill had 220 co-sponsors in the House and 49 in the Senate. "When we tell them that now, that really gets their attention," says ARHP member Ann Kunkel, a pediatric rheumatology education coordinator at the University of Kansas Medical Center in Kansas City. "It says: This is a bipartisan bill. And this year I'm amazed." At press time, the bill had 121 co-sponsors in the House and 28 in the Senate.

Because Kennedy is the chairman of the Senate Health, Education, Labor, and Pensions Committee—which is deliberating over the bill—Kunkel is confident the bill will make it to a floor vote this year.

This year, advocates say, passing the bill is more important than ever. Arthritis now affects 46 million American adults. "And the baby-boom generation is now entering retirement," Kunkel says, "so in the next 10 years, we're going to see a huge increase of people with osteoarthritis and other kinds of arthritis problems." Indeed, the Centers for Disease Control and Prevention (CDC) estimates that by 2030, nearly 67 million—that's 25%—of Americans will have arthritis.

Busy Visit for Volunteers

The ACR advocates—including 22 patients, 21 physicians, and 17 members of the ARHP—arrived in Washington on March 12, and began their full schedule of events at the Washington Court Hotel. They spent the afternoon at a training session, led by two seasoned lobbyists, on how to effectively talk to elected representatives. A staff member from the House Energy and Commerce Committee also dropped by to talk candidly about health priorities in the House.

"They told us the dos and don'ts," says Joseph Flood, MD, chair of the ACR Government Affairs Committee. The dos: be well informed, unafraid, and above all, brief—Congressmen can usually only give 10- or 15-minute appointments. The don'ts: "Don't knock another disease, don't be untruthful," says Dr. Flood. "It's not necessary to talk to them about who you voted for or who you contributed money to."

After the training session, advocates met for dinner and keynote presentation from an animated staffer from the House of Representatives. "It was awesome to be able to socialize with everybody who was fighting for the same cause," Norstebon says.

On March 13, the advocates collectively visited 122 Congressional offices; on 21 visits, the advocates met with their actual representatives, as opposed to staff. The biggest issue they discussed was the passing of the Arthritis Prevention, Control, and Cure Act, which focuses on federal funding of arthritis research, recruitment of more doctors into the rheumatology specialty, and public-education campaigns. Federal funding for arthritis research has declined since 2003. Today, National Institutes of Health (NIH) funding amounts to less than $8 per person with arthritis.

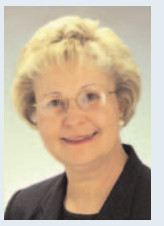
A Case for Research and Care

The funding issue is especially critical to Deborah McCloskey, co-chair of the ARHP Advocacy Subcommittee, who for the past 19 years has worked as a nurse at the scleroderma program at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School in New Brunswick. Because scleroderma affects only about 300,000 people nationwide, pharmaceutical companies don't invest in scleroderma research, and the field relies on federal support.

McCloskey's clinic recently took part in one NIH-funded study evaluating cyclophosphamide on scleroderma lung disease patients. One of her more severe patients, Joseph Berardi, had terrible lung function and decided to enroll in the study. After two years on the drug, Berardi's lung function has improved dramatically—as was the case for most of the 144 other subjects.

The study's positive results were published in the June 22, 2006, issue of the *New England Journal of Medicine*. Still, "that whole time, there was always the threat of funding being cut," says McCloskey. "The NIH is the primary source of funding for clin-

Why Do YOU Volunteer?



"Advocacy is so important right now because there are certain things that can only happen by going through Congress. It's one of our American rights—shame on us if we don't take the time to get involved."—*Ann Kunkel, ARHP*

"One of the really refreshing things about all this is how much doctors and other healthcare providers care about their patients getting their due from the federal government. They give up time from their practices and families, go off to Washington, eat rubber chicken and sleep on uncomfortable beds, and make a difference—I hope."—*Joseph Flood, MD, chair of the ACR Government Affairs Committee*

"A lot of people are under the misconception that physician reimbursements and NIH funding are physicians' issues—but they have everything to do with what [nurses] do. It really affects everyone on the team. We're all here to provide the best possible care for our patients, and it really does impact how we all function."—*Debbie McCloskey, chair of ARHP Advocacy Committee*

ical research, and the only way were going to make any advances is through clinical research."

McCloskey brought Berardi and his wife to the Hill for this year's Advocacy Day. "Every single office we visited said absolutely they would support the NIH issues after hearing his story."

The proposed legislation also addresses the dearth of pediatric rheumatologists in the United States. About 300,000 U.S. children have arthritis, with only 162 pediatric rheumatologists to treat them—and 13 states don't have a single pediatric rheumatologist. Dr. Flood explains that the needs of a child rheumatology patient—with their growing bones and active lifestyles—are fundamentally different from that of an adult. "I frequently joke that children are a different species than adults," he says. The Arthritis Prevention, Control, and Cure Act supports incentives, such as the repayment of student loans, to encourage health professionals to specialize in pediatric rheumatology.

With arthritis now the leading cause of disability in America, public educational campaigns about disease prevention are of utmost importance. "There are even primary care doctors who aren't aware of major advances," Kunkel says. "If you get to your doctor early in your disease, we actually have therapies now that can prevent it from becoming disabling."

The economic benefits of prevention especially resonated with lawmakers this year. Every patient who is able to work, as opposed to collecting disability payments, reduces the country's astronomical costs of healthcare. In 2003, U.S. arthritis treatment costs totaled $127.8 billion, up from $86.2 billion in 1997, according to CDC figures. "It's not too hard to figure out that would be good for the nation," Kunkel says. "As one legislator told me, this is a no-brainer bill."

Advocates Head Home with Hopes High

What was Congress's overall reaction to the advocates?

"It depends on the member," Hackett says. "Almost all of Congress has people working on health issues; it just may not be their priority."

Kunkel says that the recent political climate has changed these priorities. "I've never met a Congressman opposed to the bill. But the Iraq War has taken a lot of the nation's attention, and I think some of that would have gone to healthcare."

Still, most of the advocates left Washington feeling overwhelmingly optimistic.

Just a few weeks after returning to Montana, in fact, Norstebon received a letter from the office of her senator, Max Baucus. "The Senator is taking a look at this legislation and doing everything he can to make sure that beneficiaries like you get the care you need," the letter read. "He was very impressed by your presence and is committed to working on the issue this year." The Arthritis Prevention, Control, and Cure Act, the letter later stated, will most likely come up for consideration in spring or late summer.

Virginia Hughes is a medical journalist based in New York City.

MEDICAL ASPECTS OF DISEASE

continued from page 1

Have We Reached an Estrogen Comfort Zone?

Rights were not granted to include this image in electronic media.Please refer to the printed publication.

A review of research on prescribing estrogens in systemic lupus erythematosus

>> By Jill P. Buyon, MD

Strong Evidence from Recent Trials

The Safety of Estrogens in Lupus Erythematosus National Assessment (SELENA) trial comprised two separate studies. (I was the principal investigator on both in partnership with Dr. Michelle Petri.) One study focused on oral contraceptives (OCs) and the other on postmenopausal hormone replacement therapy (HRT).[1,2] Both studies were designed as non-inferiority trials to establish that exogenous estrogens were not more likely than placebo to increase the risk of a severe flare.

The rationale for choosing severe flare and not all flares as an endpoint is that for many women a mild flare (e.g., an increase in arthralgias readily treated with over-the-counter nonsteroidal medications) might be an acceptable tradeoff for use of an effective and easy form of birth control. However, because the trial involved a drug that might increase the risk of flare, vigilance with regard to safety mandated that all flares be captured, even those that were extremely mild. Importantly, my colleagues and I excluded patients with a thrombophilic risk, defined specifically as:

- History of deep venous thrombosis, arterial thrombosis, or pulmonary embolus;
- Presence of IgG, IgM, or IgA anticardiolipin antibodies (GPL >40, MPL >40, or APL >50) and/or demonstration of lupus anticoagulant by dilute Russell viper venom time test (dRVVT); and
- History of myocardial infarction.

An important caveat regarding both trials is that patients' lupus had to be inactive or stable-active for two months prior to randomization.

At first glance, the entry criteria for the trials might suggest that the results would be generalizable only to patients with relatively mild lupus (i.e., without organ-threatening disease). In fact, this was not the case, because approximately 40% of the patients in both trials had a history of lupus nephritis. Many patients had significantly active lupus in the past. While results obtained in the OC trial might not be applicable for the patient with active nephritis about to receive immunosuppressive agents, that same patient, when stabilized for several months, could then have become eligible. The presence of anti-dsDNA antibodies and low levels of complement in nearly a third of the patients again indicated that the results would likely be applicable to the patients seen in the "real world" of lupus.

The results of three large prospective trials indicate that there is generally excellent tolerance of exogenous hormones with regard to disease activity.

Study Specifics and Findings

For the SELENA-OC trial, 183 SLE patients were enrolled between June 1997 and July 2002 (with follow-up through July 2003) at 15 U.S. sites. To eliminate bias toward patients who would be likely to do well on OCs, patients were excluded if they had used OCs for more than one month after being diagnosed with SLE. Patients were randomized double-blind to OCs (triphasic 35 µg ethinylestradiol plus 0.5 to 1 mg norethindrone for twelve 28-day cycles) (N=91), or placebo (N=92) and evaluated at months 1, 2, 3, 6, 9, and 12. Thirty-seven percent were Caucasian, 33% African American, 16% Hispanic, and 14% Asian. As detailed in Table 1 (see page 18), the primary endpoint—severe flare—was rare: seven of the 91 patients on OCs (7.7%) versus seven of the 92 patients on placebo (7.6%). The 12-month severe flare rate was 0.084 for OCs and 0.087 for placebo, a difference of -0.0028 (P=0.95). (See Figure 1, right.) The upper limit of the one-sided 95% confidence interval (CI) for this difference was 0.069, within the pre-specified 9% non-inferiority margin. Mild/moderate flare rates were similar: 1.40 versus 1.44 flares/person-years (OCs versus placebo), risk ratio (RR)=0.98, P=0.86.

Serious adverse events were rare in the cohort as a whole. There was one serious adverse event—a deep venous thrombosis—among the OC subjects, and three serious adverse events in the placebo group: one ocular thrombosis (after randomization but prior to taking placebo), one superficial thrombophlebitis, and one death a year after study drug (placebo) was discontinued due to severe flare at three months. None of the three subjects who experienced thrombotic adverse events had developed anticardiolipin antibodies.

Another compelling prospective study evaluating the safety of OCs was conducted in Mexico.[3]

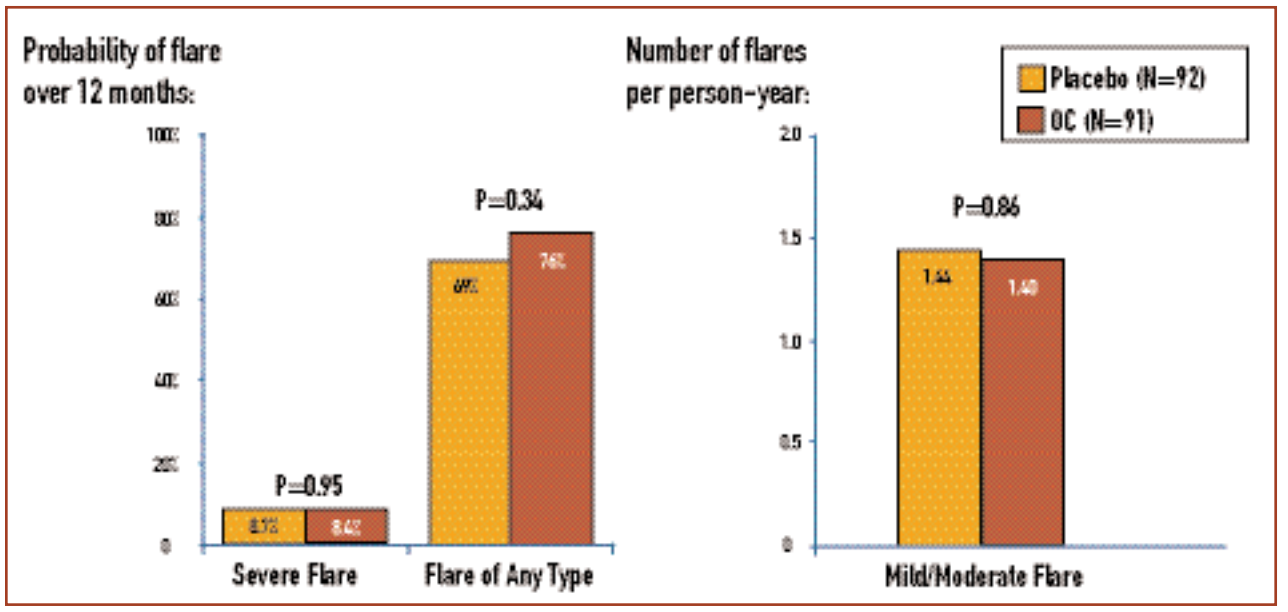


FIGURE 1: Treatment for one year with OCs is unlikely to cause lupus flares (in inactive or stable-active patients without antiphospholid/anticardiolipin antibodies and/or history of thrombosis).[1] Subjects were randomized to receive triphasic ethinylestradiol 35 mg plus norethindrone 0.5-1 mg for twelve cycles of 28 days.

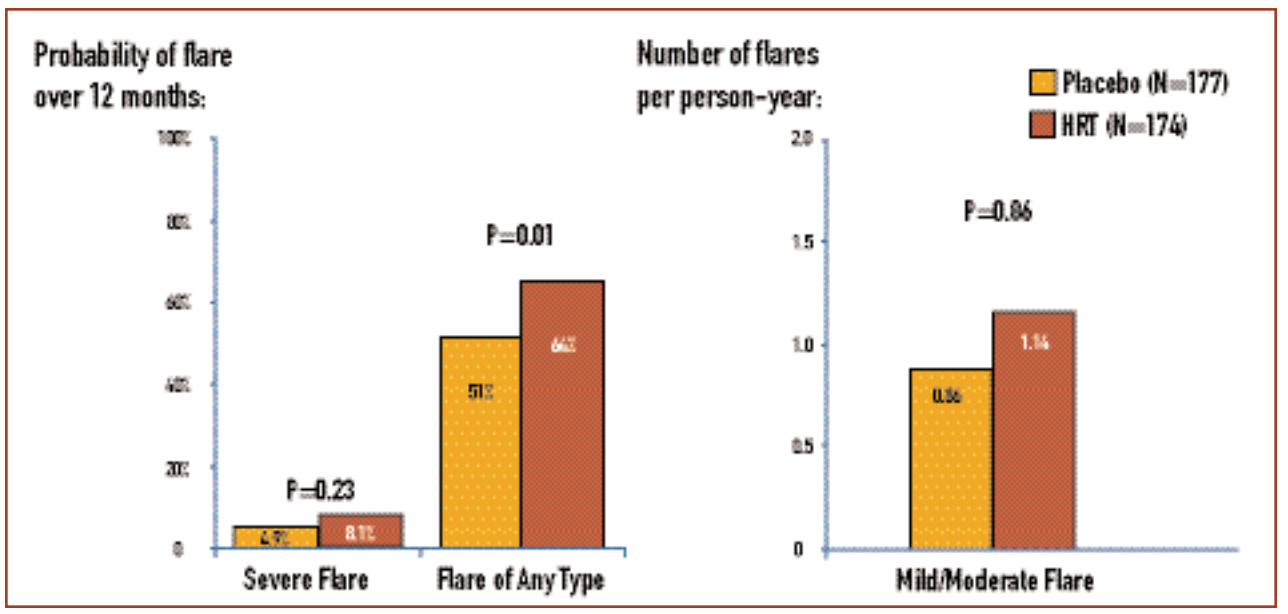


FIGURE 2: HRT for one-year increases mild/moderate, but not severe flares (in inactive or stable-active SLE patients without antiphospholid/anticardiolipin antibodies and/or history of thrombosis).[2] Subjects were randomized to receive 0.625 mg conjugated estrogen (plus 5 mg medroxyprogesterone for 12 days per month) for 12 months.

This was a single-blind trial that enrolled 162 women with SLE. Patients were randomized to combined oral contraceptives (30 µg ethinyl estradiol plus 150 µg levonorgestrel), a progestin-only pill (30 µg levonorgestrel), or a copper intra-uterine device (IUD) (TCu 380A, Orthopharmaceuticals), with 54 patients in each treatment group. In this study, the primary outcome was global disease activity, not a severe flare per se. In contrast to SELENA, it was not specifically stated whether women could have received OCs after the diagnosis of SLE for any period of time. Furthermore, patients were not excluded based on titers of anticardiolipin antibodies.

Disease activity remained mild and stable in all groups throughout the course of evaluation. There were no significant differences among the groups during the trial in disease activity, incidence or probability of flares, or medication use. Thromboses occurred in four patients (two in each of the two groups receiving hormones). The authors of this study concluded that global disease activity, maximum SLE Disease Activity Index score, incidence of flares, time to first flare, and incidence of adverse events were similar among patients with SLE, irrespective of the type of contraceptive they received.

The SELENA-HRT study comprised 351 menopausal SLE patients enrolled from 16 university-affiliated rheumatology clinics/practices in 11 U.S. states. Patients were randomized to twelve months of treatment with active drug (0.625 mg conjugated estrogen daily plus an additional pill containing 5 mg medroxyprogesterone for days 1 through 12 of the month) or placebo, and evaluations at months 1, 2, 3, 6, 9, and 12 from the time of enrollment. The occurrence of severe flare was rare in both treatment groups: the 12-month severe-flare rate was 0.081 for HRT and 0.049 for placebo, yielding an estimated difference in severe-flare rates of 0.033 (P=0.23). (See Figure 2, above.) The upper limit of the one-sided 95% CI for the treatment difference was 0.078, which was within the pre-specified margin of 0.09 for non-inferiority.

In contrast to severe flares, mild/moderate flares were significantly increased in the HRT arm: 1.14 flares per person-year for HRT and 0.86 for placebo (RR=1.34; P=0.01). The probability of any type of flare by 12 months was 0.64 for HRT and 0.51 for placebo (P=0.01). There was one death in the study, which occurred in the HRT group. There were three deep-vein thromboses (two on HRT and one on placebo), one stroke on HRT, and one thrombosis in an AV graft on HRT.

Mining Retrospective Data and Basic Science

Studies on the influence of past use of estrogens in the development of SLE have not yielded consistent results. (See Table 2, p. 18.) The concern and confusion regarding estrogen effects in SLE have led to studies of estrogen receptor expression in peripheral B cells of SLE patients. Overall, levels of estrogen receptors do not differ between SLE patients and non-autoimmune women. However, a variety of truncated estrogen receptor transcripts that can be produced. One study suggests that a short transcript encoding a constitutively activated estrogen receptor α may be present at higher levels in SLE.[4] Murine data suggest that an estrogen-mediated breakdown in B cell tolerance is genetically determined either by polymorphisms of the estrogen receptor genes or, more likely, by polymorphisms of estrogen-inducible genes or of other genes in pathways that involve estrogen-inducible genes.[5]

Benefits Beyond Birth Control

The clinical relevance of determining the safety of OCs in SLE extends beyond birth control. A well-established salutary effect of estrogen, clearly relevant to women with SLE, is the preventive effect on bone loss and increase in bone mass at the lumbar spine, radius, and hips. Estrogens suppress bone-resorbing cytokines such as interleukin-1 and interleukin-6 and exert positive changes in calcium homeostasis by restoration of a defective synthesis of 1,25–dihydroxyvitamin D and augmentation of intestinal calcium absorption. In a retrospective cohort of 702 women with lupus followed for 5,951 person-years, fractures occurred in 12.3% of the patients, a nearly five-fold increase compared to healthy women.[6] In a separate study, osteoporosis was detected in 22.6% of 84 premenopausal SLE patients and appeared to be related to disease duration and use of glucocorticoids.[7] Similar observations were noted in a combined (pre- and postmenopausal) cohort of 75 SLE patients, again emphasizing an association with the use of steroids.[8] Although prospective studies of OCs have not been performed on glucocorticoid-treated premenopausal women, observational epidemiologic studies suggest that women who received OCs had higher adjusted bone mass density than women who did not.[9]

The ACR Task Force on Osteoporosis Guidelines recommend OCs to prevent glucocorticoid-induced osteoporosis in premenopausal women with oligo- or amenorrhea. However, an alternative form of contraception, medroxyprogesterone acetate injectable suspension (Depo-Provera), was associated with an increase in osteopenia/osteoporosis after two years of use in a non-SLE female population.[10]

Cardiovascular Considerations

While there are untoward effects of estrogens on clotting parameters, and data from the prospective Heart and Estrogen/progestin Replacement Study (HERS) and the NIH-sponsored Women's Health Initiative have not substantiated the expected cardioprotection of hormone replacement in postmenopausal women (even suggested potential risk for coronary heart disease, albeit age from menopause is likely a factor), favorable effects of estrogens on several surrogate markers of cardiac risk may still be relevant to premenopausal women with SLE.[11-13] Accumulating data on large numbers of SLE patients strongly support accelerated atherosclerosis, the precise etiology of which remains undefined. It is presently unknown whether OCs confer a beneficial cardiac effect given that estrogens increase HDL cholesterol; decrease both LDL cholesterol and lipoprotein(a); decrease circulating P-selectin, which tethers leukocytes to endothelial cells and activated platelets; and enhance basal nitric oxide production and release. Estradiol reduces the vascular response in an in vitro model of immune injury, the rabbit cardiac allograft, which may mimic the pathogenesis of SLE-accelerated atherosclerosis. Observational studies suggest that higher es-

continued on page 18

 continued from page 17

TABLE 1:

Severe Flares by Treatment Group in the SELENA-OC Trial[1]

OCs (N = 7)	
1	Nephritis/multi-system flare *
2	Multi-system flares †
1	Abdominal vasculitis
1	Thrombocytopenia
1	Severe rash
1	Fever
Placebo (N = 7)	
4	Nephritis
1	Pleural effusion
1	Central Nervous System
1	Myositis

* Flare after qualifying visit, but before beginning study drug.
† In one patient, flare occurred after discontinuation of study drug.

trogen status is associated with a decreased mean serum total homocysteine concentration, a risk factor for vascular occlusion.[14] Estrogens may have an antioxidant effect, inhibiting peroxidation of vascular smooth muscle membrane phospholipids and thereby peroxidation induced cell growth and migration, an important step in atherosclerosis.

The increased thrombotic risk associated with estrogen may outweigh its protective effects on atherosclerosis in women with established plaque, at least for the first years before longer-term cardioprotective benefits can take effect and have a major impact. Most studies suggest that estrogen inhibits the neointimal response to acute injury in normal blood vessels, but this vasoprotective effect is not seen in vessels with pre-existing atherosclerosis. In contrast, one placebo-controlled study has suggested that short term administration of 17β estradiol is effective in improving effort induced myocardial ischemia in female patients with coronary artery disease.[15] Acute administration of conjugated equine estrogens prior to induction of ischemia in dogs attenuated the ventricular arrhythmias of ischemia as well as those of reperfusion.[16] In nonhuman primates, OCs do not increase the risk of arterial thrombosis. In fact, there was a reduction in the incidence of thrombosis in the OC-treated animals versus untreated controls.[17] Furthermore, OCs inhibited atherosclerosis in a prospective treatment study in 193 adult female cynomolgus monkeys.[18]

Conclusion

The results of three large prospective trials indicate that there is generally excellent tolerance of exogenous hormones with regard to disease activity. In contrast to the agreement of the two studies on premenopaual patients and OCs with regard to all types of flares, there was a small but significant risk of increasing the natural flare rate of lupus by adding a short course of HRT. Fortunately, the great majority of these flares were mild/moderate.

What is uniformly disconcerting in these trials is the risk of thrombosis, which can certainly erode confidence in choosing OCs or estrogen replacement therapy. This risk must be carefully weighed, and it seems prudent to fully evaluate patients for evidence of thrombophilia before instituting therapy. At the very least, the history of a previous venous or arterial event would be a clear-cut contraindication. The identification of a circulating lupus anticoagulant, anti-cardiolipin, or anti–beta 2 glycoprotein I antibodies of any isotype above a modest range should be reason to dissuade a patient from considering OC or estrogen replacement therapy. While the presence of a false positive Venereal Disease Research Laboratory (VDRL) alone is unusual and likely to be identified by the obstetrician/gynecologist, it too might be reason for seeking alternatives to estrogen use. Given the rapid pace of scientific discovery, we might soon be able to identify which patients might experience flares when exposed to exogenous estrogens.

THE RHEUMATOLOGIST

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TABLE 2:

Retrospective Studies of Estrogens and Flares and Influence of Past Estrogen Use

Study	Details	Findings
Past use of oral contraceptives and the risk of developing systemic lupus erythematosus. *Arthritis Rheum.* 1997;40:804-808.	Review of 121,645 women followed every two years as part of the Nurses' Health Study.	Past users of OCs had a small but significant increased risk (RR=1.4) of developing SLE compared with never-users.
Hormonal and reproductive risk factors for development of systemic lupus erythematosus: results of a population-based, case-control study. *Arthritis Rheum.* 2002;46:1830-1839.	Population-based, case-control study of 240 female SLE patients and 321 female controls.	There was a weak association between SLE and current use or duration of use of OCs (adjusted odds ratio 1.3, 95% CI 0.9-2.1), and no association with past use.
Influence of oral contraceptive therapy on activity of systemic lupus erythematosus. *Arthritis Rheum.* 1982;25:618-623.	Retrospective case-control study of lupus patients with a history of nephritis.	Lupus flares in nine of 26 patients during the first three months after combined OCs compared to none of 11 patients taking progestogen-only formulations.
Oral contraceptives in systemic lupus erythematosus: side-effects and influence on the activity of SLE. *Scand J Rheumatol.* 1991;20:427-433.	Study of 31 SLE patients taking OCs compared with 31 non-users.	No difference in flare rates between groups.
Can women with systemic lupus erythematosus safely use exogenous estrogens? *J Clin Rheumatol.* 1995;1:205-212.	Retrospective multicenter survey of 55 women who had used OCs after SLE was diagnosed.	Seven patients (13%) reported an exacerbation of disease activity, most confined to the musculoskeletal system (calculated flare rate was 0.45 per 100 patient-months).
Hormonal supplementation as treatment for cyclical rashes in patients with systemic lupus erythematosus. *J Rheumatol.* 1995;22:2159-2162.	Report of three patients with menstrual-related skin rashes.	All patients experienced significant improvement in skin disease after taking OCs.

SHUTTERSTOCK

 continued from page 1

ON BOARD with BABY

Rheumatology programs make strides in work–life balance support

>> By Sheri Polley

Because of this support and understanding, she cites only one major challenge upon returning to work: "I returned to work full time when my triplets were only three months old. The biggest challenge at that time was staying awake!"

With a growing number of women choosing rheumatology as their specialty and younger physicians seeking balanced professional and personal lives, the field will have to be nimble to meet the needs of today's young physicians. The medical profession faces a unique set of challenges in this endeavor. It is not usually feasible to close up shop for several months to give birth—or even to take the day off because a child is ill or to attend his or her school play. Some specialties are more amenable to flexibility in scheduling than others, and with the proper planning and support, rheumatology can provide the adaptability necessary to enjoy a fulfilling career and a rewarding family life.

Proactive Policies

Some rheumatology departments are ahead of the curve and already have policies that help physicians succeed both at work and at home. All of the universities discussed herein—UM, Yale, and Temple—have policies allowing their faculty to exclude up to one year from the countable years of service that constitute the tenure probationary period for childbearing or dependent care.

The staff and faculty at the UM Medical School Division of Rheumatology are very familiar with accommodating the needs of expectant and new parents. According to Janet Stevens, administrator for Fellowship Program and Faculty Affair Issues, since 2002, the university has had 10 fellows and faculty members take time off when they became new parents (seven maternity leaves, two paternity leaves, and one leave for adoption)—with two more maternity leaves already expected this year. The division has made it a priority to provide as much support to its team members as possible.

Carol Cottrell, division administrator at UM, says the university is constantly reviewing and updating its policies as necessary to make them as family-friendly as possible. There is a standard practice guideline currently in effect that allows new parents modified duties. This flexible policy allows the faculty member to work with the relevant dean to modify their duties.

Audrey Uknis, MD, is associate dean of the office of admissions at Temple University in Philadelphia. Temple's residency policy regarding how coverage is handled in the absence of a member of the house staff was updated based on Dr. Uknis' experience when, as a second-year resident, she was unexpectedly confined to bed with preterm labor 20 weeks into her pregnancy. Now, residents are fully aware that they may be expected to fill in for someone for a short or extended period of time. The university has "reserve residents" who may be pulled from their electives to provide this coverage as needed.

Rheumatology: A Family-Friendly Choice

Rheumatology lends itself quite nicely to a healthy work–life balance, says Lisa Suter, MD, instructor of medicine at Yale School of Medicine. She cites three primary reasons:

- A large proportion of rheumatology physicians are women;
- Many rheumatic diseases are more common in women; and
- The vast majority of clinical work is not emergent and allows for greater scheduling flexibility.

Dr. Suter feels these things contribute to a parallel understanding among colleagues and patients alike, creating a very supportive environment.

"Rheumatology offers a career opportunity that is fulfilling and extremely interesting but allows everyone—not just women—to have a life," says Audrey Uknis, MD, associate dean of admissions at Temple University School of Medicine. "This makes rheumatology an increasingly popular option for a lot of people."

Make Policies Work

Without the support of the entire team—from clerical staff to clinical staff to faculty to administrators—policies are just words on paper. Communication is extremely important. All personnel should know the policies and what benefits are available to them, as well as what may be expected of them regarding coverage for other team members. Also, any individual who expects to take advantage of such benefits must communicate that impending need appropriately and promptly. If handled properly by all those involved, a short-term inconvenience can have the long-term effect of fostering an atmosphere of caring and support among team members.

Seetha Monrad, MD, clinical lecturer at UM, found the division very accommodating. She received assistance with all of her necessary paperwork and rescheduled her clinics "with very little fuss." This understanding and support were especially helpful when she felt overwhelmed with her son's health issues.

Wendy Marder, MD, clinical instructor in internal medicine/rheumatology at UM, has also utilized some of the university's programs and policies. Dr. Marder also received assistance filing paperwork and ensuring that her funding source was appropriately managed during her absence when she gave birth to her first child. She especially appreciates the periodic e-mails sent about university childcare opportunities, including reminders to register for emergency childcare services provided by the university (which requires an annual renewal). (See "Support Services for Busy Parents," below, for more examples.) She decided to reduce her effort to an 85% appointment and feels that she has been supported completely in this decision. "Our division has a very supportive atmosphere from the support staff through the division chief," she says.

That division chief is David Fox, MD, and his colleagues are not at all surprised at his vision and support in the area of work–life balance. "David Fox is a very progressive, liberal-thinking individual," says Dr. Uknis. "It takes a forward-thinking person who understands the realities of today and takes time to actually implement some important policies."

> Individuals need to take a certain amount of responsibility for making the balance between career and family work for them.—*Primal Kaur, MD*

Personal Responsibility

Primal Kaur, MD, assistant professor of medicine at Temple, says individuals need to take responsibility for making the balance between career and family work for them. "You have to show a certain efficiency when you're married and have children," she advises. "I make a list in my mind of what I have to do for today and make sure I'm on time for finishing it. I do what I'm expected to do and pursue my career interests and make sure I finish everything in time to go home and be with my family."

Dr. Kaur chose rheumatology because of the freedom it allows her to meet those goals. Early on in her medical education she felt that her husband, a non-physician, was "left behind" in her life, and that they didn't really have time for each other. "I wanted to do something where I could balance my lifestyle with his lifestyle, and that's when rheumatology came into the picture," she says. "I felt it would give me the time I need to spend with my family."

Sheri Polley is a freelance writer based in Pennsylvania.

Big Ideas for Small Practices

The policies and programs at large institutions can be adapted to fit even small-town rheumatology practices. Here are some tips to bringing balance to your practice.

- **Make work–life balance a priority:** There are many creative ways to make this work. A good starting point is your local hospital. Upon investigation, you may discover that many support programs already exist in your area. If they don't, you will likely discover that other physicians in your area have a mutual interest in *creating* such programs. Working together, you can duplicate some of the support systems available at much larger practices and institutions.
- **Share the load:** Consider job-sharing for clerical and nursing staff. For example, hire two part-time people to fill one full-time position. It may be feasible to cross-train staff between offices of different specialties to providing emergency coverage when necessary. With an open mind and some pre-planning and creativity, you can find mutually beneficial staffing solutions.
- **Be flexible:** Arranging for physician coverage, especially long-term, can be more challenging than staff coverage. It may involve covering a little more geographic distance or a more flexible patient schedule. The keys: Be prepared, communicate, and plan for absences—both expected and unexpected—before they occur.
- **Reap the rewards:** Time and effort invested in ensuring a work environment that respects and supports the family will be rewarded with a less stressed and more productive staff. Staff members are then free to spend their time at work focused on their work—and on the common goal of quality patient care.

Support Services for Busy Parents

As any parent can attest, the actual birth or adoption of a child is only the beginning. Parenthood opens up a whole new world of concerns and issues that must be incorporated into minds and schedules. Many organizations provide resources and contacts to assist parents in dealing with some of the common parenting issues.

UM's Web of Resources

UM developed a Work/Life Resource Center Web site to support a healthy work–life balance for its faculty and employees. The site offers confidential assistance and support with:

- Locating child care;
- Locating elder/dependent care;
- Locating emergency, back-up child care;
- Balancing work and personal responsibilities;
- Creating flexible work schedules;
- Using the Expectant Parents' Resource Program; and
- Planning maternity leaves.

Yale's WorkLife Program

Yale School of Medicine in New Haven, Conn., has the WorkLife Program, which originates from the Office for Women in Medicine, directed by Merle Waxman. According to Waxman, this program addresses issues such as:

- Day care (offered on-site);
- Leaves of absence;
- Stopping or slowing of the promotion cycle;
- Emergency back-up childcare; and
- Lactation rooms on campus for nursing mothers.

The program also offers a variety of classes, including:

- Kindergarten readiness;
- Shopping for daycare;
- Interviewing nannies; and
- Being part of the "sandwich generation," which must deal with young children and aging parents at the same time.

Waxman has no doubts regarding the long-term effects of such support services. "Women make wonderful physicians, but they may need a little more support at certain times in their career development," she says. "A little support early on reaps wonderful results later on."

 continued from page 1

PAC a Punch on Capitol Hill

New political action committee will be a voice for rheumatology

>> By Elaine Zablocki

Looking at the major medical associations, we were one of the few that did not have a political action committee," says Kristin Wormley, government affairs director for ACR. "Having a PAC makes us more of a presence on Capitol Hill."

Contributions to the PAC will be voluntary and separate from ACR membership dues. Any ACR member who is a U.S. citizen is eligible to contribute to the PAC.

In the past, some ACR members have made individual financial contributions to political candidates, but the organization as a whole has not been able to contribute to political campaigns. Because ACR has formed a PAC, now its members will be able to contribute as a group to politicians who understand the viewpoint of rheumatologists, rheumatology health professionals, and rheumatology patients. This is especially important now that Congress is considering a number of issues that deeply affect rheumatologists, Wormley says. (See "Rheumatology Goes to Washington," p. 14, for more on legislation affecting rheumatology.)

It is so important for ACR to take a proactive role and participate in activities in Washington, D.C. — *Sharad Lakhanpal, MD*

Members Weigh In

Some ACR members with a special interest in national healthcare issues have been happy to learn that ACR will now have its own PAC. "ACR has grown to be a significant body," says Sharad Lakhanpal, MD, of Rheumatology Associates in Dallas, Texas. "Whether we like politics or not, the fact is that decisions taken by politicians are going to affect our lives and livelihood. It is so important for ACR to take a proactive role and participate in activities in Washington, D.C." Dr. Lakhanpal already sent in his PAC contribution.

"Over the last two years the ACR government affairs committee has recommended a PAC to the ACR board of directors," says Joseph Flood, MD, chair of the ACR government affairs committee who is president of Musculoskeletal Medical Specialties, Inc., and a clinical faculty member at the Ohio State University College of Medicine and Public Health in Columbus. "We think this is an important way for us to ensure that our message is clearly articulated to Congress. PACs are designed to support those who share our opinions by making contributions to candidates." He reports that the fledgling PAC has already received many contributions from ACR members.

"It is really essential to form this PAC, since healthcare and rheumatology are influenced so much by the actions of legislators in Washington, D.C.," says Ann Kunkel, BS, an education coordinator in pediatric rheumatology at the University of Kansas Medical Center, in Kansas City. "Private health insurers tend to follow the lead set by Medicare, so it's really important for us to have a voice there." Kunkel serves on the ARHP education committee.

Deborah A. McCloskey, RN, BSN, nursing care coordinator of the Scleroderma Program at the University of Medicine and Dentistry of New Jersey, in New Brunswick, agrees. "Forming a PAC is a great idea and a major accomplishment," she says. "We deal with diseases that are relatively small in numbers. Forming a PAC will give us a louder voice at the table. If we want to maintain a place so we can influence legislators on behalf of our practice and our patients, this is the right thing to do." McCloskey is co-chair of the ARHP advocacy committee.

The Fine Print

A complex series of laws and regulations affects contributions to political candidates and legislators. (The Federal Election Commission "Campaign Guide" fills 134 pages.) Since the ACR is a 501(c)(6) organization, it is able to form a PAC as a standing committee of the parent organization. The ACR's PAC will be overseen by a committee of nine members, each serving a four-year term with the opportunity to serve two additional terms. It is organized as a "Separate Segregated Fund," which means that all contributions to the PAC go into a separate bank account, and are not comingled with ACR general funds.

Like any other political action committee, the new rheumatology PAC will be subject to financial limits under federal law. It will be able to contribute up to $5,000 to any one candidate during a primary election campaign, and then another $5,000 during the general election.

"The ACR Government Affairs Committee will continue to examine proposed legislation and any political issues that concern rheumatologists," explains Wormley. "The Political Action Committee will review contributions and campaign finance reports, and ensure that ACR complies with all regulations on political contributions."

In addition, ACR contracts with Patton Boggs, a Washington, D.C.-based advocacy law firm, to serve as its outside counsel. The PAC, with advice from the Government Affairs Committee and Patton Boggs, will determine which legislators and candidates should receive contributions from ACR.

NEED TO KNOW

For more information about the PAC, contact Kristin Wormley at kwormley@rheumatology.org or visit the advocacy section of www.rheumatology.org.

ACR members in the United States will soon receive information about the new PAC, suggesting various ways they can become more involved in the political process on behalf of rheumatol-

continued on page 24

Other Societies Pleased with PACs

Because federal legislation affects so many aspects of medical practice, most large medical societies, and many of the smaller specialty societies, have already formed political action committees.

A number of physician organizations tell The Rheumatologist how pleased they are with their political action committees. For example, the American College of Cardiology formed a PAC in 2001. "Having a PAC means you are able to present your message in more venues than you had before," says Frank Ryan, director of the college's PAC. "We really work to support the candidates who we feel understand the needs of our patients. In addition, our members appreciate the fact that there is full disclosure through reports filed with the Federal Election Commission. It is a very open process."

The American Academy of Neurology does not have a PAC at present, but has been discussing the subject for the past four years. As a first step, they set up an office in Washington, D.C., two years ago. At their next annual meeting, on May 1, the members voted on a bylaw change that would allow the academy to set up a 501(c)(6) organization as a necessary first step towards forming a PAC.

In 1998 the American College of Physicians (ACP), which didn't have a PAC, merged with a smaller group, the American Society of Internal Medicine (ASIM), which did have a PAC, and the newly formed organization did not retain the PAC. However, in 2005, they started it up again.

"Our thinking has changed over the past few years, given how much Congress is involved in decision-making that affects physicians," says Patrick Hope, legislative counsel for ACP-ASIM.

The group is pleased with the results of its first election cycle. "While many organizations send their staff to DC-based fundraisers, we try to hold these events back in the district." Hope says. "That means our physicians get more face time with legislators. When you're discussing healthcare policy and reimbursement issues, it is so much more effective if members of Congress get to talk directly with physicians."

Reading RHEUM

HANDPICKED REVIEWS OF CONTEMPORARY LITERATURE

PEDIATRIC PAIN

Ibuprofen Best for Acute Traumatic Musculoskeletal Injuries

>> By Kathleen A. Haines, MD

Clark E, Plint AC, Correll R, Gaboury I, Passi B. A randomized, controlled trial of acetaminophen, ibuprofen, and codeine for acute pain relief in children with musculoskeletal trauma. Pediatrics. *2007; 119(3):460-467.*

Abstract

Objective: The authors' goal was to determine which of three analgesics—acetaminophen, ibuprofen, or codeine—given as a single dose, provides the most efficacious analgesia for children presenting to the emergency department with pain from acute musculoskeletal injuries.

Patients and methods: Children six to 17 years old with pain from a musculoskeletal injury (to extremities, neck, and back) that occurred in the preceding 48 hours before presentation in the emergency department were randomly assigned to receive orally 15 mg/kg acetaminophen, 10 mg/kg ibuprofen, or 1 mg/kg codeine. Children, parents, and the research assistants were blinded to group assignment. The primary outcome was change in pain from baseline to 60 minutes after treatment with study medication as measured by using a visual analog scale.

Results: A total of 336 patients were randomly assigned, and 300 were included in the analysis of the primary outcome (100 in the acetaminophen group, 100 in the ibuprofen group, and 100 in the codeine group). Study groups were similar in age, gender, final diagnosis, previous analgesic given, and baseline pain score. Patients in the ibuprofen group had a significantly greater improvement in pain score (mean decrease: 24 mm) than those in the codeine (mean decrease: 11 mm) and acetaminophen (mean decrease: 12 mm) groups at 60 minutes. In addition, at 60 minutes more patients in the ibuprofen group achieved adequate analgesia (as defined by a visual analog scale <30 mm) than the other two groups. There was no significant difference between patients in the codeine and acetaminophen groups in the change in pain score at any time period or in the number of patients achieving adequate analgesia.

Conclusions: For the treatment of acute traumatic musculoskeletal injuries, ibuprofen provides the best analgesia among the three study medications.

Commentary

Pediatric rheumatologists deal with pain. More often than not, pain is the symptom that brings children to our offices. If we make a diagnosis of an inflammatory arthritis, pain control often appears to be relatively straightforward, as we prescribe NSAIDs, DMARDs, and possibly corticosteroids to diminish inflammation and the resultant pain. However, the majority of children who present with pain complaints do not have juvenile inflammatory arthritis or other arthritis. Rather, they have patello-femoral syndrome, hypermobility, or the dreaded "growing pains"—those mysterious wandering leg pains that have the family up half the night and the child completely recovered by daybreak. Which analgesic agent works best for musculoskeletal pain in children is a question of interest to the pediatric rheumatologist.

> I was sorely disappointed that, as the authors state, at best 50% of children achieved adequate analgesia with the highest recommended dose of ibuprofen.

The authors of the above study have investigated whether acetaminophen, ibuprofen, or codeine provides the most effective pain relief—as determined by rapidity of onset and by amount of relief—in children age six to 17 with acute musculoskeletal pain. They recruited 336 children with soft-tissue injury or closed fracture and randomly assigned them to receive one of the above three agents at the maximal recommended dose of each agent. The analgesics were formulated as a purple, grape-flavored liquid given by a nurse not involved in the study to maintain blinding, as the volumes were not identical among the drugs. Pain scores using a 100 mm visual analog scale (VAS) were recorded at 0, 30, 60, and 120 minutes after drug administration. (The use of the VAS in children older than six has been validated.) A 15-mm change in pain score was considered to be clinically significant and pain rated at <30 mm was considered adequate pain control. Both of these endpoints fall within acceptable ranges in several studies of pain measure in children.

The baseline pain scores in each group were not significantly different, ranging between 51 and 57 mm VAS. However, only the group receiving ibuprofen had a clinically significant diminution of pain after 60 minutes (-27 mm, $p<0.001$). In addition, 52% of patients receiving ibuprofen achieved adequate pain relief as measured by a VAS of <30 mm. Patients receiving acetaminophen did not have clinically significant pain relief until 60 min (-17 mm) and those receiving codeine reported pain relief at 120 min (-17 mm). Only 36% and 40% of the acetaminophen and codeine groups respectively achieved adequate pain control. In patients with a high degree of pain at baseline (VAS >30 mm), ibuprofen provided the most rapid relief, achieving significance by 30 minutes; codeine was equally effective at 120 minutes. Of interest, patients with fractures received the most benefit from ibuprofen. Diminution of pain in patients with soft-tissue injuries did not achieve significance in any group. Side effects were equivalent.

One of the more common myths of adulthood is that children do not suffer from pain without serious illness. Yet cross-sectional studies of the prevalence of pain in children have demonstrated between 20% and 40% of children have pain at any one time. Looking retrospectively, 80% of school-age children will report having had pain at some time in a three-month period. Hence, knowing how to treat pain in children is clearly important. Upon encountering this study, I assumed it would help me overcome my reluctance to use narcotic analgesics in treating pain. However, I was startled to see ibuprofen outperforming codeine. On second look, I was sorely disappointed that, as the authors state, at best 50% of children achieved adequate analgesia with the highest recommended dose of ibuprofen.

I am not sure how to translate this study in children with acute pain to our patients with various pain syndromes. Growing pains usually respond very nicely to NSAIDs, perhaps reflecting the acuity of this problem. Patients with hypermobility and pain and those with patello-femoral syndrome often have more chronic pain. Do these patients parallel those in the cohort with soft tissue injury, who were more resistant to pain relief, or the group with fracture, who received reasonable pain relief—or are they different still? My take-home message for hypermobile/patello-femoral pain: try pushing ibuprofen higher than my usual 10 mg/kg and add on a narcotic analgesic (at least for short periods) and get those kids to physical therapy. I think I will save acetaminophen for treatment of low-grade fever.

The Role of DKK-1 in RA

JOINT REMODELING

>> By Maripat Corr, MD

Diarra D, Stolina M, Polzer K, et al. Dickkopf-1 is a master regulator of joint remodeling. Nat Med. *2007;13(2):156-163.*

Abstract

Degenerative and inflammatory joint diseases lead to destruction of the joint architecture. Whereas degenerative osteoarthritis results in the formation of new bone, rheumatoid arthritis leads to bone resorption. The molecular basis of these different patterns of joint disease is unknown. By inhibiting Dickkopf-1 (DKK-1), a regulatory molecule of the wingless (Wnt) pathway, we were able to reverse the bone-destructive pattern of a mouse model of rheumatoid arthritis to the bone-forming pattern of osteoarthritis. In this way, no overall bone erosion resulted, although bony nodules, so-called osteophytes, did form. We identified tumor necrosis factor–α (TNF-α) as a key inducer of DKK-1 in the mouse inflammatory arthritis model and in human rheumatoid arthritis. These results suggest that the Wnt pathway is a key regulator of joint remodeling.

Commentary

continued on page 24

PAC A PUNCH | continued from page 23

ogy. "Some of the other specialty societies such as orthopedics and radiology have been particularly effective in getting their message across, and I believe their political action committees have played an important role in this process," says Stuart Kassan, MD, of Colorado Arthritis Associates in Denver. "The bottom line is that a political action committee will allow us to advocate most effectively for our patients, for the specialty, and for science." | THE RHEUMATOLOGIST |

Elaine Zablocki is a medical journalist based in Eugene, Oregon.

continued from page 23

Inflammatory arthritis is coupled with structural changes in the underlying bone. These bony changes can be either erosive, as seen in rheumatoid arthritis (RA), or proliferative, as exemplified by ankylosing spondylitis. Hence, soluble regulators of bone remodeling have been a topic of intensive investigative interest. Recently, the Wnt signaling pathway has been identified as a key pathway in maintaining adult bone mass and bone turnover.

Wnt proteins are extracellular ligands which bind to the G-protein-coupled seven-transmembrane domain frizzled receptors and the low-density lipoprotein receptor-related protein 5 and 6 (LRP5/6) coreceptors. Receptor ligation triggers a cascade of events that stabilizes beta-catenin, and enables its nuclear translocation and subsequent activity as a transcriptional cofactor.[1] Gain of function polymorphisms in the LRP 5 coreceptor results in elevated bone mass and bony proliferation, and loss of function variants result in the osteoporosis pseudoglioma syndrome.[2,3] The DKK family of soluble Wnt antagonists binds to LRP and another receptor called Kremen. (See Figure 1, below.) Diarra et al. have identified one of these molecules, DKK-1, as a key modulator of bone remodeling disorders. In addition its potential as a therapeutic target, serum levels of his protein might be a surrigate biomarker for disease-associated bone remodeling.

To examine the role of DKK-1 in inflammatory arthritis, Diarra and colleagues used a monoclonal antibody to mouse DKK-1 in three separate models of murine arthritis. Although treatment with an anti-TNF antibody diminished paw swelling, anti–DKK-1 administration had no effect on paw size. However, anti–DKK-1 protected against bone erosion and there was an increased formation of bony nodules (osteophytes) at the joint margins in the anti–DKK-1 treated animals. Fewer erosions also correlated with fewer osteoclasts seen in the anti–DKK-1 treated animals. An additional effect of anti–DKK-1 treatment on inhibiting bone resorption was the associated increase in osteoprotegerin (OPG) expression. OPG is a soluble antagonist for the receptor activator of NF-kB ligand (RANKL), a critical factor for osteoclast differentiation. The effect of anti–DKK-1 on resorption appeared to be secondarily mediated through OPG. After experimental reduction in articular OPG expression, the osteoclasts re-emerged in anti–DKK-1–treated animals, supporting this hypothesis. In previous reports, DKK-1 had been found to suppress osteoblast differentiation. Hence, DKK-1 might toggle the balance between bone repair and resorption

Although the source of systemic DKK-1 remains unclear, inflamed synovium from RA patients was shown to express DKK-1 locally in the joint. In addition, fibroblast-like synoviocytes were induced to express DKK-1 by exposure to TNF-α in culture. As a correlate, serum levels of DKK-1 declined progressively during six weeks in RA patients who were started on anti-TNF therapy. In addition, serum levels of DKK-1 were proportional to their disease activity score (DAS) 28, whereas ankylosing spondylitis patients had low baseline levels of circulating DKK-1.

This elegant series of experiments suggests that DKK-1 or other Wnt signaling modulators might prove to be useful therapeutic targets for therapies to reduce bone erosion in RA. However, in addition to attenuating bone erosion the experimental mice had aberrant bony proliferation, suggesting that osteophyte formation may be a potential side effect that would require monitoring. In addition, the Wnt pathway regulates multiple cellular functions including proliferation and differentiation. Wnt signaling antagonists have been reported as key molecules in tumor suppression, angioneogensis, and cardiac disease amongst other potential comorbidity issues. These initial findings by Diarra et al. are very promising in a potential new target to abrogate bone erosion, but further investigating into the effects on other organ systems is warranted. THE RHEUMATOLOGIST

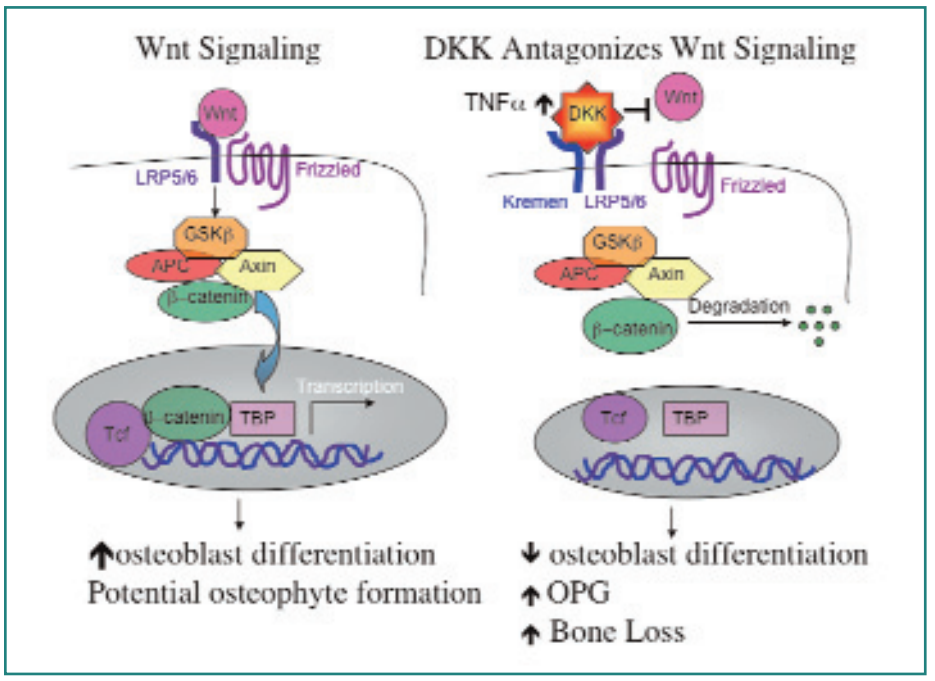

FIGURE 1: **DKK inhibits Wnt signaling and promotes bone loss.** Binding of Wnt to its receptor complex, consisting of a member of the Frizzled (Fzd) family the LDL-receptor-related proteins LRP5/6, leads to stabilization of β-catenin by inhibiting the phosphorylating activity of glycogen synthase kinase (GSK-3β). Unphosphorylated β-catenin accumulates in the cytoplasm and translocates into the nucleus, where it activates target gene expression through interacting with T-cell (TCF) and other transcription factors. Tumor necrosis factor–α stimulation leads to increased levels of Dickkopf, a soluble Wnt inhibitor. DKK binds to Kremen and LRP5/6, resulting in internalization of the receptors, hence limiting Wnt signaling. β-catenin is phosphorylated and degraded. DKK-1 inhibits osteoblast differentiation and promotes OPG expression.

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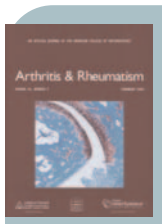

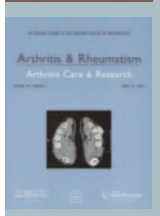

SCIENCE FROM OUR SISTERS

Recommended reading from *A&R*

Meningococcal C Vaccine Safe and Effective for Juvenile Arthritis Patients

Vaccination against meningococcal serogroup C (MenC) does not aggravate juvenile idiopathic arthritis (JIA), nor is the vaccine inhibited by immunosuppressive therapies, according to a study published in *Arthritis & Rheumatism* (2007;56:639-646).

For this multicenter cohort study, researchers followed 234 patients age one to 19 for six months before and six months after vaccination, with patients serving as their own controls. No significant increase in disease activity was seen in the six months after vaccination when compared with the six months preceding. Furthermore, a subgroup of 166 patients did not experience more relapses after vaccination—in fact, the relapse risk in the month after vaccination was smaller than in the other 11 months studied.

The group of patients had a strong immune response to the vaccine, with the average anti-MenC IgG geometric mean concentration increasing from 0.4 µg/ml before vaccination to 28.9 µg/ml after vaccination. This increase is similar to that seen in healthy children given the vaccine.

Some patients taking disease-modifying anti-rheumatic drugs, methotrexate, tumor necrosis factor-α blockers, and prednisone had reduced responses to the vaccine, but even these patients demonstrated adequate protection in a serum bactericidal antibody titer test.

"Patients with JIA can be vaccinated safely and effectively with the MenC conjugate," wrote lead author Evelien Zonneveld-Huijssoon, MD, Wilhelmina Children's Hospital at the University Medical Center Utrecht in The Netherlands, and colleagues. This was true even for patients receiving highly immunosuppressive medication.

National Look at Arthritis-related Work Disability

Almost a third of Americans with physician-diagnosed arthritis—about 6.8 million people—report that their condition affects their ability to work, according to a study published in *Arthritis Care & Research* (2007; 57(3):355-363).

For the study, the investigators analyzed data of 31,044 individuals between age 18 and 64 who completed the 2002 National Health Interview Survey (NHIS).

People with recurrent pain or an unknown income were more likely to report work limitations associated with arthritis, as were African Americans and Hispanics. Women, people with good or excellent health, and individuals with a college degree or income more than $20,000 reported arthritis significantly less frequently.

In contrast to some previous research, level of education—except for a college degree—did not correlate with arthritis disability, nor did insurance status.

The authors note several limitations to the study. The self-reported results are subject to the limitations of the respondent's recall, and, in cases with multiple comorbidities, it can be difficult to identify the source of the disability. Furthermore, the NHIS did not distinguish between people unable to work because of arthritis and those whose work was limited by the condition, and the survey data provide no insight into whether the arthritis preceded the work limitations.

Lead author Kristina Theis, MPH, a researcher at the Arthritis Program of the Centers for Disease Control and Prevention, and colleagues suggest several directions for further research: "What work are people with arthritis unable to do? Which groups are more affected and why? How can interventions for these groups be tested, targeted, delivered?"

Considering the effect work limitations due to arthritis have on the workforce and the economy, this study highlights a need for ways to manage or prevent arthritis-attributable work limitations, the authors note.

"Concurrently, the role of early diagnosis and appropriate medical and self-management remains strong, as does the role of public health in educating individuals with arthritis and AAWL and in promoting appropriate self-management," they write.

Office VISIT

A DAY IN THE LIFE OF MICHAEL J. MARICIC, MD

>> By Eric Butterman

CARE AND COMPASSION

For Michael J. Maricic, MD, the heat is always on—and not just from the scalding temperatures of the ever-present Tucson sun. Strolling through the lobby of his bone clinic, the same sign awaits him every morning: "Our mission is to provide state-of-the-art diagnosis and therapy of rheumatic disorders, combined with compassionate care." Compassion is a primary adjective in that sentence and in his mind, and Dr. Maricic hopes this commitment will make him and his partners a top practice in a very busy market. After all, Arizona is a place where people retire—often taking their rheumatism with them.

Fresh Approach with Every Person

Some physicians think they've seen it all, but Dr. Maricic constantly reminds himself to take a fresh perspective to every patient. "Even if I'm able to immediately diagnose the problem, you also have to diagnose the patient's attitude toward their illness," he says. "I've seen patients with the exact same issues and yet one is walking around with energy while another feels they're in constant pain. I have to give one a lot more support than the other."

Dr. Maricic, who studied medicine at University of Zagreb in Croatia, always starts his day with a mandatory cup of coffee. For the next nine and a half hours he will have little to no down time.

"I see patients from eight to five-thirty every day right through lunch," he says. "I also spend one half-day per week in clinical research and two half-days with medical students [from the University of Arizona]. I'm going over internal medicine and rheumatology with them, but I'm making sure we get time in with patients, rather than lecture-driven. Students have to learn how to deal with people. I also do consults during the week. … I have to make myself available to hospitals as they need me."

Business Is Never Usual

Although he doesn't want a day to be business as usual, Dr. Maricic isn't immune to the fact that rheumatology is a business. "I have a strong interest in osteoporosis and bone disease and always have—can't do rheumatology without getting involved in metabolic bone disorder. You have to participate in that aspect of rheumatic care and 20% to 30% of my referrals are for bone-related disorders.

"From an income standpoint it's a helpful part of our practice and we participate in osteoporosis clinical trials that help to buffer some of the cuts in Medicare," he continues. "Reimbursement of pharmaceutical trials pays better than Medicare. So, for a rheumatologist, clinical trials have many positives. Of course, it's not lucrative compared to the past, and reimbursement will go down further. … None of us got into this thing to get rich."

As Dr. Maricic calls it a day, that same lobby sign underscoring compassion greets. If he ever changed the message, though, it would probably include that other healing word: listen. "I spoke to a woman not long ago who complimented me on the way I really heard her and thanked me for looking into her eyes as we talked."

Dr. Michael J. Maricic doesn't find any day easy—or without its rewards.

Dr. Maricic pauses and the tone of his voice lowers slightly. "She didn't get better from a pill; it was her attitude and because I dealt with her like a person and gave her hope that she could get better. When you stop having that interest in your patients, it's time to do something else." THE RHEUMATOLOGIST

Eric Butterman is a freelance writer based in New York City.

MAKE AN APPOINTMENT

Know a rheumatologist or rheumatology health professional to whom we should pay an "Office Visit"? Send your suggestion to the editors via e-mail at: dantolin@wiley.com.

From the COLLEGE | continued from page 13

CODING CORNER ANSWER question on p. 9

May's coding answer: First, keep in mind that Medicare only covers a bone-mass measurement for a beneficiary once every two years. The physician or ancillary staff will need to have the patient sign an Advance Beneficiary Notice (ABN) to ensure reimbursement before the patient leaves the office.

Physicians are required to have a signed ABN in the medical record of each patient that has a reasonable and necessary service. The above scenario is deemed reasonable and necessary and should be coded with the correct CPT code appended by a modifier, -GA. The -GA modifier will notify CMS that you have a signed and dated ABN on file for that service and the physician can bill the patient if Medicare does not reimburse for the service. If you do not have a signed ABN, then the CPT code should be appended with a -GZ.

Remember that the patient should not be billed for a denied Medicare-covered service unless an ABN has been signed or there is a statement in the medical record indicating that the patient refused to sign the ABN.

April's coding question: Paul, a new 50-year-old patient, comes in with a referral from his primary care physician. Do you code this as new patient visit or consultation visit?

The correct answer is: It would depend on whether the primary care physician is requesting your medical opinion or just referring the patient for insurance reasons. If the primary care physician is requesting your medical opinion and you have properly documented this in the patient's medical records, you can bill for a consultation. If this is only a referral request because of an insurance guideline then it will have to be billed as a new patient visit. Visit the Practice Support section of www.rheumatology.org for more documentation aids.