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ARTHRITIS FOUNDATION MALAYSIA

Joint Efforts

Doctor's Edition

THE OFFICIAL NEWSLETTER OF ARTHRITIS FOUNDATION MALAYSIA | www.afm.org.my

01
APR, 2012

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This Issue

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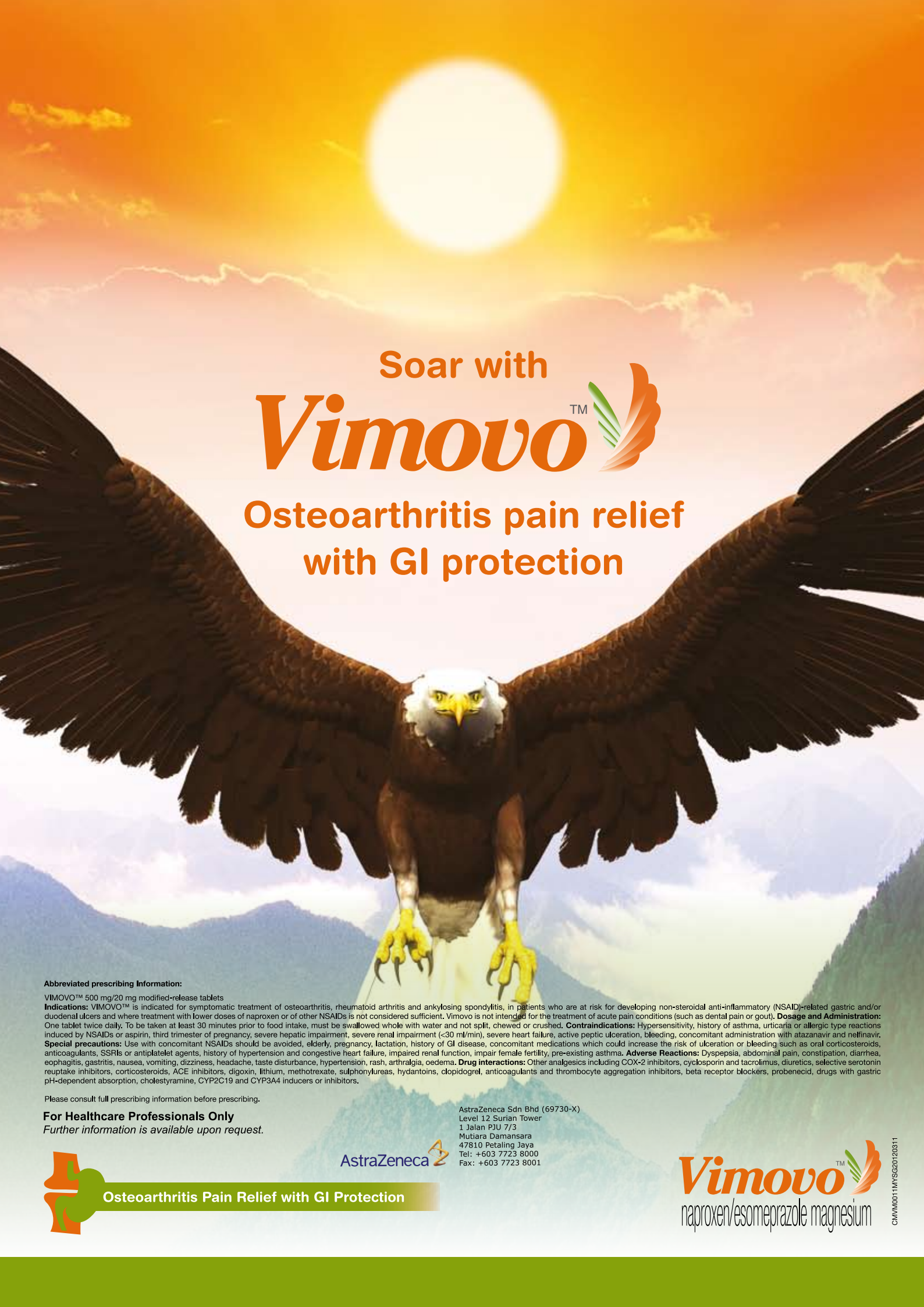

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PRESIDENTIAL NOTES

'What is the cause of arthritis?' – a very common question asked of me, and one to which I invariably answer – 'It depends on what type of arthritis you mean'. The most common form of arthritis, that which is ingrained in our minds – the image of an elderly person using a stick to walk, hobbling in discomfort - would be Osteoarthritis. This is the commonest form of arthritis and, it seems, the only one that people associate with.

In reality, there are at least one hundred different kinds of arthritis, each often with different causes. These range from degenerative, autoimmune, metabolic, infective, trauma, genetic – the list goes on and on, and commonly, any given kind of arthritis may have several contributory causes.

It is important to find out the kind of arthritis you have as the type of treatment that is appropriate depends on it.

In the process of evaluating a person with arthritis, finding out what kind they have is foremost on a doctor's mind. In particular, whether the kind of arthritis that patient has carries with it a risk of rapid bone and joint damage. In these cases it is then important to start definitive treatment early. Given the nature of arthritis, treatment is usually for a prolonged period, in some cases, for an indefinite time.

Effective treatment of chronic diseases such as arthritis, not to mention diabetes, heart disease and high blood pressure depends heavily on patient compliance as well as choice of treatment. There are many factors, both internal and external, that influence compliance. Both patients and physicians would do well to understand these factors so that we can improve the care of chronic disease and ultimately, make a difference to the outcome of these diseases.

The AFM remains committed in its efforts to inform the public about all aspects of arthritis. I hope you find this issue of Joint Efforts informative.

Dr Amir Azlan Zain
PRESIDENT
AFM

Taking medication on a long term basis is one of the many things arthritis patients have to get used to once they begin treatment of the disease.

Many patients tell of being overwhelmed at the point of diagnosis, dealing with the daily realities of the disease, the changes to their bodies and the accompanying discomfort and pain, not many are able to understand at the outset the long term impact the disease will have on their lives.

The good news for many arthritis patients is that today, there are more, and increasingly better drugs to deal with the many symptoms for this multi-faceted chronic disease. The availability of information via the internet brings together patients to share experiences, opinions and to gain encouragement and moral support.

That said, it is essentially the patient who has to decide how to approach the matter of medication. Doctors can strategise treatment regimes and prescribe accordingly, but a patient who is unwilling and uncommitted to the process might be lax in complying with the medication's required dosage, and frequency, and as such, affect the effectiveness of any medication regime.

For young patients, and physically dependent patients, there will be the added complication of caregivers, who will be required to be equally invested in the treatment methods and subsequent medication regime that a patient undergoes.

Observations and adjustments to treatments can only be done if patients, and caregivers, are able to give valuable feedback, responses and informed opinions on the effects of respective treatment options. In the information age, the patient needs to take responsibility and ownership of the situation, in order to gain maximum returns from their interaction with their doctors.

Coupled with this of course is the cost consideration, there are very real economic constraints when it comes to using cutting-edge drugs, the full effects of which still remain to be discovered. But it's an exciting and hopeful time to be a patient, and with this in mind, this issue of Joint Efforts has chosen to focus on giving information on the various types of treatment options available for arthritis patients, and what they can learn to help themselves in seeking the best solution to managing the disease in the best way possible.
We hope it will be a fruitful and informative read.

Sincerely,

Diana Abdullah
EDITOR

Send your ideas, articles, materials or medical questions to:

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Letter Box 60, No 5, Jalan Lagoon Selatan, Bandar Sunway, 46150 Petaling Jaya, Selangor Darul Ehsan.
Tel: 603-5621 6177 Fax: 603-5621 7177
Contact person: Ms Yoges *(Monday-Friday: 0830-1630 hrs)*

For Additional information on Arthritis:

The Malaysian Society of Rheumatology
http://www.msr.my

Rheumatology : Research, Treatment and Education
http://www.rheumatology-info.com

Rheumatology Update
http://www.rheumatologyupdate.com.au

ANNUAL GENERAL MEETING & PUBLIC FORUM

The AFM's 19th Annual General Meeting and Public Forum was held on the afternoon of Saturday, 21st April, at the Crown 2 room, in The Empire Hotel in Subang Jaya. With present day concerns over the use of corticosteroids in treating many forms of arthritis, and constantly looming bogeyman – Side Effects – it was clear that almost all of those present were very interested in what AFM President Dr Amir Azlan Zain had to say in his talk titled, **Steroids : Are they All that Bad?**

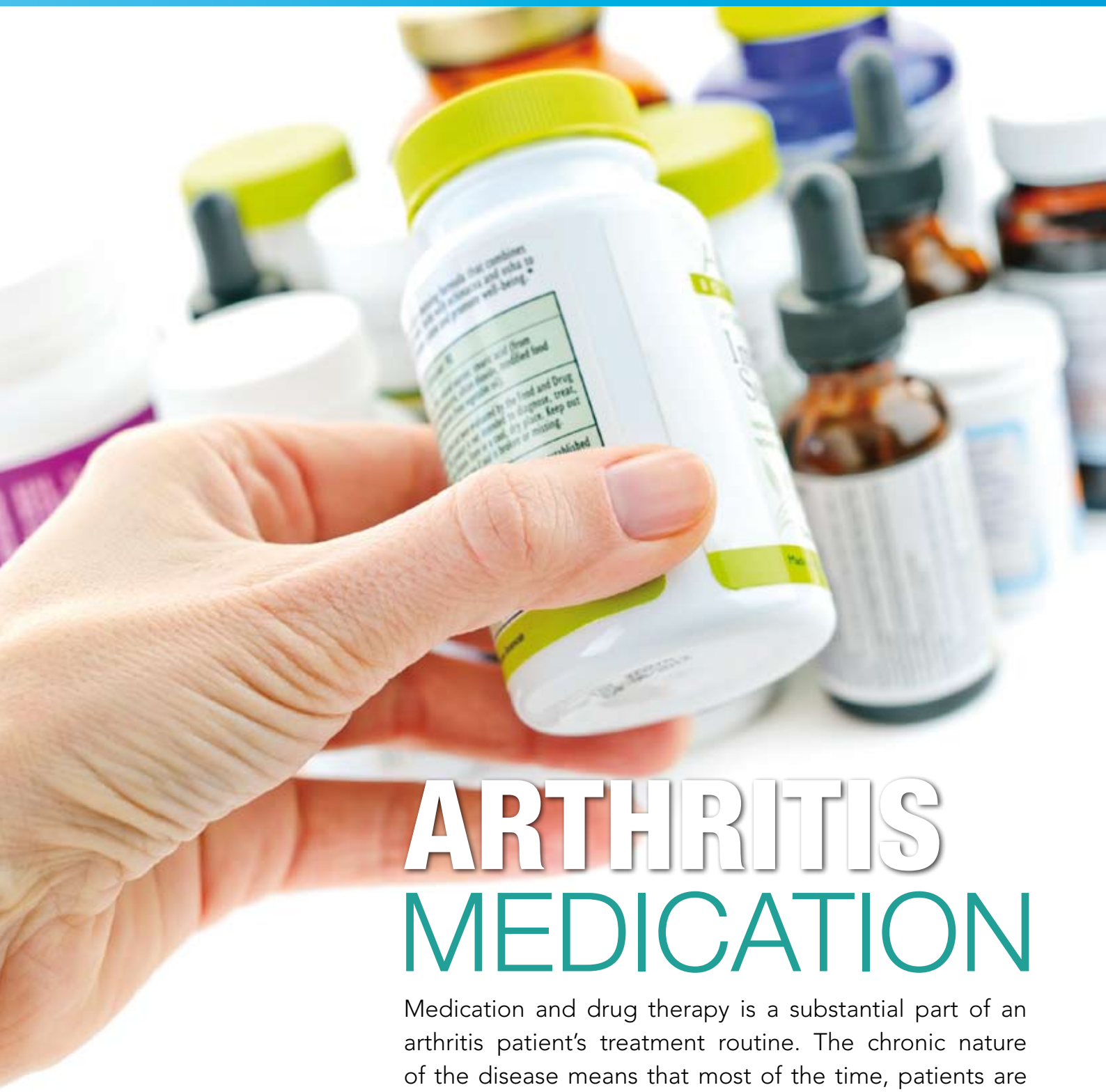
Dr Amir's concise history of the use of steroids, its continuing effectiveness and the advocacy responsible use – low dosage for short periods, made the case for the use of steroids in treating the many symptoms presented by various forms of arthritis.

He underlined the many benefits of use of steroids to treat arthritis – it can actually save lives, and if not that, at least improve the quality of life and relieve discomfort for a patient. In addition, it works very dramatically when put to use in many cases of arthritis. For all these reasons, Dr Amir said, there continues to be a role for the use of steroids in modern medicine, particularly if the possibility of side effects is reduced by always using as low a dose of steroids for as short a period as possible.

As Dr Amir concluded by saying, "**We should treat Steroids with respect, not fear**," many felt it was a fitting ending to an enlightening talk. Thereafter he fielded questions centred on effects of steroid use on the nervous system, which could happen if steroids are used for more than a year at a stretch.

Dr Vimala Marimuthu, consultant physiotherapist at Physio Plus then took the stage to introduce listeners to "Bend, Stretch, Pull & Hold ! – Activities in Arthritis." The session was well received and left everyone wanting more.

After which the business of the 19th AGM was swiftly concluded and everyone present partook in the refreshments which were provided by the day's sponsors RotthapharmMadaus.



ARTHRITIS MEDICATION

Medication and drug therapy is a substantial part of an arthritis patient's treatment routine. The chronic nature of the disease means that most of the time, patients are taking medications, in isolation or in combination, over a long period of time.

As new drugs become available for arthritis treatment, the challenge continues to be how to choose the right types of drugs, in the right combination, to suit a particular patient. Every patient is different, and each patient's needs changes over time.

Rheumatoid arthritis patients, for example, will find that their medicine cabinet is fairly full. There is medication designed to fight inflammation and pain, and yet others which help with disease progression. Some medications may even reduce the risk of heart disease, a problem many people with rheumatoid arthritis face. But it's not all rosy: Like all medications, these drugs have side effects, some of which can be quite serious.

And exactly what is available out there?

Traditionally, rheumatoid arthritis has been treated with a combination of DMARDs, or disease modifying anti-rheumatic drugs, and two other classes of medications, non-steroidal anti-inflammatory agents (NSAIDs) and corticosteroids.

Rheumatoid Arthritis Medications: DMARDs

"The gold standard for rheumatoid arthritis, the initial drug used in treatment unless there's a good reason not to, is methotrexate," says Elinor Mody, MD, director of the Brigham and Women's Hospital Women's Orthopedic and Joint Disease Center in Boston.

"Methotrexate is a chemo drug when used in high doses, but is given in low doses for rheumatoid arthritis," Dr. Mody explains. "Methotrexate has 20 years of success in treating rheumatoid arthritis."

PRO: Methotrexate and other DMARDs not only help control symptoms, they can also minimize joint damage and stave off future complications.
CON: Doctors must monitor your blood work and symptoms closely while you take methotrexate since it can affect the liver, bone marrow, and lungs[1].

Other DMARDs that can be prescribed along with or instead of methotrexate include:

- **SULFASALAZINE** "Sulfasalazine is used more often in Europe due to costs and historical preference," Mody says.
- **Leflunomide** It works similarly to methotrexate.
- **ABATACEPT** Abatacept is a newer drug, given once a month, that helps prevent the immune system from attacking the joints.
- **RITUXIMAB** "Rituximab was originally used in Hodgkin's lymphoma, but was found to be useful in treating rheumatoid arthritis[2]. It's usually used with methotrexate," Mody says.
- **HYDROXYCHLOROQUINE SULFATE** Originally prescribed as an anti-malaria drug, it helps treat stiffness, swelling, and inflammation.

Rheumatoid Arthritis Medications: Anti-TNF drugs

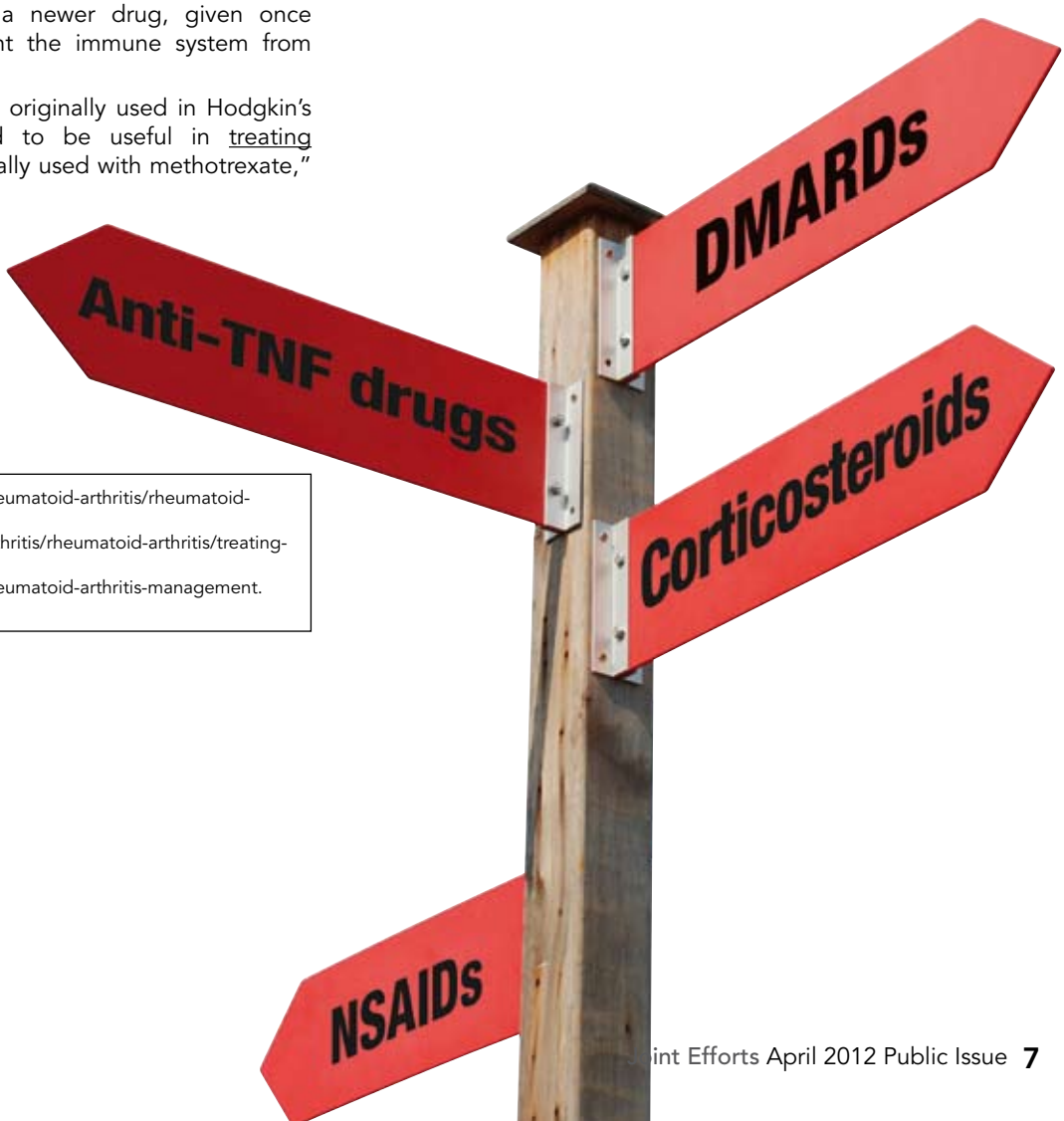
Anti-TNF, or anti-tumor necrosis factor, medications work by blocking the effects of TNF (a protein that encourages inflammation and revs up the immune system), thereby decreasing the joint inflammation that is a hallmark of rheumatoid arthritis.

Anti-TNF drugs are considered DMARDs because they can stave off disease progression. Using methotrexate in combination with an anti-TNF medication is common. "We start methotrexate and maximize the dose for two months, then add the anti-TNF drug," Mody explains. They are injected and are very successful in managing rheumatoid arthritis[3], she adds.

Anti-TNF drugs include:

- Etanercept
- Infliximab
- Adalimumab

PRO: Anti-TNF medications are effective in controlling symptoms and preventing complications of rheumatoid arthritis.
CON: They can cause several potentially life-threatening side effects. Because these drugs interfere with the immune system, they increase your risk of infection, including tuberculosis. Additionally, some of these medications have been linked to the development of lymphoma, a cancer of the white blood cells.



1 http://www.everydayhealth.com/rheumatoid-arthritis/rheumatoid-arthritis-lungs.aspx
2 http://www.everydayhealth.com/arthritis/rheumatoid-arthritis/treating-rheumatoid-arthritis.aspx
3 http://www.everydayhealth.com/rheumatoid-arthritis-management.aspx

Rheumatoid Arthritis Medications:
Corticosteroids

Corticosteroids like prednisone and methylprednisolone are powerful medications. "We try not to use prednisone too much," says Mody. "There is some evidence, if used early on, that it can make the course of the disease easier. But, in general, we try to stay away from it because of the serious side effects."

PRO: Corticosteroids help blunt rheumatoid arthritis symptoms.
CON: They can lead to a host of side effects, including weight gain, high blood pressure, elevated blood sugar, and mood disturbances.

Rheumatoid Arthritis Medications:
NSAIDs

This class of drugs includes over-the-counter medications such as aspirin, ibuprofen, and naproxen, as well as prescription-strength drugs.

PRO: NSAIDs reduce joint inflammation and offset symptoms.
CON: They have no effect on the eventual progression of the disease, can irritate the lining of the stomach, and damage the kidneys when used at high doses for extended periods.

Rheumatoid Arthritis Medications:
The Heart Disease Connection

For reasons that are not entirely understood, people with rheumatoid arthritis are at a higher risk of heart disease than their healthy peers.

However, certain rheumatoid arthritis drugs may have a beneficial effect in that regard. One recent study indicates that long-term use of DMARDs and anti-TNF drugs to manage rheumatoid arthritis indirectly protects cardiovascular health. More research is needed to identify whether specific medications are more effective than others in preventing cardiac complications.

More and more medications are being developed to treat rheumatoid arthritis.

Ideally, a patient, together with his or her doctor, will have to work out a suitable medication regime for the problem at hand, and agree on the course of action, and re-evaluate the situation at specific intervals. In order to do this, a patient would do well to have some level of knowledge of the drugs that are being offered, and its side effects if any, and then consider whether or not he or she will be willing to take the medication, as prescribed, for the required period. If a prescribed medication is not administered according to instructions, then its efficacy might be compromised and be of minimal benefit.

Arthritis patients today have the benefit of using the internet to find out more about the medication choices open to them, and also to reach out to a wider network of fellow sufferers who are able to impart their own experiences and the lessons learnt, as well as to their experiences with different drugs. Even allowing that drugs work differently on different people, it often helps if an arthritis patient can share his or her experience with omeone going through the same thing, or someone who has experienced the situation in the past.

Studies have shown that people who are well informed and participate actively in their own care experience less pain and fewer visits to the doctor than do other people with Rheumatoid Arthritis.

As one longtime patient puts it "I urge you to do your due diligence, before taking any medication research the side effects (every drug has a side effect).

Talk to others who have taken the drug for long periods of time to help you decide if this drug produces the results you are looking for.

It is so important I want to repeat, YOU are responsible for your long term health, become an expert on RA while working with your doctor/s to find the treatment that is best suited to you."*

Another patient had this to say : "The best advice I can give to anyone who has been diagnosed with RA is to get your hands on every piece of information you can. Ask your doctors about the long term effects of the arthritis itself as well as the medications you use to treat it. It's a difficult balance to take one day at a time but also be aware of the future damage that can occur."**

Given that there is currently no known cure for arthritis, medications are intended to stop progression of the disease, not halt the disease or return one to health. This is MANAGING disease, and you will be expected to continue with the medication for life, or, for as long as the medication works.

One patient's view, after years of experimenting with different drugs , suggests that patients consider boosting their overall general health, through nutrition or any other means that they have found to be effective. In addition, they must consider, the long term effects of the drugs that they were taking.

Having said that, "**This disease must be treated**, it is not a disease you want to try to will away or suffer through. Whether you choose the path of finding what is causing the disease and making necessary changes or taking the medications is up to you, but you must take action to stop the progression of this disease."

**excerpts and text from http://www.livingwithrheumatoidarthritis.com/*
***excerpt from http://www.healthcentral.com/rheumatoid-arthritis/c/97/15793/ten*

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Full prescribing information available upon request

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GUIDE TO HELP RHEUMATOID ARTHRITIS PATIENTS REACH TREATMENT GOALS

Important factors in considering a treatment plan

By discussing the following issues with your patients, you can help them actively participate in developing a treatment plan:

- How long they have experienced symptoms of RA
- Current and past medication for RA
- How long they have been on their current treatment
- Whether their current medication controls their symptoms
- Whether their current treatment halts the progression of joint damage
- Whether a different treatment approach is needed

National Institute for Clinical Excellence (NICE) and American College of Rheumatology (ACR)

NICE (UK) and ACR both agree that goals of RA treatment include controlling joint pain and inflammation; reducing joint damage, disability, and loss of function; and maintaining daily activities or improving quality of life.[1,2]

	NICE	ACR
Nonsteroidal anti-inflammatory drugs (NSAIDs)		• Useful in initial treatment but do not alter the course of the disease[2] • Should not be used as monotherapy[2]
DMARDs	• Early use of DMARDs is recommended[1] • Methotrexate (MTX) is recommended for initial treatment[1]	• The majority of patients should be started on DMARDs within 3 months of diagnosis[2] • MTX or combination therapy preferred[2]
Biologics	• Recommended in patients for whom treatment with at least 2 DMARDs has failed[2] • Identifies considerations when choosing a biologic[1]	• Identifies considerations when choosing a biologic[2]

References: 1. National Institute for Clinical Excellence. Guidance on the use of etanercept and infliximab for the treatment of rheumatoid arthritis. Technology Appraisal Guidance–No. 36. National Institute for Clinical Excellence. March 2002. Available at: http://guidance.nice.org.uk/TA36/guidance. Accessed September 25, 2007. **2.** American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. Guidelines for the management of rheumatoid arthritis: 2002 update. Arthritis Rheum. 2002;2:328-346.

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MAL-ENB-2010-011

Diagnosed with Rheumatoid Arthritis:

10 YEARS LATER

by Cathee McKeown *Friday, November 02, 2007*

When I was first diagnosed with Rheumatoid Arthritis, I really had no idea of the long term effects of this disease. In the beginning, I was overwhelmed with the pain and changes in my body. All I could think about each day was the doctors' visits and the endless amounts of medication. I didn't know anyone else who had RA who I could ask questions. I felt alone and scared. When I read through the message boards on the RA Central website, I feel the frustration of those who have been recently diagnosed. I know the fear of having so many unanswered questions. Now, 10 years into my RA journey, I still have questions but I have a lot more answers!

My RA came on fast and furious. I was a pretty healthy person until this disease came along. RA swept me off my feet and I am still running! Well, let me tell you from experience, it's a race worth running right from the start.

> The sooner you are diagnosed, get educated and start treatment, the better the outcome 10 years down the road. I made a lot of mistakes in the beginning by just taking my doctors advice and not really researching all of my options.

My first and probably hardest lesson learned was the decision to start taking prednisone. I never had a clue what this miracle drug would do to me years later. I was put on such a high dose of prednisone, which did help with my pain, but caused me to gain 50 lbs within months of taking it. I had "moon face", thinning of the skin, bruises, hot flashes and mood swings, just to name a few. Prednisone can actually deplete your bone density when taken long term, which people with arthritis certainly don't need. I developed terrible stretch marks on my legs, thighs and lower back due to weight gain and loss of elasticity due to prednisone. These were side effects that I never knew about until it was too late. The thing with prednisone is that it does help. That is the irony of it all. During my worst flares the only thing that would get me through was prednisone. It was like choosing evil over pain. That's how desperate I would become. There is a definite need to take prednisone when you have rheumatoid arthritis. I just know that had I been informed about the terrible long term side effects of this drug, I would never have taken it so lightly. So for all of you getting ready to ride the prednisone train, please stop and find out everything you can before boarding. The same goes for all recommended medications and treatments.

> Ask questions. Be informed. Since RA is a chronic disease, that means you will be dealing with it in one form or another for the rest of your life.

The best advice I can give to anyone who has been diagnosed with RA is to get your hands on every piece of information you can. Ask your doctors about the long term effects of the arthritis itself as well as the medications you use to treat it. It's a difficult balance to take one day at a time but also be aware of the future damage that can occur. Take it from someone who learned the hard way. You will be much better off preparing for the long term as well as dealing with what happens today.

Article source: http://www.healthcentral.com/rheumatoid-arthritis/c/97/15793/ten

Minggu Kesedaran Artritis Reumatoid Hospital Putrajaya with MyWIRA Gallery from 13th–17th June 2011

MY WIRA Public Forum

... at its photo gallery, Hospital Putrajaya

From June 13 to 17, Hospital Putrajaya was the proud host of the My WIRA Public Forum that was held at its photo gallery on the lobby of the ground floor.

My WIRA (Malaysian Women in Rheumatoid Arthritis) is an awareness project by the Arthritis Foundation Malaysia in partnership with Abbott Laboratories (M) Sdn Bhd aiming at raising the awareness of rheumatoid arthritis (RA) in Malaysia. As RA affects mainly women, My WIRA aims to champion the cause of improving women's health and reduce or prevent the loss of functionality and productivity, maintaining and defending women's independence and celebrate their contributions to society-building.

This campaign proudly showcased a group of women with RA, from all walks of life, highlighting their tremendous inner strengths in the pursuit of their dreams despite the agony of RA.

Daily, the gallery had 150 to 200 visitors while the public forum that was held on 17 June in Bahasa Malaysia at the hospital's auditorium boasted 200 attendees. The topics covered were: "Apakah itu Artritis Reumatoid" (What is Rheumatoid Arthritis) by Dr Liza Binti Mohd Isa, "Rawatan Artritis Reumatoid" (Rheumatoid Arthritis Treatment) by Dr Heselynn Binti Hussein, and an exercise session entitled "People with Arthritis Can Exercise" with Encik Adam Oh Abdullah.

The exercise session conducted by the phsiotherapist

The working crew behind the successful Minggu Kesedaran Artritis Reumatoid

Public checking some of the MyWIRA panels

1 Attendees of the Public Forum listen attentively to the interesting presentation from the expert.
2 Dr Azmillah (Head of Medical Department) sharing some medical tips to the audiences.
3 An excellent way to stay healthy is to exercise the joints.
4 Information counters near the MyWIRA gallery for public to ask further questions
5 MyWIRA panels at the lobby hall.
6 Physiotherapist from Hospital Selayang showing the aerobic moves.

RHEUMATOID ARTHRITIS
AWARENESS WEEK Hospital Selayang

In conjunction with the National Rheumatoid Arthritis Day, from 18-22 July, a photo gallery on Rheumatoid Arthritis (RA) was set-up at the main lobby of Hospital Selayang.
Between 100-150 people a day visited.

Also on hand were nurses and medical staff to offer any information on RA, namely how to determine if RA drugs were genuine, the difference between RA and OA, aids available for RA patients such as splints, pickers, and the rest of it.

On Thursday 21 July, a public forum was held at the Specialist Clinic on level three from 8.00 to 11.30 am. The topics covered were "What is RA?" by Dr Hazlyna Baharuddin, "Treatment for RA" by Cik Nurhafiza, "Arthritis in children" by Dr Lim Sern Chin and "Daily care for joints" by Durratul Husna Mohamat Kasim.

The information provided useful background and awareness-building knowledge of the disease. Most wanted to know if glucosamine would be useful, if there were a cure for RA, or if nerves are affected by RA and – especially -- the difference between RA and OA.

While Dr Hazlyna fielded these questions, Cik Nurhafiza went through the list of most common RA medication and their side effects. She also touched on the proper dosages and administration of these medications, later emphasising the importance of regular blood tests and folic acid.

Dr Lim Sern Chin, on the other hand, explained JIA (Junior Idiopathic Arthritis) that affects patients below the age of 16. She spoke on the symptoms of arthritis in children, the importance of taking swift action so as to avoid, or limit, the deterioration of joints.

As management of RA is crucial to the quality of life and preservation of joint integrity, Durratul Husna Mohamat Kasim emphasised the role of an occupational therapist, then discussed the best ways to manage RA, and how joints can be protected.

To break the monotony, Dr Ahmad Zaidi quizzed the attendees. Prizes were given to those who answered correctly. This certainly livened things up!

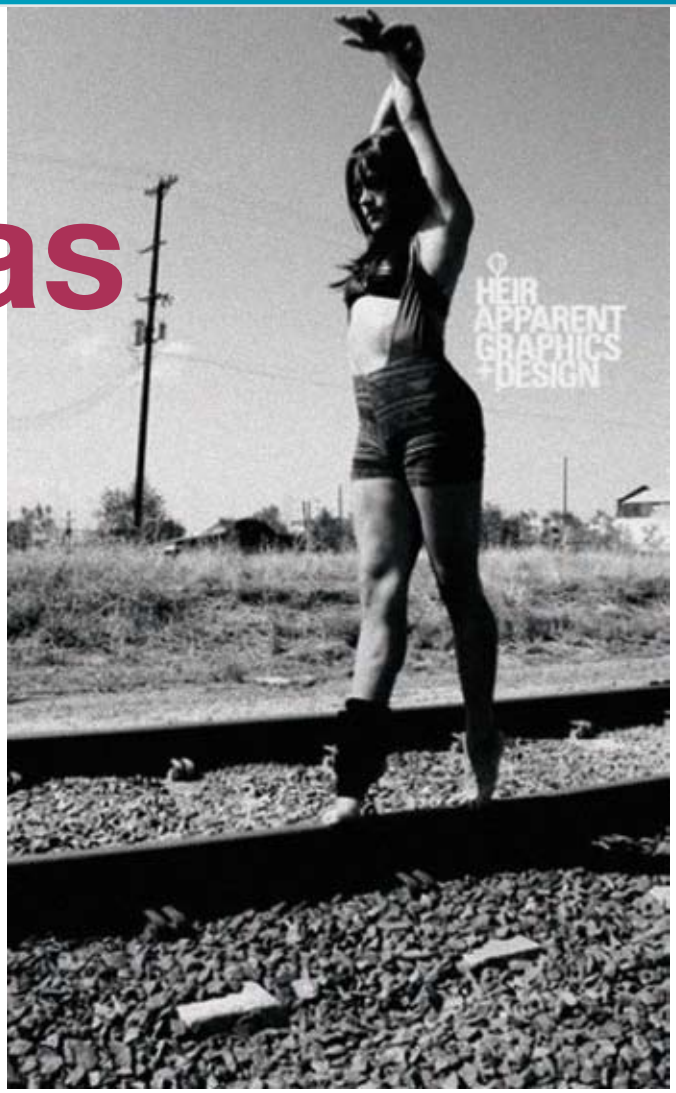
Once everyone was still basking in the glow of exhilaration from the quiz, and therefore more mentally engaged, the physiotherapy unit held an exercise session called "We Can" (Kita Boleh).

Yes, you guess it right: participants had a blast!

A Free Spirit with Juvenile Arthritis

An Interview with Gabi Rojas

by Lene Andersen *Wednesday, July 20, 2011*



Gabi Rojas grew up in the circus, traveling through cities in the US, making friends wherever she went. When her mother changed jobs from being a trapeze artist to a dance instructor in Albuquerque, New Mexico, Gabi went from tumbling to dancing and found her happiness in expressing her thoughts and feelings through movement to music. She became known as The Dancer in school and appeared in talent shows. Until the pain started. Until she was diagnosed with Juvenile Arthritis. Until at 13, she had her first full-blown flare and stopped dancing, stopped walking.

I Wanted to Be Invisible

Gabi's JA started small with pain in her fingers, then it got bigger and added pain in her shoulders, elbows and wrists and at 13, she began to "really understand the nature of my disease" when consumed by a bad flare. "There were times where I couldn't walk, I needed help with brushing my hair and I had trouble sleeping. My mother heated blankets throughout the night to help my joints because they were so stiff." During this time, Gabi tried a lot of different medications that either didn't work or give her bad side effects, like losing her hair.

She considers herself lucky that she went to a school with a disability center that enabled her to get "extra help, like a laptop, help with walking down the hall." She "had to learn to process differently in class, because I couldn't take notes" and there were times where she went to school in a wheelchair. There were also times when she was isolated at home - "being still was terrible for me and I bottled up a lot of feelings."

Becoming someone other than The Dancer changed the social aspect of school. "People distanced themselves from me" and she spent her time at home listening to music. Sade was a particular inspiration because of "the beauty of her voice that had a sadness in it. I cried a lot during that time and was very depressed." Gabi shared a story about creating a chart where she logged the number of times she cried in a day as she tried to cry less.

Gabi describes herself pre-JA as "very physical, with high energy, a free spirit." During her JA flare, she "wanted to be invisible."

Dancing Again

At 16, her mother brought Gabi to a new rheumatologist who prescribed Enbrel "and that was the change." She started the new medication just before going to a marine biology summer camp in San Diego and by the end of the summer, she started feeling strong again. In her junior year, she joined the dance team and by the time she was a senior, she became the dance captain, working on routines after school. She won a dance scholarship to college and after she graduated, **auditioned for So You Think You Can Dance** and got great feedback from the judges. She didn't make it to the final 20, but got a job with the the **Cleo Parker Robinson Dance** company in Denver. Unfortunately, earlier this year she injured her back and had to stop dancing while she heals.

I Want to Give Back

Gabi is still on Enbrel and says she "feel[s] almost fully healthy, although weather changes gives me some aches and pains." She is currently taking some time to heal her injury and is doing a lot of thinking. "I've been ignoring RA to do dance and I want to get healthy, I'm tired of beating up my body."

The time between days 13 and 17 are an important part of developing socially and Gabi feels that there is "a big gap" because she spent those years fighting JA. She describes herself as in some ways feeling older than her contemporaries due to learning to process pain and challenges, but young in other ways. Her illness has had ripples and she still has "a lot of social anxiety, I don't know what to say." To challenge herself, she's purchased a copy of the book **The Art of Mingling** and got a job bartending to get "a bit more socially equipped."

Gabi still feels "a disconnect, a dichotomy like I am part free spirit, part cautious" and wants to get more in touch with the free spirit part of herself. She is considering letting go of dance for a while to go back to school for a degree in physical or occupational therapy because she "wants to give back, be more involved. I've pushed it so much aside to have a 'normal' life and now I want to embrace it all."

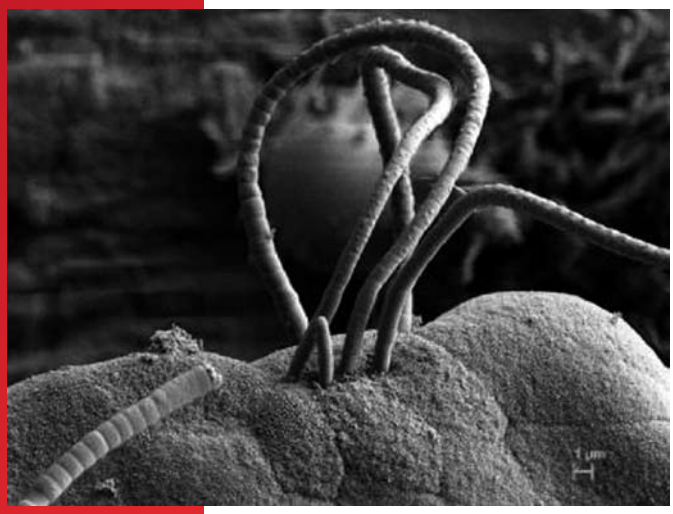
We wish you the best of luck in your journey, Gabi!

Article source : http://www.healthcentral.com/rheumatoid-arthritis/c/80106/141772/free

Learning How Gut Bacteria Influence Health:

Scientists Crack Sparse Genome of Microbe Linked to Autoimmunity

ScienceDaily (Sep. 14, 2011) — Scientists have deciphered the genome of a bacterium implicated as a key player in regulating the immune system of mice. The genomic analysis provides the first glimpse of its unusually sparse genetic blueprint and offers hints about how it may activate a powerful immune response that protects mice from infection but also spurs harmful inflammation.



A little-known bacterial species called segmented filamentous bacterium, or SFB, can activate the production of specialized immune cells in mice. This scanning electron microscope image of an SFB colony shows a mass of long hair-like filaments created when the bacteria stay attached to each other after they divide. (Credit: Ivaylo Ivanov (Columbia University Medical Center), Dan Littman (NYU Langone Medical Center) and Doug Wei (Carl Zeiss SMT, Inc.))

The researchers, led by Dan Littman, the Helen L. and Martin S. Kimmel Professor of Molecular Immunology at NYU School of Medicine and a Howard Hughes Medical Institute Investigator, and Ivaylo Ivanov, PhD, of Columbia University Medical Center, published their findings in the September 15, 2011, issue of Cell Host and Microbe. The study suggests that the gut-dwelling microorganism, named segmented filamentous bacteria (SFB), is genetically distinct from all 1,200 bacterial genomes studied so far, reflecting its relatively unique role in the gut.

Although SFB was first identified more than 40 years ago, it wasn't until 2009 that Dr. Littman and an international team of collaborators discovered that it can recruit specialized T cells, called Th17 cells, in the small intestine of mice. These potent immune cells, they subsequently found, protected the mice from disease-causing Citrobacter rodentium bacteria, but also made them more susceptible to inflammation and autoimmune arthritis. Those initial results suggested other intestinal bacteria might also regulate immune function.

"What has become clear in the last couple of years is that individual bacteria can specifically influence particular branches of the immune system," says Dr. Littman. In the new study, his team deciphered SFB's 1.57 million letters of DNA, almost 2,000 times smaller than our own genome and about one-third the size of its closest relative.

The microbe's sparse genome lacks many genes needed for its own survival, such as ones for making amino acids and other essential nutrients. As a result, it is dependent on other gut-dwelling bacteria or its host for food, according to the study. The examination of its 1,500 genes, however, suggests it is well adapted to the small intestine, where it clings to the thin lining and may help prevent other microbes from breaching the barrier.

Although the study didn't uncover any definitive signs of the SFB living within us, Dr. Littman suspects the resourceful bacteria have adapted to certain human populations. Even if it isn't found in our intestinal tract, scientists could apply what they have learned to obtain insights into the function of similarly acting microorganisms within us.

"Maybe in humans, there is another bacterium that is different from SFB but behaves functionally in the same way," says Dr. Ivanov, who conducted the latest analysis as a postdoctoral researcher in Dr. Littman's lab.

Recently, Japanese researchers found intestinal bacteria in humans that can boost development of regulatory immune cells in mice, thereby keeping the inflammatory activity of Th17 cells in check. Dr. Littman and his NYU collaborators may have also uncovered a microbe in the intestinal tract of rheumatoid arthritis patients that alters immune function. These emerging results underscore the need to understand how the microbes living in our bodies may impact our health.

"This research brings us the potential genetic mechanisms that trigger differentiation of Th17 cells which we have long believed to have a strong role in the development of autoimmune diseases, including rheumatoid arthritis (RA), psoriatic arthritis (PsA), and Crohn's disease," said Steven Abramson, MD, professor, Departments of Medicine and Pathology and director of the Rheumatology Division at NYU Langone Medical Center. "With more than 50 million Americans suffering from at least one autoimmune disease, this research gives scientists and clinicians a greater ability to apply knowledge gained in the laboratory to actual clinical cases, moving it from 'bench-to-beside' to give patients a tremendous advantage and physicians the ability to fine-tune medications and protocols based on patient response."

http://www.sciencedaily.com/releases/2011/09/110914122649.htm

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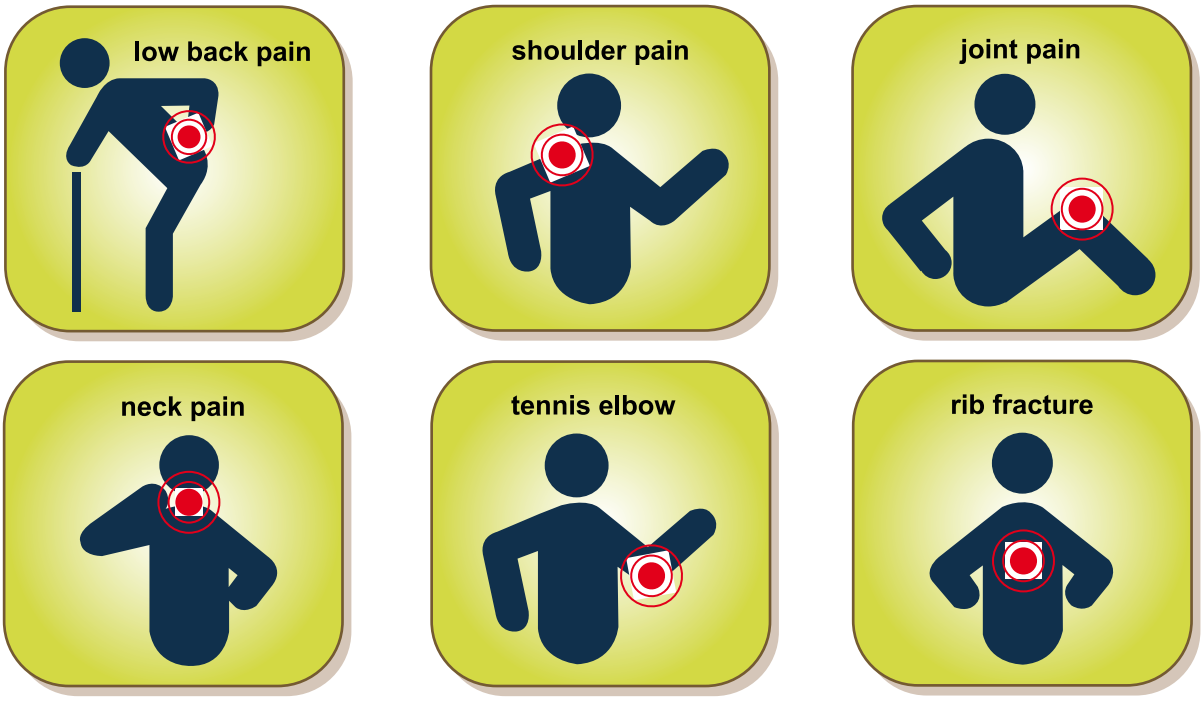

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THE ARTHRITIS FUND

The Arthritis Foundation Malaysia administers the Arthritis Fund, a charitable fund dedicated to the assistance of needy arthritis patients.

Established in 2003 with the specific aim of helping underprivileged arthritis patients with their treatment, the Arthritis Fund has thus far extended help by funding up to 90 % of the cost of joint replacement surgeries for needy patients.

To date, some 60 patients have been helped by the Fund, and most of them had full disbursement of the costs of joint replacement. The demand for funding is ever increasing and AFM is attempting to reach more patients with refinements to the quantum of financial assistance.

Patients with severe arthritis sometimes experience irreparable joint damage. Such patients require total joint replacement, but this is an expensive solution.

Many patients forego surgery and continue to deteriorate and suffer pain because they are unable to afford the implant. The cost of each implant is about RM 7,000 for a knee, and about RM 6,000 for a hip. Implants for younger children cost more.

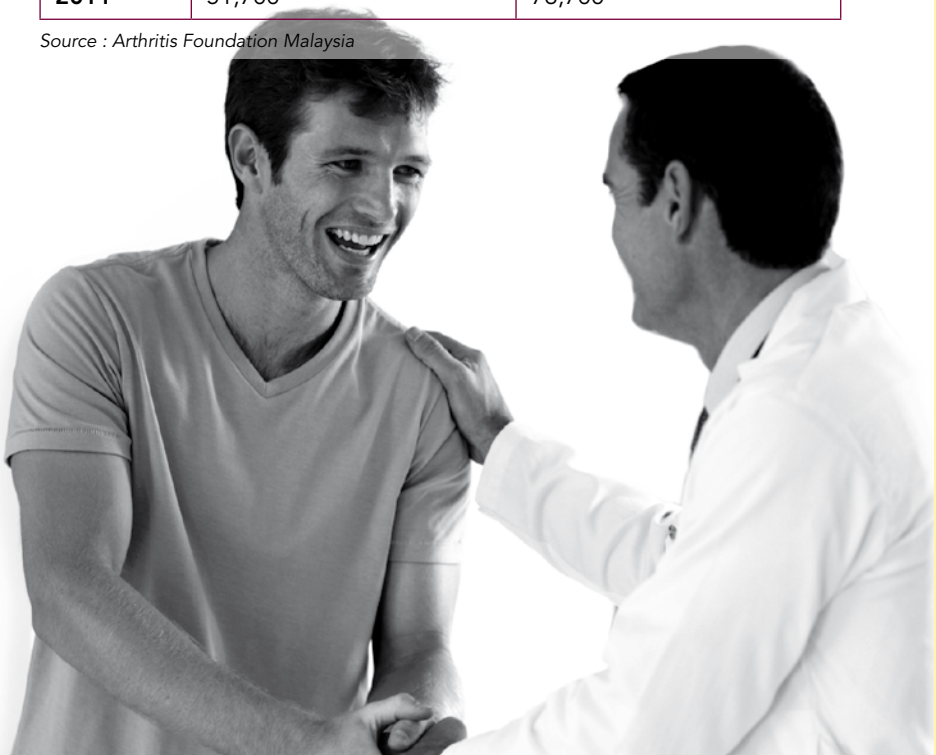
The Fund tries to help as many patients as it can. However, in order to ensure that its' objectives are met, the AFM has been strict in maintaining qualifying criteria for the help it extends.

It is the AFM's hope that benefactors, big and small, will continue to dig deep to contribute to the Arthritis Fund. Not only are all contributions to the Fund tax exempt, but donors would be assured that their donations will be used to improve the lives of patients ravaged by arthritis.

Funds approved and disbursed by the AFM's Arthritis Fund in the last five years

Year	Approvals (RM)	Disbursements (RM)
2007	52,395	56,495
2008	55,700	31,000
2009	29,500	45,650
2010	130,300	80,600
2011	51,700	76,700

Source : Arthritis Foundation Malaysia



WHO IS ELIGIBLE?

- The recipient (patient) must be a Malaysian citizen or permanent resident.
- The recipient's monthly income should not be more than RM3,500.
- The subsidy will cover the cost of the implant and incidentals. The surgery will have to be performed at a government hospital by an experienced Senior Orthopaedic Surgeon.
- No monies will be paid to the patient. Payments will be made directly to the supplier of the implants.
- All applications are reviewed and approved by the 'Arthritis Fund Committee' which consists of seven members. Approval will be based on eligibility and availability of funds. The decision of the Committee is final.

HOW TO APPLY?

- Obtain an Application Form from the AFM Secretariat (address on the cover) or call 03-5621 6177 to have it mailed to you, or download it from the AFM website: **www.afm.org.my.** Application forms are also available from the **UNIT KEBAJIKAN PERUBATAN** at the Government Hospitals.
- Complete the Application Form and give it to your attending medical team, who will provide details of your condition and your requirements. Every application requires references from 2 doctors.
- The social welfare worker will then evaluate your eligibility for sponsorship.
- The completed Application Form is sent to AFM, where it will be reviewed by the Arthritis Fund Committee.
- The Committee will revert within 2 months on whether or not your application has been approved.

FIND A RHEUMATOLOGIST

The following is a list of hospitals which offer Rheumatology services:

Wilayah Persekutuan
- Ampang Putri Medical Centre, Kuala Lumpur
- Gleneagles Intan Medical Centre, Kuala Lumpur
- Hospital Kuala Lumpur, Kuala Lumpur*
- Hospital Pusrawi, Kuala Lumpur
- Hospital Putrajaya, Putrajaya*
- Hospital Universiti Kebangsaan Malaysia, Kuala Lumpur*
- Al-Islam Specialist Hospital, Kuala Lumpur
- Pantai Hospital, Kuala Lumpur
- Prince Court Medical Centre, Kuala Lumpur
- Pusat Pakar Tawakkal, Kuala Lumpur
- Pusat Perubatan Universiti Malaya, Kuala Lumpur**

Selangor
- Hospital Selayang, Batu Caves*
- Hospital Serdang, Serdang*
- Sime Darby Medical Centre, Subang Jaya, Petaling Jaya
- Damansara Specialist centre, Petaling Jaya
- Sunway Medical Centre, Petaling Jaya
- Hospital Tengku Ampuan Rahimah, Klang*

Pulau Pinang
- Hospital Pulau Pinang, Pulau Pinang*
- KPJ Penang Specialist Hospital, Bandar Perda, Seberang Prai

Melaka
- Hospital Melaka*

Johor
- Hospital Sultan Ismail, Pandan, Johor Bahru*
- Columbia Asia Hospital, Nusajaya, Johor.

Kedah
- Hospital Sultanah Bahiyah, Alor Setar*

Negeri Sembilan
- Hospital Tuanku Jaafar, Seremban*

Perak
- Hospital Raja Permaisuri Bainun, Ipoh*
- Hospital Pantai Putri, Ipoh

Kelantan
- Hospital Raja Perempuan ZainabII, Kota Bahru*

Terengganu
- Hospital Sultanah Nur Zahirah, Kuala Terengganu

Sabah
- Hospital Queen Elizabeth, Kota Kinabalu*

Sarawak
- Hospital Kuching, Kuching*

** Government or University Hospital - Patients wishing to see a rheumatologist at a government or university hospital require a referral letter from their general practitioner or another doctor.*

*** The hospital also has a private wing, University Malaya Specialist Centre*

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KEEPING CURRENT

AFM constantly updates its registry and routinely delists members whose subscriptions are persistently in arrears. The only notice of this to members will be when they fail to receive their copies of *Joint Efforts*. Please remember to check your subscription status and keep it current. Do note that Lifetime memberships, at a one-off payment of RM200, would eliminate the need to keep tabs on your subscription status, and would ensure uninterrupted receipt of *Joint Efforts*.

For further clarification, please call Ms. Yoges at +603 56216177 (Mon to Fri, 8.30 to 16.30 hrs).

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Signature of applicant Date

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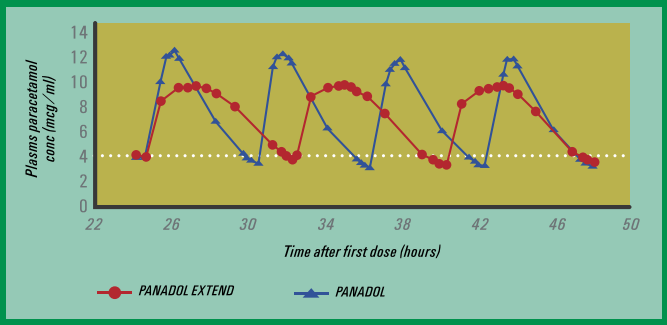

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References **1.** Jordan, K.M., Arden, N.K., Doherty. M, *et al*, EULAR recommendations 2003. An Evidence based approach to the management of Osteoarthritis: Report of a task force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCSIT). Ann Rheum Dis 2000; 59: 936-944. **2.** Clinical Practice Guidelines on the Management of osteoarthritis 2002. Ministry of Health Malaysia, Malaysia Society of Rheumatology and Academy of Medicine of Malaysia. **3.** Altman RD, Hochberg MC, Roland WM, Schnitzer TJ. Recommendations for the medical management of osteoarthritis of the hip and knee. Arthritis Rheum 2000; 43:1905-1915. **4.** GSK data on file: Panadol Extend Monograph. **5.** M Yelland, Single patient trials comparing NSAIDs with paracetamol for osteoarthritis and chronic pain. Discipline of General Practice, The University of Queensland. **6.** Singh G., Gastrointestinal Complications of Prescription and Over-The-Counter Nonsteroidal Anti-Inflammatory Drugs: A View from ARAMIS Database. American Journal of Therapeutics 2000; 7:55-61. **7.** Whelton A., Renal and Related Cardiovascular Effects of Conventional and COX-2 Specific NSAIDs Analgesics. American Journal of Therapeutics 2000; 7:63-74. **8.** Jenkins C., Recommending Analgesics for People with Asthma. American Journal of Therapeutics 2000; 7:55-61. **9.** Henrich W.L., *et al*. National Kidney Foundation Position Paper. Analgesics and the Kidney: Summary and Recommendations to the Scientific Advisory Board of the National Kidney Foundation from an AD Hoc Committee of the National Kidney Foundation. American Journal of Kidney Diseases 1996; 27:162-165.

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