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EDITORIAL

We play an important role in promoting good oral and dental health. I happened to attend a session on dentistry and felt that I should share the carry home messages with you. Daily morning and night brushing of teeth is a habit which has to be inculcated right from early childhood. Brushing teeth properly (rotatory movements of the brush over gums and teeth) removes plaque and food particles which get lodged in the crevices of the teeth. Use of mouth wash in the morning (to freshen the mouth and for the antibacterial action) and use of dental floss at night is recommended. Dental floss (a piece of braided nylon cord) is wrapped around the middle fingers and then gently eased between the teeth with the aid of the forefinger and the thumb to remove plaque and food particles. Tooth brushes should be changed every three months. Regular preventive visits to the dentist should be encouraged. The family physician after treating the acute symptoms of pain, swelling etc. should refer the patient for evaluation and curative treatment to the dental surgeon. Patient education about the deleterious effects of oral and inhaled tobacco cannot be over emphasized.

INCHES Health Foundation is gladdened by overwhelming response to 16th. January programme on 'Hypertension - Target organ damage' held in association with Dadar Medicos Brotherhood at Hotel Avon Ruby. We are sorry that we had to refuse registration to many delegates because of space constraints. The programme featured Dr. Atul Ingle (renal aspects), Dr. V.K.Shah (cardiovascular effects) and Dr. Ramesh Patankar (cerebrovascular complications).

Dr Ramesh Subramanian
Editor

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Diagnosis & Management of RA

Terminology

- *Early RA*
 - RA of less than 2-3 years duration
- *Very early RA*
 - RA of less than 3 months duration

Early RA:

Importance

- *Morbidity*
 - Some difficulty of activities of daily life - 50 % by 2 years
 - Some work disability - 60 % by 3 years
 - Some joint damage - 70 % by 2 years
- *Mortality*
 - Median life expectancy shortened by 7 yrs in males and 3 yrs in females

Diagnosis

- Persistent (~ 6 weeks) polyarthritis of small & large joints
- Absence of clinical / investigational features to suggest a diagnosis of other connective tissue disease or spondylarthropathy
- Rheumatoid factor / erosions may or may not be present early on in the disease

Investigations

- CBC / ESR
- SGPT / S. creatinine
- X rays hands and feet
- X rays of other joints
- X ray chest PA view
- Rheumatoid Factor
- Other tests only if indicated

Treatment:

- Patient education
- Disease control and not cure
- Drugs to control pain and drugs to modify disease
- DMARDS work slowly!
- First few years of the disease are vital
- Side-effect of the uncontrolled disease is worse than those of the drugs

Relief from pain and inflammation

- NSAIDS
 - Full dose NSAIDS
 - Any NSAID with efficacy & tolerability
 - Taper NSAIDS once DMARDS start acting
- Specific situations

- Long acting NSAIDS at night for early morning stiffness
- Cox 2 NSAIDS if dyspepsia
- Short acting NSAIDS during pregnancy / lactation
- Analgesics & spasm relievers
 - Paracetamol - 6-8 tabs per day
 - Dextropropoxephene, tizanidine, tramadol
- COX-2 Inhibitors
 - As efficacious as other NSAIDS
 - GI side effects as much as placebo. Care to be taken in patients with pre-existing acid peptic disease
 - Does not affect platelet function
 - Renal side effects as much as other NSAIDS
 - CARDIOVASCULAR side-effects detected with Rofecoxib
 - ? Class effect

Role of steroids

The facts

- 40-60 % of RA patients are on a small dose of steroids!
- Patients on steroids (side-effects apart) seem to do well inspite of long disease duration
- Steroids: Modes of use
 - Small to moderate dose taper
 - 15mg taper
 - Intramuscular methylprednisolone
 - 80 to 120 mg 1-3 injection 4-6 weeks apart
 - Intravenous prednisolone
 - 3 IV methylprednisolone pulses
 - Intra-articular steroids

DMARDS

- Chloroquine (CHQ)
- Hydroxychloroquine (HCQ)
- Methotrexate (MTX)
- Sulphasalazine (SZP/Sazo)
- Leflunomide (LEF)
- TNF blockers

Choice of Therapy

A. Patient factors

- Disease activity / severity
- Co-morbid conditions
- Patient preference

B. Drug factors

- Efficacy
- Safety
- Cost
- Ease of administration

Therapy Details

- Majority would be on MTX (7.5mg/week) and chloroquine / HCQ
- MTX could be increased by 2.5 mg every 4-6 weeks depending on response

- After reaching 15mg/wk some may need to be switched to injectable MTX and increased dosage (17.5mg-20mg/week)
- After 3 months of optimal therapy if the disease is active then one could switch to or add other DMARDS (LEF vs. Sazo)

Drug combinations

- RA is locally invasive cancer!
- 3 Recent studies have shown better efficacy of combination DMARDS over single DMARD
- In the short term, combinations have not been more toxic than single DMARD.
- Combinations used
 - MTX+CHQ
 - SZP+CHQ
 - MTX+SZP+CHQ
 - MTX+Leflunomide
 - MTX+biologic agents
 - Low dose steroids with any of above combinations
- Drug toxicity
 - *Chloroquine*
 - Serious – maculopathy
 - Mild- skin, gastrointestinal
 - *Methotrexate*
 - Serious- bone marrow suppression, hepatotoxicity, pulmonary fibrosis
 - Mild - gastrointestinal
 - *Sulphasalazine*
 - Bone marrow suppression, hypo/azoospermia, photosensitivity
 - *Leflunomide*
 - Gastrointestinal, hepatotoxicity

Disease activity measures

- Joint swelling
- Early morning stiffness
- Appetite & weight
- Low Hb, high platelets and raised ESR
- Progression in joint damage

Anti TNF therapy:

- Infliximab
 - Both circulating & bound TNF molecules
 - Useful in RA
 - Very useful in spondyloarthopathy with / without complications
 - ? More infections
 - Method of administration
 - IV infusion.
 - 0, 2, 6 weeks, followed by every 4-8 weeks
- Etanercept
 - Only circulating
 - Useful in RA
 - Less useful in spondyloarthopathy without complications
 - Less infections

Adverse effects/safety

- Infections: TB outbreak in the U.S
- Aplastic anaemia
- Demyelinating CNS diseases
- ANA positivity
- Rarely drug induced lupus

Guidelines for starting Anti TNF therapy

- Patients must have failed at least 2 DMARDS including MTX (20-25mg/wk).
- Must have active disease. DAS scores more than a particular level.
- No major infections in the preceding 6 months.
- No malignancies in the preceding 12 months.
- Non pregnant, non breast feeding women.
- Infliximab added to methotrexate.
- Choice between infliximab and etanercept usually depends on age of the patient, ability to administer subcutaneous injection, hand dexterity etc.
- Follow-up these patients for 3 years

Cost

- Etanercept
 - 6 months treatment: Rs. 2.4 lakhs
- Infliximab
 - 6 months treatment: Rs. 3.6 lakhs

Anti-TNF therapy: summary

- At the present for resistant cases
- Only injectable form
- Efficacy very good
- Safety reasonable
- Cost exorbitant
- Ongoing studies for early RA. Long term data needed

Early aggressive treatment of RA- : Problems

- Early arthritis sometimes may not evolve into persistent RA: Over-treatment
- Is aggressive therapy essential for mild disease?

Summary

- Early aggressive therapy best option
- Developments in markers which predict aggressive disease
- Combination DMARDS
- Etanercept / infliximab at the moment reserved for progressive resistant disease
- Rehabilitation a joint effort. Should be thought of from Day 1

(Based on a lecture by Dr C Balakrishnan, Consultant Rheumatologist, PD Hinduja Hospital, on Sunday, 28th November 2004 at INCHEs Update 2004)

Know the drug

VAXIGRIP

It is a sterile suspension of influenza viruses for active immunization against influenza.

Indications:

Recommended for persons at high risk for influenza-related complications viz

- Adults and children with chronic cardiac or pulmonary disorder or chronic conditions like diabetes, cancer, immunodeficiency or immunosuppression, renal disease and anemia.
- Children aged 6-23 months or persons above 65 years
- Pregnant woman in high risk group
- Residents of nursing homes and other chronic care conditions.
- High risk group embarking on travel to destinations of high influenza occurrence

Contraindications:

- history of hypersensitivity to egg or egg proteins, thiomersal or neomycin
- Allergic reaction to a previous dose of influenza vaccine.
- Infants under 6 months of age.

Warnings:

- Given with care in persons with coagulation disorder or on anticoagulant therapy.
- Not to be injected in buttock region
- Immunocompromised person may not get an expected response.
- Delayed in patient with an active neurological disorder.
- Given to pregnant woman only if she falls into a high risk group.

Adverse Reaction:

- Local: soreness at vaccination site - local redness, swelling induration and bruising.
- Systemic: fever, myalgia, arthralgia, lymphadenopathy, headache etc.
- Rarely allergic reactions like hives, angioedema, allergic asthma, and anaphylaxis.
- Guillian Barre Syndrome associated with this vaccination – rarely
- Route of Administration:
- Given intramuscularly into the deltoid muscle.
- In infants, given to anterolateral aspect of the mid thigh.

- Recommended dose

Age group	Dose	No. of doses
6-35 months	0.25 ml	1 or 2
3-8 years	0.5 ml	1 or 2
> 9 years	0.5 ml	1

Children below 9 years require 2 doses 4 months apart unless vaccinated 1 year back.

Ref.: product monograph

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Medinews

Surgical treatment of migraines reduces sick days and increases employee productivity ASPS study

[Migraine](#) sufferers who had surgical treatment reduced the amount of time missed from work by 73 percent, according to a study published in the January issue of Plastic and Reconstructive Surgery. Additionally, surgical treatment substantially lowered the annual cost of [migraine](#) care for patients, the study found.

According to Dr. Bahman Guyuron, MD, clinical professor of plastic surgery, Case Western Reserve University, Cleveland, by identifying the trigger areas for migraines and performing targeted surgical procedures, migraine headaches were significantly reduced or eliminated and hence the amount of time missed from work was reduced.

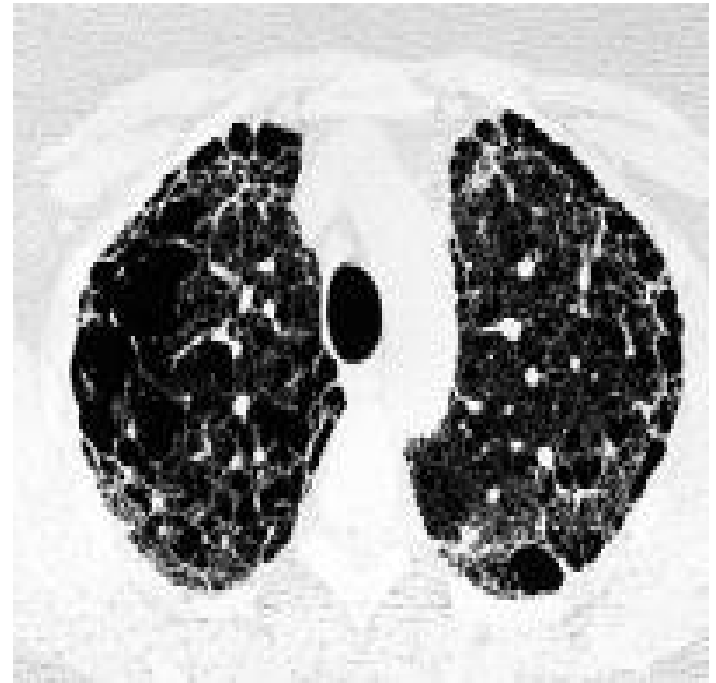
Patients in the study were injected with Botox to help determine which muscles in the forehead, or back of the head, triggered their migraines. Once identified, these muscles were then surgically removed.

Prior to surgery, migraine sufferers missed 4.4 days of work per month, according to the study. After surgery, patients only missed 1.2 days per month and the employee out of pocket expense for annual treatment was reduced from approximately \$7,612 to \$925.

Plastic surgeons successfully reduced the frequency, intensity or duration of migraines for 92 percent of the patients studied. In fact, the surgical treatment eliminated [migraine](#) headaches for 35 percent of the patients studied.

medical news today .com,30/12/04

Quiz Mania 39 Investigation? Diagnosis?



Reply before February 20th. 2005 to
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Answer to Quiz Mania 38
Anteroseptal acute myocardial infarction