

PSORIATIC ARTHRITIS NEWS AND VIEWS

VOLUME- 4 ISSUE- 08 April 30, 2004

PSORIATIC ARTHRITIS MEDICAL NEWS

ARTHRITIS DRUG CLEARS FIRST HURDLE

March 2004 Reuters - London, and submitted by our PA friend, Michael Szczygiel

Celltech's biggest new drug hope, CDP 870 for rheumatoid arthritis, has cleared the first of its final stage clinical hurdles, Britain's biggest biotechnology firm said today, boosting its shares. Celltech, which believes CDP 870 has the potential to be a \$1-billion-a-year seller, also said it was on course to sign a lucrative partnership deal on the medicine by the end of June. 'It's good news and shows they've got a viable drug,' said Frances Cloud, an industry analyst at Nomura. 'But we need to see more details before we can judge how successful it's going to be in what is a very competitive market place.' Celltech, one of Europe's few profitable biotechnology firms, said the first Phase III trial for CDP 870 met its goal as assessed by the number of patients achieving a 20 per cent reduction in the American College of Rheumatology score at 24 weeks. Side effects were consistent with previous studies.

It also said a 'significant' response was seen after only one week of treatment, which some analysts thought could give Celltech an edge as it looks to take on established treatments for rheumatoid arthritis such as Johnson & Johnson's Remicade, Amgen's Enbrel and Abbott's Humira. 'The positive results from this Phase III clinical trial with CDP 870 in rheumatoid arthritis underpin Celltech's confidence that this drug has a very promising future,' chief executive Goran Ando said in a statement. However, Samir Devani, an analyst at Code Securities, was disappointed the firm did not release the actual scores achieved against the American College of Rheumatology benchmark. 'We believe this adds an element of uncertainty as to the competitive profile (of CDP 870),' he said, though he added that any fears would be eased by the signing of a partnership deal. Celltech said it would present detailed results at an undisclosed scientific meeting in the future.

Celltech believes a new partnership deal for CDP 870 will be better than a previous agreement with Pfizer Inc, which was one of the most lucrative ever for a European biotech firm. The deal with Pfizer broke down last year when the US drugs giant tried unsuccessfully to renegotiate terms. Analysts think Biogen Idec, GlaxoSmithKline, Aventis and Serono are all potential partners to help Celltech market CDP870. Celltech, which sells a portfolio of largely acquired medicines to fund its biotech research, also plans to launch CDP 870 as a treatment for Crohn's disease, a bowel disorder, using its own sales force.

Analysts think CDP 870 could reach the market as a treatment for Crohn's in 2006 and for rheumatoid arthritis a year later. Celltech said it would complete a second Phase III study on CDP 870 in rheumatoid arthritis in the third quarter of this year, and start final tests on the drug during the second half.-Reuters

PSORIASIS TREATMENT STRATEGIES

There are a variety of treatments that can be used alone or in combination to manage psoriasis, including topical treatments, phototherapy, and oral and injected medications.

Deciding on a treatment approach is something that you'll do with your doctor, and your decision will be based on a number of things: the severity of your psoriasis, any treatments that you've used before, whether you have other medical conditions, and finally, your own opinion about what treatment sounds best.

Doctors have traditionally used a "1-2-3" approach to treating psoriasis, starting with topical creams and ointments and moving on to phototherapy and systemic or biologic medications. However, this incremental approach is only a rule of thumb and your doctor may suggest a different strategy in your case. Here's a brief outline of the major approaches to treatment.

Topical treatments: Using topical treatments, such as creams and ointments, is the basic first step in treating psoriasis. The most commonly used medicines are steroid creams and ointments. Others include Dovonex, retinoids such as Tazorac and more traditional remedies such as coal tar. For psoriasis that covers more than 10% to 20% of the skin, topical treatment usually won't work, at least not on its own.

Phototherapy. Psoriasis responds to ultraviolet (UV) rays, and regular exposure to the sun or artificial ultraviolet lights can cause the symptoms to subside. Approaches include UVB (exposure to ultraviolet B light) and PUVA (exposure to ultraviolet rays combined with the drug psoralen, which increases the light sensitivity of the skin). Newer techniques include lasers, which can focus

the beneficial effects of light specifically on psoriatic lesions.

Systemic treatments. For psoriasis that doesn't respond to other treatments, oral medications such as methotrexate (Rheumatrex and Amethopterin) and cyclosporine (Neoral or Sandimmune) may be useful. However, many of these drugs have potentially severe side effects and you'll need to be monitored closely when using them.

Treatments with new medications. Recent discoveries about the causes of psoriasis have led to some new approaches to treatment. There's a great deal of excitement about biologic treatments for psoriasis, which specifically target the immunological response that causes the symptoms of psoriasis. Early evidence indicates that these new drugs have significantly fewer side effects than traditional systemic therapy. So far one of these drugs, Amevive, has been approved to treat moderate to severe psoriasis. Other biologic drugs under study

to
treat psoriasis include Enbrel, Remicade, Humira, and Raptiva.
What about Alternative Medicine?

If you've looked around a bookstore or searched for psoriasis on the Internet, you may have already discovered some of the hundreds of alternative methods for treating the condition. Almost every herb, pill, or therapy has some supporters -- you'll find people who swear by vitamins, enemas, acupuncture, and shark cartilage or emu oil. Believe it or not, there are even special spas in Turkey where people with psoriasis go to relax in a hot pool, breathe in the steam, and have the psoriatic plaques eaten off of their body by hungry, little fish.

You may be tempted to try a treatment that's out of the ordinary, especially if conventional medicine doesn't seem to be helping much. Just be cautious and remember that no alternative approach has ever been proven helpful in treating your condition. Some alternative approaches may not be safe.

In general, you should check with your doctor before trying anything. Even some of the herbal supplements and over-the-counter treatments that you can get at the drug store are risky, especially when taken in combination with other treatments. One popular over-the-counter medication for psoriasis, Derma-Cap, was withdrawn from the U.S. market a few years ago when it was discovered to illicitly contain a powerful steroid. Always be suspicious of miracle cures, and

never assume that an alternative approach is necessary harmless.

Coping With Treatment

Treating psoriasis can be complicated. For instance, you have to strike a balance between the amount your symptoms bother you and the difficulties imposed by treating them. While one medication may cause the fewest side effects, you may notice another one works better.

Treatment takes commitment. It's important that you ask yourself what you're honestly willing to do. You may want to please your doctor when you're in the office by agreeing to whatever treatment he or she suggests. However, don't agree to phototherapy sessions three times a week if you know that, realistically, you'll have to cancel half of them. Don't say that you'll take a medication twice a day if you're the sort of person who will forget most of the time. Don't agree to use coal tar in your hair each night if you know that you just can't take the mess.

Psoriasis is not the sort of condition where you can let your doctor make your choices for you. Only you know how far you're willing to go for treatment, so you have to be involved in making the decision.

One of the terribly frustrating things about psoriasis is that effective treatments may not stay effective. Just when you finally feel like you've found a cream or medication that keeps your psoriasis under control, you may have another flare-up. It can be discouraging, and you may be tempted to give up.

Nevertheless, you shouldn't give up. There are other treatments and combinations of treatments that you can use. It's important to keep trying.

"A lot of people who need treatment for psoriasis aren't getting it," says Bruce E. Strober, MD, PhD, co-director of the Psoriasis and Psoriatic Arthritis Center at New York University. "They may have lost faith in treatments for the condition. But we have a lot of good medications that they don't know about."

Reviewed by Charlotte E. Grayson, MD. SOURCES: Bruce E. Strober, MD, PhD, Associate Director of Dermatopharmacology, Department of Dermatology, New York University School of Medicine; Co-Director of the Psoriasis and Psoriatic Arthritis Center; consultant for Amgen, Biogen, Genentech, Fujisawa, and 3-M. Jeffrey M. Weinberg, MD, Director of the Clinical Research Center, St. Luke's-Roosevelt Hospital Center, New York City; Assistant Clinical Professor of

Dermatology, Columbia University College of Physicians and Surgeons; consultant for Amgen and Genentech. National Institute of Arthritis and Musculoskeletal Skin Diseases web site. American Academy of Dermatology web site. WebMD Medical Reference with Healthwise: "Psoriasis." American Academy of Dermatology, PsoriasisNet web site. National Psoriasis Foundation web site. WebMD Medical News: "Psoriasis Treatments Entering New Era." WebMD Medical News: "New Psoriasis Treatment Offers Hope." WebMD Medical News: "New Psoriasis Drug Available." Medscape Medical News: "Studies Pile Up for Efficacy of Biologics." © 2003 WebMD Inc. All

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TOPICAL TREATMENTS FOR PSORIASIS

For most people with mild psoriasis, therapy begins with topical treatments - medicines in creams or ointments that are applied to the skin and scalp. There are a number of different approaches possible, and it may take some time to find the one that works best for you.

Here are some of the most common topical treatments:

• Corticosteroids, or steroids such as cortisone, are most frequently prescribed to treat mild to moderate psoriasis. These creams mimic some of the properties of naturally occurring hormones. They work by reducing inflammation and

slowing the growth and build-up of skin cells. They come in all sorts of forms: creams, ointments, lotions, and foam, among others.

Cortisone comes in different strengths designed for use on different parts of the body. While stronger potency steroids might be necessary for tough to treat patches of psoriasis on the elbows or knees, weaker formulas are good for more sensitive skin on the face or groin. Directions for use vary depending on the particular medication, although you will probably have to apply it once or twice a day. Your doctor may recommend that you try occlusion, which means applying the steroid cream and then wrapping the area with tape or plastic to increase the effect.

Steroids can cause side effects, such as thinning of the skin, changes in the skin color, bruising, and dilated blood vessels. If you stop using steroids suddenly -- without gradually reducing the dose -- you may have a flare-up of

psoriasis. If steroids are used on too much of the body, it's possible to develop more serious health problems. Women who are pregnant or nursing shouldn't use steroids.

Although steroids may work very well at first, your psoriasis may become resistant to them over time. Your doctor will probably recommend them only for short-term use. In some cases, steroids may be injected instead of applied to the surface of the skin.

☞ Dovonex (calcipotriene) is a form of Vitamin D that is sold as a cream or ointment. It treats psoriasis by slowing down the growth of your skin, and it's safer than steroids for long-term use. Because Dovonex can irritate the skin, it should only be used in small amounts. Be careful not to get it on the healthy skin surrounding the psoriatic plaques. Your doctor will probably tell you to apply it once or twice a day. Dovonex is toxic if ingested, so keep it away from pets and children.

☞ Tazorac (tazarotene) and other retinoids are gels or creams derived from vitamin A. Retinoids come in different strengths to treat different types of psoriasis in different locations, including the scalp and nails. Usually, you would apply a small dab to each lesion once a day, typically before bed. Tazorac

is often combined with steroid treatment. Women who are pregnant or who might become pregnant should only use topical retinoids under close medical supervision, if at all.

☞ Anthralin (Drithocrema, Micanol, and others) is an effective medication for psoriasis that has been used for over a hundred years. It was originally derived from the bark of the araroba tree. Anthralin works by affecting the growth

of skin cells in patches of psoriasis. It also reduces inflammation. The advantages of anthralin are that it works well, especially on hard to treat plaques, and causes no serious side effects. The disadvantages are that it can irritate the skin and stains everything, including clothing, sheets, and even skin.

☞ Coal tar has been a topical treatment for the symptoms of psoriasis for centuries. It's sold in many different forms, both with and without prescription, with strengths ranging from 0.5% to 5%. Tar shampoos are often helpful in treating psoriasis of the scalp. Other forms of coal tar can be applied to the skin. Coal tar has a reputation for being messy and smelly, which is unfortunately deserved. It can also stain clothing and irritate the skin.

However, coal tar products that are on the market now are much easier to use than they once were. Follow the directions carefully. Some studies have shown that the chemicals in coal tar are cancerous, but this is only true at very high doses.

It's safe to use coal tar when you follow your doctor's instructions.

☞ Salicylic acid is used to remove the scales that develop on patches of psoriasis. It's sold in lotions, gels, soaps and shampoos. Salicylic acid is especially useful in combination with other topical treatments. By removing the flakes of dead skin, salicylic acid allows these other medications to better penetrate the lesions. However, use salicylic acid sparingly; putting too much on

your body at once can cause toxicity.

☞ Moisturizers and lotions sold over the counter can keep your skin moist and help control flare-ups in mild cases of psoriasis. In general, the greasier

lotions that trap moisture in your skin are more effective.

Limitations of Topical Psoriasis Treatments

Treating psoriasis with topical ointments and creams is an imprecise science. You may find that an approach works for a while, then stops working. Another cream that you tried before without success may suddenly become effective. Because many of these topical treatments can irritate your skin and may become less effective over time, your doctor may suggest that you cycle through different types of creams. Topical treatments are also frequently used in combination with each other and with phototherapy or oral medications. While occlusion -- applying a topical treatment and then wrapping the area in tape or plastic wrap -- is appropriate for some medicines in some cases, it should not be used with others. Check with your doctor.

Using topical treatments can sometimes be difficult. Coal tar doesn't smell good, many of the creams and ointments can be greasy, and quite a few can stain clothing or skin. Scalp treatments may require that you sleep in a shower cap. Make sure that you understand the directions for taking your medication and

their potential side effects before you start using them.

If you don't like a treatment -- because it causes side effects or because you find using it difficult -- be sure to talk to your doctor about a substitution. If you don't use your medication regularly, your psoriasis may get worse.

Reviewed by Charlotte E. Grayson, MD. SOURCES: Bruce E. Strober, MD, PhD. Associate Director of Dermatopharmacology, Department of Dermatology, New York University School of Medicine;

SYSTEMIC TREATMENT FOR PSORIASIS

Systemic treatment -- treatment that affects the body's whole system -- is an approach that's typically used only in severe cases of psoriasis. This means psoriasis that hasn't been helped by other therapies or that covers more than 20% of the body. While systemic treatment, usually an oral medication, can help clear your psoriasis, many of the drugs can cause serious side effects. Your doctor will probably want to monitor you closely.

Here are some of the most common systemic treatments for psoriasis:

Methotrexate (Rheumatrex and Amethopterin). Taken either orally or by injection, methotrexate suppresses your immune system, which in turn reduces the effects of psoriasis. Usually, you would take it once a week and see results after four to six weeks.

Methotrexate can have serious side effects. In the short term, you might experience nausea, fatigue or insomnia. In the long-term, methotrexate can cause

damage to the liver and blood cells. Make sure to tell your doctor about any other medical conditions you have, since methotrexate is not appropriate for people with diseases such as anemia, liver disease, or other ailments. You should

also cut out alcohol, since even one glass a day in combination with methotrexate may be enough to cause liver problems. Women who are pregnant or considering becoming pregnant should not take the drug. Their male partners

should

also avoid this drug. While taking methotrexate, your doctor will do regular blood testing to monitor your blood cells and liver function.

Cyclosporine (Neoral or Sandimmune). Another drug designed to suppress the immune system, cyclosporine, is typically used in only severe cases of psoriasis

where nothing else seems to work. It comes as an oral medication or a liquid. While it can be effective at clearing psoriasis, its benefits typically last only for as long as you're using it. Cyclosporine also carries risks. It can cause kidney problems, high blood pressure and high cholesterol and it shouldn't be used with people who have weak immune systems or women who are pregnant or breast-feeding. People receiving PUVA therapy (a form of phototherapy) should also not use cyclosporine. Because of its toxicity, experts recommend that you not take the drug for more than a year at a time.

Retinoids. These drugs are derived from Vitamin A and they work by affecting the way that skin cells grow and are shed. Retinoids are sold as different brand names, including Soriatane and Accutane, and their effects vary somewhat. Soriatane can cause serious birth defects. Women who use this drug should not be pregnant or plan to become pregnant within three years after finishing treatment. Accutane shouldn't be taken by people who drink alcohol. It can also cause birth defects, so women should not use it if they are or are planning to become pregnant.

Hydrea (hydroxyurea). A medication designed to treat cancer, Hydrea has fewer side effects than some of the more potent systemic medications. However, it is also less effective. It does have some side effects of its own, such as problems in the bone marrow and an increased risk of skin cancer. Hydrea shouldn't be used by women who are pregnant or might become pregnant.

Other drugs. A number of other drugs used for cancer, preventing transplant rejection and other conditions -- such as Tabloid (thioguanine), Azulfidine, Prograf, and CellCept -- are also used for treating psoriasis in some cases.

Reviewed by Charlotte E. Grayson, MD. SOURCES: Bruce E. Strober, MD, PhD, Associate Director of Dermatopharmacology, Department of Dermatology, New York University School of Medicine

THE ACHES AND PAINS OF WEATHER

There's no evidence linking back pain to humidity and barometric pressure, but there are theories

(HealthDayNews) -- For centuries, people with back pain have complained that their symptoms worsen with changes in humidity and barometric pressure.

Despite that long history, however, experts with the American Academy of Orthopaedic Surgeons (AAOS) say there's simply no hard evidence showing how such weather affects back pain.

Still, doctors say reports of back pain and other types of arthritic pain

getting worse when there are swings in barometric pressure continue to come in and there are various theories as to why.

One theory is that changes in barometric pressure could somehow affect the fluid that surrounds and lubricates joints, says Dr. Edward Hanley, chairman of the orthopedic surgery department at Carolinas Medical Center in Charlotte, N.C.

However, because such changes in barometric pressure typically don't have other significant effects on the body, it's hard to determine why or how they'd impact the joints.

"The changes in the atmospheric barometric pressure are so subtle that it's very difficult to detect any differences in pressure within joints or the spine," he explains.

Hanley says that most back pain that people experience is related to problems in the vertebral disks in the spine. The disks can act as shock absorbers, and they are less able to withstand normal stresses as people age.

To avoid back pain, the AAOS advises exercising to keep muscles that support your back strong and flexible; using correct lifting techniques; maintaining a healthy weight; avoiding smoking; and maintaining proper posture when sitting and standing.

SOURCES: Edward Hanley, M.D., chairman, department of orthopedic surgery, Carolinas Medical Center, Charlotte, N.C.; American Academy of Orthopaedic Surgeons Copyright © 2004 ScoutNews, LLC. All rights reserved.

UVA RAYS MAY PLAY BIGGER ROLL IN SKIN CANCER - STUDY INDICATES NEED FOR SUNBLOCK THAT PROTECTS AGAINST BOTH A AND B RAYS

By Kathleen Doheny - HealthDay Reporter

March 2004 Ultraviolet-A (UVA) rays have long been known to cause aging of the skin, but they may play a bigger role in promoting skin cancer than previously thought, researchers report.

"Studies have shown that sunlight causes skin cancer, but have not determined which part of sunlight," says study author Gary Halliday, a professor of dermatology at the University of Sydney in Australia. "There is good evidence that

UVB [ultraviolet-B] is important [in causing skin cancer], but our studies show that UVA is also very important."

The research appears in the online issue of the Proceedings of the National Academy of Sciences.

UVB rays have shorter wavelengths and are primarily responsible for sunburn and are known to contribute to skin cancer, including the deadliest form -- melanoma. UVA rays are longer wavelength rays that can damage the skin's connective tissue and lead to premature aging. UVA rays have been considered less carcinogenic than UVB rays.

For the new study, Halliday's team evaluated cells from biopsies taken from 16 patients with squamous cell skin cancer and solar keratosis, precancerous skin growths caused by sun damage. The researchers used a technique called laser

capture microdissection and searched for "signature" DNA mutations that are characteristically caused by either UVA or UVB wavelengths.

Damage from UVA causes a different mutation in the cell than does damage from UVB, skin cancer experts say.

The researchers looked at cells called keratinocytes in the epidermis, the outermost layer of skin. They found the majority of UVA signature mutations were

found in cancer cells residing in the basal keratinocyte layer of cells, the area that houses stem cells that give rise to keratinocyte cells that migrate upward. Most UVB signature mutations were found in the more superficial, upper layer of keratinocytes.

The finding in human skin cancers mirrors that of several animal studies, Halliday says. "A number of experiments in animal models show that UVA is involved in skin cancer," he says. "However, this is the first report to show UVA causes gene mutations in human skin cancer."

Another skin cancer expert, Dr. Vincent DeLeo, chairman of dermatology at St. Luke's-Roosevelt and Beth Israel medical centers in New York City, calls the new study exciting but says more research is needed to verify the results.

"What [the study] is saying essentially is that in squamous cell and solar keratosis there are changes in the DNA of the basal cells that look like the changes were made to some extent by UVA rather than UVB," he says.

"We've known UVA is a carcinogen, but most experts thought those [skin cancer] tumors were caused by UVB primarily," DeLeo adds.

Researchers talk about a UVA or UVB "footprint" or "fingerprint," and that is a special mutation that has been found in the cancer cells, suggesting which type of wavelength caused it, he says.

"They [the Australian researchers] are showing these [UVA mutations] at the base of the tumor, but then at the top show UVB mutations." That finding, he says, "warrants more study."

In future research, Halliday says he hopes to study how damage to DNA caused by UVA and UVB rays is repaired differently and how the body protects itself against the two different wavelengths.

Meanwhile, Halliday says, "Our studies indicate that it is important to protect from both UVB and UVA. Therefore the best advice is to avoid sunlight exposure as much as possible, and if this is not possible to use a sunscreen which protects for both UVB and UVA," he says.

DeLeo agrees, adding, "protecting yourself from UVB alone is not enough. Use a broad-spectrum sunscreen [that protects against both A and B]. Sunscreens in the U.S. today are not as effective in the A range as the B."

SOURCES: Gary Halliday, Ph.D., professor, dermatology, University of Sydney, Australia; Vincent DeLeo, M.D., chairman, dermatology, St. Luke's-Roosevelt and Beth Israel medical centers, New York City; March 22-26, 2004, Copyright © 2004 ScoutNews, LLC. All rights reserved.

STUDY QUESTIONS VALUE OF INFLAMMATION TEST (The Associated Press) April 2004

New research suggests that a blood test for inflammation isn't all that useful for predicting the risk of having a heart attack.

The study in the New England Journal of Medicine casts doubt on one of the hottest ideas in the field of heart disease -- that inflammation levels are a powerful indicator of heart disease.

In addition, it challenges year-old recommendations from the U.S. government that doctors consider the test for some patients.

The researchers determined that inflammation is only a moderate predictor of heart disease. They concluded that the test doesn't contribute much to the predictive value of stronger risk factors such as high cholesterol, high blood pressure and smoking.

"There's no good scientific reason to be using it as a predictive test," said Dr. John Danesh, one of the British researchers at the University of Cambridge.

However, a key U.S. researcher in the field had a different take on the findings, saying they confirm earlier studies and the use of the test. Dr. Paul Ridker of Harvard's Brigham and Women's Hospital in Boston contends inflammation

is a strong risk factor and can spot people with no other signs of heart disease.

"My concern is that even in the face of overwhelming evidence that this inexpensive blood test works, we are at risk of moving backward rather than forward," said Ridker, who supports expanded use of the test.

Doctors can screen for low-level inflammation in the bloodstream by testing for C-reactive protein, or CRP, which fights infection. The painless inflammation can come from minor infections or irritations somewhere in the body.

Many experts believe chronic inflammation can weaken the walls of arteries, causing fatty buildups to rupture and trigger heart attacks.

In the latest research, Danesh and his colleagues used data from an Iceland study of heart disease that began in 1967. They compared 2,459 people who had a heart attack or died of heart disease over 20 years of follow-up with 3,969 participants who did not have a heart attack. Frozen blood samples were tested for CRP levels.

The researchers calculated that those with higher levels of CRP had a 45

percent increased risk of heart disease compared with those with the lowest levels. The researchers also analyzed 22 studies on the topic and found that patients with higher CRP levels had a 50 percent higher risk of heart disease.

That is far less than the early studies indicated. Eleven of the 22 studies analyzed were done before 2000, and together they showed a 100 percent increase in risk, or a doubling of the danger, the researchers said.

"It's a cautionary tale about how high the bar really needs to be before we roll out scientific advances into the community and into the clinic," Danesh said.

The researchers said their findings suggest that the recent recommendations for CRP testing should be reviewed. A co-author of the guidelines, however, defended them.

Dr. Thomas Pearson of the University of Rochester said the panel noted the weakness of the evidence and urged more study when it drew up the guidelines. He said the panel members were criticized by some as being too conservative.

"I think this is validating our conservatism," he said.

The guidelines, issued last year by the Centers for Disease Control and Prevention and the American Heart Association, do not support testing for everyone.

They give doctors the option of testing those judged to be at 10 percent to 20 percent risk of heart disease, based on such factors as age, high cholesterol and high blood pressure.

Since then, many doctors have begun routinely screening patients for CRP.

Ridker said the Iceland study used a lower CRP level than his studies to determine risk in the highest group, which could account for the lower findings.

He is now studying whether using cholesterol-lowering statin drugs to bring down CRP levels in patients is beneficial. Diet and exercise can also lower CRP. Copyright 2004 The Associated Press. All rights reserved.

RHEUMATOID ARTHRITIS IN FAMILIES

Rheumatoid Arthritis in Families with multiple cases of rheumatoid arthritis (RA), certain features show significant familial clustering. These features include positivity for rheumatoid factor in the blood, the presence of nodules, and the age at the diagnosis of RA.

Comment: This is an old-fashioned study. The fact that families with multiple cases of RA share features is interesting but not surprising. They are, after all, family members and might be expected to manifest RA in a similar manner. This study is compatible with (but does not prove) the presence of genetic factors influencing the expression of RA.

Barbara K. Hecht, Ph.D., Frederick Hecht, M.D, Medical Editors,
MedicineNet.com

THE GENETICS OF RHEUMATOID ARTHRITIS

March 2004 (HealthDayNews) -- Researchers have identified several disease features that are common among people with rheumatoid arthritis (RA) who are related. A report on their findings appears in the March issue of Arthritis and Rheumatism.

The results point to certain genetic factors that influence susceptibility to the disease and its progression. The findings could help scientists identify new markers for prognosis in people with RA.

Researchers studied 1,097 siblings from 512 families with multiple cases of RA. The volunteers provided clinical and demographic information, including whether their parents had RA.

The researchers obtained radiographs of the hands and feet of each study subject, tested all of them for rheumatoid factor, and analyzed the subjects against a list of disease symptoms and possible manifestations.

The study found that the presence of serum rheumatoid factors of nodules was strongly correlated among siblings. There was also a significant sibling correlation for age at RA diagnosis and disease severity.

Interestingly, the study found that, regardless of the total number of brothers or sisters in these families, the number of siblings stricken with RA was remarkably consistent -- between two and three.

This finding challenges previous findings that the number of people with RA is higher in larger families.

"We did not observe an increase in the number of affected siblings as total sibship [the amount of children born to a couple] size increased. The striking difference in our results compared with those reported by investigators in The Netherlands indicates the need for further study of this issue," study author Dr. Damini Jawaheer writes.

Robert Preidt -SOURCE: John Wiley & Sons Inc., Copyright © 2004 ScoutNews, LLC.

Good Health to All,

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Issue 2004 04/30/04 -8