NEWS LETTER

PAKISTAN SOCIETY FOR RHEUMATOLOGY

February 2021 Volume 1

PRESIDENT'S MESSAGE:

This newsletter is the first official publication of the Pakistan Society for Rheumatology. This newest activity is a welcome addition to the already existing activities being carried out by our society and its members. In the past we mainly relied upon yearly annual international conferences and local seminars for disseminating awareness and updating knowledge of rheumatic disorders among the members and the public. The COVID pandemic besides its clinical implications has forced the medical community to exercise social distancing. This has made the conventional ways less practical. This newsletter is indeed a welcome addition to support the PSR's mission during these turbulent times. It will help rheumatology health professionals enhance their patient care and improve their practical management through reporting of clinical views, discussions, presentations, research and updates in rheumatology.

The publication committee of this newsletter comprises of outstanding members from both academia and practice. The aim of this newsletter is to meet the current education needs of health professionals through easy-to-read articles on both clinical topics and practical management, but the style will be more personal and friendly.

PSR wishes the current chairperson, Dr. Tahira Umer and rest of her team the best in this difficult and important task.

PROF. WAJAHAT AZIZ
President
Pakistan Society for Rheumatology

EDITOR'S MESSAGE:

It gives me and my team a great pleasure to present the first issue of official newsletter of PSR. We feel honoured and humbled by the trust with which our senior PSR faculty has put this responsibility on our shoulders. The format of this newsletter is planned to cover the news and activities happening at Rheumatology departments along with research highlights and patient education material. At the same time to keep our trainees involved, we have included a simple quiz.

My team has worked very hard to produce an interesting and inspirational newsletter. We are targeting to produce two to three issues every year. We hope that this newsletter will be of interest to our readers and looking forward to the feedback eagerly.

Thank you

DR. TAHIRA PERVEEN UMER
Editor in Chief-PSR Newsletter
Assistant Professor and
Head-Department of Rheumatology
Liaquat National Hospital, Karachi

NEW RHEUMATOLOGY COMMITTEE OF CPSP:

The new committee of Rheumatology was selected by CPSP Council and President CPSP in October 2019. First official meeting held in the same month in regional center of CPSP, Karachi. The committee includes Prof. Nighat Mir, Prof. Wajahat Aziz, Prof. Tafazzul-e-Haque, Dr. Babur Salim and Dr. Tahira Perveen Umer.

During first meeting, Prof. Nighat Mir was elected as convener and Dr. Tahira Perveen Umer as secretary of the committee by the members. Multiple tasks were identified to further improve the curriculum and training which included revision of syllabus, supervisors and examiners criteria, methods for evaluation of candidates during their training period including MINI CEX and DOPs and reviewing MCQs pool. A decision was made to add coopted members to help each committee member in completing their assigned tasks. The Coopted members are Prof. Sumaira Farman Raja and Dr. Muhammad Ahmad Saeed, Dr. Aflak Rasheed, Dr. Lubna Nazir, Dr. Tab-e-Rasool, Dr. Uzma Rasheed, Dr. Shazia Zammurud, Dr. Saba Samreen, Dr. Haris Gul, Dr. Muhammad Mushtaq.

Despite COVID Pandemic, the CPSP Rheumatology committee had many meetings (virtual), during which sub committees were formed to cater the tasks identified. We are working hard to further improve the training program of Rheumatology.

RESEARCH HIGHLIGHTS:

COMPILED BY: DR. MUHAMMAD HAROON

CAN IMAGING DETECTED SUBCLINICAL ARTHRITIS HELP US COMMENCE DMARDS TREATMENT IN RA:

Imaging-detected subclinical synovitis is increasingly used. To alter therapies, and has been considered as a starting point for DMARD-therapy. Data from three longitudinal cohorts were reviewed in this study. Natural course of arthralgia patients with subclinical synovitis was examined and the frequencies of non-progression to clinically apparent inflammatory arthritis (i.e 'false-positives') were noted. It was concluded that ''replacing clinical arthritis by subclinical synovitis to identify RA introduces a high false positive rate (44-89%). DMARD-initiation in absence of clinical arthritis may lead to considerable overtreatment".

Reference:

Rogier C, Wouters F, van Boheemen L, van Schaardenburg D, de Jong P, van der Helm - van Mil A. Subclinical Synovitis in Arthralgia: How Often Does It Result in Clinical Arthritis? A Longitudinal Study to Reflect on Starting Points for DMARD Treatment [abstract]. Arthritis Rheumatology. 2020; 72 (suppl 10).

IL-23 INHIBITOR IMPROVES AXIAL SYMPTOMS IN PATIENTS WITH PSORIATIC ARTHRITIS RELATED SACROILIITIS:

Initial trial (2018) of IL-23 blockers failed to show its efficacy in Ankylosing spondylitis, but a recent study shows very good improvement in axial disease symptoms of Psoriatic arthritis with its use.

Psoriatic Arthritis (PsA) patients with sacroiliitis have been shown to have improvements in axial symptoms up to 1 year with guselkumab treatment, according to a study presented at the 2020 Virtual Meeting of the American College of Rheumatology (ACR).

This study looked at whether guselkumab has the ability to benefit the inflammatory axial symptoms. The researchers analysed data from the phase-3 DISCOVER-1 and DISCOVER-2 trials, focusing on patients with PsA who had either documented imaging confirmation of sacroiliitis in the past or pelvic radiograph confirmation of sacroiliitis at screening. The pooled analysis of both clinical trials yielded 312 patients in both studies, with 118 having been administered placebo every 4 weeks, 91 receiving guselkumab 100 mg every 8 weeks, and 103 receiving guselkumab 100 mg every 4 weeks. At baseline, mean Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores ranged from 6.5 to 6.6, and Ankylosing Spondylitis Disease Activity Scores (ASDAS) ranged from 3.9 and 4.0. Improvements in axial symptoms of PsA were greater through week 24 among patients receiving guselkumab every 4 weeks or every 8 weeks compared with placebo. At week 24, mean change in lumbar spine in the BASDAI was -2.7 for patients receiving guselkumab every 4 weeks or every 8 weeks, which was significant (P< .001). At 6 months, the lumbar spine mean change in spinal pain -- a specific measure on the BADSAI -- was -2.5 for patients receiving guselkumab every 4 weeks and -2.7 for those receiving guselkumab every 8 weeks (P< .001). The lumbar spine mean change in ASDAS was -1.4 for patients receiving guselkumab every 4 weeks or every 8 weeks (P< .001). In both arms of guselkumab, there was a substantial improvement in spine symptoms. This opens the door to the possibility that the drug may work in axial PsA.

Reference:

[Presentation title: Efficacy of Guselkumab, a Monoclonal Antibody that Specifically Binds to the p19 Subunit of IL-23, on Axial-Related Endpoints in Patients With Active PsA With Imaging-Confirmed Sacroiliitis: Week-52 Results From Two Phase 3, Randomized, Double-Blind, Placebo-Controlled Studies. Abstract 2025].

IN COVID, WHAT MAKES SOME PATIENTS SO MUCH SICKER THAN OTHERS?

Advancing age and underlying medical problems explain only part of the phenomenon. Why does one 40-year-old get really sick and another one not even need to be admitted? In some cases, it has been shown that immune systems are hit by friendly fire. Researchers hope the finding will help them develop targeted therapies for these patients. In an international study (published in *Science*), 10% of nearly 1,000 COVID patients who developed life-threatening pneumonia had antibodies that disable key immune system proteins called interferons. These autoantibodies were not found at all in 663 people with mild or asymptomatic COVID infections. Only four of 1,227 healthy individuals had the autoantibodies. The study, published on Oct. 23, was led by the COVID Human Genetic Effort, which includes 200 research centers in 40 countries. This is a breakthrough finding, and rather one of the most important things we've learned about the immune system since the start of the pandemic.

In a second Science study by the same team, authors found that an additional 3.5% of critically ill patients had mutations in genes that control the interferons, which serve as the body's first line of defense against infection. Another unexpected finding noted was that 94% of patients in the study with these autoantibodies were men. About 12.5% of men with life-threatening COVID pneumonia had autoantibodies against interferon, compared with 2.6% of women. That was unexpected, given that autoimmune disease is far more common in women. However, several genes involved in the immune system's response to viruses are on the X chromosome. Women have two copies of this chromosome along with two copies of each gene, which provides women a backup in case one copy of a gene becomes defective. Men, however, have only one copy of the X chromosome, and they have no backup in case there is a defect or harmful gene on the X chromosome.

Science 23 Oct 2020:
Vol. 370, Issue 6515, eabd4585
DOI: 10.1126/science.abd4585

NEW EUROPEAN CONSENSUS ON MANAGEMENT OF OSTEOPOROSIS IN PATIENTS WITH ADVANCED CKD:

A collaboration of different societies has resulted in the publication of the European Consensus Statement on the diagnosis and management of osteoporosis in chronic kidney disease (CKD).

Patients with advanced CKD suffer from impaired bone quality and quantity, with a non-vertebral fracture risk which is 4-to 6-fold higher than the fracture risk of matched controls.

Highlights from the Consensus Statement:

- Clinical risk factors for osteoporosis in patients with CKD comprise traditional risk factors including older age, female sex, low body mass index, fragility fracture history, glucocorticoid treatment and CKD-specific risk factors such as long dialysis duration.
- Bone mineral density (BMD), as assessed by dual-energy x-ray absorptiometry (DXA) predicts fractures in patients with CKD; however, DXA probably underestimates the actual fracture risk as it does not account for impaired bone quality. FRAX predicts fracture probability in all CKD stages.
- Routine DXA screening in all patients with CKD is not supported by current evidence. Screening in n postmenopausal women, or men aged older than 50 years may be considered.
- Patients aged older than 50 years with a prior fragility fracture may be considered for treatment without the need for further BMD assessment. In the absence of a major osteoporotic fracture, a DXA T-score threshold ≤-2.5 at the lumbar spine or hip is recommended, recognising that a higher threshold of -2.0 or -1.5 may be more appropriate.
- A sufficient supply of calcium should be guaranteed and vitamin D stores should be repleted.
- Regular weight-bearing exercise should be advised, which should be tailored to the abilities of the individual patient.
- The falls risk needs to be evaluated regularly and acted upon.
- Evolving evidence indicates that antiresorptive agents may be effective in advanced CKD and that vascular and skeletal risks are not excessively high.
- Renal risks of bisphosphonates are poorly explored in patients with stage 4 or 5 CKD, which calls for caution.
- Denosumab confers no risk of kidney function decline, but the risk of severe hypocalcaemia with denosumab is increased in CKD and hence important to have concomitant vitamin D and calcium supplementation.

Reference:

https://academic.oup.com/.../doi/10.1093/ndt/gfaa192/5938134

UNLIKELY TO ACHIEVE SUSTAINED REMISSION OFF THERAPY IN GPA (GRANULOMATOSIS WITH POLYANGIITIS):

Earlier understanding and practice was to plan weaning off therapy after around 2 years of therapy, but this study shows that after 10 years, only 7% of GPA patients achieved sustained remission off therapy and have never relapsed. A French Vasculitis Study Group analysis of their GPA reveals that after 10 years, only 7% of GPA patients achieved sustained remission off therapy (SROT) and have never relapsed. This registry included 795 GPA patients. They defined SROT as remission (BVAS=0) without glucocorticoids (GC) or immunosuppressants (IS) for ≥6 consecutive months. Three years post diagnosis, 92 SROT patients were compared to 342 controls who had relapsed and/or were still taking GC or IS. While baseline characteristics were not different between cohorts, those achieving SROT at 3 years were more to be treated with intravenous cyclophosphamide-induction therapy (P=0.01). By 5 years, those in SROT were again more likely to receive cyclophosphamide infusions (P=0.03), but also rituximab-maintenance therapy (5-year, P<0.001). There were 74 GPA Registry patients with 10-year follow-up data after conventional maintenance therapy; 15 (20%) had achieved SROT at 3 years and 5 (7%) maintained it at 10 years. Even with more intensive therapy, sustained remission off therapy was unlikely in GPA patients.

Reference:

Arthritis Rheumatol. 2020 Oct 7. doi: 10.1002/art.41551. Online ahead of print.

CASE REPORT:

PREGNANCY IN A MCTD PATIENT TAKING BOSENTAN FOR PULMONARY ARTERIAL HYPERTENSION

Maryam Aamer, Muhammad Ahmed Saeed, Nosheen W Salman, Sumaira Farman

Abstract:

Maternal mortality in women with pulmonary arterial hypertension (PAH) remains high in pregnancy and post-partum period despite recent advances. The current European Society of Cardiology/ European Respiratory Society guidelines recommend that women with PAH should not become pregnant and early termination should be discussed. Women who choose to continue with their pregnancy should be treated with a multidisciplinary approach. Our patient managed to continue the pregnancy until 32+4 weeks with a good multidisciplinary approach and rigorous monitoring. The baby was delivered via semi-urgent LSC-section with good maternal and fetal outcomes. No gross fetal anomalies were found despite being inadvertently exposed to Bosentan during the first two trimesters of pregnancy.

Case Report:

We describe here a case of a 32-year-old female whose illness started in 2009 with Raynaud's, joint pains, mild cough, and shortness of breath on moderate exertion. She was diagnosed with mixed connective tissue disease (MCTD) predominant Scleroderma pattern by a rheumatologist. Her ANA 1:5120speckled and, Anti Smith RNP high titer positive. She was also found to have mild pulmonary hypertension (PAP 30-39 mm of Hg). She was initially treated with Methotrexate, low dose Prednisolone, and Bosentan at another center.

The patient got married in 2015, first pregnancy was terminated at 20 weeks with joint consensus between Cardiology, Obstetrics, and Rheumatology and couple counseling due to high pulmonary artery pressure of 55 mg of Hg.

The patient was referred to our care in October 2020 when she was again pregnant at 22 weeks of gestation. The couple was counseled for termination of pregnancy but on their wish, it was carried on. The patient was reviewed by a pulmonologist and her PFT showed severe restriction. She had a cardiology review and repeat echo showed PAP of 39mm of Hg. She was categorized in WHO FC class III without RV involvement. Her Bosentan was discontinued considering teratogenicity (FDA category X) and switched to Sildenafil. The patient had a review by Rheumatology, Obstetric team, and cardiology team every two weeks until 26 weeks of gestation thereafter she was reviewed weekly. Fetal echo which was also un-remarkable.

At 29 weeks of gestation, she came for an Obstetric review when she was tachycardia and borderline hypotensive and was complaining of cough, shortness of breath, palpitation, and chest pain. Her fetal monitoring was satisfactory so she was referred immediately for cardiology review which showed stable PAP of 40mmof hg and sinus tachycardia. The patient was then referred to the Rheumatology team and was started on IV antibiotics for Community-acquired pneumonia.

At 30 Weeks gestation she developed worsening shortness of breath and mild chest tightness, she was hemodynamically stable and her chest was clear on auscultation. Because of persistent chest tightness, she was started on treatment dose Enoxaparin until PE was ruled out. Due to the non-affordability patient could not have CTPA, her venous Doppler both legs were negative for DVT. She was moved to HDU and had a pulmonologist review. Her symptoms were considered likely to be due to diaphragmatic push secondary to increase intra-abdominal pressures. She was kept on a prophylactic dose of Enoxaparin given her background pulmonary hypertension as per guidelines. The patient had daily Obstetric review with weekly Obstetric Doppler during admission to monitor fetal wellbeing which remained satisfactory.

From week 32 patient had daily CTGs. At 32+ 3 days, the CTG showed decelerations, and a plan was made for the C section on a semi-urgent basis. The patient was assessed by the Anesthesia team and because of the high risk associated with general anesthesia in pulmonary hypertension; she underwent spinal anesthesia and lower segment cesarean section instead of induction of labor. The baby having a weight of 1.5 Kg was delivered with an

APGAR score of 7 with a good cry. The patient and baby remained well in the post-op period with no immediate complications.

Learning Points:

1. It is crucial to managing pregnancy in a patient with pulmonary arterial hypertension with a multidisciplinary approach including Rheumatology, Cardiology, Obstetrics, Neonatology, Anesthesia, and Pulmonology teams. Regular and rigorous monitoring along with multidisciplinary team discussions regarding the mode of anesthesia, mode of delivery, and post-partum care can improve outcomes.

2. Despite being on Bosentan inadvertently we did not find any major birth anomalies.

References:

1. Katsuragi S, Yamanaka K, Neki R, et al. Maternal outcome in pregnancy complicated with pulmonary arterial hypertension. Circ J 2012; 76: 2249–2254.

2.Hsu CH, Gomberg-Maitland M, Glassner C, et al. The management of pregnancy and pregnancy-related medical conditions in pulmonary arterial hypertension patients. Int J Clin Pract Suppl 2011; 175: 6–14.

3. Jais X, Olsson KM, Barbera JA, et al. Pregnancy outcomes in pulmonary arterial hypertension in the modern management era. Eur Respir J 2012; 40: 881–885.

4. Bedard E, Dimopoulos K, Gatzoulis MA. Has there been any progress made on pregnancy outcomes among women with pulmonary arterial hypertension? Eur Heart J 2009; 30: 256–265.

5. Hemnes, A., Kiely, D., Cockrill, B., Safdar, Z., Wilson, V., Al Hazmi, M.,Lahm, T. (2015). Statement on pregnancy in pulmonary hypertension from the Pulmonary Vascular Research Institute. Pulmonary Circulation,5(3), 435-465. doi:10.1086/682230

NEW FACE OF PSR WEBSITE :

Dr. Babur Salim (Chair) and Dr. Saba Samreen (Co-Chair) have worked together for the new PSR website. This website focuses on update of new and upcoming national as well as international events. Recent covid-19 guidelines have been added and are constantly being updated. Patient portal for disease pamphlets in easy understanding have been added and are a hallmark of the website. To meet international standards a click link is available for finding a rheumatologist in ones area has been added. A picture gallery featuring rare and interesting images is made accessible. For the first time online system is being utilized for making a membership application.

WEBSITE COMMITTEE:

Dr. Babur Salim

Chair Website Committee

Dr. Saba Samreen

Co-Chair Website Committee

COVID-19 CLINICAL GUIDANCE FOR ADULT PATIENTS WITH RHEUMATIC DISEASES :

COURTESY: DR. BABUR SALIM

Developed by the ACR COVID-19 Clinical Guidance Task Force
This summary was approved by the ACR Board of Directors on April 11, 2020.

Panel members voted on agreement with draft statements using a numeric scoring system, and consensus was determined to be "low" (L), "moderate" (M) or "high" (H)

RECOMMENDATIONS

GENERAL STATEMENTS FOR PATIENTS WITH RHEUMATIC DISEASE

• The risk of poor outcomes from COVID-19 appears to be related primarily to general risk factors such as age and comorbidity (H).
• Patients should be counseled on general preventive measures, e.g., social distancing and hand hygiene (H).
• As part of a shared decision-making process between patients and rheumatology providers, select measures to reduce healthcare encounters and potential exposure to SARS-CoV-2 (beyond general preventive measures) may be reasonable, e.g., reduced frequency of lab monitoring, optimal use of telehealth, increased dosing intervals between intravenous medications) (M/H).
• If indicated, glucocorticoids should be used at the lowest dose possible to control rheumatic disease, regardless of exposure or infection status (M/H).
• Glucocorticoids should not be abruptly stopped, regardless of exposure or infection status (H).
• If indicated, angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) should be continued in full doses or initiated (M/H).

ONGOING TREATMENT OF STABLE PATIENTS IN THE ABSENCE OF INFECTION OR SARS-COV-2 EXPOSURE

• Hydroxychloroquine or chloroquine (HCQ/CQ), sulfasalazine (SSZ), methotrexate (MTX), leflunomide (LEF), immunosuppressants (e.g., tacrolimus, cyclosporine, mycophenolate mofetil, azathioprine), biologics, Janus kinase (JAK) inhibitors and nonsteroidal anti-inflammatory drugs (NSAIDs) may be continued (this includes patients with giant cell arteritis with an indication, in whom IL-6 inhibitors should be continued, if available) (M/H).
• Denosumab may still be given, extending dosing intervals to no longer than every 8 months, if necessary to minimize healthcare encounters (M).
• For patients with a history of vital organ-threatening rheumatic disease, immunosuppressants should not be dose-reduced (M).

IN PATIENTS WITH SLE:

• In newly diagnosed disease, HCQ/CQ should be started at full dose, when available .
• In pregnant women with SLE, HCQ/CQ should be continued at the same dose, when available (H).
• If indicated, belimumab may be initiated (M).

TREATMENT OF NEWLY DIAGNOSED OR ACTIVE RHEUMATIC DISEASES, IN THE ABSENCE OF INFECTION OR SARS-COV-2 EXPOSURE

ACTIVE INFLAMMATORY ARTHRITIS:

• For patients well-controlled on HCQ/CQ, this disease-modifying anti-rheumatic drug (DMARD) should be continued, when available; when unable to access (including in patients with active or newly diagnosed disease), switching to a different conventional synthetic DMARD (either as monotherapy or as part of combination therapy) should be considered (M/H).
• For patients well-controlled on an IL-6 inhibitor, this DMARD should be continued, when available; when unable to access the agent, switching to a different biologic should be considered (M). The panel noted uncertainty regarding the use of JAK inhibitors in this situation.
• For patients with moderate to high disease activity despite optimal conventional synthetic DMARDs, biologics may be started (H). The panel noted uncertainty regarding the use of JAK inhibitors in this situation.
• For active or newly diagnosed inflammatory arthritis, conventional synthetic DMARDs may be started or switched (M).
• If indicated, low-dose glucocorticoids (≤10 mg prednisone equivalent) or NSAIDs may be started (M/H).

OTHER RHEUMATIC DISEASES:

• In patients with systemic inflammatory or vital organ-threatening disease (e.g., lupus nephritis or vasculitis), high-dose glucocorticoids or immunosuppressants may be initiated (M).
• In the context of a drug shortage due to COVID-19, new HCQ/CQ prescriptions for non-FDA approved indications should be avoided (H).

ONGOING TREATMENT OF STABLE PATIENTS FOLLOWING SARS-COV-2 EXPOSURE (WITHOUT SYMPTOMS RELATED TO COVID-19)

• HCQ, SSZ, and NSAIDs may be continued (M/H).
• Immunosuppressants, non-IL-6 biologics, and JAK inhibitors should be stopped temporarily, pending a negative test result for COVID-19 or after 2 weeks of symptom-free observation (M). The panel noted uncertainty regarding temporarily stopping MTX or LEF in this situation.
• In select circumstances, as part of a shared decision-making process, IL-6 inhibitors may be continued (M).

RHEUMATIC DISEASE TREATMENT IN THE CONTEXT OF DOCUMENTED OR PRESUMPTIVE COVID-19 INFECTION

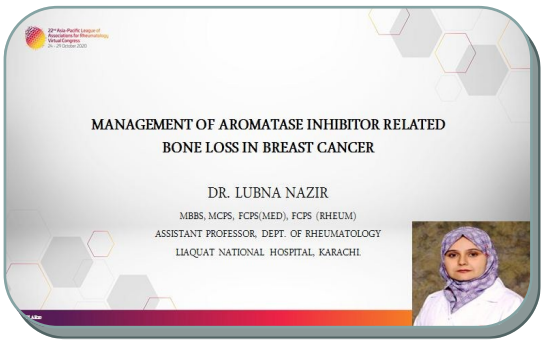
• Regardless of COVID-19 severity, anti-malarial therapies (HCQ/CQ) may be continued, but SSZ, MTX, LEF, immunosuppressants, non-IL-6 biologics, and JAK inhibitors should be stopped or held (M/H).
• For patients with severe respiratory symptoms, NSAIDS should be stopped (M). The panel demonstrated low consensus with regards to stopping NSAIDs in the absence of severe symptoms.
• In select circumstances, as part of a shared decision-making process, IL-6 inhibitors may be continued (M).

REINITIATING TREATMENT FOLLOWING COVID-19

• For patients with uncomplicated COVID-19 infections (characterized by mild or no pneumonia and treated in the ambulatory setting or via self-quarantine), consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) within 7 to 14 days of symptom resolution. For patients who have a positive PCR test for SARS-CoV-2, but are (and remain) asymptomatic, consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) 10 to 17 days after the PCR test is reported as positive (H).
• Decisions regarding the timing of reinitiating rheumatic disease therapies in patients recovering from more severe COVID-19-related illness should be made on a case-by-case basis (H).

PRESENTATION AT APLAR:

Dr. Lubna Nazir Assistant Professor of Rheumatology, LNH, gave a live program, oral talk entitled "Management Of Aromatase Inhibitor Related Bone Loss In Breast Cancer" in 22nd APLAR conference held in OCT 2020. Her talk highlighted the magnitude of this problem and outlined the current evidences and available recommendation for evaluation and treatment of breast cancer patients at risk of developing osteoporosis, due to adjuvant AI therapy.



COPCORD:

COURTESY: DR. MUHAMMAD AHMED SAEED

COPCORD household survey conducted in Lahore published in IJRD in November, 2020

Community Operated Program for Control of Rheumatic Disorders (COPCORD) is a combined initiative of WHO and ILAR. A COPCORD survey was conducted last year by our team, funded by an APLAR grant.

Fig: The lead investigator with clinical assistants conducting household survey in Nain-Sukh, Lahore.

A total of 4920 subjects from a semi-urban community in suburbs of Lahore were enrolled. Musculoskeletal pain in the last seven days was reported in 1407 (28.6 %) of whom 1034 (21 %) subjects had spinal pain. ASAS criteria of Inflammatory Back Pain (IBP) was met in 329 (6.7 %) and prevalence of Ankylosing Spondylitis was reported as 1 %.

CASE SUMMARY:

BY DR . SAAD AHMED — MEDICAL TRAINEE, COLCHESTER HOSPITAL, UK

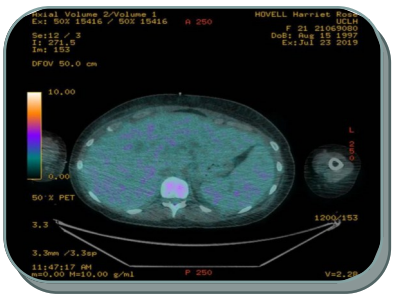


Fig-1 :Axial view of the patients 18 F FDG PET-CT scan showing significant hepatosplenomegaly.

ABSTRACT – EBV ASSOCIATED HLH TREATED WITH ANAKINRA AND RITUXIMAB

A 22-year-old female developed a mononucleosis-like illness lasting five days. Two weeks following this she presented with fevers, night sweats and right upper quadrant pain. She was diagnosed with HLH based on high fevers with hyperferritaemia, hypertriglyceridaemia, pancytopaenia and hepatosplenomegaly. Investigation revealed an EBV viral load of 230,000,000 copies/ml. A diagnosis of primary-driven EBV HLH was made. She was treated with Anakinra and a single dose of rituximab.

Following treatment her EBV viral load reduced to 660 within nine days and her blood counts and liver function returned to normal. She was discharged from hospital on day sixteen.

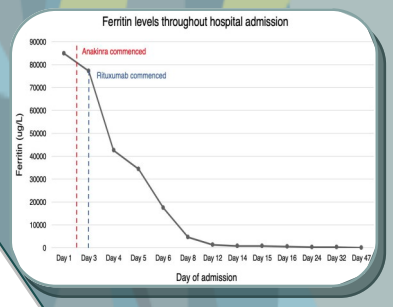


Fig-2 : Ferritin levels (ug/L) plotted over time from admission to hospital.

GLOBAL RHEUMATOLOGY EDUCATIONAL INITIATIVE BY ARTHRITIS CARE FOUNDATION:

(ENDORSED BY PSR, DECEMBER 18-20, 2019)

Arthritis Care Foundation Pakistan (ACF), in collaboration with Royal Society of Medicine (RSM) and Royal College of Physicians (RCP), organized a three-day educational program "Global Rheumatology Educational Initiative" in Lahore, it was held in three major teaching institutions Services Institute of Medical Sciences (SIMS) Lahore, University of Health Sciences (UHS) Lahore and Fatima Jinnah Medical University (FJMU) Lahore, respectively. Internationally renowned speakers from United Kingdom were Prof. Dr. Ali Jawad (Vice President Global, RCP), Prof. Dr. John Axford (Honorary Secretary, RSM) and Dr. Maaz Ali Abbasi (Consultant Radiologist, University College London Hospitals NHS Foundation Trust, UK).

It was a three days educational activities attended by 600+ participants including Rheumatologists, Fellows in training, Internists and Post Graduate Trainees of Medicine along with Medical students. The program included State of the Art Lectures , Panel Discussion, Case Based Interactive Workshop, Hands-on Ultrasound Workshop and Dedicated Session for Family Physicians.

Members of Scientific & Organizing Committee were Prof. Nighat Mir Ahmad MD, Prof. Dr. Sumaira Farman Raja, Dr. Muhammad Ahmed Saeed, Dr. Saira Elaine Anwer Khan, Dr. Muhammad Yasir Imran and Dr. Bilal Azeem Butt.

ACADEMIC ACTIVITIES AT FATIMA MEMORIAL HOSPITAL, LAHORE.

BY DR. MUHAMMAD HAROON

EVENTS ORGANISED BY THE DEPARTMENT:

Grand Round. 18/12/2020. Masterclass in Giant Cell Arteritis

Grand Round. 15/02/2020. Lupus Mysteries

RHEUMATOLOGY PATIENTS TELEPHONE HELPLINE

We are delighted and proud to have established "Rheumatology Patients Telephone Helpline" in our department. The aim of this dedicated direct telephone helpdesk is to give timely advice and appropriate intervention at the times of crisis and when symptoms become worse. This service is available between 11.00am and 02:00pm Monday to Saturday, and if needed, we also offer a call back telephone service from a doctors/nurse. We believe that this service will help people avoid unnecessary visits to the outpatient clinic during this COVID crisis. Provision of this service outlines our commitment to the quality of service that we provide to our rheumatology patients.

We continuously strive to provide a high quality, coordinated service to our patients by using the skills and experience of all members of our multidisciplinary team. We aim to build on this achievement to help meet the ongoing challenges of this disease.

PRIME REGISTRY:

In last more than one year, we have been striving hard to embrace research as a core part of our daily practice. We have established a "Research Centre" in our department. We have successfully managed to establish Registry of Rheumatic diseases (PRIME) and have already included large number of patients in this cross sectional assessment; and patients are also included for prospective assessments.

Additionally, we are also conducting a first of its kind in Pakistan, genetic studies for our patients with rheumatic diseases. We so far have managed to establish Bio Bank of more than 700 well characterised patients with rheumatic diseases.

QUIZ:

COURTESY: DR. TABE RASOOL

8 years old girl with 4 month history of pain and swelling of right knee, left elbow and wrist. There is no history of fever, weight loss, skin rash, alopecia, oral ulcers or Raynaud's. Her routine labs CBC, ESR, CRP, LDH, ASOT are normal, ANA turned out to be positive while Rheumatoid factor is negative. Echocardiography is also normal.

Q: How frequently should this girl be advised to see Ophthalmologist for Slit-lamp examination?

Answer on page 7

APLAR YOUNG RHEUMATOLOGISTS (AYR) GROUP:

COURTESY: DR. BABUR SALIM

ABOUT US:
APLAR Young Rheumatologists (AYR) group was first conceptualized in 2016.
The purpose of AYR has been to provide a conductive and nurturing environment within APLAR for young rheumatologists to network and collaborate in education, research and social activities.
The AYR working group represents 22 countries.

The first interim board of AYR (appointed in June 2018) consists of nine members :

CHAIRPERSON:
Dr Yew Kuang Cheng (Singapore)

VICE CHAIRS:
Prof YukinoriOkada (Japan) and Dr Jiuliang Zhao (China)
SECRETARY:
Dr Babur Salim (Pakistan)

TREASURER:
Dr Geraldine Zamora Racaza (Philippines)

EDUCATIONAL CHAIRPERSONS:
Dr GhitaHarifi(UAE) and Dr Priscilla Wong (Hong Kong)

WEBMASTERS:
Dr Himantha Atukorale (Sri Lanka) and Dr Padmanabha Shenoy (India).

The AYR board oversees tasks such as international collaboration, social media, membership recruitment drive and educational activities including AYR symposia.Our organization has gradually grown, with a membership drive being initiated at the 2018 APLAR Congress in Taiwan.
The first APLAR Young Rheumatologists symposium and trainee preceptorship session was held at the Brisbane APLAR congress 2019 with the participation of a large number of trainees and consultants.

BENEFITS

Free access to APLAR Educational Resources
Free online access to IJRD
Reduced registration fees for the Annual Congress and Focused Meetings (Trainees and Poster presentation)
Poster Award and Travel Grant

MEMBERS OF AYR CAN APPLY FOR:

APLAR-EULAR SCHOOL OF RHEUMATOLOGY (ESOR) program
APLAR-EULAR Exchange Program
Positions within the AYR Board
Research and Clinical Fellowships
Travel grants to attend APLAR and Focused Meetings.

RHEUMATOID ARTHRITIS; FOR PATIENT AWARNESS:

COURTESY: DR. BABUR SALIM

It is an autoimmune disease that leads to inflamed joints causing warmth, tenderness and swelling. This denotes that the immune system has started attacking your body's own tissues like germs and viruses that attack the body during infections.
The warmth and redness seen is due to the increased flow of blood in the joints.
It can occur at any age including childhood to very old age, but 2/3 cases start in 20s to 40s.
It is twice as common in women.

COMMON SYMPTOMS:
Symptoms of rheumatoid arthritis have a tendency to come and go especially in the beginning. Sometimes you may experience increased disease activity called flare-ups or low or absent disease activity called remission.

Common symptoms of rheumatoid arthritis include:

Joint pain and swelling
Increased stiffness in the morning,
Tiredness (fatigue), depression, irritability
Anemia
Flu-like symptoms, such as fever, lethargy, malaise
Less commonly
Weight loss
Inflammation in the eyes
Rheumatoid nodules (fleshy lumps below the elbows or on hands and feet)
Inflammation of other body parts- lungs, blood vessels and the membrane around your heart, although it is rare.
Rheumatoid arthritis varies from one person to another but most of time has a gradual onset. Initially the small to medium joints like fingers, wrists and feet may become painful and swollen, often intermittently.
There may be stiffness when you wake up in the morning.
If you experience painful, swollen joints and stiffness in the morning that lasts longer than half an hour, you should consult a Rheumatologist.
Research shows that the sooner you start treatment for RA, the more effective it's likely to be. So, early diagnosis is important in management.

OUTLOOK:

Since RA affects different people in different ways, it is difficult to predict the consequences of this disease for individual patients as it varies.
75% patients continue having pain in their joints, swelling and flare-ups.
Around 20% have a continuous disease with mild symptoms.
Few patients, around 5% will develop severe disease with profound deformities and disability.

HOW IS RA DIAGNOSED?
No single test gives a definite diagnosis of RA in its early stages of the condition.
Doctors usually arrive at a diagnosis based on your symptoms, physical examination and the results of x-rays, scans and blood tests.
Just a positive RA factor is not enough to diagnose it.

TESTS:
ESR, CRP
RF
Anti CCP Antibodies
X-RAYS OF HANDS to look for changes like erosions and joint damage

TREATMENT OPTIONS:
Regular physiotherapy and proper foot wear are important.

In medications, four main groups of drugs are used to treat rheumatoid arthritis:
Painkillers (analgesics)
Non-steroidal anti-inflammatory drugs (NSAIDs)
Disease-modifying anti-rheumatic drugs (DMARDs)
steroids

REMEMBER:
Most patients being treated for RA require more than one drug from the start. This is because different drugs work in different ways.
A common combination is a painkiller, an NSAID and one or more DMARD.
Because DMARDs take some time to start working patients may also be given a steroid, which can reduce the inflammation and ease the symptoms while the DMARDs take time to effect.

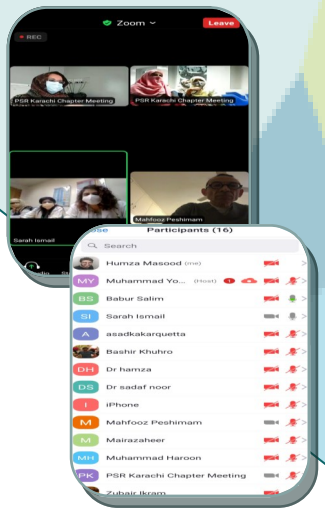
- Regular follow-up is the most important part of treatment.
- The safety and efficacy of drugs requires monitoring at regular intervals.
- This disease is usually found sporadically but less often runs in families .
- It is not necessary that your child will have it.
- Men and women with RA once controlled with drugs can have children .

PSR MONTHLY MEETING:

KARACHI CHAPTER

The Rheumatologist of Karachi have been conducting a monthly meeting since long, for case & topic discussions, that has been inspirational and a source of training for physicians, GPs and trainees. This venture was started by our senior Rheumatologists which included DR. AZRA ARIF ALI, DR. KAMRAN HAMEED, DR. S. RAZA JAFFERY, DR. S. MAHFOOZ ALAM AND DR. MIRZA SHAKIL BAIG.

This legacy has been carried forward by DR. TAHIRA PERVEEN UMER and her team at Liaquat national Hospital, Karachi. Later famous Rheumatologists from Lahore, Rawalpindi and Peshawar were also taken aboard.



FAUJI FOUNDATION HOSPITAL - RAWALPINDI

INTERNATIONAL GRANT 2019:

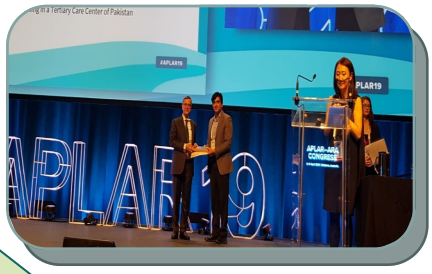
The Department successfully received the grant from 'Asia-Pacific Initiative for Rheumatology Nurse Education' (APLAR-ASPIRE). The workshop to teach the nurses, medical students and physiotherapists will be held from 7th Feb-9th Feb 2019.

NATIONAL GRANT:

Department's project for MSK Ultrasound got accepted by HEC (higher Education Commission), and has started diagnostic and therapeutic MSK ultrasound as well

BEST POSTER AWARD:

Department has achieved best poster award in Asian Pacific League of Associations for Rheumatology (APLAR) 2019 in Australia (Brisbane)



REPRESENTATION OF RHEUMATOLOGY DEPARTMENT OF FAUJI FOUNDATION HOSPITAL RAWALPINDI:

At Asian Pacific League of Associations for young rheumatologists (AYR) booth, Taiwan.

FUTURE PLANS:

Department will be conducting Pakistan society for rheumatology international conference in 2021

BABUR'S SIGN:

Validation of Babur's sign, a New Clinical Test for the Identification of Wrist Joint Synovitis in Rheumatoid Arthritis Patients Salim B*, Faisal MJ, Shahid M, Samreen S, Gul H, Nasim A, Afzal A. Department of Rheumatology, Fauji Foundation Hospital, Rawalpindi, Pakistan; **Rheumatology: Current Research**

INTERNATIONAL ACTIVITIES IN 2020:

- Fauji Foundation Rheumatology Department was awarded a grant from International League of Association for Rheumatology (ILAR) for COVID study
- Dr Babur and Dr Saba samreen were appointed to help the task force of APLAR for the recommendations of COVID19 in rheumatic disease patients.
- Dr Haris Gul, Dr Salman Mushtaq, Dr Zahid Pir helped the focal persons.
- Dr Shahida Perveen, a post resident in rheumatology was assigned to run the APLAR COVID face book page as a member.
- Dr Babur and Dr Saliha Ishaq were appointed as focal person by PSR to work in liaison with COVID 19 Global rheumatology alliance (Dr Shahida actively participated with Dr Babur).
- Dr Babur has been assigned by APLAR young rheumatologist group for updating the APLAR website.

NEXT ISSUE OF NEWSLETTER:

We will publish the next issue in June 2021, Insha Allah Taala.

Please send us your departmental activities from December 2020 till May 2021, including titles of research papers published in National and International Journals.

The write-ups for the news and happenings in your Rheumatology department should be upto 100 words, each research highlight upto 200 words, summarized latest guidelines for any Rheumatic disease management upto 300 words and case report upto 400 words.

We will also be glad to publish an interesting quiz and images (with two liner description) sent by you.

Send your write-ups latest by 30 May, 2021 at the following addresses:

Tahira.Perveen@lnh.edu.pk
Humza.Masood@lnh.edu.pk
Drhamza84@gmail.com

THANK YOU:

Mr. Humza Masood for designing and formatting this newsletter.

Quiz Answer:

A: Every 6 months for 2 years then yearly.

Reference:

- 2019 ACR/Arthritis foundation guideline for the screening, monitoring and treatment of JIA. Arthritis care research, Vol-71, No:6 June 2019.