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Welcome to the winter edition of Arthritis Today. Children feature strongly in this issue; on page 10 we look at a rare form of brittle bone disease that can affect youngsters in the womb and throughout their lives, and report on the results of an arc-funded trial which will improve their quality of life. And on page 24, we highlight research which aims to help doctors predict the likely prognosis for children with juvenile idiopathic arthritis, and how this could ease some of the fears experienced by parents. The reputation of steroids has fluctuated over the years. They are now regarded as an essential part of the treatment of inflammatory conditions – albeit with strict caveats. We have a special report on the pros and cons of these drugs on page 13. We also report on page 7 on the very first head-to-head drug trial in the UK of the new biologic therapies – anti-TNF α inhibitors. Which is the more effective drug? We aim to find out. This will be the last magazine in this current format – from April we will have a new look, to reflect the charity’s re-launch at the end of February. (see page 4)

Enjoy your read.

Jane Tadman, Editor, Arthritis Today

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Front cover: Professor David Scott of King’s College Hospital with a patient. (See page 30)
New leader for the Arthritis Research Campaign

Dr Liam O’Toole was appointed as the chief executive of the Arthritis Research Campaign in the early autumn, taking up his post in November 2009. Chairman of the charity’s board of trustees, Charles Maisey, said: “Liam O’Toole comes with enormous strengths in the areas of UK scientific research policy and high-level stakeholder management. We are delighted to have recruited him as chief executive at a key time in the charity’s development.”

Dr O’Toole has joined the charity having played a leading role in many of the major changes that have taken place in the UK’s health and medical research landscape over the past decade. He was previously the Head of the Office for Strategic Coordination of Health Research (OSCHR), a joint office funded by the Department of Health and the Department for Business Innovation Skills. Prior to that he was the chief executive of the UK Clinical Research Collaboration, a partnership of organisations working to establish the UK as a world leader in clinical research.

Dr O’Toole joins arc at a very exciting time and will spearhead the next phase of the charity’s development.

He will lead the organisation through a phase of repositioning and will build on the recent investments in fundraising and marketing to raise our profile and increase the income generated through our fundraising activities. As a result we will significantly increase our funding of medical research and education activities.

Dr O’Toole said “I’m delighted to be taking up the post of chief executive of this important charity at such an exciting time. I believe that we have a genuine opportunity and also a major responsibility to grow the organisation and maximise the impact of everything we do for the benefit of those living with arthritis. I look forward to working with all those involved with arc in the coming years.”

Why fish oils help inflammatory arthritis

New research from Queen Mary, University of London and Harvard Medical School has revealed precisely why taking fish oils can help with inflammatory types of arthritis.

In a paper published in Nature, researchers describe how the body converts an ingredient found in fish oils into another chemical called Resolvin D2 and how this chemical reduces the inflammation that leads to a variety of diseases.

The research also suggests that Resolvin D2 could be the basis for a new treatment for diseases including sepsis, stroke and arthritis. Unlike other anti-inflammatory drugs, this chemical does not seem to suppress the immune system.

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The researchers, who were funded by the Arthritis Research Campaign, the Wellcome Trust and the National Institutes of Health, looked at a particular ingredient of fish oils called DHA. They were able to show how the body converts DHA into Resolvin D2 and discover its exact chemical structure.

Mauro Perretti, Professor of Immunopharmacology at Queen Mary, University of London, led the UK team. He said: “We have known for some time that fish oils can help with conditions like arthritis which are linked to inflammation. What we’ve shown here is how the body processes a particular ingredient of fish oils into Resolvin D2. We’ve also looked in detail at this chemical, determining at least some of the ways it relieves inflammation. It seems to be a very powerful chemical and a small amount can have a large effect.”

“This research is important because it explains at least one way in which fish oils can help in different types of arthritis. We can also work on this chemical and see if it can be used not only to treat or even prevent arthritis, but also as a possible treatment for a variety of other diseases associated with inflammation.”

STOP PRESS

Look out for an extra mini-version of Arthritis Today which you will receive at the end of February. We will be relaunching the Arthritis Research Campaign as part of a major move to raise the profile of arthritis and specifically of the charity in order to increase our research activities in our determination to make a real difference to people’s lives. We are producing a mini magazine to explain to our donors and supporters the purpose of these exciting changes, and our aspirations for the future. You will also receive a new-look Arthritis Today as normal in April.
UK physios ‘unsure’ about exercise benefits for osteoarthritis

Many physiotherapists in the UK are uncertain about the benefits of exercise for people with osteoarthritis of the knee, a new survey has found.

People with the condition are advised to maintain a healthy body weight and perform quadriceps (thigh muscle) exercises to improve mobility and reduce pain.

However, a new survey from the Arthritis Research Campaign National Primary Care Centre at Keele University has found that attitudes towards exercise and knee osteoarthritis differ among physiotherapists.

The researchers, led by Dr Melanie Holden, had noticed that the amount of exercise recommended by physiotherapists for patients with knee osteoarthritis often differs from recent recommendations.

To investigate the reasons for this, they surveyed 1,152 UK-based chartered physiotherapists, 538 of whom had treated a patient with osteoarthritis of the knee within the last six months.

Analysis of the survey results in the journal Arthritis Care and Research revealed that only 56 per cent of physiotherapists ‘largely’ or ‘totally’ agreed that knee problems could be improved by local exercise.

Respondents tended to regard exercise adherence as the responsibility of the patient rather than their physiotherapist.

The Arthritis Research Campaign said it was appalled by the outcome of the study.

“As physiotherapists are generally the health professionals who are most likely to deliver this care, it is dispiriting to know that only just over half of them are aware of how exercise can help,” said a spokeswoman.

“Obviously more needs to be done to inform and educate physiotherapists more effectively.”

Ankylosing spondylitis has ‘substantial impact’ on sex life

People with ankylosing spondylitis often find that their disease has a major impact on their sexual relationships, according to a new study carried out by the Arthritis Research Campaign National Primary Care Centre at Keele University.

Ankylosing spondylitis is an inflammatory form of arthritis that predominantly affects the spine and may lead to severe stiffness of the back, typically affecting young men.

Researchers recruited 612 patients, all of whom lived in the UK and were attending specialist rheumatology centres.

Participants – 71.6 per cent of whom were men – were asked to fill out questionnaires to obtain information on their sexual relationships and characteristics of their disease.

A total of 552 participants answered the question on sexual relationships and 38 per cent of these said that this aspect of their lives was affected ‘moderately’, ‘quite a bit’ or ‘extremely’ by their disease.

The extent of the problem appears to increase with age, and alongside other factors such as poor physical function, depression, greater disease activity and unemployment.

Publishing their findings in the journal Rheumatology, the researchers concluded that ankylosing spondylitis has a “substantial impact on patients’ sexual relationships”.

“Management of ankylosing spondylitis and its impact on sexual relationships should be directed not only towards physical outcomes such as disease activity and physical function, but should also take into consideration the psychological state of the patient,” they suggested.

New lupus and heart disease study

A new investigation aims to find out if the drug rituximab can reduce the risk of heart disease in lupus patients.

Dr Ben Parker at the Arthritis Research Campaign Epidemiology Unit in Manchester has been awarded a clinical research fellowship over three years of £214,000 to establish that by more effectively controlling the inflammation that causes lupus to flare up, the drugs may also reduce heart disease in the future.

Their study is one of the first to examine how drugs used for the treatment of lupus affect the cardiovascular system.

Rituximab is not licensed for the treatment of lupus, an inflammatory type of rheumatic disease that affects mainly younger women which carries with it a five to six-fold increased risk of developing coronary heart disease, but it is prescribed to patients with severe disease when other drugs fail.

The condition can affect the joints, brain, skin, kidneys and other internal organs.

Sixty patients with severe disease will be recruited for the study at the Lupus Research Clinic at the Wellcome Trust Clinical Research Facility.

“We will measure the particles found in the blood stream after a blood vessel has been damaged; a new and exciting technique that has not been done in lupus patients before,” explained Dr Parker. “We will also take a small sample of tissue from patients, and test how the blood vessels behave in the laboratory.

“In combination, these techniques will hopefully provide exciting new insights into why patients with lupus have a higher rate of heart disease, and how we as clinicians can tailor the drugs we prescribe more individually in the future.”
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As more and more new biologic drugs come onto the market – tocilizumab, certolizumab-pegol and golimumab are the first of the next “wave” of exciting new therapies – patients with inflammatory arthritis will have more choice of treatment than ever. Biologic drugs, which include anti-TNF therapies, block triggers of inflammation and are used to treat inflammatory forms of arthritis. But the advent of these new drugs has prompted a question that both clinicians and patients need answering swiftly – which of them works best?

Jane Tadman reports.

A lack of head-to-head trials has hampered the research community’s ability to answer that vital question. The unwillingness of pharmaceutical companies to submit their big money-making blockbuster against another company’s blockbuster has meant that most of these new medicines are only ever trialled against the drug used as first line treatment for mild to moderate disease – methotrexate – which inevitably means a deeply favourable outcome on the part of the new drug. In the case of tocilizumab, for example, it means that the pharmaceutical company producing it can quite truthfully claim that their new drug is six times better than existing therapy – meaning methotrexate.

Which biologic to use first?

“Comparing a new biologic drug against methotrexate doesn’t really show how effective it is and is used to meet regulatory approval to prove that a new drug works, but it doesn’t help rheumatologists who are faced with the question of which biologic to use first,” says senior lecturer and honorary consultant rheumatologist at Gartnavel General Hospital in Glasgow, Dr Duncan Porter.

Researchers for the independent Cochrane Review found in a review of all available studies that although biologic drugs were all effective, there was little data on direct comparisons that could help doctors decide which to prescribe. “We believe that direct head-to-head comparisons of biologic drugs in patients suffering from rheumatoid arthritis (RA) are needed,” said lead researcher Jasvinder Singh. “These trials should examine efficacy and safety at different stages and severity levels of the disease.”

At the moment clinicians are bound by guidelines laid down by the National Institute for Health and Clinical Excellence (NICE) in England and Wales and the Scottish Medicines Consortium (SMC) in Scotland, which state that one of the three anti-TNF (tumour-necrosis factor) therapies, infliximab, etanercept and adalimumab, have to be used if a patient fails on a conventional therapy such as methotrexate. The next choice...
is the anti-B-cell drug rituximab, which targets the body’s white blood cells. However, it will only be a matter of time before rituximab’s manufacturer, Roche, decides to apply for a licence to use rituximab before anti-TNF therapy. And when that happens, the need to know which of the two types of drug is more effective will no longer be theoretical.

So with excellent timing, the Arthritis Research Campaign has just awarded almost £1 million to fund the first head-to-head biologics drug trial in the UK, with more than 300 RA patients starting to be recruited across Scotland from January.

“We know these two treatments work, but we don’t have very good evidence about which works better, or about which offers the NHS better value for money, and that’s what we plan to find out,” says Dr Porter, principal investigator of the trial, called ORBIT (Optimal management of RA patients requiring a biologic).

Dr Porter will lead a team of researchers from the Scottish Collaborative Arthritis Network, and other colleagues from the Pathobiology of Early Arthritis Cohort (PEAC) Consortium, which includes researchers from around the UK.

Patients will be recruited from hospitals throughout Scotland and randomised onto one of the two types of drugs for 12 months. If they fail to respond after four months they will switch to the other. The three-year trial will also be extended into England in late 2010/2011.

Impact on the NHS budget

ORBIT could have a significant impact on the NHS budget, as well as benefiting patients. The cost of anti-TNF therapy is approximately £9,000 – £10,000 a year per patient. Rituximab costs £4,700 to £7,000, so were rituximab to prove as effective as anti-TNF therapy, the NHS could save up to £20 million a year. If anti-TNF was shown to be more effective, this information would provide evidence to inform NICE/SMC appraisals which might otherwise conclude that rituximab offers a more cost-effective approach.

The team is restricting the anti-TNF drugs to etanercept and adalimumab, which are both given by injection and are the current market leaders. (Infliximab, the third anti-TNF therapy is given by an infusion.) The NHS is paying for their supply on the trial, as both are NICE approved, while Roche will provide the rituximab.

Who will do better on what drug?

The research team will also try to predict which patients will do better on which drug, something that cannot currently be done; testing patients’ blood at the start of their treatment by identifying specific biomarkers. “At the moment this is complete trial and error, and identifying this upfront would save the patient going on the wrong drug first,” added Dr Porter. Identifying and predicting patients’ response to drugs in advance is regarded as something of a Holy Grail by the research and medical community, as it brings ever closer the prospect of ‘personalised medicine,’ reducing costs, and improving quality of life for patients.

While all patients on the trial will have blood taken for biomarkers, a subgroup will have a synovial biopsy, to compare different types of inflammation. The hypothesis the team is working on is that those with diffuse inflammation (where the inflammatory cells are scattered through the joint lining) will do better on anti-TNF therapy than those with focal inflammation (where the cells are affected together in clumps) who may do better on rituximab.

A related psychological study

The study is very much a collaborative venture, involving experts in the field such as Professor Iain McInnes from Glasgow University, who is the chief scientific investigator and arc Professor of Rheumatology in Birmingham Chris Buckley. Dr Jon Packham from Keele University is running a related psychological study, based on the premise that response to anti-TNF is often influenced by a patient’s mood at the time they start their treatment, which should yield some fascinating results.

Medical director of the Arthritis Research Campaign Professor Alan Silman said: “This research is a very exciting and important development which will be of enormous benefit not only to patients but also to the NHS and other funders of these very effective but expensive new therapies for RA.”
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Diagnosed with the brittle bone disease osteogenesis imperfecta before he was even born, Luke Hall’s mother says she stopped counting how many fractures he had during his childhood when it got to 40. But Luke is one of the lucky ones.

Luke, from Leeds, is not classed as having severe brittle bone disease. Now aged 14, he looks like any other teenager, and he leads a normal, active life. Like many affected youngsters, Luke has a higher than normal pain threshold, and he has become almost blasé about fracturing bones, mainly in his legs and hands.

“When I have a fracture I don’t really bother going to hospital anymore because there’s nothing much they can do, and it means sitting around in A&E for hours,” he explains. “I usually take painkillers like ibuprofen and paracetamol, and just get on with things.”

Luke thinks the last time he had a fracture was about four months earlier. “I think I broke my wrist because it clicks, but it’s not painful any more. A couple of years ago I broke my ribs, and I went to hospital but they just told me to go away and take painkillers.”

At one point Luke had fractures in both his feet. “I dragged him to the doctor who said we were unduly worried,” remembers Luke’s mum Dorothy Hall. “Later he went for an x-ray, and walked into the x-ray department with his fractured feet and his shoes still on. The doctor couldn’t believe it when he saw the x-ray and realised what pain he must have been in.”

Dorothy knew her son had a one-in-two chance of being born with osteogenesis imperfecta because her husband, Luke’s dad Kevin, also had a mild version of the condition. “I knew from my first scan that he had it, and they identified that he had fractures when he was in the womb, so I had to have a caesarian which was the safest thing to do,” she says.

Luke was looked after at the child development centre at St James’s Hospital in Leeds, but no drug treatment was available and it wasn’t until Luke was nine that by chance Dorothy heard about the clinic run by Professor Nick Bishop at Sheffield Children’s Hospital.

At that time Professor Bishop, an internationally renowned expert in brittle bone disease in children, had recently arrived from Cambridge to take up a post of Professor of Paediatric Bone Disease at Sheffield University. He was also just setting up a clinical trial, funded by the Arthritis Research Campaign, to find out if giving affected children drugs used to treat osteoporosis in adults – bisphosphonates – could reduce the number of fractures they suffered.
The Halls were happy for Luke to take part in the trial, and from then on he took a weekly tablet of risedronate. More than 50 children with osteogenesis imperfecta took part in the arc trial, the results of which are about to be published in the Journal of Bone and Mineral Research.

Previous research by Professor Bishop had shown that an intravenous bisphosphonate called pamidronate increased children’s bone density by up to 40 per cent, and the trial results from this latest study confirmed that risedronate increased bone mass and reduced bowing deformities of the limbs.

“Parents tell us that their child has more energy”

“All children on the trial experienced a reduction in fracture risk and there was no specific difference between the top and bottom dosage groups,” says Professor Bishop. "We learnt that the dosage of treatment you give is important in increasing bone mass, but we cannot honestly be sure about the dose of treatment and the reduction in fracture risk.”

However, the trial has established that a dose of 2mg a week will reduce the risk of fracture and keep children’s bone pain under control. Professor Bishop says: “When we stopped their treatment at the end of the trial (we stop their treatment for six months in case they run into any side-effects) many of the children came back to us before the six months were up complaining that they did not feel well, and wanting to be back on the treatment. The drug made them feel better in themselves. Parents tell us that their child has more energy when on the treatment, and are happier, not so grumpy.”

Professor Bishop believes that the take home message from the trial is that for children with a milder form of osteogenesis imperfecta, risedronate is a perfectly reasonable way to treat them. However, for severely affected children, babies or adolescents at the end of their period of growth, then intravenous pamidronate is a better first-line option. “It’s taken us seven years to find out but this is a big step forward, as it helps us to tell what is best for the patient. We need to target risedronate appropriately, and not use it as a first-line treatment for all children.”

Dorothy Hall thinks that since Luke has been on risedronate his energy levels have gone up. “He can do more, and has more of an appetite. As he has got older he has become more aware of his limitations and takes a bit more care, and is less likely to have as many fractures, although whether that’s due to the drugs or his attitude we’re not sure. DXA scans have shown that Luke’s bones have got thicker.”

Nick Bishop says he encourages children to take part in sport as it’s good for their self-esteem, and while there is a risk of fracture, there’s a balance to be struck between wrapping children in cotton wool, and letting them get on with life.

Luke Hall definitely takes the latter view. “I can’t go on a trampoline, go ski-ing or play rugby but I wouldn’t want to anyway,” he says. “I played football until recently, and if I’d wanted to I would have carried on – I didn’t stop because of having brittle bones. I watch what I do. But I still do things. Having brittle bones is annoying, but it doesn’t stop me doing much.”

What is osteogenesis imperfecta?

Osteogenesis imperfecta affects one in 15,000 children. There are about 14 new cases a year, with the majority at the milder end of the spectrum. Children with more severe disease have enormous needs, with their height restricted, and
spending much time in wheelchairs. When Professor Bishop started his clinic in Sheffield, the projection was that his patient cohort would be around 125. The number is now 275. Sheffield is one of the main centres in the UK and treats more children than Great Ormond Street Hospital, with children referred from all over the UK, typically by a paediatrician. “I think there may be more cases than we know about, and recognition is still quite low; many orthopaedic surgeons still refer cases quite late on,” says Nick Bishop. “If a doctor thinks a child has brittle bone disease he or she should get them seen by a specialist team because they have a lot to offer. Early diagnosis and treatment are very important especially when we need to reconstitute the vertebrae — you can only treat children before they stop growing, so there is a limited window of opportunity.

“We get children from around the time of birth, who need treatment within the first four weeks of their life, children with recurrent fractures or those with a family history, children who were told there was nothing could be done for them. We have a major job of education that we try to do.

“A child with mild osteogenesis imperfecta could expect between five and ten fractures in their lifetime, with moderate disease between 30 and 50, and with severe disease 200 and 300 if untreated. We can substantially reduce that number, but we cannot stop them completely. “In all the time I have been in Sheffield we have never lost a single child even though they have been extremely ill. In the old days, severely affected infants would have died by the time they were six months old. We have helped them through, although often with significant physical disabilities, and they can do more, and be more independent and mobile. As a result of a multi-disciplinary team approach they receive medical therapy, occupational therapy, physical therapy, education, support for their family, and close liaison with other services like school and social care. It’s a disease that affects many areas of the children’s lives.”

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ATSR10
Steroids have gone from being feted to feared – and hated for their side-effects. Do they still have a place in the treatment of inflammatory arthritis? Jane Tadman reports.

When the anti-inflammatory effects of glucocorticoids were discovered by Philip Hench and his collaborators back in the 1940s they were hailed as wonder drugs, very much in the same way that anti-TNF therapy is acclaimed now. They transformed the treatment of rheumatoid arthritis (RA) and other forms of inflammatory conditions, and Hench went on to be awarded the Nobel Prize for his groundbreaking research.

However, although steroids were hugely effective in suppressing the effects of inflammation, it became clear in the 1950s that they were also responsible for some very unpleasant side-effects such as osteoporosis, diabetes, high blood pressure, thinning skin, weight gain and mood swings. Nor did they work for everyone.

The tide of medical opinion turned against steroids. “A whole generation of rheumatologists were very reluctant to use them,” recalls rheumatologist and now director of the arc epidemiology unit Professor Deborah Symmons. “As a trainee, I had to get permission to prescribe them.”

Professor Symmons and many other rheumatologists and medics in current practice believe that the pendulum has now swung, if not all the way, but back towards the middle ground, and that steroids have their place – primarily as a means of getting inflammation under control in early disease while other more-long term therapies are started, and in damping down severe flares.

“Steroids are very useful in reducing the symptoms of rheumatoid arthritis in patients with early disease; they are also important in creating trust and confidence in the patient,” says Dr Arthur Pratt, a specialist registrar at the Freeman Hospital in Newcastle and an arc clinical research fellow.

“Our practice at the Freeman is to use them as a tool for inducing remission in early RA, for example in an intramuscular pulse, or an intra-articular injection, as steroids work much more quickly than methotrexate. They are also useful to provide short-term relief if a patient is between drugs or is switching to a different disease-modifying anti-rheumatic drug (DMARD).”

Professor Deborah Symmons concurs. “Steroids buy time. They make...
it possible for people to go to their wedding, or to celebrate their Golden Wedding anniversary. They also have a place in reducing flares. What we try not to do these days is to use them in tablet form as maintenance therapy over a long period, because of the side-effects.”

Professor Symmons ran a recent arc clinical trial of more than 200 patients with very early inflammatory arthritis which showed that three intramuscular steroid injections given at weekly intervals postponed the need for the prescription of a DMARD in one in five people, and actually prevented one in ten people from developing RA. Interestingly, there was also no evidence that giving people who developed RA three steroid injections at weekly intervals very early in the disease process came to any harm by having their treatments delayed by the course of injections.

In conditions other than RA, side-effects of long-term steroid use are seen as a necessary evil. In lupus, where there are fewer newer, effective drugs than in RA, the doses have to be higher to control the potentially life threatening disease, and in lupus patients whose kidneys and brain are affected, the dose can be up to 60mg daily or more.

“Nothing acts faster than a steroid”

“Nothing acts faster than a steroid, so if time is of the essence, you give it, and tomorrow you think about trying something else, and get the steroid dose down,” explains Professor Symmons. “Very sick people with lupus have high doses of steroids to save their lives — although this may lead to long term problems it is a matter of balancing the benefit over the risk.”

Although the use of long-term oral steroids may be less common than in past years, there can be exceptions. Dr Pratt says he would only use them in special circumstances, for example in an elderly woman with longstanding RA to whom he would not want to give an anti-TNF drug.

And rheumatologist and Arthritis Today’s resident doctor Philip Helliwell has used long-term low dose (7.5 – 10mg) steroids in combination with other DMARDS on working men with manual jobs and kept them in work without any side-effects.

He thinks the use of steroids in treating inflammatory arthritis is more widespread than some clinicians would have us believe.

“If you look at any rheumatology department a quarter to a third of their patients — people with RA, connective tissue conditions like lupus and polymyalgia rheumatica — will be on oral steroids. And they still have many benefits — when used correctly,” he says.

“A lot of us use them covertly — 90 per cent of all RA patients are given steroid injections into the joint to quell their flares or before they are put on methotrexate. They are seen as old-fashioned, and the current teaching orthodoxy is not to put people on them anymore — but it still happens. Steroids are ubiquitous.”

One condition for which a long-term low maintenance dose of steroids is usually prescribed is polymyalgia rheumatica, or PMR, with a bisphosphonate (bone-building drug) administered to counter any osteoporotic side-effects. “Steroid tablets are very effective in PMR,” says Deborah Symmons. “Most people are on them for two to three years, and we try to taper the dose down to 7.5mg fairly quickly, and slowly wean them off. A small number of people find their condition comes back once the dose is reduced, and will need other drugs, such as methotrexate or azathioprine which reduce the need for high dose steroids.”

The consensus among medics then, is that steroids still have an important part to play. “In an ideal world we wouldn’t give them at all because of the side-effects, but for inducing remission, and as an adjunct to other treatment they have to be considered,” says Dr Pratt. “In 2009, steroids still do have a role.”

Steroids in childhood arthritis

It’s in the treatment of juvenile idiopathic arthritis (JIA), where the use of steroids has changed most dramatically over the past few years, believes one of the country’s leading academic paediatric rheumatologists, Professor Helen Foster (right).

“The use of steroids has changed; we can’t use anti-TNF from the start of the disease but those who are on methotrexate and have an increasing number of flares can go onto anti-TNF, which is very effective and therefore enables us to reduce the amounts of steroids. Long-term side-effects are what we try to avoid,” she says.”

“You’re much less likely these days to see a child with a steroid-induced ‘moon face’, and one of the other side-effects — stunted growth — is now much less common. We rarely have to give growth hormone treatments now.”

The current best use of steroids is to bring immediate relief to a sick child who is in distress. “A child can be miserable and unwell and within 12 hours of administering a steroid you have a different child — the effect is very dramatic,” adds Helen Foster.
“It’s particularly effective in the case of systemic JIA which starts with a rash and fever; an intramuscular steroid pulse brings relief that can last several weeks. Then we’d prescribe methotrexate and possibly a low dose oral steroid too.”

Steroid injections into the joint are also given to children with arthritis, and are considered to be safe and effective. The down side is that a general anaesthetic has to be administered to very young children first because the injections are very painful and sometimes have to be given in up to eight joints.

Dr Madeleine Rooney, a paediatric rheumatologist in Belfast, is heading an arc-funded clinical trial which aims to reduce thin bones (osteopenia) in children with JIA, and also rheumatic diseases such as juvenile dermatomyositis, lupus and vasculitis, who are taking steroids for their condition, by prescribing bisphosphonates. She is hoping the ongoing UK-wide trial will lead to world-wide guidelines on how to prevent steroid-induced osteopenia.

Nicky Talbot, whose seven-year-old daughter Emelye was diagnosed with JIA at the age of ten months, and has only recently stopped taking oral steroids, says she has an extremely positive view of the drugs.

“They got her through those initial years when she was too young to take anything else, and luckily for Emelye she didn’t suffer any of the associated side-effects such as the moon face or weight gain,” says Mrs Talbot, from Bangor in Northern Ireland.

Emelye, who is now on methotrexate, has also had steroid injections into her many affected joints over the years, which helped her retain a relatively normal and active life. “She is great at understanding her disease, and she knows what has to be done is for her own good, even though it might not be very nice at the time,” added Mrs Talbot.

**Research into steroids**

Because of their side-effects and the fact they don’t work in everyone, researchers are keen to find alternatives to steroids. Several arc-funded scientists are currently engaged in this activity, including a team at the Kennedy Institute in London, who are investigating the ways in which glucocorticoids function at the cellular level.

Another researcher is Dr Stuart Cooper, senior lecturer and clinical endocrinologist at the University of Birmingham, who has shown that the level of steroids within the bone rather than in the blood is a critical factor regulating the effects of glucocorticoids, and that these levels are determined by a particular enzyme that converts inactive steroids to their active forms. His team is examining the impact of this enzyme in the formation of bone-forming and bone-resorbing cells, its effects on osteoporosis, and its role in the adverse effects of steroids.

His research is ongoing, but so far he has found that the same process that sensitises bone to steroids also sensitises the synovial tissue. This would limit the usefulness of steroids that are designed to bypass these mechanisms, as the reduced effect on bone would be offset by a reduction in their anti-inflammatory effect. Dr Cooper is also in the process of finding out why bones are so affected by steroids. The aim is to enable better prediction of side-effects in people given glucocorticoids, and develop new drugs with reduced bone effects.

**How are steroids administered?**

Steroids may be given in four ways. Most often they are given as a single daily morning dose in tablet format. Occasionally the dose is given on alternate days. The enteric coated format of prednisolone causes less stomach irritation than the uncoated (plain) format. Prednisolone also comes in a soluble form which is useful especially in children. Secondly, prednisolone may be given by intravenous infusion. This is useful in the situation where someone has life threatening illness and a quick response is vital. If children need to have steroid therapy they tend to prefer an intravenous to an intramuscular injection. Thirdly, they may be given into the muscle as a ‘depot preparation’ which is released over a number of weeks. This is the format often used to ‘buy time’ in patients with inflammatory arthritis. The side-effects with a single injection are minimal. Finally, they may be injected directly into the joint. This is the preferred option when only a small number of joints are inflamed as it produces fewest side-effects.

**What are steroids and how do they work?**

Steroids are a synthetic drug that resembles cortisol, a hormone produced naturally by the body.

They work by reducing inflammation and by damping down the activity of the immune system.

Steroids produce anti-inflammatory chemicals to minimise tissue damage.

There are many different types of steroids, for example prednisolone, methylprednisolone, and hydrocortisone.

For arc’s drug sheet on steroid injections go to:

http://www.arc.org.uk/arthinfo/patpubs/6250/6250.asp

For arc’s drug sheet on steroid tablets go to:

http://www.arc.org.uk/arthinfo/patpubs/6251/6251.asp

Paper copies of the drug sheets are available to order on 01904 696994.
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Keeping the memory alive

After Sally Morris’s beloved husband Clive died from complications of rheumatoid arthritis, she decided to throw herself into raising money for the Arthritis Research Campaign. Sally told *Arthritis Today* what motivates her.

Clive Morris was just 50 when he died from complications of rheumatoid arthritis (RA) two years ago.

Clive, larger than life, hard-working and devoted to his wife and family, had developed the condition 15 years earlier, but despite his deteriorating health, continued to work as an IT project manager until shortly before his death.

“Clive did a lot of flying for work and he developed DVT and a pulmonary embolism, and six months later was diagnosed with RA, although we don’t know if there was any sort of connection,” explains his widow Sally, who lives in Coventry with two of the couple’s younger children, daughters Hattie, aged ten, and Gabby, 15. Their two older boys, 21-year-old James and Jake, aged 19, are both at university.

After his diagnosis, Clive was put on a succession of drugs to control his condition but, from the first, suffered a series of bad reactions, and developed a number of complications. Sulphasalazine ruined his digestive tract, and although methotrexate was effective in controlling flares, he contracted ulcers, and his immune system was badly compromised. Clive also had septicaemia, and developed a lump on his neck which was found to be cancerous. He and Sally had just returned from a 25th wedding anniversary cruise when they were told he had only weeks to live. Clive died in October 2007.

“Clive was an incredible man; he used to go to work in absolute agony. His hands would be like sausages, and his knees and ankles were very badly swollen much of the time, but he was one of those men who would not give up,” remembers Sally, now 50.

“He lived for me and the kids, and was a larger-than-life personality. I can see him now, standing on the touchline in complete agony watching his sons playing rugby.”

After his death, Sally, a fitness instructor, who was already involved in running various charity events, made a conscious decision to do something to keep Clive’s memory alive.

“I said to the children that I felt we should do something so that their dad’s death was not in vain, and that it was something I felt strongly about. They said straight away: ‘what can we do?’ ”

“I thought about raising money for either a cancer or an arthritis charity, but
REMEMBERING CLIVE

cancer gets so much money anyway, and people look at arthritis and think you can’t die from it, and dismiss it. But I saw one of the Arthritis Research Campaign’s fantastic posters that says: ‘Arthritis may not kill you but it can take your life’ and thought that was exactly right.”

Her first fundraising event was a memorial ball for Clive, complete with an Elvis impersonator (Clive had been a huge Elvis fan). A second ball, at the Meriden Hotel in Coventry which the whole family attended, followed this year, before Sally, who is extremely fit after 30 years in the fitness business, decided to do something a little more physically strenuous – a successful London to Paris cycle ride with her sons over three days.

“Despite training, the boys found it quite tough, and I teased them about not being able to keep up with their old mum!” Sally recalls. The events have so far raised more than £5,000 for the Arthritis Research Campaign, with another ball and other events planned for 2010.

Fred Johnson, regional fundraising manager for the charity in South Wales and the West Midlands, says that Sally’s energy and willingness to raise money is inspirational. “She works tirelessly to raise money for arc despite looking after four children and having a demanding career,” he says. “She is always thinking about her next fundraising idea. I only wish there were a lot more Sallies in Wales and the Midlands.”

Sally’s children have always been very supportive of her fundraising efforts. “From the start, after Clive’s death, I always gave them the option of getting involved or not, and if they hadn’t wanted to, then I wouldn’t have done it,” she says.

Her children, a demanding job, and all her fundraising commitments have kept Sally very busy since Clive’s death, deliberately so. “That’s the way I like it, and it helps me,” she acknowledges. “People have said to me that I’ve not given myself time to stop and grieve, and I probably need to allow myself to do that. But it’s a two-way thing. It’s been good for the children – and for me – to do something worthwhile.”

The Arthritis Research Campaign has now awarded funding for its first three new national centres of research excellence. All receive £2.5 million over five years. Arthritis Today reports on their progress to date.

**Nottingham**

Our newest centre is the Arthritis Research Campaign National Pain Centre at Nottingham University, which aims to improve treatments for arthritis – the most common cause of chronic pain.

As the world’s first national centre for research into understanding pain in arthritis, with further £3 million from the university, it will be officially opened in spring.

The centre represents an ambitious bid to tackle chronic pain involving a multi-disciplinary, integrated approach to clinicians and scientists from different research fields including rheumatology, neuro-imaging and psychology.

The researchers’ aims over the next five years will be to gain a better understanding of how people experience pain, to use that knowledge to fully understand the biological basis of pain in osteoarthritis, to develop new drugs to treat pain more effectively and to target existing drugs more effectively at individual patients.
Director Dr David Walsh from the School of Clinical Science’s Division of Academic Rheumatology said the centre offered a “wonderful opportunity” to produce more effective pain treatments. “There is a huge unmet need for better pain relief for people with arthritis,” he said.

“Current treatment can help some people, but the future holds huge potential for developing new and better treatments for the millions who suffer from chronic pain. Bringing together a team like this, of world experts in their fields, to look at the problem from completely different angles presents us with a wonderful opportunity.”

Professor Alan Silman, arc medical director said: “Pain is the number one concern for all patients with arthritis, and there have been too few recent advances in how to manage it. Several million people suffer both day and night, with only conventional painkillers helping to keep the pain at bay.

“A truly innovative approach”

“Our new centre is charged with a truly innovative approach; covering the basic pathways of pain perception and the changes in the tissues caused by arthritis to identify completely new targets for developing effective, safe and acceptable treatments.”

Current drug treatments to relieve the pain of osteoarthritis are unsatisfactory, and although exercise, weight loss and self-management help some sufferers, many more people struggle to find adequate, side-effect-free pain relief. Joint replacement surgery is available for people with severe, unremitting pain, but even this is not a solution for everyone. Many osteoarthritis sufferers turn to unproven supplements, but few have been shown to work.

Dr Walsh and his team will use osteoarthritis of the knee as an initial model for their research, although it is expected that their work will help people with other types of arthritis pain over time.

“It is well recognised that the experience of osteoarthritic pain involves the interplay between the way that the nerves present in the joint (the peripheral nerves) detect changes in the joint tissues that occur in osteoarthritis, how these nerve signals from the joint are processed by the spinal cord and brain and translated into feelings of pain, and how this is influenced by the way a patient thinks and feels about their pain,” explained Dr Walsh.

“However, our understanding of the relative contributions of each of these factors to the final experience of pain is incomplete – which is our great challenge.”

A full-length feature on the new pain centre will follow in Arthritis Today in April.

Cardiff

The Arthritis Research Campaign Biomechanics and Bioengineering Centre at Cardiff University was officially opened by His Royal Highness the Duke of Gloucester in September.

The Duke met researchers, arthritis sufferers, clinicians and fundraisers during the opening ceremony. The centre is dedicated to world-leading research to find bioengineering solutions to arthritis, and brings together biomedical scientists, medics, engineers, rheumatologists, physiotherapists and orthopaedic surgeons.

One exciting new aspect of the research is to relate molecular changes in the joint to pain and inflammation, to then show how overworked joints are linked to pain and disease development. This should lead to better drugs and physical therapies, as well as improvements to joint replacement techniques and, further in the future, to identify novel alternatives to orthopaedic surgery.

Welsh First Minister Rhodri Morgan described the new centre as “a real feather in the cap for Welsh science.”

Keele

The first of our national research centres, the Arthritis Research Campaign National Primary Care Centre was officially opened by the then health Minister Lord Darzi in December 2008 and has enjoyed a productive first 12 months.

One of the centre’s main aims is to have a direct impact on the way people with common musculoskeletal problems such as osteoarthritis and back pain are treated and to increase the status of research in the primary care setting (ie the GP surgery) where most people with arthritis receive their care.

Centre director Professor Peter Croft is enthusiastic: “Our first year has been an exciting one,” he says. “The stability and the resource provided by the charity’s investment in centre of excellence status has given tremendous impetus, energy and sense of purpose to our staff and our NHS partners in the research, and to the patients and public who support our studies, the local community and Keele University as a whole.”

One main objective of the charity’s investment strategy was to provide the centre with the basis to mount strong bids for external funds from sources which have often not prioritised musculoskeletal illness in the past. During the centre’s first year, it was awarded two of the Department of Health’s National Institute of Health Research (NIHR) programmes of £4 million over five years: to investigate optimal care for osteoarthritis in primary care and how to enhance the treatment of patients with low back pain.

Adds Professor Croft: “These awards directly recognise the framework for applied health research supported by the Arthritis Research Campaign. They provide evidence of the expansion of applied health research into common musculoskeletal syndromes and of support for individuals to carry out and lead such research.”

The Primary Care Sciences Research Centre, where the arc centre is based, is also due to receive the prestigious Queen’s Anniversary Prize for Higher and Further Research, a national honour awarded every two years for work of outstanding excellence, at a ceremony at Buckingham Palace in February.

(See page 5 for more news of the primary care centre’s latest research results).
The Hints Box

Where can our book group find book holders?

I am 68 years old and have recently joined a reading group, which gives us all great pleasure. Unfortunately I am not the only one who struggles keeping paperback books open, as we don’t like the idea of bending them in half, damaging the spine.

The only book-holders we have seen are bulky and difficult to use. Can anyone suggest any solutions? I am sure this must be a common problem to many of your readers and therefore we all look forward to a solution.

Katherine Moore, Newcastle-under-Lyne, Staffordshire

Shoes for wider feet

With reference to earlier correspondence about comly shoes for arthritic feet, I agree about Hotter Shoes – they have been wonderful for me – but now I need a wider shoe than they were able to supply. However I have found Wider Fit Shoes, which supply women’s widths from EE-8E, and men’s EE-6E. The linings I have in the 4E shoes I now have are most comfortable.

Wider Fit Shoes Ltd, 19–21 Inchester Road, Rushden, Northants, NN10 9XF.
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Email: enquiry@widerfitshoes.co.uk
www.widerfitshoes.co.uk

Margaret Cobb, Carnforth, Lancashire

How to make cleaning the bath easier

Clean your bath and wash basin using a dish-mop on a wooden stick handle. No more back or shoulder pain, and no more bruised knuckles from cleaning the taps. I’ve had severe rheumatoid arthritis for 35 years and now I can do these jobs for myself!

Mrs M Marshall, Elvington, York, Yorkshire

Champagne reduces my arthritic pain

I have been looking back through old copies of Arthritis Today which I always keep as they are very good for information and my own research and reference. I came across a letter from someone who had experienced an anti-inflammatory effect from drinking champagne. I believe there is definitely something in this as I too find my joints (especially my knees) are less swollen after drinking alcohol. I thought it was the dehydrating effect of the alcohol itself but now I am left wondering if it is in fact the polyphenols which are found in the grapes. I have had inflammatory arthritis since the age of three. I do not take any second-line drugs since having an ulcer, and as NSAIDS stopped me ovulating I no longer take these. So I am always looking for an effective alternative. Currently I take plant isoflurance or plant oestrogens, but have also read that green tea may help? I think more research should go into the effect of wine/champagne and also statins.

Zoe Harber, Haverhill, Suffolk

Editor’s Note: Although we have no immediate plans to investigate the beneficial effects of champagne or wine on arthritis, we are co-funding a £1million trial with the British Heart Foundation to find out if more people with rheumatoid arthritis would be at reduced risk of developing cardiovascular disease by taking statins.

Where can I buy fish body oil?

Reading the spring issue of Arthritis Today and the 80-page complementary medicines report that fish body oil scored five out of five for rheumatoid arthritis, I can only find cod liver oil. I would be very grateful if anyone could tell me of and where fish body oil is available either in capsule form or oil.

June Ross, Stourbridge, West Midlands

Editor’s Note: Fish body oil, also known as Omega-3 fish oil, is available from pharmacies and many mail order or internet outlets.

I think the ‘flu vaccine caused my rheumatoid arthritis

In response to Cherry Tugby and various correspondence in Arthritis Today about the ‘flu vaccine triggering rheumatoid arthritis, I also have experienced the same thing. I had the flu jab and within a week I had a number of flare-ups and was diagnosed with rheumatoid arthritis. I didn’t have any problems before the ‘flu jab and when I asked the doctors they said it was nothing to do with it, which they would do, but now I am convinced that’s what brought it on, and people should be aware.

Patricia Richardson, Wellingborough, Northamptonshire

Send your hints to Jane Tadman, arc, St Mary’s Gate, Chesterfield, Derbyshire S41 7TD
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Project grants

Dr Andreas Roposch, Institute of Child Health, University College London, London; investigating the relative importance of different risk factors for developmental dysplasia of the hip in babies, £154,965, 30 months.

Dr Fiona Poland, Institute of Health and Social Science Research, University of East Anglia, Norwich; exploring ways to encourage treatment uptake in children with benign joint hypermobility syndrome, £33,085, 36 months.

Professor Michael McDermott, Leeds Institute of Molecular Medicine, University of Leeds, Leeds; regulation of ‘natural’ cell death in rheumatoid arthritis, and how different drugs may influence this process, £167,964, 36 months.

Dr Helen Collins, Division of Immunology, Inflammation and Infectious Diseases, King’s College London, London; could reducing iron in the diet and removing excess iron from the joint reduce inflammation in rheumatoid arthritis? £193,661, 36 months.

Dr Frank Ward, Department of Medicine and Therapeutics, University of Aberdeen, Aberdeen; exploiting the potential of naturally occurring CTLA-4 to reduce damaging immune responses in systemic lupus erythematosus – a novel treatment and diagnostic tool? £172,504, 36 months.

Professor Susan Brain, Cardiovascular Division, King’s College London, London; pain and inflammation in rheumatoid arthritis – the role of the TRPA1 receptor and its potential as a new therapeutic target, £192,714, 36 months.

Professor David Abraham, Royal Free Centre for Rheumatology, University College London, London; exploring Nkx2-5, a protein that may have an important role in regulating blood pressure in the lungs of patients with scleroderma, £124,374, 24 months.

Dr Richard Stratton, Royal Free Centre for Rheumatology, University College London, London; identifying the factors that drive skin fibrosis in systemic sclerosis, £99,224, 24 months.

Dr Patrick Case, Avon Orthopaedic Centre, University of Bristol, Bristol; do particles released by hip resurfacing replacements cause widespread chromosomal damage? £100,124, 18 months.

Dr Catherine Boulter, Cardiff School of Biosciences, Cardiff University, Cardiff; understanding how defects in a gene controlling joint and bone formation may lead to osteoarthritis and bone disease, £197,342, 36 months.

Professor Cosimo De Bari, Division of Applied Medicine, University of Aberdeen, Aberdeen; exploiting the potential of joint tissue stem cells to prevent osteoarthritis, £163,301, 36 months.

Travelling Fellowships

Dr Gareth Jones, Department of Infection, Immunity and Biochemistry, Cardiff University, Cardiff; investigating the differing roles of the proteins IL-6, IL-11 and IL-27 in rheumatoid arthritis – new opportunities for treatment? £43,069, 12 months.

Dr David Gibson, Musculoskeletal Education and Research Unit, Queen’s University, Belfast; validating the use of body fluid proteins to predict outcome in juvenile idiopathic arthritis, £47,803, 12 months.

Orthopaedic clinical research fellowship

Mr Neal Millar, Division of Immunology, Infection and Inflammation, University of Glasgow, Glasgow; investigating the role of the inflammatory molecule interleukin-33 in tendon disease, £144,887, 36 months.

Clinical studies/trials

Professor Michael Hanna, Department of Molecular Neuroscience, Institute of Neurology, MRC Centre for Neuromuscular Diseases, London; trialling the safety and tolerability of Arimoclomol for the treatment of sporadic inclusion body myositis, £133,413, 18 months.

Dr Lee-Suan Teh, Department of Rheumatology, Royal Blackburn Hospital, Blackburn; can the LupusQoL, a disease-specific health related quality of life (HRQoL) measure, detect improvement or deterioration of the impact of SLE and/or treatment on patients’ lives? £98,727, 30 months.
For little Grace Bolton, diagnosed with childhood arthritis at the age of just two-and-a-half, the future is uncertain.

Her parents, Gary and Kathryn, know that their four-year-old daughter will probably never be as fit, strong and active as her three other siblings. But what they don’t know is whether Grace’s condition will continue to dominate her life as she grows into adolescence and adulthood, or whether her arthritis symptoms will fade away, or even go into remission.

Like any parents of youngsters with arthritis, Gary and Kathryn, from Belfast, are taking each day as it comes. After the six month gap between Grace developing symptoms – a limp, swollen knees and ankles – and the shock of the diagnosis, they are happy that their little girl is receiving the best possible care from their local paediatric rheumatology team at Musgrave Park Hospital.

And despite the fact that Grace has less stamina than her contemporaries and that her younger sister has already outgrown her, she is a lively, happy child who copes well with her regular injections and drug treatments, and is already ruling the roost at her new nursery school.

But for Grace, her parents, and the thousands of families affected by juvenile idiopathic arthritis (JIA), being able to predict the future severity of disease at the time of diagnosis would be a huge boon.

For one thing, it would mean that youngsters with less severe arthritis would not be put on powerful drugs unnecessarily. But it would also ensure that the worst affected children received the treatment they needed before the disease spread and their joints were irreversibly damaged. In other words, treatment could be tailored to the child, so that they were given effective, appropriate treatment.

Reassuring parents

Doctors would also be able to reassure parents at the time of diagnosis what the future holds; something they cannot currently do.

Now the doctor treating Grace at Musgrave Park Hospital, Dr Madeleine Rooney and her academic team at Queen’s University believe they may have found a new way of predicting the outcome of disease, by developing a new blood test. With funding of £282,175 over three years from the Arthritis Research Campaign they plan to involve up to 80 local youngsters from Northern Ireland in their important project, as well as similar number of children from the USA.

JIA is an inflammatory form of arthritis affecting one in a thousand children and teenagers, between the ages of six months and 17 years.

But while some youngsters can develop the condition severely, suffering from many painful joints, stiffness and tiredness, in others the condition is not so serious, with only one or two joints affected. Sometimes the child can even “grow out” of their condition.

“In a pilot study we identified a number of proteins in the body fluids of children measured at the beginning of the disease that can correctly predict disease outcome at two years,” says Dr Rooney.

“We will be able to start better treatments earlier”

“The purpose of our study is to confirm these findings in a large group of children in Northern Ireland and also in a group of children from the USA. This will ensure that the results are meaningful in different countries. If we confirm our findings we will be able to start better treatments earlier.”

The team will look to see whether these proteins are present in the joint tissue, which they believe is an important site where inflammation begins. They will also examine the blood of affected youngsters. If they can find these proteins in the blood they can develop a simple blood test to predict the outcome of arthritis.

Adds Dr Rooney: “Not knowing how the disease will progress leads to uncertainty,
The Arthritis Research Campaign is currently funding two related studies from which it is hoped to be able to devise a ‘predictor kit’ available to all patients and clinicians: Dr Madeleine’s Rooney’s work at Queen’s University, Belfast, and research by Dr Lucy Wedderburn at the Institute for Child Heath at University College London.

The underlying premise of both projects is to discover and validate some markers in the blood of synovial fluid of children with newly diagnosed JIA, that will help clinicians to predict which course the disease might take so that appropriate treatments can be started – or not started.

However, there are differences. Dr Wedderburn is looking to find differences between only two subtypes of JIA, mild disease affecting a few joints and mild disease that in time spreads to become more severe and involving more joints. Dr Rooney is comparing all subtypes of the disease.

While Dr Wedderburn is looking at a wide range of markers – immunological and genetic, Dr Rooney is concentrating on proteins, in particular those identified in a previous pilot study.

Finally, while Dr Rooney is restricting her research to finding predictive markers, Dr Wedderburn is also hoping to understand more about the causes and development of the different types of JIA.

Grace Bolton’s childhood arthritis is so far taking a typical trajectory. Once the disease started to kick in and spread to more joints, for a time she was unable to walk because of the swelling to her knees, feet and ankles. A steroid injection helped to quickly reduce the inflammation, but when a second injection failed to have much effect, she was then put on methotrexate, which has led to her symptoms improving.

“I’d welcome anything that would help us to know how Grace’s arthritis will pan out,” adds Gary Bolton. “We’ve been given the impression that she will have this for the long term, at least until she is a teenager, but no-one knows for sure. After we recovered from the initial shock of knowing that our daughter had arthritis, we have just got on with things, and if we can get Grace living a pretty normal life, that’s as much as we can hope for.”
Professor Drew Rowan and Dr Tracey Toms explain their work in an ongoing series of questions and answers with arc-funded researchers.

**Professor Drew Rowan**

**What does your work involve?**

Articular cartilage allows our joints to move freely and acts as a shock absorber. Unlike most tissues, cartilage is made up of many proteins and few cells. One component, collagen, is perhaps the most important since when this molecule is broken down, the joint becomes irreversibly damaged. I have spent most of my career investigating specialised enzymes called proteinases that break down molecules like collagen in diseased cartilage. My group is trying to work out which are the key proteinases and how they work together in order to destroy the complex structure of cartilage. We are able to make cartilage breakdown in the lab, and use this as a model for what happens in arthritic joints. Modern molecular techniques now enable us to study these complicated events, making research today more exciting than ever and we are beginning to really better understand what some of the key players are at the molecular level that promote cartilage breakdown in disease. Our next challenge is to translate these findings into better drugs for patients.

**How long has arc been funding you?**

My lectureship at Newcastle in 1996 was originally arc-funded, and I have been fortunate to have had continual arc funding since.

**What's the most important thing you have found out in the past 12 months? And why?**

Perhaps our most important and exciting finding has been in osteoarthritis. Most proteinases are made as inactive enzymes which need ‘switching on’ (called activation) by other proteinases. We have recently identified an enzyme that is more abundant in diseased cartilage, does not need activating itself and that can activate other proteinases, and targeting this particular proteinase, could block tissue breakdown. We are busy exploring this exciting finding further as this could potentially lead to new treatments.

**What do you hope or expect to achieve as a result of your arc funding?**

I hope to help find a cure but realistically I expect that my work, like most researchers, will lead to a much more detailed understanding of the processes that occur during disease. I firmly believe that this information will generate new drugs that will increase the treatment options available for clinicians to help better manage patient disease.

**What do you do in a typical day?**

Unfortunately my lab days are long gone. Our department is quite big, and as deputy head I am kept busy making sure the lab-side of things runs smoothly. I spend rather a lot of time writing and reviewing grants and papers, but I try to make as much time as I can for research supervision – it is still a buzz to see new data from one of my students or post-docs that confirms your latest theory.

**What is your greatest research achievement?**

My work in Cambridge and Newcastle has shown that various inflammatory mediators, all known to be present in disease, can act together on cartilage to synergistically promote its destruction. These observations partly explain why the processes are much more complex than we originally thought, and why many patients fail to respond to frontline drugs. However, now we have the evidence for this added complexity, we are better placed to tackle it.

**Why did you choose to do this work?**

I was fascinated by the variety and number of proteinases in the body whilst at university and was fortunate enough to do my PhD in Cambridge in a top proteinase lab. I moved to Montreal to work in a top arthritis lab, and the link was made – I have never looked back!

**Do you ever think about how your work can help people with arthritis?**

Spending several difficult months successfully fighting cancer gave me some appreciation of how we take good health and mobility for granted. Like many, I have family members who suffer with arthritis. It is difficult to see them suffer when your research is going slowly, and you know that even if things were going really well it is unlikely to help them tomorrow. High quality basic research is time-consuming, but I am convinced that the variety of research currently funded by arc represents our best option for new breakthroughs for patients.

**What would you do if you weren’t a scientist?**

A wildlife photographer – I love the wilderness, its animals and the sheer tranquillity.

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**About Drew**

Travel is my real passion – our trips include the Arctic, Alaska, the wilds of Canada, the Galapagos Islands, the Inca Trail, Tibet and the Himalayas, and it’s Patagonia and Antarctica this Christmas! Experiencing other cultures really makes you appreciate what you have.

Drew Rowan is Professor of Molecular Rheumatology in the Musculoskeletal Research Group at Newcastle University’s Institute of Cellular Medicine

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**Do you think this is the best option for new breakthroughs for patients?**

I hope to help find a cure but realistically I expect that my work, like most researchers, will lead to a much more detailed understanding of the processes that occur during disease. I firmly believe that this information will generate new drugs that will increase the treatment options available for clinicians to help better manage patient disease.
Dr Tracey Toms

What does your work involve?
I am a rheumatology registrar currently in my second year of training. My interest in cardiovascular disease in rheumatoid arthritis (RA) led me to step out of clinical training to undertake a period of research. This will enable me to explore some of the mechanisms that may be responsible for cardiovascular disease in patients with RA, as part of a higher degree (PhD). Although, the vast majority of my working week is focussed towards my research project, I continue to have contact with patients both as part of my research project and in routine clinical practice (once weekly clinics).

How long has arc been funding you?
arc has provided significant funding to the rheumatology department at the Dudley Group of Hospitals NHS Foundation Trust over the last few years. The early stages of my research were supported by an arc funded infrastructure grant, allowing me to get my research project up and running. However, in July 2009 I was awarded an arc clinical research fellowship, providing sufficient funds to support the remaining two years of my research project.

What’s the most important thing you have found out in the past 12 months? And why?
Although I am sure the forthcoming two years will be full of exciting discoveries, I have already produced some interesting results. We have recently discovered that a large proportion of rheumatoid patients do not undergo rigorous cardiovascular risk assessment and therefore they receive suboptimal medication/lifestyle advice to reduce their cardiovascular risk.

What do you hope or expect to achieve as a result of your arc funding?
I hope that arc funding will act as a springboard for my career as a clinician and a researcher. In the immediate future it will allow me to complete my current research project (the effects of cholesterol on cardiovascular disease in RA) and gain a PhD.

What do you do in a typical day?
My days have great diversity – one of the wonderful things about research! Many of my mornings are spent recruiting and assessing RA patients and healthy controls for my research. I often have an early start to the day to ensure that my fasted research patients (a fasting state is important for some of the blood tests we perform) are assessed at a reasonable hour, and can then be provided with breakfast prior to their departure. The remainder of my day can consist of a variety of activities including the development of laboratory methods, sample analysis, data entry and analysis, and the generation of clinical papers reporting our findings.

What is your greatest research achievement?
As I am at such an early stage of my career as a researcher the honest answer would be that I am sure my greatest research achievement is yet to come!

Why did you choose to do this work?
My career path has always been guided by a genuine desire to help people and make a difference to their lives. Although we can have a significant impact through clinical practice, it is research that drives medical advances. Thus, I was keen to embark upon a period of research in order to advance understanding and potentially impact upon the management of a specific problem in the field of rheumatology. Cardiovascular disease in RA appeared to be a perfect background for my research. Cardiovascular disease is common in patients with RA and contributes to approximately half of all deaths, thus it had the potential to make a difference. In the general population, high levels of cholesterol are known to increase a person’s risk of developing cardiovascular disease. However, little was known about cholesterol in the context of RA. A greater understanding of the changes in cholesterol and their impact on cardiovascular disease offered an attractive and exciting research project, with the potential to make a real difference.

Do you ever think about how your work can help people with arthritis?
Although I spend much of my time either recruiting patients onto my study or analysing blood samples in the laboratory it is hard to forget the long-term aim of my research and the impact this may have on patients with RA. Working in a large rheumatology department reinforces the importance of the work we do and allows me to observe changes driven by research discoveries first hand.

What would you do if you weren’t a clinician/researcher?
I have always had a bit of a creative side and a bit of a sweet tooth! So the perfect job that would allow me to combine these with my love of talking to people would be to run a tea shop.

About Tracey
I think it is important to get a good work/life balance. I like to keep active and enjoy a range of hobbies from painting to scuba diving. I have recently started to learn ballroom and Latin dancing. I have two left feet but still enjoy it tremendously!

Dr Tracey Toms is an arc clinical research fellow at Russells Hall Hospital in Dudley
I am very happy on Arthrotec 150mg a day, as it cures the pain of my arthritis wonderfully. However, doctors are worried as I am on it permanently at present and they say it can lead to stomach ulcers. Now what choice does that give me, stomach ulcers, or a pain in the neck which gives me nil quality of life? I’d be interested to know your views.

Ann Case, Yeovil, Somerset

This dilemma is part of every consultation that takes place between doctor and patient. We always have to weigh the risks and benefits of prescribing drugs. This also applies to having an operation or any other procedure that is carried out. This used to be a purely medical decision but increasingly patients are more involved in the decision, and quite rightly so. Sometimes the decision is straightforward – the drug may be life-saving, for example, but more often it is a lot less clear cut and does, of course, vary from patient to patient. In your case, yes there is a risk of stomach ulcer, but the risk is low and clearly the benefit you receive is worth this risk as far as you are concerned. Arthrotec is a composite drug, which means that it has two components, the active drug (diclofenac) and another drug (misoprostil) which is designed to reduce the risk of stomach ulcers. So, that may be of some consolation to you.

I’m a rheumatoid arthritis sufferer of about 20 years, on prednisolone and methotrexate. I recently had a coronary followed by two procedures for angioplasty and a heart bypass. I believe I suffered a slower recovery because the management of my prednisolone post-operatively could have been handled better. Could you comment?

Maurice Childs, Orpington, Kent

It is difficult to comment as you don’t say in what way you think the dosage of prednisolone could have been altered for the better. Some doctors believe that methotrexate should be stopped during operations and such like as it may delay healing but clinical trials have shown no basis for this. Steroids, including prednisolone, should be increased during times of physical stress, and then tapered to their former dose when the stress is over. A heart attack, or coronary, is just one example of such stress, and an operation would be another. Why do you need more steroid during times of physical stress? Normally your body produces more of these naturally occurring hormones during such periods, but if you have been on steroids for some time the body is less able to respond. In these cases, we artificially increase the dose of steroid to do the job the body would normally do.

Help! I am just recovering from yet another attack of gout. During the past six years I have had attacks of gout approximately once a year, but from January 2009 have had frequent attacks, occurring every three weeks, in the big toe, ball of foot joint, and other parts of the foot. In January my doctor prescribed a daily intake of allopurinol 300mg, and in mid August increased the dosage to 600mg. Can you shed any light into why I am still getting gout? Blood tests have shown lower levels of uric acid. I am 84 years of age.

Mrs E Collins, Chingford, Essex

This is a difficult one. Allopurinol lowers the level of uric acid in the blood and tissues. This clearing of uric acid may take some time to happen and can be associated with new attacks of gout while the clear out is occurring. This is well recognised and usually stops after about three months. However, in some people, and particularly those people with large deposits of gouty crystals in their tissues, called tophi, this process can take longer. If you have these tophi, this may apply in your case but don’t despair, things will improve eventually. There are other reasons why you might be getting more attacks of gout. Even while you are taking allopurinol certain other drugs can work against it. These drugs include low dose aspirin, which is commonly prescribed nowadays. A high alcohol intake will also work against allopurinol, as will kidneys that don’t function too well (also common in the elderly). So, plenty of reasons there, and best to discuss with your doctor which may apply in your case.
I have osteoarthritis in both knees, not very severely, and can still walk short distances. However, in bed at night I tend to wake up about 4 or 5am with considerable pain in my left knee, sufficient to make it difficult to go back to sleep. Can you explain why it should be more painful when I am in bed? Is there anything I can do about it, apart from taking painkillers?

Susan Pomeroy, Harpenden, Hertfordshire

This is a common problem. There may be a number of reasons why this occurs. Night pain is often an indicator of severity and is used to assess the need for further treatment, such as an operation. From what you say, this may not apply in your case. It may be worth getting a medical ‘update’ on your condition, however. Sometimes pain is more noticeable when there is little else going on but, in that case, people usually find it difficult to get off to sleep. If you are woken up by the pain it suggests that the arthritus has reached a more advanced stage. It may help to take a drug with a long duration of action, say 12 hours, at bedtime. Some anti-inflammatory pills are formulated in this way, as are some painkillers – they are usually labeled ‘modified (or slow) release’.

Further to one of the questions in the autumn edition of Arthritis Today about swimming, I had had a hip replacement eight years ago and was advised to be careful swimming the breast stroke and just do gentle movements. However, when I had a knee replacement earlier this year I was told there were no restrictions. Could you possibly clarify?

Mrs C Corrigan, Stanley, Wakefield, West Yorkshire

When I answered the hip question in the last issue I canvassed opinion from a wide range of sources, including physiotherapists and orthopaedic surgeons. There is no consensus on this I’m afraid. This results from a lack of research. No one, to my knowledge, has compared different regimes of rehabilitation and exercises following hip and knee surgery. However, I think this is one of the most important aspects of the operation! What also surprises, and worries, me is that some people are given no advice on exercise at all. It may make no difference what you do, be it gentle breast stroke or knee bends but we don’t really have a clear answer at the moment. Very few exercises will actually cause lasting harm, unless you take up Taekwondo or something similar. My best recommendation is: ‘Follow local advice’.
King's College Hospital has a reputation for patient-based research that results in direct, practical outcomes. Jane Tadman reports on an arc-funded study that has influenced current rheumatoid arthritis guidelines.

Rheumatoid arthritis (RA) patients being treated at King's College Hospital in south London may not realise it, but their experiences in clinic – both good and not so good – are helping to formulate national guidelines on how to improve standards of care nationally.

While there are many good rheumatology centres around the UK, a number of national reports published recently have reached a consensus that care of people with RA is unsatisfactorily patchy around the country.

At King's College Hospital, Professor David Scott is one of the leading exponents of the concept of ‘total quality management’ and has been playing a big part in developing national guidelines to ensure patients receive a uniform, high standard of care and treatment wherever they happen to live.

Professor Scott also happens to be not only the head of academic rheumatology at King's College London but also a clinician with a strong sense of responsibility for ensuring that his own patients receive timely and appropriate treatment.

As a result of this interest, the Arthritis Research Campaign awarded Professor Scott and his team a £300,000 programme grant, five years ago. It aimed to improve patient satisfaction by developing a ‘total quality management’ approach to treatment based on the best evidence available.

Since that time, however, the national picture has changed, with the NHS developing its own emphasis on quality of care and improving the so-called patient experience.

Reports by the King's Fund and the Rheumatology Futures Group, and guidelines from campaigning umbrella group the Arthritis and Musculoskeletal Alliance (ARMA) and the government health watchdog body the National Institute for Health and Clinical Excellence (NICE) have highlighted the weaknesses in current treatment, and suggested ways in which patient care can be improved.

King's College Hospital should be given credit for its far-sightedness in preempting this national debate, believes David Scott’s colleague, rheumatologist Dr Gabrielle Kingsley. “When I used to go around talking about these ideas colleagues thought we were bonkers!” she says.

Adds David Scott: “Since we started in this research, it’s become a far bigger agenda than we thought it would be; the NHS had the same idea on a bigger scale, and a lot of the ideas we put into this grant have been incorporated into national guidelines, and should revolutionise practice.”

Results of research

The results of interviews and focus groups of patients of different ages and ethnic backgrounds, as well as health professionals, resulted in some interesting, if unsurprising findings in the arc programme grant. They include:

**Early treatment is important**

Too many people wait too long before consulting their GP with painful symptoms. GPs often fail to refer patients to a rheumatologist quickly enough. Patients should be referred within three months of persistent symptoms.
What have been the main findings of the four recently published reports and guidelines on the management of rheumatoid arthritis?

ARMA standards of care 2004
- All patients should be seen by a rheumatologist within three months of referral by their GP.
- On diagnosis patients should have a full assessment of their disease, general health, psychosocial and pain management needs.
- Patients should have an individualised care plan for the management of their disease, compiled by members of their multi-disciplinary team.

National Audit Office report on rheumatoid arthritis 2009
- Too many patients are not diagnosed or treated quickly enough – the average length of time from symptom onset to treatment is nine months – it should be three.
- Services are not coordinated enough.
- Many patients do not have sufficient access to psychological services even though depression is common.
- The provision of quick response appointments in the event of a flare is inconsistent.
- Current services do not always match the Government’s vision of a ‘systematic patient-centred approach’.

Rheumatology Futures Group report (King’s Fund) 2009
- There are ‘unacceptably wide variations’ in the quality of care as well as levels of access to treatment, particularly in early treatment and managing flares.
- Many patients want their healthcare professionals to recognise that they need more than medical care and also require consideration of the broader social and psychological issues.

NICE guidelines for rheumatoid arthritis 2009
- Health professionals must refer patients to specialists if there is long-term synovitis (inflammation of the joint lining) that persists without a known cause.
- Urgent referrals should be made if more than one joint is affected, or if there has been a delay of three months or more between symptoms appearing and the patient seeking medical advice.
- Patients should be offered intensive, early combination therapy.
- Patient-centred care should be provided, with good communication between the patient and health professional essential.

Intensive treatment is important
Intensive treatment of early and active disease is also important. In the bad old days patients were put on methotrexate and saw their rheumatologist once a year. Ideally a patient should see a medic or specialist nurse monthly if their disease is active.

Treatment of rheumatoid arthritis is not just about physical symptoms
Pain control, depression and the psychosocial assessment of the condition is ignored. There is a need to urgently address this area of care.

Rheumatology nurses are greatly valued
Nurses were thought to be better at dealing with general aspects of non-drug treatment, they were also more approachable and better at listening.

“All patients have different views. Many don’t find the experience of coming to outpatients is a good one – it’s hard to get to the hospital, difficult to park, and many of my patients think I keep them waiting too long!” says David Scott. “But in general patients feel that treatments have got better and their care has improved over the past few years.”

Differences between idealised guidelines and reality
King’s College Hospital has tried to tackle some of the concerns expressed by patients, by employing more rheumatology nurses at the Denmark Hill and Lewisham hospital sites, and attempting to provide some cognitive behavioural therapy (CBT), physiotherapy and occupational therapy (OT). But Professor Scott is all too aware of the differences between idealised guidelines and reality. “CBT, OT, physiotherapy, podiatry doesn’t happen in an organised way anywhere that I am aware of. We have a podiatrist who does some work with inflammatory patients, but it took years of negotiation, then finding the right person with experience, who wanted to do it. The multi-disciplinary team idea doesn’t really work across the country, and care needs to be better joined up between GP and hospital services.”

Professor Scott and his team were surprised by some of the findings from the research. “Our prior belief was that the main problem when managing RA patients was that they don’t receive sufficient disease-modifying anti-rheumatic drugs (DMARDs) and anti-TNF (tumour necrosis factor) inhibitors, and we thought care should be changed to maximise treatment. The results have suggested the situation is somewhat different. I now know what the problems are – although I don’t necessarily have the solutions.”

He accepts that care doesn’t improve overnight because of aspirational guidelines, but believes that the King’s College Hospital arc-funded research has played an important part in developing the quality agenda. And arc has recently awarded a foundation fellowship to psychiatrist Dr Claire Goodchild at King’s College Hospital to look at ways in which physical activity and sleep can be improved in RA patients on the back of the programme grant. “By pursuing a quality agenda patients have benefited substantially,” he says. More needs to be done, including better ways of treating pain and depression, and the long term goal is still to ensure that all RA patients receive the very best care and treatment irrespective of where they live.
Lace up your running shoes for arc this New Year

Running events are becoming increasingly important to arc’s fundraising efforts. In the left hand photo are Kerry Sullivan, who decided to run the Bristol 10K to support her sister who has rheumatoid arthritis, and friend Rebecca Tipping. In the right hand picture are Suzanne Foster from Newport and her friend Michelle McDonald from Swindon, who successfully completed the Cardiff Half Marathon. These are just two recent examples of hundreds of successful personal and fundraising achievements.

Why not make a special New Year’s resolution to join arc’s running team and help to raise vital funds for our pioneering research? We have guaranteed places available in some of the UK’s most popular running events. All you need to do is decide which one to take part in.

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If you would like to apply for one of our guaranteed places, or if you have secured your own place in the Brighton Marathon and the other Bupa Runs and would like to raise funds for arc, then please contact Lyndsey on the events hotline 01246 541108 or email events@arc.org.uk for further information and support. To take part in the Jane Tomlinson “Runs for All” 10ks; (mass participation events which are open to people of all abilities), please contact regional fundraising manager, Kathryn Leverett on 01423 324158 or email k.leverett@arc.org.uk. All our runners will receive a comprehensive fundraising pack, a team running vest and support from our dedicated events team.

Fashionable Farnham

Farnham branch in Surrey held a Fashion Show at Elphicks department store in October. The event was organised by secretary Wendy Montague with the help of Diana Standing and committee, and raised over £1,000 for arc. Wendy (4th from left) and committee member Jill Hills (3rd from left) were models as were daughters and friends of committee members. Wine and nibbles were served which added to a fun evening.

Friends in flight

What persuaded these three glamorous arc supporters to don jumpsuits and hurtle from a plane 12,000ft above Maidstone, Kent. Chantel Opperman (pictured centre), has rheumatoid arthritis and her two friends, Debbie South and Cheryl Gutteridge, joined her on this brave challenge to raise £1,750 for her favourite charity. Chantel explains: “Thanks to research and the development of fabulous drugs, I can now lead a ‘normal’ life. I figured it’s about time I gave something back, so I convinced Cheryl and Debbie to join me.”

Peaks of achievement

The Three Peaks Challenge involves climbing the tallest mountains in Scotland, England and Wales in under 24 hours and these two brave supporters not only completed it in time but also raised £647 for us. Chris Gaffney of Swadlincote, Derbyshire and Rich Ford of Alrewas, near Burton on Trent, (pictured coming down off Scafell) eventually completed the trio of peaks with a successful assault on Snowdon.

Chris’s fiancée, Leanne, is an arthritis sufferer who has just been given a new course of treatment as a result of the work of arc. Said Chris: “It was a remarkable experience and one which was made all the more special by those who supported us. This is just a small way to say thank you to arc for giving me and Leanne the chance to live a normal, happy, lovely life together.”
**Golfing success**

Roger Shaddick, seniors golf captain at Stover Golf Club in Newton Abbot, Devon, chose arc as his charity of the year after the death of his mother-in-law, who suffered from rheumatoid arthritis for many years. Roger raised a magnificent £2,688 during his year as captain, a wonderful memorial to his late mother-in-law.

**Presidential cheque**

President Janice Gosby of the Poole branch of Soroptimists International chose arc as one of her charities to benefit from her year of Presidency. Janice has suffered from arthritis for many years and has been part of the recent arcOGEN project. She is pictured at the annual lunch presenting the regional fundraising manager Jenny Oakshott with an interim cheque for £500 from the branch's many fundraising activities.

**North Wales fashion show triumph**

Amy Noden of Conwy in North Wales celebrated her improved state of health by organising a charity fashion show in November to raise funds for her favourite charity arc. Amy was only four years old when diagnosed with arthritis. After a period of remission, cruelly, it returned when she was 18 and within six months psoriatic arthritis took over her whole body, leaving her practically bedridden. Then four years ago Amy was put on etanercept, one of the anti-TNF drugs pioneered by arc, which relieved some of the pain and improved her mobility. Amy organised the charity fashion show with fellow! shopkeeper at Flirt Jane Hawksworth, and other shops in Conwy joined in the show and contributed prizes. The fashion show was an amazing success, raising £1,000 for arc’s Noddy Appeal. Many thanks Amy and friends! Pictured are models from Flirt, and with the big cheque, from left to right are: Amy Noden (ChatterBox & Lingerie Box), Darren Evans (Smartass Menswear), Diane Howard (Sunset Club), Julie Howard (The Dressing Room) and Jane Hawksworth (Flirt).

**Praise the Lord – the Haverford West arc branch lives again!**

Members of Haverfordwest Inner Wheel are pictured doing their interpretation of Sister Act, which raised £500 for arc. The local branch went into decline due to illness and the old age of its membership, but ex-branch member Lucy Imrie-Brown, having attended the opening of the arc biomechanics and bionengineering centre in Cardiff was so inspired and re-motivated that she decided to revive the old branch again. “Having seen the pioneering medical research done at the centre I feel I want to help raise more funds to enable scientists to do more good work in other areas of Wales,” said Lucy. Amen to that!

**All steam ahead**

Rixey Park Vintage & Classic Working Rally in Devon celebrated its tenth year by raising money for arc in September. BBC Radio Devon’s Tony Beard: “The Wag from Widecombe” opened the event before being “mugged” by “arc bucket dollies” (pictured). A huge vote of thanks is due to Lisa and BJ, who organised the weekend.

**Classical music & comedy a winning formula**

The Otley branch raised £400 from a concert held by Simeon Wood in October at Guiseley Methodist Church, West Yorkshire. Over 80 attended the evening and listened to a delightful array of popular classical music. As well as being an established and acclaimed flautist Simeon Wood has a unique blend of comedy which is great entertainment for all the family.

**Getting in the swing**

The annual arc corporate golf day at Whitchurch Golf Club in Shropshire raised a fantastic £4,500 for arc. Pictured are the captain’s team who were the runners up, from left: Mick Hill, Nigel Edwards (Captain), Bernard Morgan and Stuart Swain.

**Zipping over the river Tyne**

This new and exciting event for arc is happening in June and we are appealing for those seeking what will be the best thrill of all - “zipping” off the Tyne Bridge across the river at Gateshead. Registration is only £20 with a minimum sponsorship of £140 and with limited places available you should contact regional fundraising manager Marion Reed for registration details on 01388 526 860 or email: m.reed@arc.org.uk.

**FUNDRAISING**
Breakfast bounty

Bristol Breakfast Rotary nominated arc as the main charity to benefit from the Bristol Dragon Boat Festival in June. Jesse Alexander, Captain of the "arc-angel" dragon boat, and Suzie Ladbrooke, arc regional fundraising manager were delighted to join the Lord Mayor, the Lord Lieutenant and Rotarians for a delicious breakfast at The Mansion House followed by a cheque presentation of £10,000.

Pictured left to right are Rotary District Governor Stewart Gilbert, John Prior, MBE, JP and Lord Lieutenant of Bristol Mary Prior, Suzie Ladbrooke, Lord Mayor of Bristol Councillor Christopher Davies, Rotarian and organiser of the Festival David Gammon, and Jesse Alexander.

Lucrative bridge drive

Elizabeth and Tony Geddes and their sterling team of helpers once again ran their very popular bridge drive and tea at Walton on the Hill, Surrey, raising £2,200 for their branch. arc Christmas goods were also on sale.

Putting the fun in fundraising!

Pictured are some of the committed and hardworking members of the Cambridge branch with regional fundraising manager Alan Maloney after yet another hugely enjoyable and successful Bridge Drive at Comberton Village Hall in October which raised a superb £600. The branch also invited guests and supporters to a coffee morning in November which itself raised £400.

Bingo in the afternoon

Members of Thorpe St Andrew branch in Norwich are pictured hosting one of the many bingo afternoons that they hold throughout the year. During 2009 they managed to raise the fantastic sum of £689 from these events alone. The branch would like to express their heartfelt thanks and gratitude to all the loyal supporters from within the local community who have helped them over the years.

 arc angel rose offer

Order our coppery-salmon scented hybrid tea rose now to bloom in summer, available until March. Call 0870 850 5000 to pay by debit or credit card, or send a cheque (made out to Arthritis Research Campaign) to arc, St Mary’s Gate, Chesterfield S41 7TD. Each rose bush is £5.95, plus a £3.60 charge for posting and packaging.

Three Peaks Walk, Saturday April 17th 2010

Take a walk on the wild side and help us beat arthritis by taking part in a 26 mile guided sponsored walk through the beautiful Yorkshire Dales countryside. For more information call Kathryn Leverett on 01423 324138 or email her at k.leverett@arc.org.uk

Bag ladies

The intrepid members of North Somerset group have come up with a fun fundraising product which they could make and sell at a reasonable price to raise funds for arc. Sheila Radford, chair of the group, started off by decorating a jute shopping bag with pictures of a seaside scene and from there, little acorns grew and now she and Penny Lawrence, treasurer of the group, spend all their spare time ‘fraying’ for arc. The bags are made of a natural and biodegradable product which is therefore environmentally friendly so if you are looking for a present for someone who would appreciate a shopping bag decorated by people with arthritis to raise funds for research then this is the place to come. Decorated in various themes from Christmas, cats, gardens, flowers, herbs, seaside etc., all for £5.99 including an arc pen & pencil! If you would like an arc jute bag, please email Penny at northsomersetarc@btinternet.com or ring 07891 592298 with your choice of design. Postage is £1.30 for one bag.
Rise to your feet effortlessly in this elegant and stylish custom-built piece of furniture. Combined with the optional built-in, 5-point massage system, this luxury recliner really should be experienced by people who have ailments such as stress, back pain and arthritic pains. But don’t just take our word for it; experience a Willowbrook riser recliner for yourself.

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Promoter: Willowbrook, Mercury House, Kingswood Road, Hampton Lovett, Droitwich Spa, Worcestershire, WR9 0QH. Promotion open to all UK mainland residents. By entering you agree to these rules. Competition start date is 6th January 2010, all entries received after 7pm on the 27th January 2010 will not be considered and entries will not be obtained. Only one entry permitted per household. Entries made in bulk or by third parties are prohibited. All entries are entered into our monthly prize draw and the winner will be drawn at random at the end of each month. Your chances of winning are based on the number of entries received.

We will also select 100 random qualifier prizes. The winner’s prize will be a Willowbrook riser recliner chosen from six designs selected from the Willowbrook range. Optional extras will be charged as per the Willowbrook retail price list. *The 100 qualifiers will each receive £150 trade-in for their old chair and a 35% discount on their purchase of an electrically powered lift and recline chair. There is no cash alternative and the prize is not transferable. Our decision as to the winner is final. Winners will be notified within 10 days of the end of each month. A list of winners can be viewed at www.willowbrook.co.uk/winners.php. Please tick box in coupon if you DO NOT wish to receive product information from Willowbrook.

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