



REPORTER

Newsletter of the Society of Physician Assistants in Rheumatology

Month 2009

Volume X • Number X

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SPAR invites you to bookmark our new Web site at www.rheumpas.org

SPAR
950 N. Washington St.,
Alexandria, VA 22314-1534

E-mail: spar@aapa.org
Work: (866) 980-2272
Fax: (703) 684-1924

President's Report

— By Rick Pope MPAS, PA-C

This year at the ACR meeting the ARHP President's Award went to Joan McTigue, PA-C. Joan was one of the steering committee members for the 19 module online course. Her efforts for the module were recognized at the ARHP networking breakfast at the meeting in San Francisco in the latter part of October.

The first day of the ACR conference featured a Clinical Focus Course for both PAs and NPs interested in developing clinical skills and evaluation techniques. Over the course of the day hands-on examination of joints were demonstrated as well as how to evaluate for extra-articular signs including Schirmer's test, Shober's test and others specific to our specialty.

Tom Cippola, PA-C represented PAs on a four-person panel that was designed to show the positives of hiring physician extenders in rheumatology practices. This panel was proposed by Christine Stomatos, APRN. The panel included an RN and MD who spoke positively of the benefits of non-physician providers that help with the day to day management of rheumatology patients.

With the help of the AAPA, SPAR exhibited on the floor of the San Francisco convention center for three days. There were about 12 physician groups or physicians that stopped by the booth that were interested in hiring PAs in their practices. They were handed the census data for PAs in rheumatology compiled by Rod Hooker, Ph.D, PA-C for 2008. This data can be located on our Web site at www.aapa.org/spar.



Additionally, physicians interested in hiring PAs were encouraged to offer an incentive by helping to pay for the ARHP modules online. There are adult and pediatric components and the cost varies depending on whether it is purchased by a member and can be accessed at www.rheumatology.org.

This winter we will be adding two new director positions to our board. This will help to stagger the board positions so that we have both new and old members on the board in an effort to help mentor the new board members. We have asked for a student member to assist on the board and hope to have a student board member elected by July. Michelle Russell from Quinnipiac University will be acting as student representative until the bylaws are changed and there has been a formal election. In addition SPAR will financially assist two or three board members who will attend

the upcoming CORE meeting in Washington over the third weekend in February. This meeting is designed to help constituent chapters network to solve common problems that face many non-profit professional groups within the AAPA.

Lastly, we will be running an election in the mid-winter months and have a newly elected President-elect, and VP-elect, and student board member. When you receive an e-mail or regular mail ballot please take the time to vote.

Have a safe, happy, and healthy holiday season and new year.



SPAR Board of Directors

President

Richard S. Pope, PA-C
203/755-5555
pop57hjc@aol.com

Vice President

Don Flinn, PA-C
405/552-9229
dflinnpa@aol.com

Treasurer

Trishna Patel, MS, PA-C
203/755-5555
pateltrish45@yahoo.com

Secretary

Barbara Slusher, PA-C
281/481-8557
barbnmark@earthlink.net

Member at Large

Antonio Giannelli,
MsA, PA-C
269/969-6272
gnle852@cablespeed.com

Membership Director

Jon Lum, PA-C
203/755-5555
jonlum@sparheum.org

Publications Chair

Linda Davis, MHS, PA-C
817/735-5434
lidavis@hsc.unt.edu

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Society of Physician Assistants in Rheumatology

950 North Washington Street
Alexandria, VA 22314-1552
Phone: 703/836-2272, Fax: 703/684-1924
E-mail: spar@aapa.org
Web site: www.aapacoms.org/spar/

Articles, editorials, and member comments are welcome. The editorials and opinions expressed in this publication are those of the authors and are not necessarily those of the Society of Physician Assistants in Rheumatology.

SPAR Members an Integral Part of ARHP Course Success

—By Barbara Slusher, PA-C, MSW

The Advanced Practice Skills Course debuted at ACR's Annual Scientific Meeting in San Francisco, October 2008 to a fully booked audience. The course was offered by the Association of Rheumatology Health Professionals (ARHP) and was open to physicians, midlevel providers, nurses and other interested rheumatology health professionals. The course focused on musculoskeletal exam and injection techniques, and HAQ & DAS-28 measurement tools. There was a hands-on portion with real patients to teach rheumatology specific musculoskeletal exam skills and participants practiced joint injection techniques on sound-enabled joint models. Participants especially appreciated the patient volunteer portion because they could see joint pathology firsthand and apply teachings learned during the course.

Several SPAR members were involved with the course from the planning stages to delivery of the content. Ben Smith from MacIntosh Clinic in Georgia gave an awesome talk on musculoskeletal exam skills. Neil Moody from Washington state was lead facilitator for the shoulder joint injection portion. And Barbara Slusher from Houston, Texas served on the task force that helped develop the course.

Overall, the course was a resounding success and if you missed it in San Francisco, you have an opportunity to attend an encore presentation on Friday April 17, 2009 at ACR's State of the Art (SOTA) conference in Chicago, IL.

Come join us in Chicago and sharpen your joint exam skills and joint injection techniques. Registration information is available on ACR's Web site at: www.rheumatology.org/meetings/clinical/09_sota.asp



News You Can Use

December 2008

Treatment Recommendations for Psoriatic Arthritis

■ (*Ann Rheum Dis* 2008; DOI: 10.1136/ard.2008.094946.)

Summary: An international panel of arthritis specialists, including rheumatologists and dermatologists, developed 19 recommendations from the evidence-based information that is currently available on the diagnosis, follow-up, and treatment of psoriatic arthritis. Some of the highlights of the recommendations consist of approving the diagnostic classification criteria for psoriatic arthritis (CASPAR); providing guidance regarding minimum evaluation criteria at follow-up visits; utilizing sulfasalazine, leflunomide, methotrexate, and cyclosporine as first line treatment; obtaining “input” from a rheumatologist before initiating treatment with a DMARD; utilizing anti-TNF medications for DMARD failures; and avoiding completely the usage of systemic corticosteroids, gold salts, chloroquine, and hydroxychloroquine.

Comments: To my knowledge, these are the first evidence-based guidelines that address the diagnosis and treatment of psoriatic arthritis. Hopefully they will improve the quality of life of those individuals who suffer from this disease and at the same time supply additional information to support (or disprove) these recommendations. However, it is important to remember that these recommendations are not absolutes, but guidelines, that must be individualized for each patient.

D-Dimer Level and the Risk for Thrombosis in Systemic Lupus Erythematosus

■ (*Clin J Am Soc Nephrol* 2008;3:1628-1636)

Summary: This small study of 100 consecutive patients with active SLE were evaluated over a mean period of slightly greater than three years with a D-dimer test annually and with flares and other serious illnesses. When the D-dimer was positive, the patient was further evaluated for evidence of large vessel, small vessel, and Libman-Sacks thrombosis. The authors found that those individuals with the lowest peak D-dimer levels not only had the lowest incidence of thrombosis but also the lowest incidence of antiphospholipid antibodies (APA). Furthermore, they discovered in the absence of an evident thrombosis, D-dimer levels were elevated with flares and/or systemic infections. They concluded that patients with SLE, regardless of APA status, who had normal D-dimer levels, are at a very low risk of thrombosis. However, patients with SLE persistently elevated D-dimer levels that did not have a flare, serious illness, and/or another etiology for an elevated D-dimer level had a high risk for thrombosis.

Comments: This is a very interesting study with a fascinating use of the D-dimer test. We know that patients with SLE, especially if APA +, are at an increased risk for thrombosis. Unfortunately, there currently exists no precise formula, criteria, or test to determine which patients are most likely to experience a thromboembolic event. Obviously, because of the adverse effects, including hemorrhagic CVA, associated with anticoagulation therapy, the benefit vs. risk profile makes it impractical to anticoagulate every patient with SLE. However, if these findings can be reproduced in a much larger scale, longer-term clinical trial(s), a D-dimer could become a routine part of the annual SLE examination and those with levels > 2 µg/ml be placed on anticoagulation therapy. Which anticoagulation regime and at what dose would require additional placebo controlled clinical trials to determine.

Persistent Elevation of Fibrin D-Dimer Predicts Long Term Outcome in Systemic Juvenile Idiopathic Arthritis

■ (*J Rheumatol* First Release Dec 1 2008; doi:10.3899/jrheum.070600)

Summary: This very small study (n=31) assigned patients with systemic juvenile idiopathic arthritis (sJIA) a risk category based on their first D-dimer test results. These children were followed for a minimum of two years at which time a follow-up assessment and repeat D-dimer test was performed. The researchers found that in patients with a persistently elevated D-dimer level despite appropriate treatment was associated with a more severe disease course.

Comments: This small study represents another unique use of the D-dimer test. Obviously a much larger, longer-term prospective study is required to confirm these findings. If the results hold true, then perhaps this “high-risk” group of children would be based on a more aggressive treatment regime in attempts to suppress the illness. Obviously, large placebo-controlled trials would also be necessary to determine what that best treatment strategy might be. Still, just as we may in the future see D-dimer as part of the routine evaluation for patients with SLE, we might see it for children with sJIA (or for that matter any patient with a connective tissue disease) to identify those “at-risk” patients and treat them more aggressively.

Vitamin D or hormone D deficiency in autoimmune rheumatic diseases, including undifferentiated connective tissue disease

■ (*Arthritis Research & Therapy* 2008;10:123)

Summary: The fact that vitamin D receptors have been found on immune cells and these same cells produce vitamin D lead researchers to attempt to identify exactly what type of activity that they had. They confirmed that vitamin D does indeed have important immunoregulatory properties that act upon the dendritic cells, Th1 and Th17 cells, and B cells, thereby explaining

the association between vitamin D deficiency and autoimmune diseases. More interestingly, they discovered that those individuals with the lowest levels of vitamin D more often progressed from an undifferentiated connective tissue disease (UCTD) to a connective tissue disease (CTD).

Comments: Vitamin D deficiency is getting more and more attention lately. We have long known it to be a factor in the development of osteoporosis. It has also been linked with inflammation, cardiovascular disease, hypertension, parathyroid disease, Alzheimer's disease, insulin resistance, diabetes, and some types of cancer. Even though vitamin D is a fat soluble vitamin, it has to be taken in significantly larger doses than those currently being recommended in the prevention and treatment of post-menopausal osteoporosis (800 IU/day). The finding of it being associated with UCTD and CTD makes it all the more important that we discuss its intake starting with our pediatric patients. Furthermore, it supports the concept for routine screening for vitamin D deficiency in all our middle-aged and elderly patients. However, larger randomized placebo-controlled studies are going to be required to determine the exact relationship between vitamin D levels and these diseases, whether adequate intake (from direct sunlight, dietary means, or supplements) is going to be beneficial in primary and/or secondary prevention as well as treatment, and what the optimal dose should be.

Comparing non-vertebral fracture risk reduction with osteoporosis therapies: looking beneath the surface

■ (*Osteoporos Int* 2008. DOI 10.1007/s00198-008-0802-0)

Summary: This article summarizes the findings from a review of the data from pivotal clinical trials submitted to the FDA for the approval of anti-resorptive agents to determine if one agent is superior to another in terms of their ability to reduce the incidence of non-vertebral fractures (NVF) as some of these manufacturers are suggesting. The authors found many variables that could easily account for the differences in the results. For example, looking at inclusion criteria and baseline characteristics of the participants, there was significant variability among their ages, bone mineral density results, previous vertebral fractures, prior non-vertebral fractures, current fracture risk, co-morbidities, etc. Those trials who had large number of participants who were at low risk for a NVF at baseline positively influenced the overall fracture risk over the trial period. Additionally, some of the studies did not include propensity to fall and patient frailty as risk factors for fracture where others did. Obviously excluding NVFs for these reasons in some trials and leaving them in the number of NVFs in others would skew the overall number of fractures. Furthermore, the definition for NVF varied significantly from study to study, which obviously impacted the number of NVFs reported.

Comments: Although I applaud the author's effort, this still does not fully answer the question, "Is one agent superior to another?" It supplies us with factors that could potentially affect the outcome of the studies; unfortunately, despite all the author's extensive review, analysis, and re-analysis, an absolute conclusion cannot be reached because we are still comparing "oranges to apples" which is acceptable to the FDA review committees. What we need are more independently done and funded, head to head studies (like seen in the next article).

RisedronatE and Alendronate Intervention over Three Years (REALITY): minimal differences in fracture risk reduction

■ (*Osteoporos Int* DOI 10.1007/s00198-008-0772-2)

Summary: This unique study was a head to head comparison of two bisphosphonates by a source not affiliated with the manufacturer of either product. In this study, claims data from a U.S. health care corporation identified approximately 20,000 women who were either started on weekly alendronate or risedronate. Compliance with therapy was also confirmed by the claims data as were type and number of fractures. After one year, the data was compared and the authors found that even though women on risedronate had a higher incidence of hip fractures, it was not felt to be clinically significant. Overall, they concluded that there were no significant differences between the absolute rate of clinical fracture, both vertebral and nonvertebral, between the two drugs at one year.

Comments: From a clinical standpoint, this is much more useful and powerful data than comparing the results of one drug vs. placebo to another drug vs. placebo in varying clinical protocols. However, it would be great if this study or one similar to it could continue for a much longer time frame.

Effect of antioxidants combined to resistance training on BMD in elderly women: a pilot study

■ (*Osteoporos Int*, 2008; (Nov 2): [Epub ahead of print])

Summary: This very small (n=34) placebo-controlled study randomly placed post-menopausal females (average age 66 years) in one of four groups: active drug (vitamin E 600 mg and vitamin C 1,000 mg daily), resistance training 3 days/week, combination drug and resistance training, and placebo. After 6 months BMD was re-measured at the lumbar spine. It was found to be statically significantly reduced in the women in the placebo group but remained stable in the women in the other three arms of the study. However, the group receiving antioxidant therapy plus resistance training had no greater BMD stability than either group alone.

Comments: Obviously a much larger, long-term clinical trial that also involves all groups being on adequate calcium and vitamin D as well as weight-bearing exercise (instead of, or as another set

of treatment arms, resistance training) is indicated before any conclusions can be determined. It is obvious that we don't fully understand the role of oxidative stress and its impact on various disease processes, including post-menopausal osteoporosis. Since neither of these vitamins are fat soluble, with the exceptions of allergic reactions and potential drug interactions, they should be relatively safe for most women to take. Since we know that adequate calcium and vitamin D (either through diet or supplementation) and weight-bearing exercise play a significant role in the prevention and treatment of osteoporosis, it would not be unreasonable to go ahead and recommend adding these two vitamins to that regime in women with post-menopausal osteoporosis who are unwilling to take, intolerant of, or achieving poor results from currently existing post-menopausal medical treatments. Furthermore, it would be reasonable to recommend that women who are unable to get weight-bearing exercise for whatever reason, to add these antioxidants. However, it would be inappropriate to recommend to women that they could stop exercising, take these two vitamins, and get the same benefit because we do not have long-term, evidenced-based information on which to support such a recommendation, nor do we know how it will impact other disease processes that are prevented and/or treated by exercise, e.g. obesity, hypertension, and CAD.

Treatment with Potassium Bicarbonate Lowers Calcium Excretion and Bone Resorption in Older Men and Women

■ (J Clin Endocrinol Metab 2008 (Oct.): Epub ahead of print)

Summary: This small study (n=171) randomly assigned both male and female patients who were at least 50 years to one of four study arms: placebo, potassium bicarbonate, sodium bicarbonate, or potassium chloride. Additionally, each patient received 600 mg calcium and 525 IU vitamin D₃ daily for a three month period. The participants in the bicarbonate groups had significantly lower levels of urinary N-telopeptide and calcium excretion compared to the placebo group or the potassium chloride groups. Thus, the authors concluded that it was the bicarbonate, not the potassium, which was the effective component. Furthermore, they theorized that perhaps increasing the alkali content of healthy older adults' diets may decrease bone loss.

Comments: This is good news for individuals who are either unwilling or unable to take the currently available medications for the prevention and/or treatment of osteoporosis as it could be a viable alternative in the future. However, before we start making this recommendation, much larger, long-term clinical trials need to be conducted. Additionally, it would be terrific to see the results further divided into male and female; high risk vs. low risk; prevention vs. treatment; low BMD vs. normal BMD; effect on urinary peptides and excretion over time; effect on BMD; and most importantly, how this correlates with overall fracture reduction.

Seroprevalence of Parvovirus B19 in fibromyalgia syndrome

■ (Clin Rheumatol 2008 (Nov) DOI 10.1007/s10067-008-1044-4)

Summary: 75 patients with clinically confirmed fibromyalgia syndrome (FS) serum anti-B19 IgM and IgG antibodies were compared with those of 75 healthy age-matched participants. Seropositivity for anti-B19 IgM was essentially the same in both groups; however, seropositivity for anti-B19 IgG was markedly greater in the group with FS compared to the healthy controls, 81.3 percent vs. 64 percent respectively. The authors conclude that the Parvovirus B19 infection could have a role as either the causative or triggering agent of FS.

Comments: FS has still not been embraced by the medical community as a non-psychiatric condition. Part of this reluctance is the fact that its diagnosis is made solely on the basis of history and physical examination. There is no diagnostic test that can be done for definitive diagnosis. Furthermore, there exists wide fluctuations between symptoms and disability levels in individuals afflicted with the condition. All of these combined with the fact that we do not know what causes the condition makes it all the more suspect in the minds of many health care providers. Many common viruses, e.g. Coxsackie, Epstein-Barr, Hepatitis B, Hepatitis C, HIC, and enterovirus, have been implicated as the causative or triggering agent in FS and we can now add erythema infectiosum to the list. Obviously much larger studies of both individuals suffering from FS as well as controls are going to be required to convince me that this is the causative agent. Perhaps the disease is triggered by an infection, of which this is just one of the many.

If these numbers are representative of the U.S. population at large, then nearly we can assume that the overall incidence of seropositivity to anti-B19 is 72.6 percent (81.5 percent of individuals with the disease and 64 percent of individuals without the disease averaged for 72.6 percent). Therefore, individuals with FS are less than 10 percent above the national average of seropositivity and less than 10 percent of individuals without fibromyalgia are below the average seropositive rate. Since antivirals have a very low success rate in the treatment of individuals with FS, I personally think we need to be spending more time trying to effectively treat the disease and less time attempting to determine its etiology and/or triggers.

What's New in the World of Lupus Research

— By Teresa J. Aberle, PA-C
Oklahoma Medical Research Foundation
 755 Research Park Suite 530
 Oklahoma City, OK 73104

So what's new in the world of lupus research?

In short, an explosion in the identification of susceptibility genes for SLE, discovered by various lupus genetic studies, including the genetic studies of the LFRR (Lupus Family Registry and Repository).

The LFRR is a long-term research project sponsored by the National Institutes of Health and housed at the Oklahoma Medical Research Foundation (OMRF). The LFRR is a source of data (both clinical and genetic), serum, and DNA from families that have at least one member who meets the ACR classification criteria for SLE. Researchers use the information and materials to uncover the genes that reveal the causes of lupus and to ultimately develop better treatments for patients with lupus.

Why the explosion in genetic findings? Rapid advances in technology such as high-throughput genotyping and advances in statistical analysis and bioinformatics are responsible for making this possible. As an example of how these discoveries and technologies have transformed how we do genetics in our lab, in the 14-year period between 1992 and 2006 when our genotyping method of choice was microsatellite markers and gel-based detection, our lab generated approximately 1.5 million genotypes at a rate of 293 genotypes per day. Since 2007, with full implementation of the high-throughput genotyping platforms, we have produced over 400 million genotypes, a rate of 1.1 million genotypes per day. This reflects a > 3,700 fold increase in genotyping capacity! In addition, before 2007, there were nine convincingly identified lupus susceptibility genes. With the implementation of these new advances and technologies, at the end of 2008, there are now >20 convincing genetic associations with lupus.

Success in this endeavor has also been accelerated by:

(a) Databases of human genetic variation. Public databases of genomic variation have identified nearly 15 million human variants (dbSNP build 129, www.ncbi.nlm.nih.gov/sites/entrez). These databases continue to grow at a rapid pace and serve as a valuable resource to researchers.

(b) The haplotype map of the human genome. The international effort to understand common patterns of human DNA sequence variation in diverse human populations is a key resource for researchers in their quest to find susceptibility genes. This database

has evaluated 1.5 million genetic variants in 1,301 subjects from 11 different world populations (HapMap, Phase III, www.hapmap.org).

(c) High throughput genotyping. Highly accurate and rapid genotyping platforms are now available to assess in one experiment > 300,000 variants in large DNA collections.

(d) Analytical tools. The development of new algorithms and software packages capable of analyzing the massive amounts of new data in a timely fashion has become essential for all researchers. As a result, we now have over 500 multiplex pedigrees affected with SLE and over 500 simplex families. We also have the largest collection of African-American multiplex pedigrees in the world. We have established over 20 genes for SLE. This makes lupus second to inflammatory bowel disease among complex inflammatory genetic diseases for the number of genes identified.

From a clinical standpoint, we all know lupus is a frustrating but fascinating illness. Early on in my job at the studies, I thought I might become bored with the main focus of my work, that of reviewing medical records of individuals with lupus and alleged lupus. Thousands of record reviews later, I can honestly say that I am not bored. My review focuses on identifying the ACR Criteria for the Classification of SLE for each study participant. Because presentation, criteria, and evolution of SLE vary for each participant, it has remained interesting. Meticulous review to find adequate documentation of the ACR criteria is paramount. If we enroll someone in the study who does not meet at least four of the 11 SLE criteria, we have just complicated the task of genotypers and researchers who rely on our database to make these genetic discoveries.

To stay current with the clinical aspects of SLE and other autoimmune illnesses, I also see patients in our rheumatology practice with the PI (principal investigator) of the lupus genetics studies here who is also a practicing rheumatologist, Dr. John Harley. Dr. Harley had never worked with a PA before and I had no experience working with rheumatology patients, so it was new territory for both of us. Nine years later, we continue working very well together as a team, taking care of patients with all manner of autoimmune disease. Our practice is located at the University of Oklahoma Health Sciences Center, where some of the most interesting and challenging cases appear on our doorstep.

As always, the LFRR continues to seek families in which one or more members have been 'diagnosed' with SLE. If you have such a patient in your practice and they are interested in being part of the study, please feel free to give them our toll-free number: 888-655-8787 or Web address <http://lupus.omrf.org>. Or, if they give you permission, you can contact us with the patient's contact information. For more information about the OMRF or the LFRR, visit our Web site at www.omrf.org.

Local Community Involvement

—By Linda Davis, MHS, PA-C, editor

Note: This conversation was overheard while driving downtown Fort Worth, Texas on the way to volunteer for the Arthritis Foundation's Jingle Bell Run/Walk (JBR). This is a real event that occurred on Dec. 6, 2008.

PA volunteer/wife: "This has been a wild week. I had to call 911 three times for clinic patients. I made three house calls (on my own time) and the last one I had to take to the hospital. Today is Saturday (playday) and I am only going to sit at the Arthritis 'Mission' booth to give out information about arthritis."

22-year-old granddaughter/volunteer: "Be careful what you say, Grandma."

Husband/driver: "Honey, look over there. I'd better stop and let you out."

The PA sees an overturned SUV up on the sidewalk and no emergency vehicles in sight. She bounds out of the vehicle and sprints across the street, holding out her arms in both directions to stop traffic to get to the scene of the accident. She assumes control of the situation, assessing and making a plan. 911 is called. Victims are given appropriate emergency aid. Soon, emergency personnel arrive and take over the scene. After the report is given, the PA leaves to rejoin her family.

Her husband has parked the vehicle, and is now looking for his wife, finally asking, "Where's the elf?" The policeman looked puzzled at first, and then he pointed and said, "She went that-a-way."

The two volunteers are found and continued on their way to the Jingle Bell Run, taking place only a few blocks away.

The Arthritis Foundation celebrated its 60th year in 2008. It's the only national not-for-profit organization that supports the more than 100 types of arthritis and related conditions. Its mission is research, public health and public policy. It partners with multiple organizations to carry on the fight against arthritis.

The Jingle Bell Run is one of several events that occur throughout the year to raise funds for arthritis. Fort Worth held its 17th annual event and successfully surpassed its goal. This is a family event held the first Saturday after Thanksgiving, just about dusk time, when the Christmas décor, especially the lights, are all aglow in the city. Teams compete for prizes in several categories, including

best costume. Even the dogs are invited to participate, because they get arthritis, too.

Confession: The "emergency elf" was me, but you should have seen the gentleman's face at the accident scene when he woke up and saw me, dressed up in my "outfit." I wondered if he thought he had died and gone to heaven, which was really the North Pole. I'll probably never know.

Share yourself with your local arthritis foundation. I encourage reaching out to these kind of events to help us find a cure for arthritis.

Update Legislative Report from Washington, D.C.

On January 6, 2009 there will be 52 new U.S. Representatives and at least 9 new U.S. Senators with more to follow as current Senators take roles in the new Executive Administration. Congress' slate is clean. All legislation has to be introduced again. For example, the Arthritis Act will have to be introduced again in both the House and Senate. Again, Members of Congress will need to be asked to be a cosponsor of the legislation—a Member who supports passage of the bill. Even if a Member said, "no," last year, his/her answer could change. It is also not an automatic if they cosponsored previously that they will again cosponsor. They must be asked and maybe even asked multiple times to cosponsor. There are a lot of staff changes on Capitol Hill at this time, too. Staff are leaving the Hill, moving to different offices, or maybe changing positions within the same office. Be prepared to start building a new relationship with a new staff person.

The Arthritis Ambassador Program is sponsored through the Arthritis Foundation and volunteers are needed to help us to secure passage of the Arthritis Act. Volunteers are selected to help obtain contact with their U.S. Representatives and Senators by making phone calls, writing letters, and visiting their hometown or Washington, D.C. offices. If you are interested in being a part of this program, please contact me for more information at lidavis@hsc.unt.edu.

AAPA Special Election Results

By Daniel A. Buchin, PA-C

December 22, 2008

Dear AAPA Members:

Congratulations to Stephen H. Hanson, AAPA's new president-elect, who will assume the office immediately, serving as president-elect through June 9, 2009. The AAPA president term will be June 10, 2009 through June 9, 2010, and the immediate past president term will be June 10, 2010 through June 9, 2011.

Steve was elected in a special election conducted December 12-19, 2008 to fill the vacancy caused by the November 12, 2008 death of Paul Robinson, AAPA president elect. Four other candidates (James Anderson, Sandra Keavey, Patrick Killeen, and Robert Wooten) ran for the president-elect position. In accordance with AAPA bylaws, the voters were the 2009 delegates to the AAPA House of Delegates. They voted electronically between December 12-19, 2008.

Steve Hanson has many past years of AAPA leadership experience. He served on the AAPA Board of Directors from

2000-2005, holding the positions of Second Vice Speaker of the House of Delegates and Vice President/Speaker of the House of Delegates from 2002 to 2005. Most recently, he was the Liaison Coordinator from 2006-2008, managing AAPA's 17 medical liaisons to physician organizations. He has been a member of the American Academy of Physician Assistants since 1982.

Steve will immediately join 12 other AAPA Board of Directors members to lead the Academy in implementing its vision, mission, and strategic goals. Join us in congratulating Steve.

Sincerely,



Daniel A. Buchin, PA-C
Chair, Elections Committee



Society of Physician Assistants in Rheumatology
950 North Washington Street
Alexandria, Virginia 22314-1552