



SRI LANKA ASSOCIATION OF  
RHEUMATOLOGY AND  
MEDICAL REHABILITATION

## President's Message

**Dr.A.N.H. Herath MD, FRCP**

I am indeed pleased to be able to reach you through the newsletter.

As many of you are aware the 10<sup>th</sup> APLAR Congress 2002 is due to be held in Bangkok, Thailand in December this year. I am pleased to note that some of our members have made arrangements to attend the Congress. I trust that they would have a very productive and enjoyable stay in Bangkok. Our association is a member of APLAR, and our secretary will keep you informed of its activities.

The association has been successful in getting the Sinhala term used by the Ministry of Health changed to

“සන්දි හා සන්දි ආලෝක රෝග”

which was approved by the Ministry. This will eliminate the confusion created by the previous term, and save some of our time trying to sort out those patients who come to us with eczemas and hydroceles !

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## Leading Article

# Rheumatology and Rehabilitation in Sri Lanka

**From the Past to the Present... and Beyond**

*Excerpts from the President's address – SLAR&MR 2000*

**Dr. A.D.T.A. STANISLAUS**

MB(Cey), FRCP(Lond), D.Phys. Med.(Eng)

At the threshold of a new millennium, as we pause to consider where we are and chart where we hope to go, I think it is important to revisit some of those historical events that have served to shape our present. In the absence of proper records, my account is mostly anecdotal – based on the memories of a few people who have been associated with our speciality from early times and on my memories.

Our speciality goes back a long way and has had a very chequered history. The therapeutic use of heat, oils and manipulations has been in use in this country from time immemorial. Several ancient remedies to relieve pain and gain relaxation have a rational basis. They have stood the test of time and are in use even today. There is evidence that as far back as A.D. 394 – 426 King Buddhadasa who was a physician himself, had built hospitals for crippled and the deformed and provided treatment for them there. There is no doubt that physical measures such as heating, rubbing of oils, massage and manipulation were used.

In the history of modern medicine in Sri Lanka there is evidence that physical methods of treatment were in use at the General Hospital, Colombo as early as the 1920's and 1930's. the accent was on electrotherapy and massage. There were a few lamps and muscle stimulators and treatment was given by a nursing sister. Strange as it may sound today, treatment at that time was supervised by a Radiologist – perhaps the world's first instance of Interventional radiology.

The era of Physical Medicine in this country begins in 1949 and owes much to Dr. R. Neuhuber. He was one of a group of Viennese specialists employed by the Department of Health to overcome the shortage of specialists at that time. It was his efforts that laid the foundation of this speciality on modern lines. He replaced the old lamps with new, bright and glistening apparatus – long wave diathermy, infra-red lamps and stimulators. The accent still was on Electrotherapy and massage, but for the first time remedial exercises were introduced. Neuhuber must have believed very much in the Microbial Toxin Theory of Rheumatism for he had equipment for Colonic Lavage as well. He was helped in his treatments by a bright nurse who was his general factotum.



There was no mention of Physiotherapists till 1951 when, a physiotherapist trained in the UK returned to the country and was appointed to the Colombo Hospital. Very little is known of her work here, and it appears that she left soon after for greener pastures abroad.

Neuheber's treatments would undoubtedly have been popular, for we find soon after, the department selecting two young doctors for training in Physical Medicine abroad. Drs. Frank Perera and L.D.P. Gunawardena proceeded to the UK in 1952, trained at the London Teaching Hospitals and successfully completed their Diplomas in Physical Medicine from the Conjoint Board of the R.C.P.(London) and R.C.S. (England). They then proceed to the USA for further training at the Institute of Rehabilitation, New York, which at the time was headed by Dr. Howard Rusk, a legendary pioneer in medical rehabilitation. Returning to the country in 1954, they took over at the General Hospital, Colombo. Dr. Gunawardena was to leave for Kandy soon after, to start the Department of Physical Medicine there, but returned to Colombo again in 1955. From that time there were two departments in Colombo – the incongruously named "General" and "Special". Life in the General Hospital would not have been pleasant for a young physicians, being considered more as artisans and technicians rather than as clinicians, by the senior physicians of that period. Patients were often referred to them for "Heat and Massage". However they were able to introduce new techniques and a new direction to change the emphasis from passive methods of treatment to active physiotherapeutic measures. In this they were handicapped by the lack of trained physiotherapists. A few officers released from the Army Medical Corp were employed by the department to help with treatment. Due to insistent lobbying by the Physical Medicine consultants together with the Thoracic Surgeons and Chest Physicians of that time, the department recruited several young men and women and send them to the UK, Australia and New Zealand for training as physiotherapist. Dr. Frank Perera had also submitted plans to establish a school of physiotherapy in Colombo and in 1957 the programme of training in physiotherapy was introduced with C plan and WHO assistance.

In the period from 1954 up to 1970, Physical Medicine Services in the country made some

satisfactory progress. The department trained several new specialists in the UK Drs. V.C. de Silva, Bartholemeusz, Anton Jayasuriya and Roy Kulatunge. By 1970's Physical Medicine Departments manned by specialists were in existence in the General Hospitals of Colombo, Kandy, Galle, Jaffna and Ratnapura.

The 1970's were landmark years in the history of the speciality. In 1970 the Ceylon Association of Physical Medicine was in existence and its President Dr. Frank Perera was also elected the President of the Asian Pacific League of Physical Medicine and Rehabilitation. The Ceylon Association was able to host the first Assembly of the Asian Pacific league in Colombo, in November 1970. This I believe was the first international medical conference held in this country and was attended by 80 delegates from a dozen countries. It is interesting to note that the Indian Society of Physical Medicine and Rehabilitation was inaugurated in Colombo by the Indian physicians attending the meeting.

Although by this time some progress had been made in the speciality, much was still lacking especially clinically. The departments still provided fragmented physical treatments to patients with musculo-skeletal diseases and patients with short-term disabilities. There were no facilities for inpatient care and rehabilitation, and the management of rheumatic diseases still remained within the domain of the General Physician. Lamenting the lack of rehabilitation facilities, Dr. Frank Perera wrote "the time has now come to take the next logical step – to rehabilitate those patients who have been brought up to the peak of physical fitness within the limits of their disability." In 1971, Dr. L.D.P. Gunawardena with the grate deal of support from Prof. K. Rajasuriya the then DHS was able to convert the disused buildings of the old Tuberculosis hospital at Ragama, to provide inpatient rehabilitation to patients initially from the Colombo group of hospitals. Initially rehabilitation was supervised by Dr. Gunawardena who visited the hospital from Colombo. In 1973, Dr. Monica Perera, who had then returned from the UK after training, became its first full time physician. This hospital is now the fully fledged Rheumatology and Rehabilitation Hospital, Ragama.

The 1970's were also heady years for those of us who are now senior members of this association.



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The department had by then scrapped the category of part qualified specialists and the new speciality requirements were deemed to be MRCP plus the Diploma in Physical Medicine. The first to obtain these dual qualifications was I believe Dr. Mrs. Vijayaragavan.

By the middle seventies more specialists were arriving from training in the UK. In the UK too vast changes had occurred in the speciality and it had shed its physical medicine image and taken on the mantle of Rheumatology and Rehabilitation. The new arrivals trained in this new approach felt stifled by the lack of a clinical bias in the speciality as it then existed and felt uncomfortable as Physical Medicine Specialists. In 1975, in the report submitted to the Director of Health Services on my return after postgraduate training, I wrote, "Rheumatology is as much a part of Medicine as say, Neurology, Dermatology or Cardiology. Rehabilitation in the context of modern medicine is an important clinical discipline which trains the disabled to live within the limits of their disabilities, but to the full extent of their capacities... the combination of these two disciplines should constitute a speciality wide enough and responsible enough to take a honoured place in any hospital service. What has happened at present is that possession of additional expertise in treatment by physical methods has been held against the specialists in Physical Medicine. He has been reduced to the position of an overseer of physiotherapists neglecting the considerable services he could give in the total care of patients. If he is to make any worthwhile contribution to the strengthening of the health service, he should have undisputed control of the management of those patients who have become recognized as his primary concern, instead of present practice of merely organizing physiotherapy for them." Subsequently several others who felt likewise joined together to address a memorandum to Director of Health Services requesting a change in designation of the speciality to Rheumatology and Rehabilitation and provision of more clinical facilities with access to hospital beds. In June 1976, several of these demands were granted. By DHS circular No 841 the speciality of Rheumatology and Rehabilitation was created and the first appointees as specialists in this field were Drs. Kulatunga, Mrs. Markus, Mrs. Vidyasagara and Stanislaus. Also superintendents of hospitals were directed to provide such facilities as organization of clinics, staffing, equipment,

allocation of beds etc. to enable the development of the speciality. Today several years later, though such facilities do exist in several hospitals, in the so-called national Hospital of Colombo, these directions have yet to reach complete fruition.

I have so far reviewed the development of our speciality from its early beginning up to its present position. The prerogative of age I think allows me to share with you my vision of the future development of the speciality. Just now the combination of Rheumatology and Rehabilitation in a single speciality looks appropriate, as the Rheumatologist with his skills and expertise in managing physical disability, appear ideally suited to give leadership to the Rehabilitation team and direct its efforts. The last ten years have seen significant changes in concepts regarding medical rehabilitation. Many improvements in the clinical techniques and technical resources that are effective in rehabilitation have occurred. Advances in medical treatment, the survival of more people to old age and changes in social behaviour and expectation have all rekindled an awareness of the need to promote well being and social participation irrespective of the residue of disease and injury. Rehabilitation is no longer an activity considered only in the recovery phase of the illness. It is likely to be needed whenever circumstances change and is equally important in deteriorating and degenerative conditions. Hence the need for community based rehabilitation programmes to complement the gains obtained in hospital and help disabled person back to community life and employment. The future demands a single specialist to assume responsibility for the rehabilitation programme as a whole both in the hospital and community. Rheumatology itself is a wide special area in medicine. It is also very rapidly growing and evolving one. With increasing demands being made on the Rheumatologist from his own speciality, I do not think we will have neither the time nor the inclination to assume responsibility for hospital based and community based rehabilitation as well. I cannot therefore see in the future a single speciality service for Rheumatology and Rehabilitation. I see in the future where Rheumatology will stand by itself as one clinical speciality and Rehabilitation Medicine (preferably renamed Disability Medicine) as another. Having participated in the birth of our dual speciality – Rheumatology and Rehabilitation in 1976, I earnestly wish and pray that I would live to see the day it emerges as two distinct specialities. •

**Digana Rehabilitation  
Hospital**  
***A step in right direction***  
**Dr. Thilaka Nissanka MBBS, MD**

The country is in need of more inpatient facilities for patients with disabilities needing long-term hospital rehabilitation. Taking a step in this direction, Digana Rehabilitation Hospital was commenced on 26th of July, 2001. This was a joint venture of the Central Provincial Health Authority and Teaching Hospital Kandy and facilitated by the National Institute for the Care of Paraplegics (NIPS).

It is situated 7 km from Teaching Hospital, Kandy. At present there are only 20 beds (14 for males and 6 for female). An excellent gymnasium was built as an outright donation by CECB. The staff consist of MOIC, 3 medical officers, nursing staff and minor staff. Consultant Rheumatologist Dr. R.G.A. Thalagahagoda volunteers his service to this institution.

One of the unresolved major problems in this hospital is the lack of permanent physiotherapists and occupational therapists. Presently physiotherapists in the Teaching Hospital Kandy cover the work of the physiotherapists. The Social Services Department of the Central Province and other volunteer organizations have commenced a programme of counseling and vocational training.

Due to the limitation of the number of beds, admissions to this hospital are restricted only to transfers from T.H. Kandy, after assessment by the Consultant Rheumatologist in the T.H. Kandy.

A project proposal for phase II development of this Institution is in process. •

***From Journals***

Obtained from: *Journal Scan : Medscape Rheumatology 4(2), 2002*  
Robert I. Fox, MD, PhD

**Trends in Medication Use for Osteoarthritis Treatment**  
Ausiello JC, Stafford RS  
*Journal of Rheumatology. 2002;29(5):999-1005*

Ausiello and Stafford review data from the 1989-1998 National Ambulatory Medical Care Survey to evaluate therapy used during 4471 visits by patients 45 years of age or older with a diagnosis of osteoarthritis (OA). The treatment for OA with acetaminophen steadily decreased from 49% of visits (1989-1991) to 46% (1992-1994) to 40% (1995-1998) (P = .001). These findings are interesting because the recommendations of the American College of Rheumatology suggest the initial use of acetaminophen as treatment of choice for the older patient with OA.

The decline in the use of acetaminophen from 1989 to 1998, especially among elderly patients and the frequent selection of safer nonsteroidal anti-inflammatory drugs (NSAIDs) may reflect the marketing of new cyclooxygenase (COX)-2 drugs that emphasized the safety of these nonsteroidals for OA. However, the reduced use of acetaminophen, despite evidence supporting its efficacy and lower cost, suggest that better patient education is needed to optimize cost-effective OA therapy.

As rheumatologists are faced with an aging population that has limited economic resources to pay for the new generation of NSAIDs, it will be important to educate that OA population that a main goal of therapy is analgesia to facilitate an exercise program. Many older OA patients believe that an NSAID is required to treat an inflammatory condition that causes joint narrowing, but available histologic evidence (as well as the noninflammatory nature of joint fluid aspirates) suggests that the main problem is due to trabecular microfractures in weight-bearing joints that leads to pain. In addition to the cost to the patient for the NSAID, a recent study by Sturkenboom and colleagues demonstrated an average 58% additional cost due to the coprescription of gastroprotective agents (regardless of whether COX-1 or COX-2 drugs were used).

In multiple studies, the use of analgesics such as acetaminophen (3-4 g/day) and paracetamol provide analgesic relief comparable to that of NSAIDs. The lower risk of complications of acetaminophen has favored their use over traditional (ie, COX-1) NSAIDs, especially in older populations. Potential liver problems and interactions by acetaminophen with drugs such as warfarin must be monitored.



Narcotic analgesics are generally avoided because of potential complications, including constipation, sedation, addiction, and balance impairment.

In older patients with OA, recent articles have emphasized the importance of nonpharmacologic therapy, including weight loss and exercise programs. Fransen and colleagues studied 126 patients who were randomized into one of 3 allocation arms: individual treatments (n = 43), small group program (n = 40), and waiting list control group (n = 43). After reassessment at 8 weeks, patients allocated to waiting list control were randomized into 1 of the 2 active treatment arms. Assessments included both self-report measures (Western

Ontario and McMaster OA index and Short Form-36) and objective measures of physical performance (gait analysis and muscle strength). Physical therapy, either as an individually delivered treatment or in a small group format, was an effective intervention for patients with knee OA. They also note that a basic physical therapy program may need to be modified based on the degree of OA, as indicated by loss of medial joint space width on weight-bearing radiographs of the knee. Similar positive results were reported by Messier and colleagues in a study that demonstrated that chronic knee pain led to significant declines in balance and lower extremity strength. Of importance, they and others demonstrate that weight training is effective in improving balance in older adults with knee OA.

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### **A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial of Adjuvant Methotrexate Treatment for Giant Cell Arteritis**

Hoffman GS, Cid MC, Hellmann DB et al. *Arthritis and Rheumatism*. 2002;46(5):1309-1318

Hoffman and coworkers have evaluated the use of methotrexate (MTX) in patients with newly diagnosed giant cell arteritis (GCA) to determine whether MTX reduces GCA relapses and cumulative corticosteroid requirements. In a trial involving 98 patients at 16 centers, initial treatment was prednisone 1 mg/kg per day plus MTX or placebo. The initial dose of MTX was 1.15 mg/kg per week and was increased to MTX 15 mg/wk. After 4 weeks, the corticosteroid taper was initiated using a reduction of 5 mg every 4 days according to an alternate-day schedule. In the absence of relapse, patients were receiving an average dosage of prednisone 60 mg every other day at 3 months. After continuing this dose for 1 more month, further tapering was again initiated using a similar decrement of 5 mg every 4 days. Failure was defined as 2 distinct relapses or persistence of disease activity after the first relapse, despite increased corticosteroid therapy by 10 mg/day of prednisone above the prior daily dose.

The definition of a relapse was a change in erythrocyte sedimentation rate (ESR) from

normal to greater than 40 mm/hr or other feature of GCA not attributable to other conditions (ie, fever for at least 7 days, polymyalgia rheumatica, headache, scalp pain, vision loss, jaw or mouth pain, or angiographic abnormalities compatible with vasculitis). The incidence of treatment failure was lower in the MTX group after 12 months was (57%) compared with 77.3% in the placebo group. However, the apparent benefit in the MTX group did not reach statistical significance, and the relapse rate in the MTX group was unacceptably high. The number of relapses increased as corticosteroid therapy was reduced: 15% occurred during the period of daily therapy (first 3 months of the trial), 51% occurred during the period of every-other-day therapy, and 34% occurred after corticosteroid therapy was discontinued. The most common feature of relapse was an increased ESR.

This is the first multicenter trial to examine tapering corticosteroids with MTX, a common agent to spare corticosteroids in clinical practice. This study emphasizes the relapsing nature of GCA, with reports of relapse rates of 60% to 80% when patients are followed for up to 52 months.



A simple reading of the abstract suggests a lack of benefit from MTX in GCA. However, it might also be asked whether MTX might prove more effective if methods of corticosteroids taper other than alternate day were used. The authors note in their discussion that the decision to taper corticosteroids on alternate days reflects the uncertainty in the knowledge about the optimal methods to taper the steroids. Also, many of the patients relapsed when they were off corticosteroids entirely, and it might be useful to determine whether GCA patients should be maintained on minimal-dose corticosteroids (such as prednisone 5 mg/day) while receiving MTX. In this regard, a recent study by Jover and colleagues reported a single-center study with 42 patients whose clinical characteristics at entry were similar to the study by Hoffman and coworkers. They used a daily tapering regimen of corticosteroids (rather than an alternate-day regimen). Using this protocol, they found benefit from MTX in their

cohort. However, the definition of relapse was slightly different in the 2 studies and this may partly explain the differing conclusion.

The failure of MTX to "spare steroids and prevent relapse" was surprising in view of benefit of MTX in other vasculitides including Wegener's granulomatosis and Takayasu arteritis. Nevertheless, the multicenter data of Hoffman and colleagues indicate that MTX alone does not appear to be sufficient in preventing relapse in many patients given alternate-day corticosteroids or preventing relapses when the patients have entirely stopped receiving corticosteroids. Chronic corticosteroid use have significant morbidity in older GCA patients. But it appears that at least low doses must be maintained on a daily basis until further studies provide therapeutic clues to prevent relapses. Rheumatologists must also be aware that initial presentations of GCA, as well as relapses, can occur in the absence of elevated ESR.

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**Treatment of Rheumatoid Arthritis With Methotrexate and Hydroxychloroquine, Methotrexate and Sulfasalazine, or a Combination of the Three Medications: Results of a Two-Year, Randomized, Double-Blind, Placebo-Controlled Trial**

O'Dell JR, Leff R, Paulsen G, et al. *Arthritis and Rheumatism*. 2002;46(5):1164-1170

O'Dell and coworkers studied 171 rheumatoid arthritis (RA) patients who had not been previously treated with combination therapy. In particular, they examined combinations of methotrexate (MTX) with hydroxychloroquine (HCQ) or sulfasalazine (SSZ) in a 2-year, double-blind, placebo-controlled protocol. HCQ was given at a dosage of 200 mg twice a day, and MTX was started at 7.5 mg/wk and escalated to 17.5 /wk. In one arm of the protocol, the SSZ was started at 500 mg twice a day and then increased to 1 g twice daily. The primary end point of the study was the percentage of patients who had a 20% or 50% response according to American College of Rheumatology (ACR) criteria.

Intent to treat analysis revealed that, of the patients receiving the triple therapy (MTX,

HCQ, and SSZ), 78% achieved ACR 20% response at 2 years compared with 60% of those receiving MTX and HCQ and 49% of those treated with MTX alone. Similar trends were seen for ACR 50% response: 55% responded while receiving the triple therapy compared with 40% on MTX plus HCQ and 29% on MTX plus SSZ at 2 years.

This article extends the previous 1-year study on the benefit of combination therapy. It is also important to rheumatologists because most of the recent enthusiasm in the literature has focused on the use of new and expensive biological agents that may not be available to some patients. In particular, the study presents the benefit of adding HCQ to MTX in a significant proportion of patients.



Of the 171 patients who entered the trial, 58 received MTX and HCQ; 5 patients withdrew due to HCQ toxicity, including 1 patient for ocular toxicity. The data were also evaluated separately for patients who had previously received MTX. The ACR 20% response was 55% for patients who received MTX plus HCQ, and ACR 50% response was achieved by 39% of patients on this combination.

This study extends the previously published, 1-year results of triple therapy, which was particularly effective in patients with HLA-DR4 or shared epitopes. Two other groups recently reported open-label studies on the efficacy of the triple combination. For many patients, the triple regimen involves a great number of medicines to take; thus, the results of MTX plus HCQ are particularly interesting. In addition, HCQ works by proposed mechanisms distinct from MTX or biological agents and may further contribute to other combinations.

This study and other recent reviews have emphasized the benefit of combination therapy. In many parts of the country, patients might be reluctant to take the large number of pills per

day required in triple therapy; however, the addition of HCQ (2 pills per day in addition to weekly MTX) may be tolerable and economically feasible.

In addition to considerations of safety and efficacy, there are economic considerations with the new generation of disease-modifying antirheumatic drugs. In a recent cost analysis, the costs of combination therapy in "methotrexate naive" RA patients were analyzed. The least expensive option was triple therapy, which cost 1.3 times more per patient with an ACR 20% outcome (\$1500) and 2.1 times more per ACR 70% outcome (\$3100) compared with MTX therapy alone. The most efficacious option, the combination of etanercept and MTX, cost 38 times more per patient to achieve the same number of patients with similar ACR 20% outcome (\$57,000) and 23 times more per patients to achieve an ACR 70% outcome (\$34,800) than MTX therapy alone. Although we have all witnessed the benefit of biologic agents providing dramatic benefit in our refractory patients, this study by O'Dell and colleagues reminds us that many patients may respond to less expensive combinations.

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***President's Message continued from page 1***

After an in-depth study the committee developed a course content for postgraduate training in Rheumatology. This was approved by the Postgraduate Institute of Medicine. I hope many more trainees will select the field of Rheumatology.

As part of our educational activities the association participated in joint meetings with the College of Physicians and with the Kandy Society of Medicine. These meetings were well attended and our members made useful

contributions. The 2<sup>nd</sup> Annual Orthopaedic – Rheumatology combined meeting is due to be held on the 15<sup>th</sup> December 2002. I hope that many of you will attend this meeting.

The Annual General Meeting will be held on the 23<sup>rd</sup> of November when a new committee will take office. I hope that all members would extend the same cooperation given to us to new committee as well.

Lastly I am deeply grateful for cooperation extended to me by all members during my tenure of office. •

# Sri Lanka Association of Rheumatology & Medical Rehabilitation

## Committee for the year 2001/2002

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POSTAGE

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& Medical Rehabilitation**

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