ART

Association of Rheumatologists of Tamilnadu

E News letter

Sept 2021 Issue

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The Association of Rheumatologists of Tamilnadu (ART), has been registered under Societies Act 198/2006 as registration number.

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President Message

Respected and Dear Seniors, peers and colleagues,

At the outset, I wish everyone takes care and stays safe. Let us put all our prayers together for the well being and safety of all.

The new team has taken over during this turbulent period at the peak of the second wave of the pandemic. It is my bound duty to express my heartfelt gratitude to Prof.CPR and Dr.VK, for the immense responsibility shouldered by them starting from the initiative to form the ART.

They have strived together which is commendable. My heartfelt thanks to them for continuing to guide us. Taking over during this pandemic had posed certain difficulties. However the aim is to hope for the best. Having energetic and enthusiastic members is a boon and will go a long way. I am grateful to them, just as I am to all those who are helping us from outside, during these difficult times.

The tenure is short. New ideas crop up. We are trying to implement them, to the best of our ability. What with the uncertainties, only online work can be done safely as of now without interruption.

- Ideas from ART members will be honoured.
- All will get their opportunities by turns
- Hope all will coordinate

We have planned to conduct CMEs' and awareness programmes throughout the state. These CMES' will include international and National speakers apart from our ART members. Interstate Collaborations and students programmes are also in the pipeline. Monthly Rheumatology meets will resume.

Since publications have been the privilege of only a few, we have decided to start our own journal. Although it is a time consuming and demanding work, by God's grace it will be completed. Articles are invited from all. If possible depending on the availability of funds, research grants for Rheumatology students are also in the agenda.

Let us all seek God's blessings

Stay united and live up to “ART for all and by all". Stay blessed.

Yours truly always,
Prof Dr S.Rajeswari,
President

Secretary Message

Warm regards to all our ART members

First of all, I thank our past office bearers for bringing out the newsletter from the offices of ART. We hope to take it forward in the coming years. I am immensely pleased to announce that our Newsletter is going to be published regularly from now on.

I hope this newsletter is useful for the practicing Rheumatologists, Physicians and the trainees as well for updating the knowledge in the field of Rheumatology. I thank the editorial team that has been working on improving the outlook of this newsletter. I request all our members to give their contribution to make it more interesting and informative. I hope this newsletter becomes a regular publication and enlightens us on the recent advances.

All the best to the editorial team.

Dr. ArulRajamurugan,
Secretary

Editors Message

We are very happy to publish our FIRST ART Newsletter in 2021 from the Association of Rheumatologists of Tamilandu on 19th Sept 2021.

ART newsletter is unique in that it is aimed at spreading new relevant information among the regional rheumatologists of Tamilnadu and is a platform to share experiences and expertise.

It also helps to solve the puzzle in unsolved questions in patient management. It keeps us abreast of recent developments and also brings to the door important management guidelines.

We hope the E journal would evoke keen interest in the months ahead and Best wishes for long term initiatives.

Best wishes
Dr. N Subramanian
on behalf of Editorial Team.

Is our collective silence hurting us?

When history is revisited, you realize that silence of the moderate majority has inflicted most severe wounds on humanity.

What is the topic we are discussing here?

For years together, at least in the last 10 years since I have been in this field of Rheumatology, I have noticed disease modifying anti rheumatic drugs (DMARDs) and of late Iguratimod and even JAK inhibitors are prescribed by non rheumatologists. We as rheumatologists have never opposed for multiple reasons

a) We thought it was practically not feasible to regulate this in such a hugely populated country.

b) We were just content on the fact that even if the drugs were available, non rheumatologists lacked the expertise to use DMARDs judiciously.

c) We were also magnanimous enough to admit that number of rheumatologists was too small to manage the disease burden and so we had conducted numerous CME programs to non rheumatologists guiding them to treat inflammatory arthritis and refer complicated patients.

In the last decade, biologics including anti TNF drugs, Rituximab etc came into market and soon gained popularity. When non rheumatologists started to use those drugs, we did not oppose it for above mentioned reasons. Although many non rheumatologists were not confident enough to use it in view of potential adverse effects, still its use is steadily increasing especially after Covid 19 pandemic.

What has happened now that we are discussing this topic?

In the last few years Tofacitinib has revolutionized management of rheumatoid arthritis and other rheumatic diseases. After the patency of Pfizer got over, numerous Indian companies have either started manufacturing Tofacitinib on their own or started buying from the original manufacturer and distributing them. This has reduced the cost of the molecule which in turn has increased the volume of usage. This is a welcome development in a resource limited setting like ours.

But it does not end here, these pharma companies have started promoting these drugs to non rheumatologists and of late we see many prescriptions of Tofacitinib by non rheumatologists.

This is a big worry because

a) Cost is very low so no restrictions to use.
b) Most of them start Tofacitinib without even a trial of DMARD.
c) No screening protocol before starting Tofacitinib.
d) Most of arthritis (RA, SpA, PsA) will have some response to Tofacitinib and so why then patients will search for a Rheumatologist in the future if anyone with joints pain will be given Tofacitinib at the outset
e) If indiscriminate usage leads to lots of adverse events, then even we may not be able to use the drug in future.

What should be done?

Many of us don't know or understand the legal issues pertaining to use of Tofacitinib by non rheumatologists. But we have to do something. Our silence now will do harm to the society and to our speciality.

Some of the options are

a) From letter pad of ART we can issue a statement to pharma companies to stop promoting Tofacitinib (add Baricitinib if needed) to non rheumatologists. We can tell them this is making mockery of our educational qualification and it hurts our pride as a whole.
b) We can mention that, we members of ART will not support a particular brand of Tofacitinib if it comes to our notice that the particular brand is being prescribed by non rheumatologist.
c) But something has to be done now else the system will break down. It's time for us to act.

With regards

Dr N. Raja MD DM,
Vellore

Case Report

Overlap syndrome of ankylosing spondylitis and mixed connective tissue disease in female

Abstract:

Ankylosing spondylitis is a chronic inflammatory disease affecting the young men and less commonly women with a spectrum of manifestations including uveitis, arthritis, sacroileitis, colitis and psoriasis. (Spondyloarthropathy). Mixed connective tissue disorder [MCTD] is a complex and heterogenous autoimmune disease that affects women in their child bearing age. It is characterized by circulating auto immune antibodies that deposit in tissues, resulting in inflammatory response, causing irreparable tissue damage. Overlap and coexistence of these diseases are uncommon as per literature evidence. We report a 35 year old female, who had HLA B27 – positive spondyloarthropathy for 10 years and had been taking sulfasalazine, now presented with neck swelling for 4 months. She was found to have raynauds, arthritis, bilateral cervical lymphadenopathy and elevated autoantibody titers including ANA, U1SM/RNP and coombs positive hemolysis. She was evaluated for Infection and returned negative. Her immunology and clinical features supported the diagnosis of Mixed connective tissue disorder. She has responded to treatment and we believe this is the first patient with ankylosing spondylitis and MCTD as per available literature.

MESH terms:/Key words: *ankylosing spondylitis, mixed connective tissue disease, HLA B27, U1RNP, overlap syndrome, female*

Introduction:

Ankylosing spondylitis is a chronic inflammatory disease affecting the young men and less commonly women with a spectrum of manifestations including uveitis, arthritis, sacroileitis, colitis and psoriasis. (Spondyloarthropathy- SpA). HLA B27 carrier has been found to be the genetic abnormality in many patients with SpA. Patients present with inflammatory back pain and peripheral arthritis that forms part of seronegative arthritis. Mixed connective tissue disease (MCTD) is the prototype of an overlap syndrome, since its original description by Sharp and colleagues in 1972 (1), with clinical elements of Scleroderma, lupus and

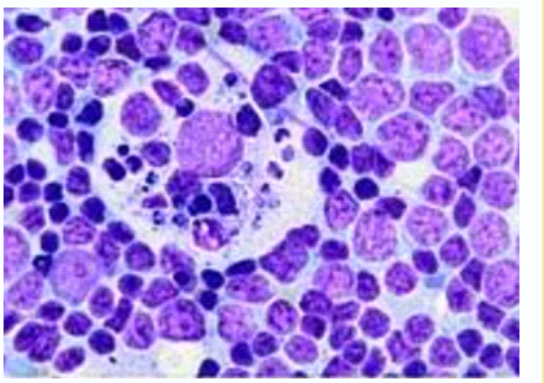
polymyositis and associated with antibodies to U1RNP. It is characterized by circulating auto immune antibodies that deposit in tissues, resulting in inflammatory response, causing irreparable tissue damage. Overlap and coexistence of these diseases are uncommon as per literature evidence.
We report a 35 year old female, with spondyloarthropathy for 10 years, now presented with neck swelling for 4 months. She was found to have features of (MCTD) Mixed connective tissue disorder.

CASE REPORT:

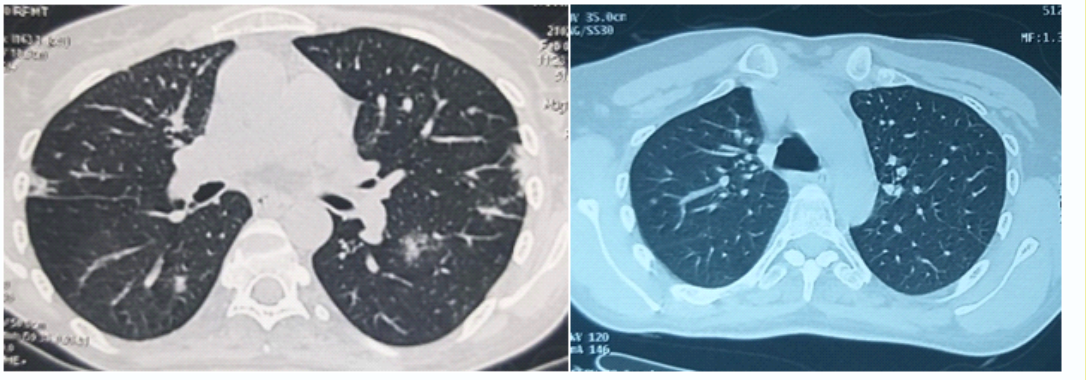
A 35 years old female, came with complaints of multiple swelling in neck for 4 months, with 10 years history of ankylosing spondylitis on treatment with sulfasalazine. She was recently treated for lymphatic TB for 3 months (empirical treatment for neck lymph nodes) without much benefit.

Her clinical examination showed pallor, lymphadenopathy, and stomatitis with restricted spinal movements due to rigid spine. There was no history of fever or rash but she had myalgia and fatigue. She didn't have contact history with patient who was on anti tuberculous therapy.

Investigations showed microcytic hypochromic anemia [Hb: 6.2gm/dl and MCV 68mmol] with platelet [426000/ul], elevated ESR [61mm] and LDH [1082U/L], CK normal. Direct coombs test was positive. Peripheral smear showed microcytic hypochromic RBC's with moderate anisopoikilocytosis, target cells and elliptocytes. WBC was normal with few reactive lymphocytes. Platelets were adequate. Mantoux was negative. She had spine MRI (Figure 1) showing evidence of established ankylosed bamboo spine. Bronchoscopy was planned but due to Covid issues it was deferred and also due to cervical spine deformities, anesthetist expressed difficulty in intubation. Excision biopsy of lymph node was not done due to the same reasons. She had FNAC (fine needle aspiration cytology) of submandibular lymph node that showed features of reactive lymphoid hyperplasia (image 1). Her HLA B27 antigen was positive.



Imaging-Ultrasound abdomen was normal. ECHO showed no evidence of pulmonary hypertension or pericardial effusion. HRCT chest showed multifocal patchy areas of consolidation in bilateral lung fields. Focal sub pleural ground glass appearances with surrounding tree in bud pattern in left upper lobe. (Image 2) No evidence of pleural effusion and no hepatosplenomegaly.



Immunology: ANA- 1 in 2560 positive, U1RNP antibodies strong positive, smith negative, DsDNA – negative, Covid RT-PCR negative and antibodies SARS CoV-2 IgG (0.09 COI), IgM (0.42 COI) were negative.

In conclusion, she had long standing ankylosed spine with features of Connective tissue disease, Coombs positive hemolytic anemia and U1 RNP strong positivity. Hence MCTD (Mixed Connective Tissue disease) was the working diagnosis and treated with appropriate therapy.

Specific features here include Polyarthritis, oral ulcers, weight loss, lymphadenopathy, raynauds, U1RNP, hemolysis.

Differential Diagnosis: Tuberculosis, Covid infection, SLE, Lymphoma

Patient was treated with antibiotics in view of consolidation and then given steroids.

Following up after 6 weeks, repeat CT scan showed near total resolution of changes in the lung. (Image 3). She has gained weight, her inflammatory markers have normalised. Her current medications include azathioprine, prednisolone and Calcium.

DISCUSSION:

Spondylarthropathies (SpA) and connective tissue diseases (CTD) are clini cally distinct entities, however, a link between SpA and CTD has been suggested by few case studies either due to altered immunological behaviour or due to drugs like sulfasazaline and biologics like TNF inhibitors. Sulfasalazine was reported to induce antinuclear antibodies (ANA) and systemic lupus erythematosus (SLE)-like syndromes such as drug-induced lupus. Lee et all in 1999 (2) and Pham et al in 1999(3) described earlier case reports of connective tissue disease in patients with ankylosing spondylitis. Brandt J and colleagues reported in 2002 (4), the development of sjogrens syndrome along with MCTD in a patient with ankylosing spondylitis while Dharmapaliah in 2018(5) reported pulmonary hypertension in a patient with ankylosing spondylitis developing CTD. All these 4 reports were described in male patients and had HLA B27, which is understandable and expected. Yongpeng and colleagues have reported manifestations of idiopathic inflammatory myopathy and ankylosing spondylitis. (6). Chandrasekara et all have described over lap syndrome of ankylosing spondylitis with SLE and dermatomyositis (7)

Our case is female and had HLA b27 positivity with ankylosed spine. She had been on sulfasalazine and managing reasonably well. Fever, weight loss and fatigue naturally were concerning and prompted evaluation.We also had difficulty in arranging the imaging and biopsy due to the covid pandemic.

Her blood count, peripheral smear and CT scan excluded lymphoma, Covid antibodies and RTPCR were negative while her mantoux test was negative too. Hence CTD is more likely.

She didn't manifest with typical features of hand edema or myositis or mechanic hands as described by Tanaka et al (8), however she had synovitis, fever, oral ulcers, raynauds, lymphadenopathy and lung infiltration with immunology showing u1 RNP antibodies, suggesting the development of MCTD.

She promptly responded to steroids. This is the first case report of a female with ankylosing spondylitis developing MCTD and responding to treatment.

Learning points: Although unusual, ankylosing spondylitis and HLA B27 can happen in females and development of fever, lymph nodes and weight loss should prompt evaluation for infection and CTD.

High index of suspicion with clinical features of CTD is essential to diagnose complex autoimmune diseases. Corona infection screen always precedes infection screen during this pandemic times.

Acknowledgements: We thank the pathologist and radiologist for the support and allowing us to use the images for this report.

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Dr S Shruthi, Dr SelvaGanesh, Dr Ramesh, Dr N Subramanian
Velammal Medical College Hospitals, Madurai.

SUMMARY OF 2021 ACR RECOMMENDATIONS FOR THE MANAGEMENT OF ANCA VASCULITIS

ANCA vasculitis comprises Granulomatosis with polyangiitis (GPA), Microscopic polyangiitis (MPA) and Eosinophilic Granulomatosis with polyangiitis (EGPA). It had total of 26 recommendations and 5 upgraded statements for GPA/MPA and 15 recommendations and 5 upgraded statements for EGPA. All are conditional recommendations due to lack of RCTs and/or low quality evidence. I shall highlight the salient recommendations here.

GPA/MPA:

Active/severe disease

1. For active, severe disease Rituximab (RTX) is recommended over cyclophosphamide (CYC) (in view of favorable toxicity profile)
2. Plasma exchange (PLEX) not to be routinely used for all cases of active glomerulonephritis or alveolar hemorrhage. Can be considered in patients with higher risk for progression to end stage renal disease (ESRD). This recommendation against PLEX is due to increased risk of infection being observed with PLEX.
3. High dose oral steroids or pulse steroids may be considered as part of initial therapy. Reduced dose of steroids (following pulse steroids) had similar outcome (ESRD) and death but with reduced risk of infection in comparison to standard dose of steroids.
4. For remission maintenance rituximab is conditionally recommended over other agents (due to lesser relapse rates). The maintenance treatment with rituximab to be done as a scheduled re-dosing than doing it on the basis of ANCA titer or CD-19 B-cell counts (as they are not accurate indicators).
5. Methotrexate (MTX)/Azathioprine (AZA) preferred for maintenance over Mycophenolate mofetil(MMF) or Leflunomide(LEF).

Non severe GPA

1. Methotrexate (in combination with steroids) preferred over rituximab, cyclophosphamide, azathioprine, mycophenolate mofetil and steroid monotherapy. (Unless there are contraindications to methotrexate. Eg: azathioprine preferred during pregnancy)

Relapse/Refractory

1. Rituximab preferred over cyclophosphamide but if patient is already on Rituximab, then to consider cyclophosphamide.

But if an extended period has passed since patient took rituximab, to re consider rituximab itself.

2. For refractory disease switching RTX to CYC or vice versa is preferred than combining the therapies. IVIG can be considered for short term management in refractory disease.

EGPA Active/severe disease

1. High dose steroids or pulse steroids to be considered as initial therapy.
2. Either cyclophosphamide (CYC) or rituximab (RTX) may be considered as induction therapy. Cyclophosphamide to be preferred in ANCA negative patients, cardiac, gastrointestinal and severe neurologic involvement. Rituximab to be considered in ANCA positive and active glomerulonephritis or if any contraindication for cyclophosphamide.
3. CYC/RTX preferred over mepolizumab for induction.

Non severe disease

4. Mepolizumab + steroids preferred over MTX/AZA/MMF for induction.
5. MTX/AZA/MMF addition to steroids preferred over steroid monotherapy for induction.
6. MTX/AZA/MMF addition to steroids preferred over CYC or RTX for induction.

Remission

7. For severe EGPA entered into remission, MTX/AZA/MMF preferred over rituximab or mepolizumab for maintenance.

Relapse with severe disease

8. Rituximab preferred over cyclophosphamide for remission re-induction irrespective of RTX or CYC used for induction. Unless, RTX was used pretty recently or if severe organ involvement like cardiac involvement is there.

Relapse with non-severe disease

9. If patients on MTX/AZA/MMF relapsed, adding mepolizumab is preferred over switching to alternate agent. Similarly mepolizumab may be added to non-severe patients relapsing on steroid monotherapy than adding AZA/MTX/MMF.
10. Mepolizumab preferred over Omalizumab for relapse in non-severe disease.
11. Use of leukotriene inhibitors is not contraindicated in EGPA patients as there is no causal association.
12. All EGPA patients should undergo baseline ECHO and Five factor score to be used to guide therapy.

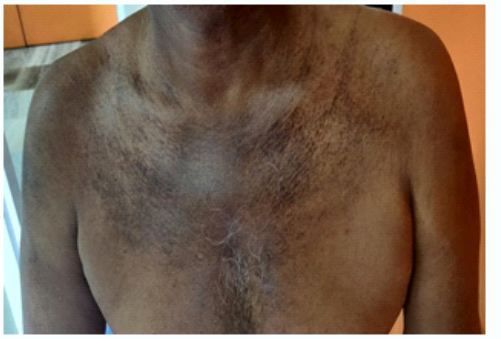
Dr S Sham MD, DM, MRCP (UK), SCE (RCP UK)
Consultant Rheumatologist
Gleneagles Global & Vijaya Hospital, Chennai.

Not so Heliotropish...Images In Rheumatology

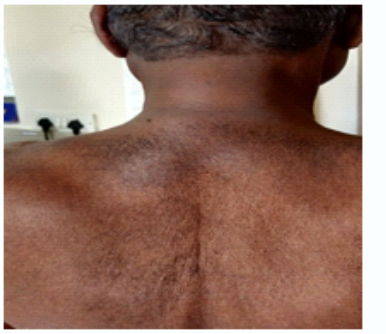
- 58 year old male presented to casualty with sub acute onset of generalized weakness , increased fatiguability , polyarthralgia and loss of appetite. Rheumatologist opinion was sought for polyarthralgia and elevated CRP
- On examination patient had proximal muscle weakness, and pathognomonic signs of dermatomyositis as shown in images – Gottron's papule , Heliotrope rash , V Sign and Shawl sign
- These images don't match the characteristic erythematous / heliotropish violaceous images we see in standard Rheumatology textbooks due to darker skin tone in our patients.

GOTTRONS PAPULES

HELIOTROPE RASH



V" sign over the anterior aspect of the chest



The shawl sign

Dr.C.Balaji MD,.DM

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American College of Rheumatology
Empowering Rheumatology Professionals

Arthritis Care & Research
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2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis

Objective. To develop updated guidelines for the pharmacologic management of rheumatoid arthritis.

Methods. We developed clinically relevant population, intervention, comparator, and outcomes (PICO) questions. After conducting a systematic literature review, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to rate the certainty of evidence. A voting panel comprising clinicians and patients achieved consensus on the direction (for or against) and strength (strong or conditional) of recommendations.

Results. The guideline addresses treatment with disease-modifying antirheumatic drugs (DMARDs), including conventional synthetic DMARDs, biologic DMARDs, and targeted synthetic DMARDs, use of glucocorticoids, and use of DMARDs in certain high-risk populations (i.e., those with liver disease, heart failure, lymphoproliferative disorders, previous serious infections, and nontuberculous mycobacterial lung disease). The guideline includes 44 recommendations (7 strong and 37 conditional).

Conclusion. This clinical practice guideline is intended to serve as a tool to support clinician and patient decision-making. Recommendations are not prescriptive, and individual treatment decisions should be made through a shared decision-making process based on patients' values, goals, preferences, and comorbidities.

Guiding Principles

RA requires early evaluation, diagnosis, and management.
Treatment decisions should follow a shared decision-making process.
Treatment decisions should be reevaluated within a minimum of 3 months based on efficacy and tolerability of the DMARD(s) chosen.
Disease activity levels refer to those calculated using RA disease activity measures endorsed by the ACR (10).
Recommendations are intended for the general RA patient population and assume that patients do not have contraindications to the options under consideration.
Recommendations are limited to DMARDs approved by the US FDA for treatment of RA. csDMARDs: hydroxychloroquine, sulfasalazine, methotrexate, leflunomide bDMARDs: TNF inhibitors (etanercept, adalimumab, infliximab, golimumab, certolizumab pegol), T cell costimulatory inhibitor (abatacept), IL-6 receptor inhibitors (tocilizumab, sarilumab), anti-CD20 antibody (rituximab)† tsDMARDs: JAK inhibitors (tofacitinib, baricitinib, upadacitinib)
Triple therapy refers to hydroxychloroquine, sulfasalazine, and either methotrexate or leflunomide.
Serious infection refers to an infection requiring intravenous antibiotics or hospitalization.
Biosimilars are considered equivalent to FDA-approved originator bDMARDs.
Recommendations referring to bDMARDs exclude rituximab unless patients have had an inadequate response to TNF inhibitors (in order to be consistent with FDA approval) or have a history of lymphoproliferative disorder for which rituximab is an approved therapy.
Treat-to-target refers to a systematic approach involving frequent monitoring of disease activity using validated instruments and modification of treatment to minimize disease activity with the goal of reaching a predefined target (low disease activity or remission).
Target refers to low disease activity or remission.
Recommendations specify that patients be at target (low disease activity or remission) for at least 6 months prior to tapering.
Dose reduction refers to lowering the dose or increasing the dosing interval of a DMARD. Gradual discontinuation of a DMARD is defined as gradually lowering the dose of a DMARD and subsequently stopping it.

Summary of Recommendations

1. Methotrexate is strongly recommended over hydroxychloroquine or sulfasalazine for DMARD-naive patients with moderate-to-high disease activity
2. Methotrexate monotherapy is strongly recommended over bDMARD or tsDMARD monotherapy for DMARD-naive patients with moderate-to- high disease activity
3. Methotrexate monotherapy is strongly recommended over methotrexate plus a non–TNF inhibitor bDMARD or tsDMARD for DMARD-naive patients with moderate-to-high disease activity
4. Initiation of a csDMARD without longerterm (≥3 months) glucocorticoids is strongly recommended over initiation of a csDMARD with longer-term glucocorticoids for DMARD-naive patients with moderate-to- high disease activity
5. For RA with low disease activity, hydroxychloroquine then sulfasalazine and then Methotrexate would be the preferred order of choice
6. A split dose of oral methotrexate over 24 hours or weekly subcutaneous injections, and/or an increased dose of folic/folinic acid, is conditionally recommended over switching to alternative DMARD(s) for patients not tolerating oral weekly methotrexate
7. Switching to subcutaneous methotrexate is conditionally recommended over the addition of/ switching to alternative DMARD(s) for patients taking oral methotrexate who are not at target
8. Addition of a bDMARD or tsDMARD is conditionally recommended over triple therapy (i.e., addition of sulfasalazine and hydroxychloroquine) for patients taking maximally tolerated doses of methotrexate who are not at target
9. Switching to a bDMARD or tsDMARD of a different class is conditionally recommended over switching to a bDMARD or tsDMARD belonging to the same class for patients taking a bDMARD or tsDMARD who are not at target
10. Continuation of all DMARDs at their current dose is conditionally recommended over a dose reduction of a DMARD, dose reduction is conditionally recommended over gradual discontinuation of a DMARD, and gradual discontinuation is conditionally recommended over abrupt discontinuation of a DMARD for patients who are at target for at least 6 months

Recommendations for specific patient Populations

1. Methotrexate is conditionally recommended over alternative DMARDs for patients with subcutaneous nodules who have moderate-to- high disease activity
2. Methotrexate is conditionally recommended over alternative DMARDs for the treatment of inflammatory arthritis for patients with clinically diagnosed mild and stable airway or parenchymal lung disease, or incidental disease detected on imaging, who have moderate-to- high disease activity
3. Addition of a non–TNF inhibitor bDMARD or tsDMARD is conditionally recommended over addition of a TNF inhibitor for patients with New York Heart Association (NYHA) class III or IV heart failure and an inadequate response to csDMARDs
4. Rituximab is conditionally recommended over other DMARDs for patients who have a previous lymphoproliferative disorder for which rituximab is an approved treatment and who have moderate-to-high disease activity
5. Frequent monitoring alone of viral load and liver enzymes is conditionally recommended over prophylactic antiviral therapy for patients initiating a bDMARD other than rituximab or a tsDMARD who are hepatitis B core antibody positive and hepatitis B surface antigen negative.
6. Addition of csDMARDs is conditionally recommended over addition of a bDMARD or tsDMARD for patients with NTM lung disease who have moderate-to-high disease activity despite csDMARD monotherapy.
7. Abatacept is conditionally recommended over other bDMARDs and tsDMARDs for patients with NTM lung disease who have moderate-to- high disease activity despite csDMARDs.

Dr N Subramanian,
Tirunelveli and Madurai

Conference Calendar 2021

Dr V Sivakumar, Consultant Rheumatologist, PSG Coimbatore.

National conferences

IRACON
Abstract Submission till 30 September 2021
IRA Review course- 05.12.21
Pre Conference Workshops-09.12.21
IRACON 2021- 10.12.21 to 12.12.21
ART webinar- 18.09.21 & 19.09.21

International conferences

European Paediatric Rheumatology Congress- September 19-21, 2021
CRUS virtual basic course- October 16 & 17, 2021
ACR annual meeting–November 5-9, 2021
Abstract submission ends on 28.09.2021.

ASSOCIATION OF RHEUMATOLOGISTS OF TAMIL NADU

Cordially invites you to

ANNUAL VIRTUAL CME

TNMC credit hours (2)

18th-19th Sept 2021

5.00 pm-8.00 pm

Dr. S. Rajeswari
Organising Chairman
President, ART
Professior & HOD, Dept Of Rheumatology., Sri Ramachandra Institute Of Higher Education And Research, Chennai.

Dr. P. S. Arul Rajamurugan
Organising Secretary
Secretary, ART
Assistant Prof., Of Rheumatology, Madurai Medical College, Madurai

Dr. John Mathew
Organising Treasurer
Treasurer, ART
Professior & HOD, Dept Of Clinical Immunology & Rheumatology. Christian Medical College And Hospital, Vellore .

Scientific Committee Members

Dr. N. Subramanian
E C Member - ART
Assistant Professior, Dept of Rheumatology, Vellammal Medical College, Madurai &
Consultant Rheumatologist, Tirunelveli.

Dr. S. Sham
E C Member - ART
Consultant Rheumatologist, Global Hospital, Chennai.

Dr. M. Hema
E C Member - ART
Assistant Professor of Rheumatology, Stanley Medical College, Chennai

Dr. M. M. Kavitha
E C Member - ART
Associate Professor of Rheumatology, Saveetha Medical College And Hospital, Chennai.

DAY	TIME	TOPICS	SPEAKER	MODERATORS
SATURDAY 18.09.21	5 PM to 6 PM	FREE PAPER SESSION FOR DM/DNB/ FELLOWS IN RHEUMATOLOGY		
	SESSION 1 - Facilitator - **Cipla Limited**			
	6 PM to 6.20 PM	Targeted therapies in Lupus Nephritis	Dr. Madheshwaran	Dr. C.Panchapakesa Rajendran Dr.V.Krishnamurthy
	6.20 PM to 6.40 PM	Newer therapeutics and targets- Skin in Systemic Sclerosis	Dr. Jagannathan	
	SESSION 2 - Facilitator - **Intas Pharmaceuticals**			
	6.40 PM to 7.00 PM	Management of Myositis - What has changed?	Dr. Aswin M Nair	Dr. Porkodi Dr. T. N. Tamilselvam
	7.00 PM to 7.20 PM	What to look forward to? Newer drugs in PsA	Dr. Nagaprabu V N	
	SESSION 3 - Facilitator - **Ipca Laboratories**			
	7.20 PM to 8.00 PM	Debate: Has the cyclophosphamide era in AAV ended? "YES" Vs Cyclophosphamide in AAV- Never out of favour	Dr.Sowndarya V A Dr. Saranya	Dr. Shanmuganandhan

DAY	TIME	TOPICS	SPEAKER	MODERATOR
SUNDAY 19.09.21	4.00 PM to 5.00 PM	GBM		
	5.00 PM to 7.00 PM	CPC		
	SESSION 4 - Facilitator - **Pfizer Limited**			
	7.00 PM to 7.20 PM	Role of nibs in Rheumatology "Look Beyond Covid and RA"	Dr. Aarthi Priya.T	Dr. S.Balameena Dr. Samikrishnan
	7.20 PM to 7.40 PM	Role of anti fibrotics in ILD	Dr. Ragunathan	
	SESSION 5 - Facilitator - **Zydus Synovia**			
	7.40 PM to 8.00 PM	Immune related disorders of Covid in Children	Dr. Mahesh Janarthanan	Dr.Sathish Kumar

You can reach us at nrheumatology2017@gmail.com with your comments.