

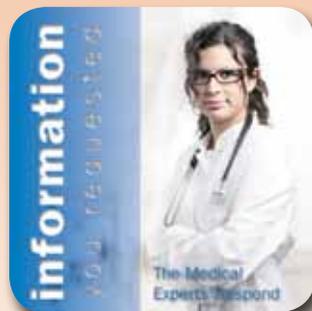
# The Moisture Seekers



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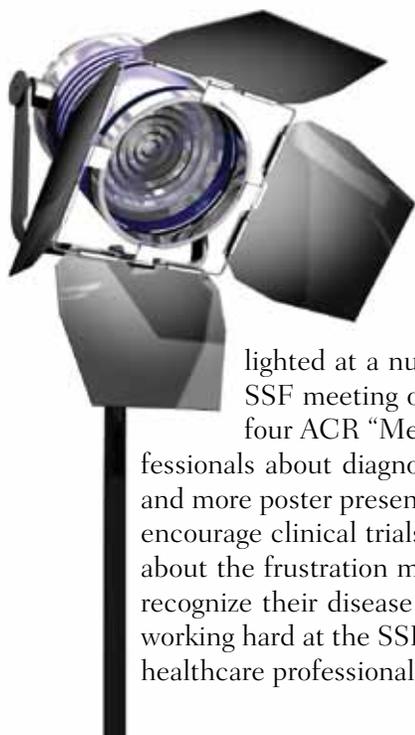
## Vasculitis in Sjögren's Syndrome

by Steven C. Carsons, MD, Winthrop University Hospital

Vasculitis is considered to be a significant extraglandular manifestation of Sjögren's syndrome (SS). While a specific type of vasculitis has not been universally associated with SS, several sub-types of vasculitis occur with considerable frequency in SS. These vasculitic sub-types have prognostic and therapeutic implications. This discussion is limited to the association of vasculitis with primary SS. Vasculitis, while not infrequently observed in secondary SS, often occurs via its association with the associated rheumatic disease (i.e. SLE).

More than 50 years ago, classification of vasculitic disorders was based on the caliber of vessels involved, but since that time, investigators discovered the relationship between immunological processes and specific kinds of vasculitis, and this has changed our way of thinking about and defining sub-types of vasculitis. However, terminology can remain in use long after its effectiveness, resulting in variable reports of vasculitis complicating SS.

*continued page 2 ▼*



## Spotlight on Sjögren's at Annual Professional Meeting of Rheumatologists

by Katherine Morland Hammitt, SSF Vice President of Research

The Sjögren's Syndrome Foundation (SSF) goal to increase professional awareness of Sjögren's (SS) received a big boost at the American College of Rheumatology (ACR) Annual Meeting this fall when Sjögren's was highlighted at a number of events: clinicians and researchers in rheumatology participated in an SSF meeting on potential new therapies for SS patients; a Clinical Symposium on Sjögren's; four ACR "Meet the Professor" sessions geared to answering questions from healthcare professionals about diagnosing, managing and treating SS patients; a Sjögren's Syndrome Study Group; and more poster presentations on Sjögren's than ever before. SSF presented a poster on its initiative to encourage clinical trials in SS and met with attendees who visited the SSF Exhibit Booth. "We know about the frustration many Sjögren's patients face when they visit healthcare professionals who don't recognize their disease and don't know what to do for them," says SSF CEO Steven Taylor. "We are working hard at the SSF to change that and are determined to reach every physician, dentist and other healthcare professional who might see a Sjögren's patient."

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"Vasculitis" continued from page 1 ▼

The majority of vasculitic syndromes described in SS involve small vessels. A list of terms used to describe vasculitic syndromes complicating primary SS is shown in Table 1.

### Small vessel involvement

A common form of vascular involvement seen in SS patients is caused by red blood cells leaking through capillaries in the skin. This occurs because of increased blood viscosity and subsequent increased pressure within the capillaries that can take place because of the higher-than-normal amount of gammaglobulins and immune complexes often observed in SS. In

most cases, this is not a true vasculitis, because inflammation does not occur in or around the vessel wall. In this condition, the immune complexes are not deposited in vessel walls nor do they activate complement.

Hyperglobulinemic purpura presents as showers of small red dots appearing under the skin or micropetechiae occurring in crops on the lower extremities. Older areas of micropetechiae undergo evolution and develop brawny excess pigmentation; new areas of micropetechiae repetitively appear. Prolonged standing or wearing of tight elastic garments may exacerbate the symptoms. This condition is alternately referred to as Schaumburg's disease and/or benign hyperglobulinemic purpura of Waldenstrom. While cutaneous vasculitis with vascular inflammatory infiltrates can occur in this condition, the "benign" in this usage distinguishes it from Waldenstrom's hypergammaglobulinemia - a malignant B cell disorder. True cutaneous vasculitis also occurs in SS as described by Alexander and

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**Table 1**

### Small and Medium Vessel Vasculitic Syndromes Associated with SS

#### Small vessel

Benign hyperglobulinemic purpura of Waldenstrom

Capillaritis

Cryoglobulinemic vasculitis

Hypergammaglobulinemic purpura (non-inflammatory)

Leukocytoclastic angiitis

Lymphocytic vasculitis

Mononuclear inflammatory vascular disease

Neutrophil inflammatory vascular disease

Palpable purpura

Schaumburg's disease

Serum sickness vasculitis

Urticarial vasculitis

Venulitis

#### Medium Vessel

Granulomatous arteritis

Mononeuritis multiplex

Necrotizing vasculitis

Systemic necrotizing vasculitis

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# Stand Up for Sjögren's This April!

Imagine your mouth full of cotton, your eyes full of sand, your brain full of fog, your body full of lead... **Imagine Sjögren's Syndrome!**

Many of you can imagine this since you live with Sjögren's! This April, it is our job to help others "imagine" living with it, too.

Please consider doing your part this April and let people know that Sjögren's syndrome is **MORE** than just dry eyes and dry mouth! Join our Imagine Campaign by contacting the SSF and requesting your Imagine Kit. Inside this kit, you will find materials to share with family, friends and local media to help them **IMAGINE...**

- having dental problems 50 times more often than the average person and often not knowing why
- having chronic fatigue that takes the living out of life
- living with a chronic disease unrecognized by many health practitioners
- constantly feeling terrible and being told it is all in your mind
- finding that water is not enough
  - living with a disability that no one understands
- burning symptoms in your feet that keep you awake at night
- feeling like you've got the flu, all day, every day, and no one knows why
- having to see a rheumatologist, dentist, ophthalmologist, OB/GYN, psychologist, neurologist, urologist, endocrinologist, internist and a gastroenterologist and being told there isn't one product to help but instead having to take upwards of 10 - 15 products.
- having Sjögren's

## **Here is how you can help this April:**

- Take our "Imagine" and Sjögren's information to local physicians, dentists or clinics.
- Write letters to newspapers telling them about your story and sharing with them our "Imagine" materials.
- Contact your local media by forwarding them our "Imagine" materials and encouraging them to do a story on Sjögren's.
- Help raise awareness, and vital funds, by participating in this year's *Friends Helping Friends* campaign with the materials you will be receiving in the mail.
- Find a local health fair and consider hosting a Sjögren's informational table.

*If you are interested in standing up and helping increase awareness this April, contact Pat Spolyar at 800-475-6473 Ext. 221 or e-mail her at [pspolyar@sjogrens.org](mailto:pspolyar@sjogrens.org).*

***Imagine – a world where everyone has heard of Sjögren's!***

***You can help us make this happen!***



"Vasculitis" continued from page 2 ▼

colleagues who classified lesions on the basis of the predominant cell type involved in the inflammatory process and infiltration of the vessel walls. Patients with one type of lesion, called neutrophil-predominant, tend to have high titers of antibodies to SS-A and SS-B as well as other specific blood markers as opposed to patients with a second type, called mononuclear-predominant. These patients may also present with neuropathy and decreased white blood cells, or leukopenia. As in other rheumatic diseases, vasculitis in SS may be accompanied by evidence of cryoglobulins in the blood.

The presence of cryoglobulins should lead to close monitoring for a potential lymphoproliferative disorder or investigation into potential infection. For example, if the cryoglobulins are composed entirely of a monoclonal protein, the clinician will be alerted to the presence of a B cell lymphoproliferative disorder. Other types of cryoglobulins may be secondary to primary SS. The presence of cryoglobulins should prompt an evaluation for chronic infection, particularly hepatitis C virus (HCV).

Approximately 10% of SS patients are positive for anti-neutrophilic cytoplasmic antibodies (ANCA), a class of antibodies associated with vasculitis that can be identified by immunofluorescence testing. With rare exception, patients with ANCA have not demonstrated lung or kidney manifestations but do display a higher incidence of Raynaud's phenomenon, peripheral neuropathy and cutaneous vasculitis as compared to SS patients who are ANCA-negative.

### **Sjögren's, Hepatitis C virus (HCV) and vasculitis**

HCV infection can closely mimic SS. Not only are salivary gland inflammation and associated symptoms of dryness significant manifestations of HCV, but cryoglobulinemia, vasculitis and lymphoma also are seen in patients with HCV alone. In certain populations, approximately 15-20% of patients diagnosed and treated for primary SS test positively for HCV antibodies or gene products. Patients who have evidence of SS and HCV infection (SS-HCV) are six times more likely to have neurologic involvement, cryoglobulinemia, and low complement but only half as likely to be positive for anti SS-A (Ro) compared to SS patients who do not have HCV. Some experts believe that HCV infection can trigger SS, while others feel that the disorders may frequently co-exist in certain populations. Nonetheless, HCV infection should be excluded in all patients undergoing evaluation for SS.

### **Is vasculitis a biological marker for lymphoma in SS?**

It has been established that patients diagnosed with primary SS are at a 30-40 fold relative risk for non-Hodgkin's lymphoma (NHL) compared to age- and sex-matched controls. Despite this, NHL will affect only 5-10% of the SS population. Identification of predictors of NHL development has been an ongoing clinical challenge. Traditional markers of lymphoma development such as increasing lymphadenopathy, splenomegaly, and development of a monoclonal protein with loss of specific autoantibodies are relatively late events. Within the past 10 years, studies conducted in Greece and Sweden have shown that among a spectrum of clinical factors, palpable purpura (vasculitic rash), low complement and the appearance of cryoglobulins confer the highest risk for NHL development. Studies support the notion that B cells driven to produce high levels of autoantibody may be prone to lymphoma development. These autoantibodies may also selectively predispose to the development of cryoglobulinemia and vasculitis. Thus, SS patients who develop the above clinical features should be closely examined for the presence of NHL.

### **Management of vasculitis associated with SS**

Hyperglobulinemic purpura may be managed using symptomatic therapy. Avoidance of tight fitting elastic on the lower extremities, elimination of long periods of standing and elevation of one's legs while sitting are all helpful in reducing elevated hydrostatic pressure. Judicious use of topical corticosteroids (i.e. 1% hydrocortisone and others) may relieve itching as may the newer, non-sedating antihistamines which may be less drying than the traditional antihistamines. Mild to moderate cutaneous vasculitis may respond to a variety of agents including NSAIDs, colchicine, dapsone, hydroxychloroquine and methotrexate. Short courses of oral corticosteroid (prednisone) may be required.

The onset of numbness or other changes in sensation, pain and/or weakness of the extremities may be indicative of a more severe vasculitis involving the peripheral nerves and or muscles. In some cases, medium caliber vessels may be involved and other organs or systems may be affected as well, including the kidney, GI tract and central nervous system. These more severe forms of vasculitis require treatment with moderate to high doses of corticosteroids and immunosuppressive agents such as azathioprine and cyclophosphamide. Intravenous immunoglobulin has

continued page 10 ▼

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"ACR Spotlight" continued from page 1 ▼

Attendees packed a lunch meeting hosted by the SSF entitled "The Promise of New Therapeutics in Sjögren's." Chaired by Elaine Alexander, MD, PhD, chair of the SSF Medical and Scientific Advisory Board, the meeting addressed the current state-of-the-art in B cell therapies in SS and new developments in lupus that likely will have implications for SS. Because of the close relationship between SS and lupus, drugs that are proven effective for lupus patients have a strong possibility of also being helpful in SS. The meeting kicked off with breaking news about successful clinical trials in lupus for a drug called Benlysta™. Clinical trial data for the first part of Phase 3 trials (the final phase for testing novel compounds before requesting approval from the Food and Drug Administration or FDA) was presented by the Vice President of Clinical Research at Human Genome Sciences. Benlysta™ is a drug that inhibits the action and survival of B cells by targeting proteins called B lymphocyte stimulators or BLS. The second part of Phase 3 trials was pronounced a success shortly after the meeting, so the company will now present its evidence to the FDA.

The company also announced two clinical trial sites in Europe that will be investigating the use of Benlysta™ in Sjögren's. Through its recent creation of a Clinical Trials Consortium, the SSF is closely monitoring and encouraging the development of new potential drugs for SS as well as the testing of drugs already on the market but indicated for other disorders. Human Genome Sciences sponsored the SSF meeting at the ACR.

At the same time, success in the second part of Phase 2 trials in lupus was unveiled for another B cell drug called epratuzumab. This drug binds to a protein on B cells called CD22, thereby modulating B cell activity. Earlier preliminary trials in Sjögren's took place in Europe and showed potential usefulness for SS patients. The company responsible for epratuzumab, UCB, previously has supported the SSF in its efforts to collaborate and encourage the development of outcome measures, or the means by which a drug's effectiveness can be measured in Sjögren's patients.

In addition, the meeting included an overview of potential B cell therapies in SS, an update on outcome measures and a report on the International Symposium on Sjögren's Syndrome that was held last fall in France. See the article on SSF participation in this symposium by SSF CEO Steven Taylor in *The Moisture Seekers*, November 2009.

The SSF Clinical Trials Consortium was highlighted in a special poster session during the ACR. The con-

sortium, chaired by Dr. Alexander, was established to increase the availability and accessibility of treatments for SS. The poster was displayed and included in the ACR Program Book and announced the Consortium and invited professionals to participate.

A Clinical Symposium on Sjögren's Syndrome moderated by past SSF Medical and Scientific Advisory Board Chair Frederick Vivino, MD, was a hit with professionals in rheumatology at the ACR. Highlighted in the *ACR Daily News*, the panelists included renowned specialists in ophthalmology, dentistry and rheumatology. Attendees filled a large auditorium to listen to the experts and lined up with questions following the presentations. For more information, see *The Moisture Seekers*, December 2009, "Understanding of Sjögren's Syndrome Continues to Evolve."

Dr. Vivino also presented four "Meet the Professor" sessions on Sjögren's. These sessions provide a hands-on opportunity for professionals to learn from and consult with experts in a specific area of rheumatology.

The number of posters at the ACR reporting on research projects in Sjögren's continues to rise. Over 40 posters were presented on Sjögren's, and a special session was held featuring five authors who provided oral presentations and responded to attendee questions. One of those posters was awarded the SSF Outstanding Abstract Award, given every year by the Foundation to recognize exceptional research by a new or young investigator. Seshagiri Rao Nandula, PhD, a post-doc at the University of Virginia received the SSF award for his project, "Activation of Innate Immunity Leads to Accelerated Development of Sjögren's Syndrome-Like Disorder in NZB/W F1 Mice."

A Study Group on Sjögren's was led by Gabor Illei, MD and Nikolay Nikolov, MD of the National Institutes of Health. The study session focused on the pathology and clinical treatment of neuropathies in Sjögren's, biomarkers for determining diagnosis and prognosis in SS patients and sex steroids and salivary cells.

Finally, the SSF Exhibit Booth drew great interest from attendees with offerings that included brochures and booklets for physicians and allied health care specialists to distribute to patients, newsletters, and books. SSF staff members and area volunteers were on hand to provide additional information, encourage professionals to participate in SSF events and offerings, and network with other exhibitors from other foundations, medical centers and companies that serve those connected with rheumatology. ■

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#### Carcinogenesis, Mutagenesis, and Impairment of Fertility:

Systemic carcinogenicity studies were carried out in male and female mice and rats. In the 78-week oral (diet) mouse study, at doses of 1, 4, and 16 mg/kg/day, evidence of a statistically significant trend was found for lymphocytic lymphomas in females, and the incidence of hepatocellular carcinomas in mid-dose males significantly exceeded the control value.

In the 24-month oral (diet) rat study, conducted at 0.5, 2, and 8 mg/kg/day, pancreatic islet cell adenomas significantly exceeded the control rate in the low dose level. The hepatocellular carcinomas and pancreatic islet cell adenomas were not dose related. The low doses in mice and rats are approximately 1000 and 500 times greater, respectively, than the daily human dose of one drop (28 µL) of 0.05% RESTASIS® BID into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed.

Cyclosporine has not been found mutagenic/genotoxic in the Ames Test, the V79-HGPRT Test, the micronucleus test in mice and Chinese hamsters, the chromosome-aberration tests in Chinese hamster bone-marrow, the mouse dominant lethal assay, and the DNA-repair test in sperm from treated mice. A study analyzing sister chromatid exchange (SCE) induction by cyclosporine using human lymphocytes *in vitro* gave indication of a positive effect (i.e., induction of SCE).

No impairment in fertility was demonstrated in studies in male and female rats receiving oral doses of cyclosporine up to 15 mg/kg/day (approximately 15,000 times the human daily dose of 0.001 mg/kg/day) for 9 weeks (male) and 2 weeks (female) prior to mating.

#### Pregnancy-Teratogenic effects:

Pregnancy category C.

**Teratogenic effects:** No evidence of teratogenicity was observed in rats or rabbits receiving oral doses of cyclosporine up to 300 mg/kg/day during organogenesis. These doses in rats and rabbits are approximately 300,000 times greater than the daily human dose of one drop (28 µL) 0.05% RESTASIS® BID into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed.

**Non-Teratogenic effects:** Adverse effects were seen in reproduction studies in rats and rabbits only at dose levels toxic to dams. At toxic doses (rats at 30 mg/kg/day and rabbits at 100 mg/kg/day), cyclosporine oral solution, USP, was embryo- and fetotoxic as indicated by increased pre- and postnatal mortality and reduced fetal weight together with related skeletal retardations. These doses are 30,000 and 100,000 times greater, respectively than the daily human dose of one-drop (28 µL) of 0.05% RESTASIS® BID into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed. No evidence of embryofetal toxicity was observed in rats or rabbits receiving cyclosporine at oral doses up to 17 mg/kg/day or 30 mg/kg/day, respectively, during organogenesis. These doses in rats and rabbits are approximately 17,000 and 30,000 times greater, respectively, than the daily human dose.

Offspring of rats receiving a 45 mg/kg/day oral dose of cyclosporine from Day 15 of pregnancy until Day 21 post partum, a maternally toxic level, exhibited an increase in postnatal mortality; this dose is 45,000 times greater than the daily human topical dose, 0.001 mg/kg/day, assuming that the entire dose is absorbed. No adverse events were observed at oral doses up to 15 mg/kg/day (15,000 times greater than the daily human dose).

There are no adequate and well-controlled studies of RESTASIS® in pregnant women. RESTASIS® should be administered to a pregnant woman only if clearly needed.

#### Nursing Mothers:

Cyclosporine is known to be excreted in human milk following systemic administration but excretion in human milk after topical treatment has not been investigated. Although blood concentrations are undetectable after topical administration of RESTASIS® ophthalmic emulsion, caution should be exercised when RESTASIS® is administered to a nursing woman.

#### Pediatric Use:

The safety and efficacy of RESTASIS® ophthalmic emulsion have not been established in pediatric patients below the age of 16.

#### Geriatric Use:

No overall difference in safety or effectiveness has been observed between elderly and younger patients.

#### ADVERSE REACTIONS

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Other events reported in 1% to 5% of patients included conjunctival hyperemia, discharge, epiphora, eye pain, foreign body sensation, pruritus, stinging, and visual disturbance (most often blurring).

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# I Stood Up...

Ben & Karen Freestone  
Texas



**O**n November 15th, Ben Freestone and his wife, Karen, stood up in a big way for the Sjögren's Syndrome Foundation. Both took part in the San Antonio Rock 'n' Roll Marathon as part of the Foundation's *Team Sjögren's* program – Karen was a race course volunteer and Ben was a marathon runner. They each stood up in their own way to make a difference for Sjögren's.

Ben started training with *Team Sjögren's* over the summer and really started to make strides as he geared up for the race on November 15th. Ben finished the course in a *Team Sjögren's* record, but most importantly, he accomplished something else he had set out to do: he helped raise awareness for Sjögren's while also raising over \$10,000 for the Sjögren's Syndrome Foundation. All of this was done in honor of his wife, Karen, a Sjögren's patient.

"I envision waking every morning feeling like you ran a marathon the day before. For many sufferers of Sjögren's it doesn't take that vivid of an imagination, and that is why I set out on this journey to make a difference," says Ben.

Karen, who was honored to have her husband stand up and take on this challenge, was the one cheering him on throughout his training! But even more exciting was that on race day, Karen was along the course as a *Team Sjögren's* race course volunteer. Not only was she cheering for Ben, but she was also cheering for the other eight *Team Sjögren's* members who took part in the November 15th marathon.

*continued page 12 ▼*

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### In Honor of Donald J. Unger

David & Mary Unger

### In Honor of Dr. Karl Auerbach's Mother

Barbara & Richard Rappaport

### In Honor of Elaine Harris

The John M. and Sally B. Thornton Foundation

### In Honor of Elaine Haumann

Rowena Kather

### In Honor of Emily Schetky

Norma Jones

Mark & Catherine Schetky

Carolyn England Thomas

### In Honor of Erica Hanson

Joann Hanson

### In Honor of Helen T. MacLeod Stefl

The Roberts Family

### In Honor of Herbert Harris

Gail & Jerry Ellstein

### In Honor of Jo Ann Snider

William Skahen

### In Honor of Joel Godbey & Kelly Morrow

Bill & Todd

### In Honor of Marion Hart

Sally Meeks

### In Honor of Nancy Beckendorf

Kirk Beckendorf



## in memoriam

### In Memory of Barbara Davis

Patricia Wielert

### In Memory of Doris Bauer

W. John Bauer

### In Memory of Gladys Elizabeth Gibbons Beach

Charlotte Beach Hankins

### In Memory of Joan Cairncross

The Bridge Ladies	Howard & Sue Busby
Elizabeth Cotton & Gordon Jones	Marijeanne Crabtree
Rhoda M. Dennison	Eleanor Duemling
Bob & Gail Dunham	Dona Frosio
Kathy Hammitt	Judi Harper
Elaine & Herb Harris	The John M. and Sally B. Thornton Foundation
Catherine McNeil	Mary Ellen & John McNeil
Kathryn A. O'Bryan	Elizabeth & Robert O'Neill
Sue Randerson	Bill & Floradel Reid
Carl & Cheri Rossi	Richard & Johanna Seignious
Nellora J. Walker	

### In Memory of Margorie Brant

The Grason Family      Adrienne A. Huether

### In Memory of Maryanna Piano

Licia Katz      Mr. & Mrs. Ted Katz

### In Memory of Susan Pinals

The NYC Support Group

*"Vasculitis" continued from page 4 ▼*

been successful in patients with peripheral neuropathy secondary to vasculitis. Rituximab has recently demonstrated efficacy for systemic necrotizing vasculitis and is under investigation for the treatment of extraglandular manifestations of SS. B cell depletion (rituximab therapy) is an attractive option for the management of SS particularly when vasculitis is associated with responsive forms of B cell NHL.

### In summary

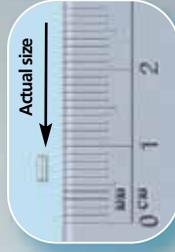
Treatment of vasculitis should be approached on several levels. The type of vasculitis must be determined and any additional disorders (such as lupus or HCV) diagnosed or ruled out. Vasculitis also should be considered in the context of other signs, symptoms and lab results used to assess the potential risk for developing lymphoma, and, if someone is deemed high risk, she/he should be monitored closely. On a day-to-day basis, a variety of management tools and drugs are available to ease symptoms. ■

If you drop artificial tears  $\geq 4$  times a day, give yourself

# More Freedom to Go DROPLESS

LACRISERT<sup>®</sup>: All-day dry eye relief in a single daily dose\*

- Significant improvement in symptoms, signs, and activities of daily living<sup>1,2†</sup>
- Dissolves comfortably in the eye to begin all-day relief—like a slow-release artificial tear<sup>2,3</sup>
- No preservatives to cause irritation or damage, even with long-term use<sup>3,4</sup>
- Simple and easy placement<sup>3,4</sup>
- Preferred by nearly 4 in 5 patients over artificial tears<sup>2</sup>



LACRISERT<sup>®</sup> is indicated in patients with moderate to severe Dry Eye syndromes, including keratoconjunctivitis sicca. LACRISERT<sup>®</sup> is indicated especially in patients who remain symptomatic after an adequate trial of therapy with artificial tear solutions. LACRISERT<sup>®</sup> is also indicated for patients with exposure keratitis, decreased corneal sensitivity, and recurrent corneal erosions.

LACRISERT<sup>®</sup> is contraindicated in patients who are hypersensitive to hydroxypropyl cellulose. The following adverse reactions have been reported in patients treated with LACRISERT<sup>®</sup> but were, in most instances, mild and temporary: blurring of vision, eye discomfort or irritation, matting or stickiness of eyelashes and red eyes. If improperly placed, LACRISERT<sup>®</sup> may result in corneal abrasion.

**Please see brief summary of Prescribing Information on adjacent page.**

For more information, visit [www.LACRISERT.com](http://www.LACRISERT.com) or call 1-877-ATON-549.

Ask your doctor about LACRISERT<sup>®</sup> today!

  
**LACRISERT<sup>®</sup>**  
(hydroxypropyl cellulose ophthalmic insert)

\*Some patients may require twice-daily use for optimal results.<sup>2</sup>

†Multicenter, 2-visit, 4-week, single-arm study conducted in moderate to severe Dry Eye patients who had previously been using AIs (N=520). Results are based on 418 patients who completed the study.

## SEARCH THE INTERNET... AND SUPPORT SSF

You can earn a penny for the SSF every time you search on the Internet! GoodSearch.com is a search engine that donates half its revenue to the charities its users designate. Bookmark [www.goodsearch.com](http://www.goodsearch.com) as your new search engine and be sure to choose Sjögren's Syndrome Foundation.

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# ATON

P H A R M A

Lawrenceville, NJ 08648, USA

Rx Only

**LACRISERT®** (hydroxypropyl cellulose) OPHTHALMIC INSERT

#### DESCRIPTION

LACRISERT™ Ophthalmic Insert is a sterile, translucent, rod-shaped, water soluble, ophthalmic insert made of hydroxypropyl cellulose, for administration into the inferior cul-de-sac of the eye.

Each LACRISERT is 5 mg of hydroxypropyl cellulose. LACRISERT contains no preservatives or other ingredients. It is about 1.27 mm in diameter by about 3.5 mm long. LACRISERT is supplied in packages of 60 units, together with illustrated instructions and a special applicator for removing LACRISERT from the unit dose blister and inserting it into the eye.

#### INDICATIONS AND USAGE

LACRISERT is indicated in patients with moderate to severe dry eye syndromes, including keratoconjunctivitis sicca. LACRISERT is indicated especially in patients who remain symptomatic after an adequate trial of therapy with artificial tear solutions. LACRISERT is also indicated for patients with exposure keratitis, decreased corneal sensitivity, and recurrent corneal erosions.

#### CONTRAINDICATIONS

LACRISERT is contraindicated in patients who are hypersensitive to hydroxypropyl cellulose.

#### WARNINGS

Instructions for inserting and removing LACRISERT should be carefully followed.

#### PRECAUTIONS

##### General

If improperly placed, LACRISERT may result in corneal abrasion.

##### Information for Patients

Patients should be advised to follow the instructions for using LACRISERT which accompany the package. Because this product may produce transient blurring of vision, patients should be instructed to exercise caution when operating hazardous machinery or driving a motor vehicle.

##### Carcinogenesis, Mutagenesis, Impairment of Fertility

Feeding of hydroxypropyl cellulose to rats at levels up to 5% of their diet produced no gross or histopathologic changes or other deleterious effects.

##### Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

##### Geriatric Use

No overall differences in safety or effectiveness have been observed between elderly and younger patients.

#### ADVERSE REACTIONS

The following adverse reactions have been reported in patients treated with LACRISERT, but were in most instances mild and transient: transient blurring of vision, ocular discomfort or irritation, matting or stickiness of eyelashes, photophobia, hypersensitivity, edema of the eyelids, and hyperemia.

#### DOSAGE AND ADMINISTRATION

One LACRISERT ophthalmic insert in each eye once daily is usually sufficient to relieve the symptoms associated with moderate to severe dry eye syndromes. Individual patients may require more flexibility in the use of LACRISERT; some patients may require twice daily use for optimal results.

Clinical experience with LACRISERT indicates that in some patients several weeks may be required before satisfactory improvement of symptoms is achieved.

Issued June 2007

References: Kuffler BH; for the LAC-07-01 Study Group. Lacrisert (hydroxypropyl cellulose ophthalmic inserts) significantly improves symptoms of dry eye syndrome (DES) and patient quality of life. Poster presented at: Association for Research in Vision and Ophthalmology (ARVO) 2009 Annual Meeting; May 3-7, 2009; Orlando, Florida. 2. Katz JI, Kaufman HE, Breslin C, Katz IM. Slow-release artificial tears and the treatment of keratitis sicca. *Ophthalmology*. 1978;85(8):787-793. 3. Lacrisert [package insert]. Lawrenceville, NJ: Aton Pharma, Inc.; 2007. 4. Hill JC. Slow-release artificial tear inserts in the treatment of dry eyes in patients with rheumatoid arthritis. *Br J Ophthalmol*. 1989;73(2):151-154.

"I Stood Up..." continued from page 9 ▼



Karen and Ben Freestone

The Foundation thanks Ben and Karen, as well as all our 2009 *Team Sjögren's* alumni, who stood up and took on that challenge. But remember, standing up for Sjögren's does not mean you have to train for a marathon. You can al-

ways come out onto the course and cheer on our *Team Sjögren's* runners. In San Antonio we had seven other race course volunteers joining Karen and we hope that we will have another great group of cheerleaders in Nashville on April 24th as we have a brand-new group of runners running in the Nashville Country Music Marathon. If you are interested in standing up for Sjögren's by taking part in *Team Sjögren's* or by volunteering on the marathon course in Nashville in April, contact the Foundation and let your voice be heard! ■

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## Cold Fingers and Toes? It Might Be Raynaud's

Reprinted from NIH News in Health, December 2008 issue

When the temperature drops this winter, it's normal to feel it most in your fingers, toes, ears and nose. But if your fingers and toes regularly turn bluish or white when the temperature dips even slightly, or if they often feel numb or painful or turn red and tingle when you're stressed or cold, it may be a sign you have something called Raynaud's disease.

Raynaud's disease is a disorder that affects blood vessels. Most studies suggest that it affects about 3-5% of the population, especially women. It can arise at any age, although it typically appears during teenage years or later.

In people with Raynaud's, blood vessels have an extreme response to cold temperatures and stress. The body's normal response to prolonged cold temperatures is to tighten blood vessels and reduce blood flow to the fingers, toes and other extremities. This helps to slow heat loss and keep warm blood flowing to your brain and other vital organs. Likewise, stressful situations normally trigger the release of hormones that can also cause blood vessels to narrow in your extremities.

But in people with Raynaud's, the response to cold and stress is far more rapid and severe. Just taking something out of the freezer or sitting in an air-conditioned room can trigger an attack, which may last for less than a minute or as long as a few hours.

During a Raynaud's attack, the blood vessels quickly narrow and reduce the flow of blood, causing the skin to temporarily turn white, then bluish. When blood flow later returns, the skin turns red. Your fingers and toes may throb or feel numb and tingly.

Most cases of Raynaud's have no known cause—a condition called primary Raynaud's disease. Primary Raynaud's is typically more of a bother than a serious illness. It can often be managed with minor lifestyle changes, like wearing warm socks around the house or wearing gloves when removing things from the freezer.

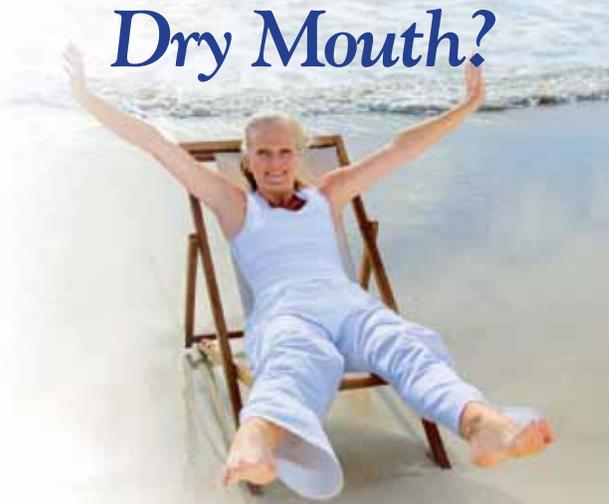
When Raynaud's disease can be linked to an underlying medical condition, it's called secondary Raynaud's or Raynaud's phenomenon. Secondary

Raynaud's is a more complex and typically more serious condition. It is most often caused by connective tissue disease, like scleroderma or lupus. Some of these diseases reduce blood flow to the fingers and toes. Secondary Raynaud's can also be caused by some medications that reduce blood flow, including certain blood pressure and migraine headache drugs.

Physicians usually recommend non-drug treatments for patients with primary Raynaud's, because they're not at risk for tissue damage. Secondary Raynaud's may require prescription medications that help to improve blood flow and heal skin sores on fingers and toes.

Be sure to talk with your doctor if you think you may have Raynaud's disease. ■

# Dry Mouth?



## Wet Your Whistle!

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**OraMoist** is a time-released patch that adheres to the roof of the mouth and then slowly dissolves, moistening the mouth for hours. Proven effective in University studies, OraMoist slowly releases xylitol and enzymes to promote oral health. Try a sample. Get hours of relief with each OraMoist patch—day or night!



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HEALTH

# Empower Yourself



As a Sjögren's patient, it's easy to feel confused or overwhelmed by the abundance of information available about the illness and how it affects your body. But now there is a wonderful opportunity to Empower Yourself and take more control of your health and day-to-day living by learning from the best minds dealing with Sjögren's. This April, join fellow Sjögren's patients and their family members, as well as healthcare professionals and other experts who specialize in Sjögren's, at the 2010 SSF National Patient Conference in San Francisco, California.

SSF programs are the best Sjögren's patient education opportunities in the country. They have helped thousands gain a better understanding of Sjögren's and will help you, too. This two-day event will feature an array of presentations from the country's leading Sjögren's experts – physicians, dentists, eye care providers, and researchers – who will help you understand how to manage all key aspects of your disease. Presentation topics will include:

- Overview of Sjögren's Syndrome
- CNS Disease in Sjögren's
- Lung Complications
- Dry Eye and Dry Mouth Issues
- Neuropathy in Sjögren's
- Sjögren's Survival: A Patient Perspective
- The Doctor/Patient Relationship
- Nutrition and Sjögren's
- Heart Disease: The Impact of Inflammation & Autoimmune Diseases

*So this April 9-10, we invite you to come to San Francisco, California, and experience a weekend to **Empower Yourself** as you gain knowledge and heighten your understanding of Sjögren's at the 2010 National Patient Conference!*

*Call 800-475-6473 or visit [www.sjogrens.org](http://www.sjogrens.org) today to receive the latest information.*



Alida Brill is an author and has written and spoken about the personal and public issues surrounding chronic illness. Her latest book, *Dancing at the River's Edge: A Patient and Her Doctor Negotiate a Life With Chronic Illness* is a personal dual memoir, written in collaboration with her physician.

Her writing appears in popular and professional periodicals and journals and she is a frequent guest on radio interview shows and television programs. She has been a featured speaker at a variety of conferences and a guest lecturer at many universities and colleges in the United States and abroad. We are delighted to have Ms. Brill as our 2010 Keynote Speaker – you won't want to miss this informative and moving presentation!

# Empower Yourself

April 9–10, 2010

San Francisco, California  
at the  
San Francisco Airport Marriott



## 2010 National Patient Conference

### 1 ATTENDEE – complete for each registrant

Attendee Name(s) \_\_\_\_\_

Attendee Name(s) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

### 2 FEES – please circle appropriate fee(s) (Note: Early Bird Deadline is March 15, 2010)

	March 15th and before	March 16th and after
SSF Members & Guests	\$165 per person	\$185 per person
Non-Members	\$190 per person	\$210 per person

**TOTAL:**

### 3 PAYMENT – Mail to SSF, c/o BB&T Bank · PO Box 890612 · Charlotte, NC 28289-0612 or Fax to: 301-530-4415

Enclosed is a check or money order (in U.S. funds only, drawn on a U.S. bank, net of all bank charges) payable to SSF.

MasterCard  VISA  AmEx Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_ CC Security Code \_\_\_\_\_

- Refund requests must be made in writing. Registrants whose written request is received by **March 26, 2010** will receive a **75% refund**. After that time, we are sorry that **no refunds can be made**.
- Dietary Requests: Unfortunately, we cannot accommodate all special dietary requirements. We can accommodate vegetarian or gluten-free dietary requests. If you require a **vegetarian** or **gluten-free** meal option, please contact Stephanie Bonner at the SSF office (800-475-6473 ext. 210) by March 26th.
- A limited number of rooms are available at the San Francisco Airport Marriott (1800 Old Bayshore Highway, Burlingame, California 94010) at the SSF rate of **\$129 per night plus tax** if reservations are made by **March 15, 2010**. Call the **toll-free** hotel reservation number at 800-228-9290 or call the San Francisco Airport Marriott directly at 650-692-9100 and refer to the group name "Sjögren's Syndrome Foundation" for the discounted rate.
- The San Francisco Airport Marriott provides a complimentary shuttle service to/from the San Francisco International Airport.

**QUESTIONS?** Call 800-475-6473 or visit [www.sjogrens.org](http://www.sjogrens.org)

## *The Moisture Seekers*

Sjögren's Syndrome Foundation Inc.  
6707 Democracy Blvd., Ste 325  
Bethesda, MD 20817

Phone: 800-475-6473  
Fax: 301-530-4415

# Spring 2010 Sjögren's Syndrome Foundation Special Event Calendar

The SSF is very excited for all of our events coming this Spring. Look at our special event calendar below to see if there is a *Walkabout* or *Sip for Sjögren's* coming to your area.

Visit [www.sjogrens.org](http://www.sjogrens.org) or contact the SSF office to learn more about our events!

## March

- 20 Long Island Walkabout & Autoimmune Disease Health Fair**  
Roosevelt Field Mall,  
Garden City, New York

## April

- 20 Sip for Sjögren's – Jacksonville**  
Deercreek Country Club,  
Jacksonville, Florida
- 24 Team Sjögren's – Nashville Country Music Marathon**  
Nashville, Tennessee

## May

- 1 Philadelphia Walkabout & Autoimmune Disease Health Fair**  
Tyler State Park,  
Bucks County, Pennsylvania

sip for  
**Sjögren's**  
a fine water  
tasting event

- 2 Sip for Sjögren's – Atlanta**  
Nelson Mullins-Atlantic Station,  
Atlanta, Georgia

- 13 Sip for Sjögren's – Harrisburg**  
West Shore Country Club,  
Harrisburg, Pennsylvania

- 15 Dallas Area Walkabout & Autoimmune Disease Health Fair**  
Grapevine Mall, Grapevine, Texas

- 22 Greater Washington Region Walkabout & Health Fair**  
Reston Town Center, Reston, Virginia

## June

- 5 Denver Area Walkabout**  
Denver Zoo. Denver, Colorado

- 5 Hartford Area Walkabout**  
Westfield Meriden Mall,  
Meriden, Connecticut

**Sjögren's Walkabout**

