

— PROFILES IN RHEUMATOLOGY —

At 100, Dr. Ephraim P. Engleman Focuses on Rheumatology's Future

BY SALLY KOCH KUBETIN

Do you love being a rheumatologist enough to still be seeing patients, teaching, and conducting research when you are 100 years old? May you live long enough to find out the answer to that question.

Rheumatologist Ephraim P. Engleman, who turned 100 years old in March, loves his specialty enough to still be very active in it. He is the longest tenured professor in any medical specialty at the University of California, San Francisco, where he is director of the Rosalind Russell Medical Research Center for Arthritis, and he continues to see patients 3 days a week.

When asked in an interview with RHEUMATOLOGY NEWS what he considers to be the most important advances in rheumatology since he began his career in the 1940s, Dr. Engleman listed without reservation, "the discovery and proper use of cortisone, an invaluable drug in all medical specialties including rheumatology and joint replacements." Dr. Engleman also included the development of biologic therapy, noting "its long-term undesirable effects [having] not yet been determined." Anticytokine therapy also made the list of important advances in rheumatology.

As for the greatest challenges facing the specialty, he listed "lack of national recognition of the rheumatologist's critical role in the optimal management of patients with musculoskeletal diseases, the commonest of the chronic disorders. Fur-

thermore, the kinds of services provided by rheumatologists are not adequately reimbursed in contemporary health insurance; thus, it is difficult for many rheumatologists to sustain viable practices."

He is touching the future by endowing the ACR REF/Ephraim P. Engleman Resident Research Preceptorship. The grant is \$15,000. The deadline for online applications is Feb. 1, 2012. The purpose of the grants is to attract promising physician scientists to rheumatology.

Dr. Engleman was born in San Jose, Calif. While an undergrad at Stanford University, he had a brief musical career as a violinist. He continues to play to this day. He graduated with his MD from Columbia University, New York, in 1937. Following medical residencies at University of California, San Francisco, and Tufts University, Boston, he was a fellow at the Massachusetts General Hospital where he received his training in rheumatology with Dr. Walter Bauer, professor of medicine at Harvard. Dr. Engleman recalls with affection his mentor Dr. Bauer, a pioneer in arthritis research. Anyone who completed a fellowship under him was guaranteed a

successful career in rheumatology.

During World War II, Dr. Engleman

saw military service as a major, serving as chief of the Army's Rheumatic Fever Center.

Any impulse he may have had to retire has been blocked by recognition of his career achievements by his peers in academia and elsewhere. He served as president of a number of organizations including the American Rheumatism Association, now the American College of Rheumatology, from 1962 to 1963; the National Society of Clinical Rheumatology

(1967-1969); and the International League Against Rheumatism (1981-1985). From 1975 to 1976, Dr. Engleman chaired the congressionally mandated National Commission on Arthritis, a task force charged with recommending remedies for the inadequate status of arthritis research, teaching, and patient care in the United States. Among its recommendations were the creation of what is now the Institute of Arthritis, Musculoskeletal, and Skin Diseases and tripling of the ongoing federal budget for arthritis research. The task force's report also called attention to the surprising number of medical schools with no curriculum in rheumatology. ■



Dr. Ephraim P. Engleman

COURTESY DR. EPHRAIM P. ENGLEMAN

Rx Drug Overdoses Up In Florida

BY FRANCES CORREA

FROM THE MORBIDITY AND MORTALITY WEEKLY REPORT

Deaths from prescription drug overdose rose 84% in Florida in 2003-2009, based on data from the Florida Medical Examiners Commission.

The greatest increases in death rates were seen in users of oxycodone (265%), alprazolam (234%), and methadone (79%), contrasting starkly to a decline in cocaine-related deaths (39% from 2007 to 2009)

VITALS **Major Finding:** Overdose deaths from oxycodone and alprazolam more than doubled during 2003-2009 in Florida, whereas overdose deaths from heroin were halved.

Data Source: Data from Florida medical examiners.

Disclosures: The researchers reported no relevant financial disclosures.

and heroin-related deaths (62% from 2003 to 2009). In 2009, the number of prescription drug-related deaths (13.4 per 100,000 people) in Florida was four times the amount of deaths from illicit drugs (3.4 per 100,000), according to the data reported in MMWR.

The total number of Florida drug-overdose deaths in 2003-2009 was 16,550.

Of those, 86% were ruled as unintentional by the medical examiners' office, 11% were ruled suicides, 3% were of undetermined intent, and fewer than 1% were ruled homicides or pending. (Numbers do not add to 100% due to rounding.)

The Florida data were described as "more timely and specific" than national data derived from death certificates, according to the report.

"These findings indicate a need to strengthen interventions aimed at reducing overdose deaths from prescription drugs in Florida," wrote Bruce Goldberger, Ph.D., of the University of Florida, Gainesville, and his colleagues (MMWR 2011;60:26:869-72).

The authors noted a large increase in the number of pain clinics operating in Florida "that prescribe large quantities of oxycodone and alprazolam, some of which is ultimately used for nonmedical purposes."

Some of their customers travel from Appalachian states to purchase drugs for resale, according to grand jury findings in Broward County, Fla.

The report calls on states to institute drug-monitoring systems, tighten restrictions on pain clinics, and regulate wholesale distributors of frequently abused prescription drugs. ■

Costs Rise With Spreading Drug Shortages

BY ALICIA AULT

The persistent shortages of several medications, especially injectable and infusion products, are now affecting virtually every hospital department, according to data released July 12.

The American Hospital Association and the American Society of Health System Pharmacists surveyed their memberships and found that 99.5% of hospitals had experienced one or more drug shortages in the last 6 months. Most hospitals reported delaying treatment or rationing certain products, and almost all said that the shortages have led to increased drug costs. This is not the first time the shortages have been reported to be a major problem. But it appears from the new data that shortages have grown from affecting mostly oncology departments to affecting the majority of clinical care areas at the hospital.

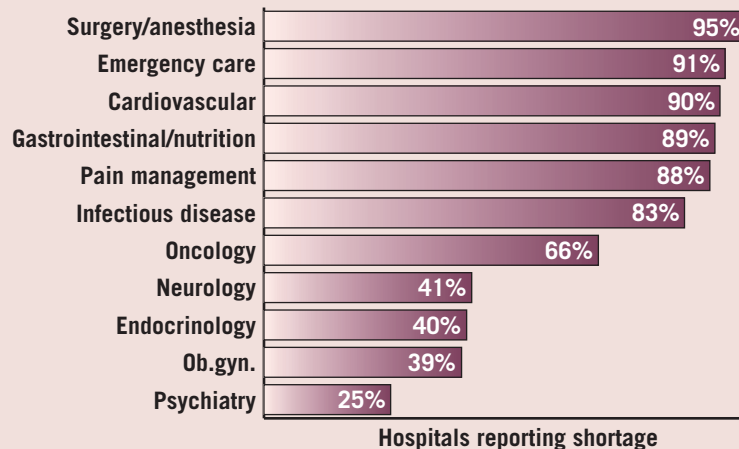
The June 2011 AHA survey included responses from 820 hospitals. Of all respondents, 90%-95% said that within the

last 6 months they had experienced shortages of medications for the following clinical uses: surgery/anesthesia, emergency care, cardiovascular, gastrointestinal/nutrition, and pain management.

Shortages were also noted in infectious diseases, oncology, neurology, endocrinology, obstetrics/gynecology, allergy, and psychiatry. Three-quarters of

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Drug Shortages Reported Across All Treatment Categories



Note: 820 acute care hospitals responded to a survey conducted June 1-22, 2011.
Source: American Hospital Association

Feds to Fund Nonprofit CO-OP Insurance Plans

BY FRANCES CORREA

FROM A PRESS BRIEFING BY THE
CENTERS FOR MEDICARE AND
MEDICAID SERVICES

Consumer Operated and Oriented Plans insurers will provide more health plan options for individuals and small businesses, officials from the Centers for Medicare and Medicaid Services said.

The new insurers “will provide consumers more choices [and] greater plan accountability, and help ensure a more competitive insurance market,” Steve Larsen, director of the Center for Consumer Information and Insurance Oversight at the CMS, said during a press briefing to announce the proposed rule on CO-OPs. He added that he hopes CO-OPs will provide affordable options for small businesses that often pay up to 18% more in health care costs than do large businesses.

Although plans created under the CO-OP program will have requirements similar to those of plans offered through state exchanges, CO-OP plans will be required to use any profits they make to lower premiums, improve the quality of care, or improve benefits available to consumers.

In addition, CO-OP plans will be governed by a board composed chiefly of plan members elected by their peers, and enrollees will have the opportunity to help decide the direction of health plans. CO-OPs will also be required to

tailor two-thirds of their plans to serve either individuals or small businesses.

The CMS will issue \$3.8 billion in start-up and capital loans for CO-OP insurers, and will evaluate potential insurers for their financial viability to ensure that they will be able to turn a profit.

Despite opportunity for consumer benefits, the CMS is also bracing for potential costs, including default on the loans. According to the proposed rule,

the CMS estimates that 35% of solvency loans and 40% of start-up loans may not be repaid. The rule also states that the CMS estimates spending \$600 million for start-up loans and \$3.2 million for solvency loans. Start-up loans must be repaid in 5 years, and capital, or solvency, loans must be paid in 15 years. However, Mr. Larsen said those estimates are “conservative,” and the actual expectation is a much lower rate of default.

The agency will be pushing to have a CO-OP available in every state; so far, it estimates that 57 entities will participate in the program.

Rhode Island and Texas have announced that they plan to have a CO-OP available. Existing health CO-OPs include Puget Sound Health CO-OP in Washington and the Health Partners CO-OP that operates in Wisconsin and Minnesota. ■

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Recent Developments in Systemic Sclerosis and Pulmonary Arterial Hypertension

Featuring:

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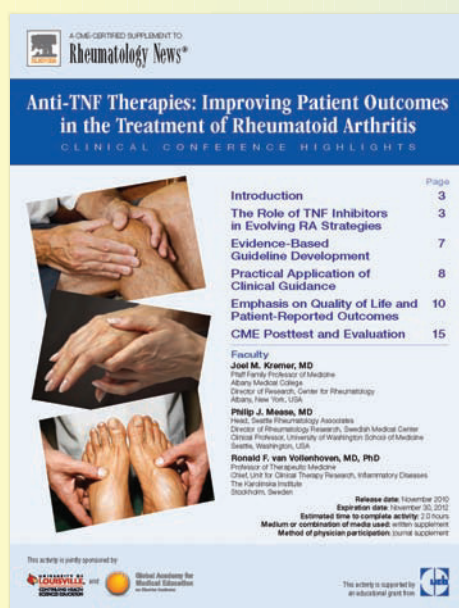
hospitals said they rarely or never received advance notice of the shortages.

In a separate study, researchers from the University of Michigan and the ASHP reported that the number of shortages in 2010 (211) was the highest ever recorded in a single year. The researchers surveyed ASHP members about the impact of 30 recent shortages; 353 pharmacists responded.

Pharmacists spent about 9 hrs/wk managing shortages, with an estimated annual labor cost of \$216 million. Shortages seemed to hit bigger hospitals harder. When asked if drug shortages created an increased burden, 97% of respondents agreed or strongly agreed; 93% said shortages increased costs, and 55% said shortages compromised care (Am. J. Health-Syst. Pharm. 2011;68:e13-21 [doi:10.2146/ajhp110210]).

The shortage problem is attracting more attention in Congress. In February, Sen. Amy Klobuchar (D-Minn.) introduced the Preserving Access to Life-Saving Medications Act (S. 296), which would give the Food and Drug Administration the authority to require early notification from pharmaceutical companies when a shortage appears to be imminent. At press time, the bill had 11 cosponsors.

Rep. Diana DeGette (D-Col.) and Rep. Tom Rooney (R-Fla.) introduced the bill in the House in mid-July. ■



Anti-TNF Therapies: Improving Patient Outcomes in the Treatment of Rheumatoid Arthritis

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