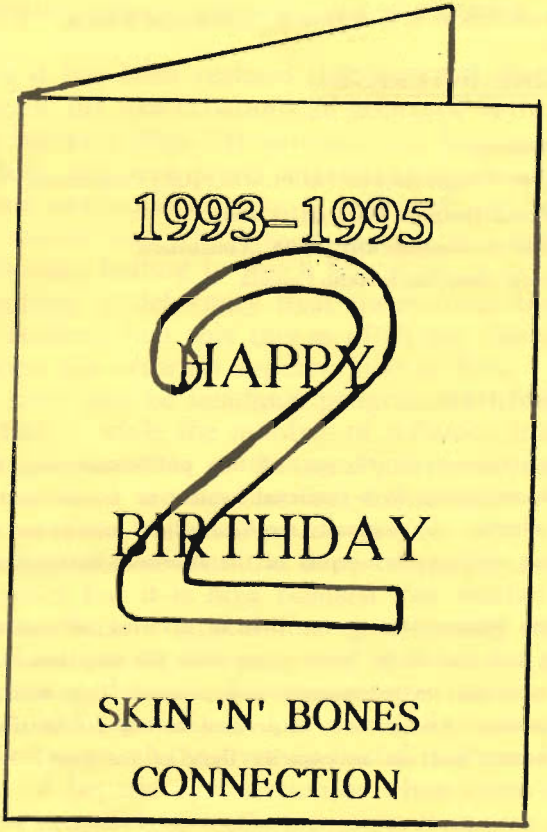
Psoriatic Arthropathy Alliance News Journal.

ISSUE NUMBER FOUR MAY 1995



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We also believe that at the time of printing all information to be correct but cannot be held responsible for any inaccuracies that may occur,nor do we endorse any products that may appear in this Journal. All opinions expressed herein are of the contributors and not necessarily those of the PAA.

WHAT'S NEW ABOUT PSORIATIC ARTHRITIS?

by Dr.D.N.Golding MA,MD,FRCP
Consultant Rheumatologist

Psoriatic Arthritis is a certain type of inflammatory polyarthritis that we seem to be seeing more frequently. It is a fact that 10% to 20% of patients with psoriasis have an associated arthritis,which differs from rheumatoid arthritis in many ways - for example,predominant involvement of the terminal interphalangeal joints of the fingers (sometimes the toes) and asymmetrical involvment of joints is commonly seen.Recently new ideas about this fascinating condition were discussed at a conference held in Malta and I shall mention a few observations on psoriatic arthritis made at this conference.

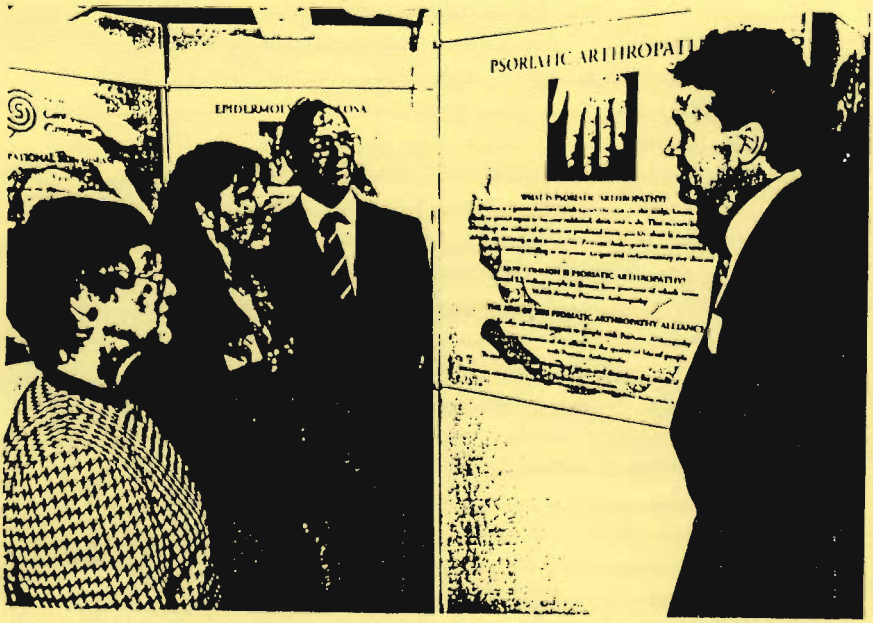
Recently it has been realised that various infections can trigger off exacerbations of psoriatic arthritis. Certain bacteria,often Streptococci,can lead to a flare-up of both skin and joints and in these circumstances immediate antibiotic therapy is indicated. While it used to be thought that psoriatic arthritis was a relatively mild disorder,leading to much less joint destruction and resulting in deformity than rheumatoid disease,it is now realised that this this is often not the case - even when the arthritis appears mild at first glance,there may be insidious progression of joint destruction - while the number of inflamed joints decreases,the number of damaged joints can increase. This means that second-line anti-inflammatory drug therapy is often indicated at an early stage.Sulphasalazine was the drug of choice until recent years but it is now realised that methotrexate is a more effective second-line agent,having the added bonus of improving the psoriatic skin lesions as well as the joints. Liver and bone marrow function must be monitored regularly and in doubtful cases an ultrasound scan of the liver is useful.If there is any question of hepatic dysfunction,or when there is failure to respond to methotrexate,cyclosporin A may be effective and safe in low dosage,provided renal

function is monitored carefully,especially if the patient is also taking non-steroidal anti-inflammatory drugs.

There is much controversy as to whether spa treatment has any specific effect on arthritis or skin disorders.It is,however,known that psoriasis undoubtedly is improved dramatically,albeit temporarily,by a course of treatment at the Dead Sea,thought to be a result of prolonged exposure to unharmful ultra-violet rays (which is possible in that part of the world,lying 600ft below sea level).Less well known is that many of those patients suffering from severe psoriasis do also have painful joints,some being quite disabled because of their arthritis,and that pain and function often show significant improvement along with the skin lesions.

HOUSE OF COMMONS 21st November 1994

SKIN CARE CAMPAIGN EXHIBITION



Back: Chris Friend Executive Committee Member
Middle: Julie Chandler - Director PAA
Front: Tricia Hobbs - Executive Committee Member & Membership Secretary
Right: David Chandler - Director PAA

REPORT

Skin Care CAMPAIGN

16th March 1995 House of Commons
All Party Parliamentary Group For Skin

At this meeting,it was split between two guest speakers,Mrs Tina Funnell,Chief Executive,from the National Eczema Society,and Mrs Linda Henley,Director of the Psoriasis Association.

A presentation was given about the work of the Eczema Society,what it had achieved and its plans for the future and its commitment to working with other charities,patient groups and medical/non professionals for the advancement of better patient care and information.

Mrs Henley gave a brief and concise history of the Psoriasis Association and its commitment to research into the skin disease,the work that they do offering help and advice both over the phone and via post. They manage to be thrifty with costs by staying in Northampton as opposed to being London,and with modern communication as it is there is no need to be in the centre of the Capital. Because the Charity had been in existence for 25 years,they found that they did not have to do much publicity themselves,it was automatically publicised as they were so well known. She also stated that due to modern day living and pressures,regional groups were diminishing and unfortunately so was their membership.Since their formation in the 1960's they have had 22,000 members but this has since dropped down to 12,000,and consists mainly of older people. She also stated an interesting fact that Psoriasis affected mainly older people,leading one to think younger people were less affected by the disease! She touched upon job discrimination due to the illness,a very important subject.

We were all then invited to offer questions to the speakers. Education and treatments,their advancement

came up and the Dermatologists present in the audience were approached on these areas. David Chandler from the Psoriatic Arthropathy Alliance, posed a Question to Mrs Henley following on about job discrimation,as a major charity what were their thoughts and actions on this. Unfortunately the response was "just one of those things".Further debate ensued and questions raised by David Congdon MP,and also an opinion was sought by Chris Friend,Advisor to the PAA, from Mrs Henley.A question was also raised by another member of the audience, as to why the Psoriasis Association had not wished to work with other groups in the Skin Care Campaign and the response was that the proposal was duly put before their Board and due to the financial implications of the proposal,it was felt that the Association could not carry out both continuing research grants and the Skin Care Campaign,so they decided to go it alone and "Paddle their own boat",thus rejecting the proposal.

All in all it was a very interesting meeting and discussion.

REPORT:
JOHN BOWIS MP

As mentioned in Newsletter 4,we were fortunate enough to be able to secure a meeting with Mr John Bowis MP,Under Secretary of State for Health.

Mr Bowis along with his advisors listened with genuine interest to all that we had to say with regard to the illness and took on board the difficulties facing the organisation.

The meeting went well and lasted for nearly an hour,with Mr James Clappison,our local MP,sitting in on the proceedings.Incidently Mr Clappison is also taking a close interest in the organisations activities,which is good news.

We now hope to continue co-operative,useful dialogue with the Department of Health and will also keep them advised of our activities.

David.

NAIL CHANGES IN PA.

* Nail disease (dystrophy) occurs in both hands and feet.

* Nail changes occur in up to 80% of patients with psoriatic arthritis compared to 30% of patients with psoriasis alone.

* Patients most commonly complain of brittle nails that fragment and are difficult to keep clean.

* The type of changes in the nails are

  -Pitting
  -Onycholysis (peeling of the nail from the nail bed)
  -Hyperkeratosis (thickening of the nail)
  -Salmon patch - brown discolouration of the nail (in association with Onycholysis)
  -Ridging (both transverse and longitudinal)

  None of these features are SPECIFIC for PA,but a combination of pitting and onycholysis or the presence of more than that 20 pits suggests psoriatic nail disease.

* The severity of nail disease varies between patients from a few pits and mild onycholysis to severe nail distortion.

* Nail disease may be associated with adjacent distal interphalangeal joint disease.

* There is no effective treatment for nail disease,although the severity does alter with time.

PHOTOTHERAPY

It is the unfortunate fact of psoriasis that,as yet,no theories have been conclusively proven as to the cause.Many conflicting opinions abound as to possible reasons and the nervous condition,dietary habits and the overall lifestyle of the sufferer are important factors when prescribing treatments.

But,as many sufferers can confirm,the success of these treatments can be very much a "hit-and-miss"affair. Basically all options are systematically covered to try and control the condition - often with only partial success. There are many short term treatments on the market,such as steriod creams,but purely for reasons of health,these cannot provide a permanent solution to the problem. Other less potentially dangerous treatments such as tar baths and rubs can be very effective but can also be messy,unpleasant and time consuming.

However,it is worth noting that psoriasis predominantly appears to affect those in the colder,northern countries of the world,where the summer months are short. The sunnier,southern climates have far fewer sufferers of this condition.

In fact,many people find that during the Summer,their psoriasis is greatly relieved,only to flare up again during the Winter. The significant factor with this is the exposure to the important ultra violet (UV) rays in the sunshine.

As most people with psoriasis are painfully aware,the skin goes through an exaggerated regeneration process.The cells are renewed up to 7 times faster than usual resulting in thickened,scaly patches of skin. Exposure to UV light suppresses this abnormal reconstruction and allows the skin to function "normally".

UV treatment is not a new technology. Doctors have

been using artificial UV light to treat skin disorders since the turn of the Century. Later,UV light and drug combinations were introduced as a treatment. The success rate of this was not impressive,however,as the UV spectrum of these artificial lamps was not sufficiently similar to the sun. Moreover,it is only since the 1970's that new information has been discovered and made more widely available on this type of therapy.

The commercial availability of UV or "Phototherapy" treatment has been refined by the F Wolff Institute in Switzerland. Dr.Wolff - the originator of the fluorescent tube - was arguably the first modern doctor to realise the importance of Phototherapy in successfully treating skin conditions such as psoriasis.

Naturally many people are concerned as to the effects of UV light but research has shown that the risks involved with exposure to UV are about the same as becoming an outdoor worker who is exposed to sunlight daily. It is also worth remembering that most other psoriasis teatments also have their risks.

Nevertheless,when the unit is responsibly used in conjunction with medical advice then it has been proven to be one of the most effective ways of allaying the painful and distressing symptoms. As a rule of thumb,the treatment is used over a period of several weeks to alleviate the symptoms and then no further treatment is necessary until the psoriasis starts to reappear. This "resting" period can last weeks or months - obviously,the effectiveness of the treatment depends on the metabolism of the individual.

Furthermore,Phototherapy is also one of the easiest treatments to administer and represents relief without the need for drugs. In addition to the many hospitals and clinics who offer this type of therapy,there are now units available for self-treatment in the home.

The introduction of the DermaMed Phototherapy lamp has made self-treatment a realistic option for psoriasis

sufferers. Regular,lengthy trips to the hospital should become unnecessary and individuals can follow the programme set by their Dermatologist or GP in the privacy and comfort of their own home.

A free catalogue giving all the information about the DermaMed Phototherapy treatment lamp can be obtained from Nordic Special Needs at Fairview Estate,Holland Road,Oxted,Surrey,RH8 9BZ or by telephoning 01883 716111.

Ms.Muir Long,Nordic.

This article has been supplied to us for members information only and we do not ourselves endorse such products. More information or queries should be dealt with direct with Nordic. It must be stressed that if you are considering this product please discuss your intentions with your Dermatologist as he/she can best advise you as to the product's suitability for your needs.

BOOKLIST

BOOKS BOOKS BOOKS

Balliere's Clinical Rheumatology
Psoriatic Arthritis
Guest Editors: V.Wright & P.Helliwell
8:2.1994
ISBN -0-7020-1820-1 (Single copy)
Approx £30.00

Arthritis: What really works
Dava Sobel & Arthur C.Klein £7.99
Robinson Publishing

Psoriasis
S.G.Gaetti
ISBN 0533072026 £8.10

PSORIATIC ARTHRITIS OF THE FEET

When Psoriatic Arthritis (PA) presents as polyarthritis it is probably just as common for it to involve the small joints of the feet as the hands,although no reliable statistics exist to demonstrate this. The feet are also one of the sites for the occurrence of inflammation of tendon ends (enthesopathy) found at the tip of the calcaneum and Achilles tendon insertion in particular. The presence of "sausage" toes is one of the "supportive" features in the criteria for diagnosis of PA. The pain of PA of the feet is often the dominant feature to sufferers and a potent cause of disability. It is surprising that descriptions of foot involvement in psoriasis (including the skin problems of onycholis and plantar pustular psoriasis) are given so little prominence,in textbooks.

In about 4% of patients enthesopathy may precede the onset of arthritis. Plantar fasciiitis with calcaneal spur formation is the commonest type seen.Early morning heel pain and foot stiffness which resists all forms of treatment (eg.injection,physiotherapy,heel pads) for 6 months,most particularly if bilateral should alert a clinician to the possibility of an inflammatory systemic condition. PA and sero-negative spondylarthritis are the two commonest conditions that present like this and patients should be watched carefully. Enthesopathy may accompany all forms of PA in 40% of sufferers and may need specific treatment locally for symptom control.

Although PA can be confused with Rheumatoid Arhtritis (RA),when it presents as a symmetrical polyarthritis of the metacarpal and metatarso-phalangeal joints,it can usually be distinguished by involvement of other more speific joints and the absence of rheumatoid factor in the blood. It is commoner for this type of arthritis to be asymmetrical and to involve only the first matatarso-phalangeal joint,together with one or two

interphalangeal joints. Erosions of many small joints may be seen on X-rays. The combination of croisions,absence of rheumatoid factor,sausage digits and involvement of the first interphalangeal joint is typical of PA. Other joints in the feet,especially the fifth metatarso phalangeal and ankle joints may also become painful and swollen but less commonly so.

The initial sypmtoms of foot arthritis are of pain and swelling,warmth,and stiffness. Morning stiffness does occur inPA but is far less dominant than in RA. Evening stiffness and swelling with limited walking distance are the commonest problems to patients. The wearing of shoes for more than a few hours at a time and the need to change shoe height,weight and width two or three times a day are familiar features to patients and clinicians alike.

More long-term the feet can become deformed. This can occur remarkably quickly-within 6 months if the arthritis is not adequately treated. The usual deformaties are clawed toes,hyperextension of the big toe and some inrolliing of the ankle with flattening of the metatarsal arch.Stiffness of the joints rather than instability also happens quickly and can again become irreversible within a few months.The occurence of callouses and ulcers on the soles of the feet is less common than in RA but "corns" over the interphalangeal joints can be very painful.

Despite this seemingly depressing description,the nature of PA in the majority of cases,is to be milder than RA for conditions such as Reiter's syndrome. The arthritis is more circumscribed,milder in onset and subject to long periods of remission. This means that disability is less but as far as the feet are concerned,can work against adequate treatment.Both patients and clinicians tend to ignore the symptoms and deformity and stiffness can develop insidiously.This leads to future problems including osteoarthritis,tendon contractures,callouses and disability. These features may be prevented if treatment is adequate.

The treatment of the feet in PA must initially include a full assessement of the involved joints and tendons.A walking assessement should be included together with the usual blood tests,full history and

diagnosis of any already developed lower limb deformities.If suppressive medication is considered necessary this should be started promptly.The slow action (3 months) of such drugs means that any delay in initiating treatment can allow the development of erosions and deformity.

Local treatment to the feet is always necessary to some degree.This may include corticosteriod injections to the worst involved areas,(painful but effective for up to 6 months),anti-inflammatory gels and physiotherapy. Anti-inflammatory and analgesic drugs will also be needed to control pain intiially.

It is vitally important that the patient understands at the outset the importance of joint protection and exercise and the effects that weight-bearing and footwear can have both for goodand bad on the feet.Advice early in the course of the arthritis from a physiotherapist and/or a chiropdist can do much to prevent deformity. The patient should betold to remeasure length and width of his or her feet (not many adults bother to do this after the age of 21) and purchase shoes that are both wide,deep and long enough to encompass swollen feet,have deep soles and support of the arches and ankles.Invariably this excludes most female fashion shoes although not some modern boots. Clinicians can do no more about this potential battle-ground than point out the dangers of unsuitable shoes. Unfortunately fashion and power dressing are the usual winners.

Patients also need to learn the type of mobilising and stretching exercises that will prevent stiffness and deformity.These should be carried out every day when the arthritis is active and should always be done non weight bearing. Massage baths,hand massage and gravity assistance can also be used for symptom control as part of the regime.

If deformity has already developed or if plantar fasciitis causes a painful limp,shoe inserts may be needed. Here a chiropodist or skilled orthotist can be invaluable. Silicone gel and various synthetic materials can help to redistribute weight. There is a new silicone gel and mineral substance incorporated into heel and toe caps which is proving very popular with patients which is now obtainable.Surgical shoes and

more sophisicated splints are seldom necessary except for the severest cases. Similarly orthopaedic surgery for correction of deformed joints is only justified in the presence of long-standing deformity where pain is preventing adequate mobility and all alternative medical treatments have failed.

PA of the feet can be a potent cause of pain and disability.Adequate recognition and treatment of the problem is seldom ideal. If addressed early this form of arthritis can be properly treated and much future pain prevented. Such treatment needs a multi-disciplinary approach in partnership with the patient.

Written by Dr.A.Virginia Camp FRACP,
Consultant Rheumatologist,Amersham Hospital,Bucks.
(Featured in Jan/Feb 1995 Vol 52.No 1.Chiropody Review).

REPORT:

EARLY RHEUMATOID ARTHRITIS GROUP (ERAG)

The above meeting was hosted by Dr.P.Emery of Queen Elizabeth Hospital,Birmingham,who also spearheads this particular interesting Group of Rheumatologists,whose aims are to encourage early and proper treatment of arthritis,RA especially. They hope by early enough diagnosis to put patients into long term remission,in particular those with the poorest prognosis. They hope to spread the word that EARLY DIAGNOSIS IS ESSENTIAL and the patients right.

The meeting broadly covered the need for new approaches in treatment and assessment. Internationaly renowned rheumatologists were there from the UK and abroad,including Professor T.Pincus from the Vanderbilt University,Nashville and Dr.O.Della-Casa from Italy.

David was invited along together with a member of Arthritis Care who suffers from RA to talk about RA and Psoriatic Arthritis from the "Patients point of view" and hopefully give those in attendance an insight into the other side of the illnesses.

David quite rightly said in his talk, patients with PA and other forms of arthritis live with their illness 24 hours a day,365 days a year.He also spoke of how difficult it was treating psoraisis when you have very sore fingers and thumbs to actually apply the topical creams,the difficulties he faces regularly such as at work,when driving a car,releasing a handbrake,and putting pressure on pedals on bad days can bring tears to your eyes,even enjoying his new daughter, such as playing and picking her up,changing clothes and nappies can be a task in itself,as many of you I am sure have experienced and know only too well.

Although he was extremely nervous he put the main points across and I am sure had the eyes and ears of all in that room that day. Interest was shown,some questions asked and information was given out to those who wanted to know more about the work of our small organisation.

REPORT:

THE SKIN CARE CAMPAIGN EXHIBITION

House of Commons November 21st 1994

The Skin Care Campaign was brought to the attention of MPs and Peers at a presentation and exhibition held in the House of Commons in November,which ran for a week.

The display which was presented in the Upper Waiting Hall, was impressive and eye catching. The display boards depicted information and pictures on the conditions of the Patient Groups involved ie Psoriatic Arthropathy,Eczema,Vitiligo,Melanoma,

Epidermolysis Bullosa,Acne and Occupational Skin Disease.

For the whole week the display was manned by members of the individual groups and Dermatology nurses from St.Johns Dermatology Unit. This gave us all a great opportunity to educate MPs and Peers on the various skin conditions,the Campaign,and the extent of skin disease and its consequences. We are pleased to report that there was alot of interest shown,and those who tried to reach their destinations unoticed were quickly mugged by us,so not many escaped all our clutches!!

The event was kindly sponsored by Dawn Primarolo MP,and the opening of the Exhibition was undertaken by the Under Secretary of State for Health,the Hon.Tom Sackville MP.

MEET THE SKIN CARE CAMPAIGN TEAM

Back to front:
John Tressider (Melanoma Network,Alison Dudley (Acne Support Group),John Dart (DEBRA),David Chandler (Director PAA),Julie Chandler (Director PAA), Peter Longland (Chairman Eczema Society),Laura Warren Administrative Assistant (Skin Care Campaign),Maxine Whitton (Chairperson Vitiligo Society)Tina

FOCUS ON DERMATOLOGY

Guy's & St.Thomas' Medical & Dental Schools
Annual UMDS Research Day
16th November 1994

ST.Thomas' Hospital,London.

We were both kindly invited along to attend the annual research day at St.Thomas' Hospital,which consisted of a series of lecturers on currant research, ranging from Epidermolysis Bullosa,Urticaria,Sunlight induced skin disease,and psoriasis.

One lecturer which was of great interest to us all was the one presented by Dr.Jonathan Barker on the research work being undertaken on"Cell-cell adhesion molecules: significance in inflammatory skin disease",which if course relates to psoraisis and PA.

There were also written abstracts covering the following:-
The mapping of disease susceptibility genes in psoriasis by JL botham,RC.Trembath,JNWN Barker.
St.John's Institute of Dermatology,Guy's & St.Thomas' Campuses,UMDS &
Departments of Medicine and Genetics,University of Leicester,Leicester.

A unique subset of T Cells (CLA positive) home to the skin but not to the joint in PA.Evidence for tissue specific lymphocyte migration.
C.Pitzalis,A.Cauli,G.Yanni,N.Pipitone,CH Smith,JNWN Barker,G.S.Panayi.
Rheumatology & Dermatology Units,UMDS,Guy's Campus.

Comparison of the dermal vessels and the expression of vascular adhesion molecules in the human,fetal,normal adult and psoriatic skin.
ME Perry,JR.Davies,Y.Mustafa,FJ.Compton.
Division of Anatomy & Cell Biology,UMDS,Guy's

Campus.

Although slightly technical if you would like to see a copy of any of these abstracts just drop us a line and we can pop a copy(ies) in the post.

JOB DISCRIMINATION?

It has become increasing evident that more and more of you have come up against job discrimination of some kind,whether it be already in your work place or applying for jobs.

We would like to hear of your experiences as we think like many other organisations this subject needs to be tackled!

Ourselves along with other member organisations in the Long-Term Medical Conditions Alliance have just began work on a project involving this prickly subject. The project's aim is to develop guidance on good practice for emloyers on employing people with long term medical conditions.

There is alot of work to be done and it won't be easy but it's a start,so please your co-operation,opinions,experiences would be much appreciated to help us in this project and for our organisation to put a good case forward to the necessary bodies.

Please participate.

Thank you.

REPRINT: Recruits still needed!!
RESEARCH PROJECT read on.....

As someone who suffers from psoriatic arthritis you are aware of the discomfort and inconvenience caused by the disease. At present,very little is known about what causes psoriatic arthritis or how it will progress. It is important,therefore, for research to be carried out which examines this disease specifically. At St.Bartholomew's hospital the immunology and rheumatology departments have undertaken a joint project which we hope will define some important aspects of psoriatic arthritis.

We and others feel that it is significant that both the skin and joints are affected in psoriatic arthritis. Among other things,we would like to examine the role played by certain cells,called T lymphocytes,which we think contribute to the tissue destruction at both these sites. in order to make these investigations,however,we are wholly dependent on the participation of people suffering from psoriatic arthritis.

If you would like to find out more about this project please contact me directly in the immunology department at St.Bartholomew's hospital or through the psoriatic arthropathy alliance. The involvement of people suffering from this disease is essential for productive research which will eventually aid in more effective management of psoriatic arthritis. Your participation would be greatly appreciated.

Elizabeth Ross
Research Assistant
Immunology Department,The Medical College of St.Bartholomew's Hospital,5th Floor,
38,Little Britain,London,EC1A 7BE.
Tele: 0171 601 8104/8199: Fax: 0171 606 0845

NEW PRODUCT INFO!!!

Recently I have had a few enquiries about the "Psoracomb". Until now I was unaware if this product was available in this Country,well it is.

According to information that I have seen it was specifically designed for use in hospitals and clinics worldwide to treat scalp psoriasis.It is apparently a portable,ultra-violet light with a comb attachment.

Approx price: £299 (including VAT)
More information please contact:-

Uvalight Technology,Aston Science Park,
Enterprise Way,Birmingham,B7 4BH.

Tele: 0121 624 2080
Fax: 0121 624 2081.

We do not in anyway endorse the use of this product merely provide you with information about it. Please consult your doctor before considering or purchasiing this product as it may be very unsuitable for your needs.

DON'T FORGET: It's ARTHRITIS CARE WEEK
29th April-6th May 1995

During this week there will be alot of exciting things happening and raising awareness.

They have also produced a new publication "Food for Thought" which aims to encourage with arthritis to look at their diets and if necessary change a few eating habits. Copies can be obtained from Arthritis Care,18,Stephenson Way,London,NW1 2HD. Please enclose SAE + 25p stamp.

We wish them very best wishes for their AWARENESS WEEK.

NEW PRODUCT INFO!!!

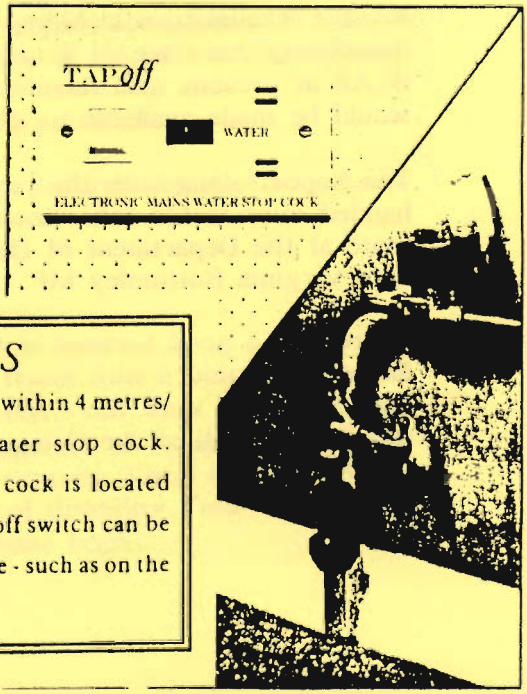
ELECTRONIC MAINS WATER STOPCOCK

We have recently been sent details of a new product which some of you may find interesting or even of use.

It's called "TapOff", which is an electric water stop cock. It allows mains water supplies to houses, flats etc to be shut off with the flick of a switch, which could make things a whole lost easier for those of us who have difficulty in turning off taps anyway. If temperature should fall below four degrees centigrade it can turn off the water automatically.

Cost: £197.40 Fitted to existing mains pipes in approx 2 hours.

Further details from:
Mr John Guest, Tapoff Limited, Courtbarn, Burwash, East Sussex, TN19 7BD. Tele: 01580 200868 Fax: 01580 200869



EASY ACCESS

Your Tapoff switch has to be installed within 4 metres/ 13 feet of your existing mains water stop cock. For example, say the existing stop cock is located somewhere under the stairs, the Tapoff switch can be mounted in a far more accessible place - such as on the wall, at the height of a light switch.

REPORT:

ARTHRITIS CARE & BRITISH LEAGUE AGAINST RHEUMATISM

HOUSE OF COMMONS 1st December 1994

David along with other members of BLAR,MPs,and Peers were kindly invited to a Reception arranged by Arthritis Care and BLAR,which was hosted by Sir Roger Moate MP.

In December BLAR launched a new report called "Diability and Arthritis" which had involved a tremendous amount of hard work but was well worth it. The report indicated many areas which needed addressing in relation to arthritis and the difficulties faced by those affected.

A purchasers pack had also been produced during the course of this year which included information about all the organisations involved in the British League Against Rheumatism,including information on ourselves,(There are 21 groups which are members of BLAR at present with membership growing.) which would be made available to all health professionals.

The Report along with the first Purchasers pack was handed over to Mr John Bowis MP,Under Secretary of State at the Department of Health for and on behalf of Mrs Virginia Bottomley MP.

There was a good turnout at the reception which lasted a few hours with much interest shown by MPs and Peers that were there,and who had the chance to mingled with all of the Groups.

USEFUL ADDRESSES/TELE No'S:

Action for the Victims of Medical Accidents,
(AVMA),
1,London Road,
London,SE23.
Tele: 0181-291-2793
Can assist with queries on all aspects of medical complaints and where to go for appropriate advice.
(Charity.)

Arthritis Care
18,Stephenson Way,
London,NW1 2HD.
0171-916-1500 Fax: 0171-916-1505
Arthritis Care Helpline (12.0-4.0pm) 0800 289170
for welfare and counselling only.
(Charity)

Contact-a-Family,
170,Tottenham Court Road,
London,
W1P 0HA.
Tele: 0171-383-3555
(Charity).
Provides information,support for parents of children with disabilities.Network of support groups.Offers information about rare conditions and syndromes,helpline and publications.

DIAL UK (Disablement Information & Advice Line),
Park Lodge,
St.Catherine's Hospital,
Tickhill Road,
Balby,Doncaster.
S.Yorkshire,
ND4 8QN.
Tele: 01302 310123
Dial UK is the headquarters of a network of approx 100 disability advice centres. Local centres give free advice on all aspects of disability.Your local centre should by in your phone book.

Special Acknowledgements

The Canadian Arthritis Society
Patricia Normandeau, The Canadian Psoriasis Foundation
Sheri Decker,The National Psoriasis Foundation,America
Arthritis & Rheumatism Council
Kate Baillie,British League Against Rheumatism
Anne Mansfield,British Society for Rheumatology

The teams at Arthritis Care and Young Arthritis Care

All those involved in the Skin Care Campaign
LMCA (Long Term Medical Alliance)
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