A

The prolonged use of higher doses of non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, naproxen, celecoxib, and meloxicam, is associated with an increased risk of adverse gastrointestinal, renal, and cardiovascular side effects, particularly in individuals over the age of 65 years. The gastrointestinal side effects include the development of ulcers, primarily in the stomach, and associated ulcer complications, such as bleeding, perforation, and occasionally obstruction. The renal side effects include electrolyte disturbances (particularly increased serum potassium levels), impairment of kidney function, and, rarely, necrosis of the renal papillae. The cardiovascular side effects include the rare occurrence of heart attacks and strokes. These side effects are more likely to occur in individuals with certain associated medical conditions, such as a history of peptic ulcer disease, heart disease, blood clots; chronic kidney disease; or ongoing treatment with anti-coagulants or corticosteroids.

Can NSAIDS be dangerous for Sjögren’s patients?

Sjögren’s syndrome is a chronic systemic autoimmune disease characterized by dry eyes and dry mouth. In addition to the salivary and tear glands it can also affect other exocrine glands leading to dryness in other organs such as the nose, ears, skin and vagina. In addition to these so-called sicca symptoms it can also involve a variety of internal organ systems such as the respiratory, gastrointestinal and nervous systems. Therefore, patients with Sjögren’s syndrome present with various combinations of a wide array of symptoms. Many of these are subjective and vague and could be attributed to other illnesses or adverse effects of medications. All of these can delay or even preclude a timely diagnosis.

Using a multidisciplinary approach involving dentists, ophthalmologists and rheumatologists increases the chance of an early diagnosis and may avoid, or at least decrease, some of the complications attributed to this disease. In this paper we will briefly review the general approach to and the various tests used in the diagnosis of Sjögren’s syndrome.

Different sets of criteria were used in the past to diagnose Sjögren’s syndrome. In the last decade most academic centers and practitioners adopted the American European International Classification Criteria. These criteria require the combination of subjective symptoms and objective signs of oral and ocular dryness, the presence of inflammation in the salivary glands and evidence of...
autoimmunity in the form of autoantibodies (Figure 1). The proper use and limitations of these criteria were discussed in detail by Dr. Daniel Small in the May 2010 issue of The Moisture Seekers. Although these criteria are widely utilized for diagnosis, they were designed as classification criteria for clinical studies. Therefore, a clinical diagnosis could be made with a similar approach but without using the classification criteria. In this article we will focus on how the various elements of the diagnosis are assessed.

The initial manifestations of dry eyes and dry mouth can often be subtle, and initially the patient might not be able to acknowledge them as unusual. The classification criteria include the following questions that have been used effectively to detect the presence of these symptoms:

For eye dryness:
- Do you feel a recurrent sensation of sand or gravel in the eyes?
- Do you have foreign-body sensations in your eyes?
- Do you use tear substitutes more than three times a day?

For mouth dryness:
- Do you frequently drink liquids to aid in swallowing dry foods?
- Have you had a daily feeling of dry mouth for more than three months?
- Do you have recurrent salivary gland swelling?

These questions should be used for clinical studies but there are other similar questions that could be helpful in clinical practice. Patients

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**Figure 1: Revised International Classification Criteria for Sjögren’s syndrome**

**OBJECTIVE SIGNS**
- Salivary Gland Involvement
  - Unstimulated salivary flow < 1.5 mL/15 min
  - Abnormal parotid sialography
  - Abnormal salivary scintigraphy
- Ocular Signs
  - Schirmer’s test ≤ 5 mm in 5 minutes
  - Van Bijsterveld’s ≥ 5

**EVIDENCE OF INFLAMMATION**
- Minor salivary gland biopsy
  - Focus score of ≥1 per 4 mm of tissue

**EVIDENCE OF AUTOIMMUNITY**
- Anti SS-A or SS-B or both

**SYMPTOMS**

**Ocular**
- Daily dry eyes for >3 months
- Persistent sensation of sand or gravel
- Use of tear substitutes >3 times daily

**Oral**
- Dry mouth
- Recurrent salivary gland swelling
- Use of liquid to aid in swallowing food

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For patients with Sjögren’s syndrome
DRY-MOUTH SYMPTOMS DON’T HAVE TO BE SO DISTRACTING.

If you experience dry-mouth symptoms due to Sjögren’s syndrome, then you already know how distracting these can be to your daily life. It might be time to ask about EVOXAC® (cevimeline HCl), a prescription treatment that works by stimulating the production of your body’s own natural saliva.

Talk to your doctor to see if EVOXAC can help, or visit DiscoverEVOXAC.com.

Please see important information about EVOXAC below.
EVOXAC® Capsules
(cinevamic acid hydrochloride)

INDICATIONS AND USAGE
Cinevamic acid is indicated for the treatment of symptoms of dry mouth in patients with Sjögren's Syndrome.

CONTRAINDICATIONS
Cinevamic acid is contraindicated in patients with uncomplicated asthma. Known hypersensitivity to cinevamic acid and benzalkonium chloride is also an absolute contraindication.

WARNINGS

Cardiovascular Disease:
Cinevamic acid has been shown to cause severe cardiac failure and death. Patients with significant cardiovascular disease may be at increased risk of developing life-threatening symptoms.

Pulmonary Disease:
Cinevamic acid has been associated with asthma-like symptoms, such as coughing and wheezing.

OVERDOSAGE:
Cinevamic acid is not recommended for use in overdose situations.

PRECAUTIONS

Caution is advised when using cinevamic acid in patients with pre-existing glaucoma, hypertension, or other cardiovascular disorders.

EDUCATION:
Cinevamic acid is a medicine to treat symptoms of dry mouth in patients with Sjögren's Syndrome. It is important to follow the instructions provided by your healthcare provider to ensure safe and effective use.

ADVERSE REACTIONS
The most common adverse reactions reported in patients treated with cinevamic acid were:

- Headache
- Nausea
- Fatigue
- Cough
- Upper Respiratory Infection

In addition, the following adverse events were reported in patients treated with cinevamic acid:

- Muscle Spasms
- Dizziness
- Vomiting
- Constipation

In rare cases, cinevamic acid may cause a rare, but serious adverse reaction known as angioedema, which can be life-threatening. If you experience any of these symptoms, stop taking cinevamic acid and seek immediate medical attention.

DESCRIPTION:
Cinevamic acid is a synthetic, non-peptide compound that acts as a selective inhibitor of cyclic nucleotide phosphodiesterase (PDE) activity. This activity results in an increase in intracellular cyclic AMP (cAMP) levels, which can stimulate various physiological processes, including the production of saliva in the mouth.

DOSAGE AND ADMINISTRATION:
Cinevamic acid is administered orally in capsules. The dosage should be individualized based on patient response and tolerated side effects.

PHARMACOLOGY:
Cinevamic acid inhibits PDE type 5, which is known to be highly expressed in salivary glands. This inhibition leads to an increase in cAMP levels, resulting in increased saliva production.

STORAGE:
Store at room temperature (15°-30°C or 59°-86°F). Protect from light.

PATIENT INFORMATION:
Cinevamic acid should be taken with meals to reduce the risk of gastrointestinal side effects. If you experience any serious side effects, stop taking cinevamic acid and contact your healthcare provider immediately.

For additional information, please visit EVOXAC.com or call 1-877-437-7763.

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DSEB50000008

PM100 Revised 1/2001 Printed in USA
should be asked about these symptoms as part of their diagnostic workup.

The degree of how dry someone feels does not always correlate with the degree of loss of salivary or lacrimal function; therefore, the next step is to objectively assess the saliva and tear production.

Keratoconjunctivitis sicca (ocular dryness) can be tested by different methods. One of the most readily available tests is the Schirmer's test. It provides a measurement of tear production and is performed by placing a piece of sterile filter paper in the lateral (outer) third of the lower eyelid. If the wetting is 5 mm or less in five minutes, it is indicative of dryness. Although, this test is well tolerated by most people, it can cause discomfort in people with dry eyes. To minimize this, patients are asked to keep their eyes shut and avoid talking or chewing during the time they have the strips in their eyes. This will minimize the movement of the strip and lessen any discomfort. Sometimes, the test is repeated after numbing the eye; however, the American European International classification criteria use the Schirmer's test done without anesthesia.

The Schirmer's test measures the amount of tears produced at the time of testing. Another way to document ocular involvement is to assess if there is any damage to the cornea from dryness. This is done by using a dye called lissamine green which stains dead or degenerated cells green. The dye is instilled into the inferior corner of the eye which is examined by an ophthalmologist using a slit lamp. The degree of staining is scored with a higher score representing more damage to the outer layers of the cornea. A score of four or more according to the Van Bijsterveld's scoring system is considered to be positive.

Dry mouth is usually one of the earliest manifestations and it is secondary to salivary gland abnormalities. The evaluation of salivary gland involvement includes measurement of salivary flow (sialometry) and on some occasions, imaging studies. The unstimulated whole salivary flow measurement is the test that is most commonly performed. In order to obtain more accurate results, patients are instructed not to eat, chew gum, smoke or drink for at least two hours prior to the saliva collection. During the collection period, the patient will be seated straight up with eyes open and head tilted slightly forward and instructed not to swallow or speak during the collection process to minimize influence on salivary flow. Immediately before the collection begins, the subject is instructed to swallow. The patient then allows the saliva to accumulate on the floor of the mouth for 60 seconds without swallowing. At the end of the minute the patient empties the entire accumulated saliva into a preweighed container.

The procedure is usually repeated four more times for a total collection time of five minutes. Although the classification criteria define abnormal unstimulated whole salivary flow as 1.5 ml or less/15 minutes, in practice the actual collection time is shorter and the results are extrapolated for 15 minutes. For example, the cutoff for a five-minute collection would be 0.5 ml. Some centers, including ours at the NIH, also measure the saliva production of each individual major salivary gland by collecting saliva through collection tubes connected to small suction cups over the salivary gland duct openings in the mouth.

Some centers, including NIH, will also perform stimulated salivary flow measurement by applying a sour tasting liquid (2% citric acid) to the top and sides of the tongue at 30-second intervals to stimulate saliva production while saliva is collected using the same method utilized for the unstimulated salivary flow. It is thought that the presence of stimulated saliva reflects residual function of the salivary glands, even if no unstimulated flow is obtained. Also, patients who have stimulated salivary flow may be more likely to respond to treatments aimed at increasing saliva production.

Selected imaging methods could also be used to establish salivary gland dysfunction, although they have not been routinely incorporated by most centers as part of the evaluation of Sjögren's syndrome.

Technetium scintigraphy is a nuclear imaging study that measures glandular function. Labeled technetium is injected into a vein and pictures are taken to measure how much radioactive substance the glands take up and how fast it is excreted. Sjögren’s patients may have decreased uptake, secretion or both. Parotid gland sialography is a test performed by instilling a contrast agent in the gland through the parotid duct. The contrast will fill up the ductal system which can be seen on an X-ray and might show a characteristic pattern that will be indicative of salivary gland disease. It is rarely used because of lack of specificity and a small chance of rupturing the duct.

Lately, ultrasound of the parotid gland has generated a lot of interest and has been found to be useful to identify structural and functional damage to the salivary glands. The advantage of ultrasound is that it is non-invasive, does not use ionizing radiation and is relatively easy to perform. However, further studies are needed to establish its use in the diagnosis of Sjögren’s syndrome.

In addition to symptoms of dryness and objective evidence of salivary or lacrimal gland dysfunction, the diagnosis of Sjögren’s syndrome requires the demonstration of autoimmunity and/or inflammation in the salivary glands. In fact, at least one of these must be present for the diagnosis. Autoantibodies are the hallmarks of systemic
autoimmune diseases. From the various autoantibodies that can be detected in Sjögren’s syndrome the anti-SS-A (Ro) or SS-B (La) autoantibodies are the most common. They are found in about 2/3 of patients who may have one, both or none. Although frequently found, they are not specific for Sjögren’s, since they are also frequently present in other autoimmune diseases. Other autoantibodies commonly present in Sjögren’s are the anti-nuclear antibodies and rheumatoid factor.

An important part of the diagnosis is to demonstrate inflammation in the salivary glands. This is most commonly achieved by obtaining a minor salivary gland biopsy. After numbing the lower lip with a local anesthetic, a small incision (0.5 – 1 inch) is made in the inner surface of the lip and several tiny salivary glands are removed. These glands are shallow and are about the size of a pencil tip eraser. The incision is closed with a few stitches. Discomfort after the procedure is usually minimal and can be relieved with intermittent icing of the lip and over-the-counter medicines such as Tylenol. Complications are uncommon but, rarely, prolonged numbness in the lower lip can occur. The biopsy is evaluated by a histopathologist and the degree of inflammation is graded on a scale of 0-12. This is called the focus score. One focus is defined as the focal collection of more than 50 lymphocytes per 4 mm² of tissue. A focus score of 1 or more would be considered positive for inflammatory glandular involvement using the American European criteria. A high focus score is fairly characteristic for Sjögren’s syndrome but, as it was discussed in the May 2010 issue of this newsletter, there are similar infiltrates observed in HIV, hepatitis C, sarcoidosis and lymphoma.

These tests and procedures are targeted to assess the signs and symptoms of salivary and lacrimal gland dysfunction and inflammation. To fulfill the criteria for primary Sjögren’s syndrome, four of the six items included in the classification criteria have to be met as long as one of them is the positive salivary gland biopsy or the presence of autoantibodies. Of course, the evaluation for Sjögren’s syndrome has many other manifestations; therefore, a thorough history and physical examination are always part of the diagnostic workup. Additional tests and procedures may be necessary to exclude other diseases or to evaluate the severity of disease manifestations before a final diagnosis and treatment plan can be made.

The heterogeneity of disease manifestations frequently makes the diagnosis of Sjögren’s syndrome challenging. A systematic approach and close collaboration among specialties will accelerate timely diagnosis which will lead to earlier intervention and the possibility of preventing or limiting structural or functional damage.

A physician must take particular care in prescribing NSAIDs for Sjögren’s patients who are over the age of 65 years or who have any of the risk factors mentioned above. Of particular relevance to Sjögren’s syndrome would be those patients who are taking regular doses of corticosteroids or who have any form of Sjögren’s-related kidney disease (interstitial nephritis or glomerulonephritis). In such Sjögren’s patients, NSAIDs can be dangerous.

Fortunately, many Sjögren’s patients do not have the risk factors mentioned above and are candidates for NSAIDs as a treatment for their arthritis or other painful conditions. In order to minimize the risk of NSAID therapy in any patient, there are certain guidelines to follow. The NSAID dose should be the lowest effective therapeutic dose. The physician should prescribe an NSAID that is less likely to cause gastrointestinal complications if chronic therapy is anticipated. Some examples would include nabumetone, meloxicam, and low-dose celecoxib, naproxen or ibuprofen. The NSAID should be taken with food. Finally, a proton pump inhibitor can reduce the risk of gastrointestinal ulceration, but this strategy should only be employed in patients with known risk factors for NSAID-induced ulcers and is best employed for short-term and not long-term NSAID therapy.

Alan Baer, MD

Q Many eye drops claim to have disappearing preservatives. Are these the equal of preservative-free drops, or should they still be used like eye drops with standard preservatives?

A The development of “disappearing preservatives” has allowed eye drops to be formulated in multi-use dropper bottles for convenience without the risk of surface damage that can occur with the more potent and persistent preservatives. The mechanism by which such new preservatives “disappear” is usually due to chemical changes in the preservative that occur upon exposure to air or the tear film. The most common such chemical reaction is oxidation of the preservative, turning it into an inactive molecule. It must be remembered, nevertheless, that the inactive molecule can be something to which sensitive patients may react. It is worthwhile, therefore, that the patient be alert to any intolerance of such medication which can occur as irritation, discomfort or red eyes. The “disappearing preservative” eye drops can be used up to four times a day in most cases without difficulty and some patients can use them even more frequently than...
If you drop artificial tears ≥4 times a day, give yourself LACRISERT®: All-day dry eye relief in a single daily dose*

- Significant improvement in symptoms, signs, and activities of daily living†
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For more information, visit www.LACRISERT.com or call 1-877-ATON-549.
Ask your doctor about LACRISERT® today!

*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.

LACRISERT® is contraindicated in patients who are hypersensitive to hydroxypropyl cellulose. The following adverse reactions have been reported in patients treated with LACRISERT® 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® may result in corneal abrasion.

Please see brief summary of Prescribing Information on adjacent page.

*Some patients may require twice-daily use for optimal results.†Multicenter, 2-visit, 4-week, single-arm study conducted in moderate to severe Dry Eye patients who had previously been using ATs (N=520). Results are based on 418 patients who completed the study.
drops with regular preservatives. It should be remembered that other eye drops, particularly those used to treat glaucoma, can contain preservatives as well and, therefore, it is important for patients to keep track of how many drops are being instilled in the eye during the day.

Truly preservative-free eye drops contain no such preservative chemicals but, therefore, require special packaging that limits the amount of the solution in the dropper to usually only one or two drops. The challenges of the smaller packaging can be a nuisance, but if the patient is sensitive to even one or two drops, the “disappearing preservative” this nuisance can be worth the better tolerance to the lubricant.

Gary N. Foukls, MD

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**Q** “What are some routine blood tests that Sjögren’s patients should be having and how often?”

**A** For the majority of patients with established Sjögren’s syndrome, routine blood tests are not necessary. Laboratory testing is important to monitor those Sjögren’s patients who are taking certain medications, who have extra-glandular involvement (such as associated diseases of the liver, kidney, or blood), or who are at higher risk of lymphoma.

The medications for Sjögren’s patients that require routine blood monitoring include NSAIDs (CBC, electrolytes, and creatinine, every 6-12 months during chronic NSAID therapy), prednisone and other corticosteroids (blood glucose, when first initiated), and immunosuppressive agents such as methotrexate, azathioprine, mycophenolate mofetil (CBC and liver function tests every 8-12 weeks and more frequently when the treatment is initiated). Patients on cyclophosphamide may need more frequent monitoring of their CBC and periodic urinalyses. In general, routine blood tests are not necessary for Sjögren’s patients taking hydroxychloroquine (Plaquenil®), pilocarpine (Salagen®), cevimeline (Evoxac®), or topical cyclosporine (Restasis®).

Certain forms of extra-glandular disease in Sjögren’s syndrome require routine blood testing to monitor the activity of the organ involvement and/or the benefits of treatment and the potential side effects of medications. Prominent examples would include interstitial nephritis with renal tubular acidosis (which can be associated with electrolyte abnormalities), biliary cirrhosis, autoimmune hepatitis, anemia, and leucopenia. Some forms of extra-glandular disease are treated with immunosuppressive agents and routine blood tests are required to monitor the therapy.

A minority of Sjögren’s patients have a type of disease which is inherently associated with a higher risk of lymphoma development. These patients are almost always identified at the time of their initial evaluation for Sjögren’s syndrome and have key clinical and laboratory features, including palpable purpura (a vasculitic rash of the lower extremities), low levels of serum complement, monoclonal proteins, or cryoglobulins. In such patients, routine blood tests are warranted every 12 months or less to look for changes that might indicate the interval development of lymphoma, including blood counts, protein electrophoreses, immunoglobulin quantitation, free light chain ratio, and complement levels.

Alan Baer, MD
This past year, we have highlighted numerous individuals and groups in our I Stood Up column in The Moisture Seekers newsletter. But in this issue I want to collectively highlight all of our donors, supporters and members!

The Sjögren’s Syndrome Foundation is so thankful to each and every donor who supports the work of the Foundation. From a person who adds $3 to his or her membership renewal to the family that donates a large gift to support an entire research grant — each gift helps us towards accomplishing our mission of education, awareness and research.

Last December you once again amazed us when everyone Stood Up and made donations to our various year-end appeals. From our Fall fundraiser mailing to our 12 x 12 online campaign, you helped us raise more restricted funds for research than in any other month of the year, collectively raising over $140,000 for research.

Just one example of your generosity happened during the last few days of December 2009 when the SSF asked our friends, members and patients to help us raise “12 x 12” online. That was $12,000 online by 12 o’clock midnight on New Year’s Eve. All of these donations were restricted to research and helped to support Sjögren’s research projects throughout the United States. Remarkably, in just three days we exceeded our goal and raised over $14,000!

Again this year we are going to ask you for your support and we know you will surprise us! But we want to take this opportunity to thank all of you for Standing Up last December and making a difference for those who suffer from Sjögren’s!

Together we are a powerful voice, and we appreciate all of you joining our effort!
During this festive time of the year, help us continue to be a light of hope for millions of Sjögren’s syndrome sufferers.

When making a donation this holiday season, consider restricting your gift to research so that we can once again increase our financial commitment to awarding more research grants in 2011 than ever before.

Each year our research committee has to turn away promising Sjögren’s research grant applications because of lack of funding. We want to ensure that we fund as many grants as possible, and with your support we can do that.

For those who have made a research gift this past year, we thank you for your continued support. Each and every gift helps us reach our goal. Please also remember, you can always ask others to make a research donation as well. Family and friends may consider supporting an organization that is important to you – you just have to ask them.

Together we all can make a difference!

☐ Enclosed is my gift of $ ___________ to support the Foundation’s 2010 initiatives and programs.

☐ I am interested in learning more about how to make a stock donation.

☐ Please send me information about listing the SSF in my will or life insurance policy.

Thank you for your support of the Sjögren’s Syndrome Foundation.

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☐ 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.

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Signature ______________________________________________________________________ CC Security Code ______________
Dry mouth associated with Sjögren’s is more than just uncomfortable and frustrating. When your body can no longer produce enough protective saliva, you are more likely to have cavities, mouth infections and bad breath. Because dry mouth is an ongoing condition with Sjögren’s, it helps to develop an ongoing daily routine in each of the following 3 management areas:

1. **Soothing & Moisturizing**: While sipping water can help, water doesn’t lubricate the way saliva does. For symptom relief throughout the day use a moisturizing liquid or gel that has supplemental proteins and enzymes. Keep a portable moisturizing spray on hand to provide soothing relief on-the-go. For night-time relief, consider a soothing moisturizing gel to help keep your mouth moist.

2. **Daily Cleaning**: When you don’t have enough saliva, food and bacteria can stick to your teeth causing plaque build-up, bad breath, and other problems. Keep your mouth clean by using fluoride toothpaste and a mouthwash without harsh ingredients. Products formulated specifically for dry mouth should be alcohol and detergent (SLS) free so they won’t irritate your mouth.

3. **Saliva Stimulation**: Your saliva not only flushes away odor-causing bacteria, it protects and lubricates your mouth. For oral dryness, stimulate saliva by chewing sugar-free gum containing xylitol.

Only Biotène, with its protein-enzyme formulations, offers products in each of the 3 management areas. *Choose the combination of Biotène products that’s right for you.*
Remember your loved ones and special occasions with a donation to the SSF in their name.

If you would like to receive information on how you can Leave a Legacy to support the Sjögren’s Syndrome Foundation’s critical research initiatives or to support one of our many other programs, please contact Steven Taylor at 800-475-6473.

Leave A Legacy – Remember Us in Your Will

In Memoriam

In Memory of Archbishop Herbert Groce
Sue & Jeff Klechinski

In Memory of Goldie Levin
Theresa Gambale
Joseph & Hanni Weinsstock
Shirley Wolfe
Bob, Jean & Laura Griffin & Jeff Wolper

In Memory of Isabel "Babe" Daldos
Virginia Ebert
Lenora L. Olivas
Darlene Daldos Schuster
Norma A. Sierra

In Memory of Junne Shreffler
Vanderbilt Dayani Center

In Memory of Margaret Kelly Pasco
Randall Davis
The Faculty and Staff of Louis P. Slade Middle School
Joseph R. Kelly & Family
Erin Masciotra
Marian Scully
David & Mary Welch

In Memory of Norman Sokol
Richard & Jane Novick

In Honor of Angela DiFilippi
Kathleen Capasso

In Honor of Susan Moliere
The North Hunterdon Regional High School Class of 1960

In Honor of the Marriage of James & Diane Lawlor
Simone D.M. Howard
Charles & Carolyn Videla

If you are interested in organizing a Sip for Sjögren’s event in your area, please contact Pat Spolyar, Director of Awareness, at 800-475-6473, ext. 221 or pspolyar@sjogrens.org.
Your dry eye symptoms may be caused by meibomian gland dysfunction (MGD). MGD is a common type of dry eye that often affects sufferers with Sjögren's Syndrome. MGD is associated with insufficient oil getting to the tear film. This causes increased tear evaporation, which results in signs and symptoms of dry eye.

SYSTANE® BALANCE Lubricant Eye Drops was specifically designed for dry eye patients with MGD. SYSTANE® BALANCE works by restoring the oil layer and re-establishing the natural tear film to relieve your symptoms.

Talk to your doctor today about MGD, and find out if SYSTANE® BALANCE Lubricant Eye Drops is right for you.

Overview of Sjögren’s Syndrome – Barbara M. Segal, MD
Dr. Segal is a rheumatologist and Associate Professor of Medicine at the University of Minnesota Medical School. Dr. Segal's clinical and research interests include Scleroderma, Lupus and Sjögren’s. She established and co-directs the Lupus and Sjögren's Clinic at the University of Minnesota Medical Center, Fairview. Dr. Segal will present a comprehensive explanation of the range of symptoms that Sjögren’s patients experience, explain their causes, and offer practical tips for managing them.

Dry Eye and Sjögren’s – Robert E. Prouty, OD
Dr. Prouty is an optometrist and co-founder of Omni Eye Specialists in Denver, Colorado. Prior to Omni Eye Specialists, he was in private practice and served as a consultant at Fitzsimons Army Medical Center, Department of Surgery. Dr. Prouty has developed and co-patented an instrument used for the human lacrimal (tear) system and has been the Primary Investigator in several industry-related research projects. He also is the director of the University of Houston’s “Residency in Ocular Disease” at Omni while holding positions at several universities as an adjunct professor. This esteemed eye care expert will discuss the latest methods and treatment options available for managing dry eye.

Research Update – Steven Taylor, SSF Chief Executive Officer
Mr. Taylor will share an update on the Foundation’s Research Program and the goals for 2011. He will discuss how research holds future promise, greater understanding and hope for better therapies for all Sjögren’s patients.

Naturopathic Approaches to Sjögren’s – Keith Wilkinson, NMD
Dr. Wilkinson is a Naturopathic Physician in a group private practice, Arthritis Health, in Scottsdale, Arizona. Dr. Wilkinson works in an integrated setting with a rheumatologist, nurse practitioner, physician's assistant, and another naturopath, as well as onsite yoga therapists, to provide comprehensive care. Dr. Wilkinson offers medical care for all types of rheumatologic and chronic disease conditions, general family practice and preventative medical care. When he works with patients, he embraces one of the principles of naturopathic medicine – Doctor as Teacher – and works to educate the patients and get them involved in their own healthcare. We know you won't want to miss this unique presentation as you will learn about alternative approaches to treating Sjögren’s.

Dermatological Issues and Sjögren’s – John R. Fenyk, Jr., MD
Dr. Fenyk is a Professor at the Department of Dermatology and an Adjunct Assistant Professor and Lecturer at the Department of Family Medicine and Community Health at the University of Minnesota Medical School in Minneapolis. Dr. Fenyk also is the dermatologist member of the University of Minnesota’s Lupus and Sjögren’s Clinic. He was in private practice for 25 years when he closed his practice in 2008 to re-enter academic dermatology full-time. Dr. Fenyk will enhance your understanding of dermatological issues associated with Sjögren’s.
This January, come to vibrant, festive New Orleans and take control of your health by learning the most up-to-date information from the brightest minds in Sjögren’s.

Our Live, Learn & Share seminars are the best one-day Sjögren’s patient seminars in the country. They have helped thousands gain a better understanding of Sjögren’s and will help you, too. Our panel of medical experts will address an array of Sjögren’s topics; plus, you’ll have the rare chance to meet and share tips with fellow Sjögren’s patients.

If you want to be your own best advocate by gaining a thorough understanding of all the key aspects of Sjögren’s, then this one-day seminar is for you.

NEW ORLEANS PATIENT SEMINAR
SATURDAY, JANUARY 29, 2011

ATTENDEE – complete for each registrant

Attendee Name(s) _____________________________________________________________
Attendee Name(s) _____________________________________________________________
Street Address ________________________________________________________________
City __________________________ State ___________ Zip __________________________
Telephone __________________________ E-mail _______________________________________

FEES – please circle appropriate fee(s) (Note: Early Bird Deadline is January 10, 2011)

SSF Members & Guests

Non-Members

January 10th and before

$65 per person

$90 (includes one-year membership)

January 11th and after

$85 per person

$110 (includes one-year membership)

TOTAL:

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 ____________

- A fee of $25 will be charged for all seminar registration cancellations. Refund requests must be made by January 10, 2011. After that date, we are sorry but no refunds will 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 January 21st.

- A limited number of rooms are available at the Four Points by Sheraton New Orleans Airport hotel, 6401 Veterans Memorial Boulevard, Metairie, Louisiana 70003, at the SSF rate of $119 per night plus tax if reservations are made by January 5, 2011. To make room reservations, please call the hotel directly at 504-885-5700 and refer to the group name “Sjögren’s Syndrome Foundation” for the discounted rate.
The Moisture Seekers
Sjögren’s Syndrome Foundation Inc.
6707 Democracy Blvd., Ste 325
Bethesda, MD 20817
Phone: 800-475-6473
Fax: 301-530-4415

Help Make a Difference...

Become an Awareness Ambassador!

Over four million Americans are estimated to have Sjögren’s, yet fewer than one million have been diagnosed!

Help the Sjögren’s Syndrome Foundation raise awareness in local communities all over the country by becoming an Awareness Ambassador.

If you are interested in learning more about this exciting program, contact us today and add your voice and donate your time to our awareness campaign!

Please contact Kathy Ivory:
800-475-6473 ext. 213 or kivory@sjogrens.org

Poor Richard’s Almanac

- At the working man’s house hunger looks in but daren’t enter: industry pays them. • Delicence is the mother of good luck. • God gives all things to industry. • Plo and toil bring the poor to wealth. • While it is called today for you be hindered tomorrow. • One today is worth two tomorrow. • Have something to do.

- If that were a servant would you not be ashamed that a good master should have your own master be ashamed to catch yourself idle? • Trouble springs from idleness ease. • Industry gives comfort and plenty and respect. • Keep thy shop and thy wife have your business done, go; if not, send. • Want of care does us more damage than the many offended sufferer. • If you would have a faithful servant serve yourself. • If you would be wealthy think of saving as well as getting. • The less examination in business the less practice makes a perfect man. • Women and wine, games and the wants great. • Many estates are spent in the getting. Since women for tea and wine for punch is each level and taste. • And the easiest way to be safe is never to be secure. • Dally not with other folk’s goods. • Help to purchase wealth to purchase the loss of life.

- The sun never repents of the day, remember it; When you befriend, forget it. • He that lives upon hope will die fasting. • He that offendeth not is become an enemy. • His master is often ignorant one. • The learned fool writes his nonsense in better languages than the up and coming, remember it. • When befriended, remember it. When you behond, forget it. • He that lives upon hope will die fasting.

- One today is worth two tomorrow. • Work while it is called to-day for you be hindered tomorrow. • One today is worth two tomorrow. • Have something to do. • One today is worth two tomorrow. • Have something to do.

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