Summer 2014, Volume 24, Number 2

The Journal of the Canadian Rheumatology Association

PHOTO CONTEST WINNER: "PEOPLE"
Photo by: Michel Zummer

PHOTO CONTEST WINNER: "PLACES"
Photo by: Michel Zummer

Focus on: Highlights of the CRA ASM

Editorial

- My Way

Awards, Appointments, and Accolades

- CRA Practice Reflection Award

Northern (High)lights

Interviews with the CRA Award Recipients for 2014

- Distinguished Rheumatologist: Dr. Boulos Haraoui
- Distinguished Investigator: Dr. Brian Feldman
- Teacher-Educator: Dr. Evelyn Sutton
- Young Investigator: Dr. Cheryl Barnabe
- Changing Medical Marihuana Regulations: What Role for Rheumatologists?

Joint Communiqué

- Reflections from the Past-President
- President's Letter
- National Update 2014
- That's Debatable! The 2014 CRA Great Debate
- AHPA in Whistler: 2014
- CIORA: Research Successes and Future Directions

Hallway Consult

- In the Beginning, it was Arthritis...

What is the CRA Doing For You?

- RA Guidelines: Practice Patterns of Rheumatologists in Canada Compared to CRA Recommendations for RA (Part V)

The CRAJ is online! You can find us at: *www.craj.ca*

Janssen Inc.
19 Green Belt Drive
Toronto ON M3C 1L9
www.janssen.ca

* Real patient. May not be representative of the general population.
All trademarks are used under license.
© 2014 Janssen Inc.

PAAB Member R&D SISA140155E

janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson

EDITORIAL

My Way

By Philip A. Baer, MDCM, FRCPC, FACR

"I planned each charted course; each careful step along the byway,
But more, much more than this, I did it my way."

— Frank Sinatra, "My Way" (lyrics, Paul Anka; composers, Claude François & Jacques Revaux), *My Way*, 1969.

The patient's journey with a chronic disease like arthritis has the structure of any story – a beginning, a middle portion, and an end. I find the best outcomes and most satisfying patient encounters occur when the patient's beginning occurs under my care, as opposed to someone else's. I am never as sure about what to do for an inherited patient as I am for someone whom I followed from their first interaction with a rheumatologist. Examples:

A patient comes with established rheumatoid arthritis (RA) on low-dose steroids and methotrexate (MTX). I know I screen everyone before MTX use for hepatitis B and C status and carry out a baseline chest X-ray. Did the previous rheumatologist do that? Does the patient recall being screened? Do I have to carry out these tests for someone on MTX for 10 years who cannot recall what was done at MTX initiation?

Could someone please standardize folic acid supplementation for MTX? I have my routine: MTX every Saturday, folic acid 5 mg on weekdays. The origin of this routine is shrouded in the mists of history, but it works for me. Inherited patients recently have arrived on the following regimens: Folic acid 1 mg or 5 mg, taken three, six, or seven days a week; folic acid 10 mg taken one or two days after the weekly MTX dose; and others. Lab work for MTX monitoring might have been ordered every four, six, eight, or 12 weeks. I ask for blood work every six weeks and, with many patients, I am lucky to receive test results every eight to 12 weeks.

An inherited RA patient calls because of a flare-up. They demand an intra-muscular (IM) injection of steroid, as done once or twice per year by their previous rheumatologist. Well, I have not given such an injection in more than 25 years of practice. I prefer injecting one or two swollen joints instead, or giving a short course of tapering oral steroids (no refills, mind you). How to explain to a patient who is convinced they need an IM injection?

Another patient I inherited had psoriatic arthritis (PsA). I received a fax from a pharmacy requesting a refill of a topical steroid medication for the treatment of his psoriasis. I sent it back with a note indicating I had not prescribed this medication, and that it should be obtained from the prior prescriber, either the treating family physician or dermatologist. Unbeknownst to me, the patient's prior rheumatologist had been in the practice of prescribing the patient's topical steroids, something I never do. Next thing I knew, the patient was berating my relatively new secretary about his missing refill, apparently perceived to be of life-saving importance. A College complaint was threatened, though never proceeded with. This led to a call to the Canadian Medical Protective Association (CMPA) and intensive chart documentation by me and by my secretary.

I suppose if we all did things the same way, it could be considered boring and a cookie-cutter approach to medical care. But, it certainly would be a lot simpler!

And so, as Friedrich Nietzsche said, "you have your way. I have my way. As for the right way, the correct way, and the only way, it does not exist."

Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
Scarborough, Ontario

CRA: CALL FOR ABSTRACTS

You are invited to submit abstracts for presentation during the 2015 CRA Annual Scientific Meeting and AHPA Annual Meeting!

Deadline for submissions is Monday, October 20th. Details will be available at *www.rheum.ca.*

CRA EDITORIAL BOARD

Mission Statement. The mission of the *CRAJ* is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.

EDITOR-IN-CHIEF

Philip A. Baer, MDCM, FRCPC, FACR
Chair, Ontario Medical Association, Section of Rheumatology
Scarborough, Ontario

MEMBERS:

Cory Baillie, MD, FRCPC
President, Canadian Rheumatology Association
Assistant Professor, University of Manitoba
Winnipeg, Manitoba

Cheryl Barnabe, MD, FRCPC, MSc
Assistant Professor, University of Calgary
Calgary, Alberta

Shirley Chow, MD, FRCPC
Assistant Professor, Division of Rheumatology, University of Toronto,
Toronto, Ontario

Michel Gagné, MD, FRCPC
Polyclinique St-Eustache
St-Eustache, Quebec

Derek Haaland, MD, MSc, FRCPC
Assistant Clinical Professor, McMaster University
Divisions of Clinical Immunology & Allergy and Rheumatology
Shanty Bay, Ontario

James Henderson, MD, FRCPC
Teacher, Dalhousie University
Fredericton, New Brunswick

Diane Lacaille, MD, MHSc, FRCPC
Senior Scientist, Arthritis Research Centre of Canada
Mary Pack Chair in Arthritis Research
Professor of Rheumatology, Division of Rheumatology
University of British Columbia
Vancouver, British Columbia

Bindu Nair, MD, FRCPC
Associate Professor
University of Saskatchewan
Head, Division of Rheumatology
Department of Medicine
Royal University Hospital
Saskatoon, Saskatchewan

Sylvie Ouellette, MD, FRCPC
Assistant Professor, Dalhousie University
Clinical Assistant Professor, Memorial University
The Moncton Hospital
Moncton, New Brunswick

Rosie Scuccimarri, MD, FRCPC
Assistant Professor, McGill University
Program Director, Division of Pediatric Rheumatology
Montreal Children's Hospital
Montreal, Quebec

Jacqueline C. Stewart, BSc (Hons), B Ed, MD, FRCPC
Rheumatologist, Penticton Regional Hospital
Penticton, British Columbia

John Thomson, MD, FRCPC
Assistant Professor, Division of Rheumatology, University of Ottawa
Ottawa, Ontario

Carter Thorne, MD, FRCPC, FACP
Past-President, Canadian Rheumatology Association
Past-President, Ontario Rheumatology Association
Medical Director, The Arthritis Program & Chief Division of Rheumatology, Southlake Regional Health Centre
Newmarket, Ontario

Michel Zummer, MD, FRCPC
Chief, Division of Rheumatology,
Hôpital Maisonneuve-Rosemont
Montreal, Quebec

The editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.

PUBLISHING STAFF

Paul F. Brand
Executive Editor

Russell Krackovitch
Editorial Director, Custom Division

Katia Ostrowski
Editor

Catherine de Grandmont
Editor-proofreader, French

Donna Graham
Production Manager

Dan Oldfield
Design Director

Jennifer Brennan
Financial Services

Robert E. Passaretti
Publisher

Copyright©2014 STA HealthCare Communications Inc. All rights reserved. *THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION* is published by STA Communications Inc. in Pointe Claire, Quebec. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of the publisher. Published every three months. Publication Mail Registration No. 40063348. Postage paid at Saint-Laurent, Quebec. Date of Publication: July 2014. *THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION* selects authors who are knowledgeable in their fields. *THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION* does not guarantee the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed herein are those of the authors and do not necessarily reflect the views of STA Communications or the Canadian Rheumatology Association. Physicians should take into account the patient's individual condition and consult officially approved product monographs before making any diagnosis or treatment, or following any procedure based on suggestions made in this document. Please address requests for subscriptions and correspondence to: *THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION*, 6500 Trans-Canada Highway, Suite 310, Pointe-Claire, Quebec, H9R 0A5.

CRA Practice Reflection Award

By Christopher Penney, MD, FRCPC

Changing one's behaviour is never easy. In my personal life, what I do and what I say I do are sometimes different. Fortunately, my spouse and family are there to point out the error of my ways and help me change my behaviour for the better.

In my professional life, I do not have a guardian angel or a spouse constantly at my side to support me in a similar fashion. I can attend small group sessions and lectures at the CRA Annual Scientific Meeting (ASM), go to weekly rounds, agree with everything said, even actively participate in the Q&A sessions, and then continue to practice in the same old fashion.

I know what you are thinking: this does not apply to me. However, I can tell you from personal experience that it does. Until I did chart audits of my own practice, I told everyone that most of my biologic patients were vaccinated and that most of my gout patients had their diagnoses established via joint fluid aspiration. I was blissfully ignorant of what I was doing.

We all now accept that, as much as possible, clinical decisions need to be evidence-based. In the near future, proof of Continuing Professional Development (CPD) required for professional practice will not be just a record of event attendance but also some evidence that your practice is in compliance with accepted standards.

Our colleagues at the Royal College have crafted the Maintenance of Certification (MOC) program and are well aware that traditional CPD programs often do not exert great influence on practice behaviour. This is why there is now a requirement by the Royal College that you devote at least eight hours (25 credits) to Section 3 activities (Self-assessment & Simulation) during your next MOC five-year cycle. No doubt that time commitment will increase in the coming years.

Presently, there are no Canadian Section 3 programs in rheumatology, which is why the CRA has elected to sponsor the Practice Reflection Award.

The CRA wants you to reflect on your practice and then show improvement in care or compliance with guidelines as a consequence of that reflection. The award will go to a CRA member who comes up with an innovative and practical method that can be shared nationally.

I refer you to the CRA website if you are interested in applying for this award. Details can be viewed here: *www.rheum.ca/en/the_cra/Awards.*

Christopher Penney, MD, FRCPC
Associate Clinical Professor, University of Calgary
Rheumatologist, Richmond Road Diagnostic & Treatment Center
Calgary, Alberta

AWARDS, APPOINTMENTS, AND ACCOLADES

The CRAJ would like to recognize the contributions of its readers to the medical field and their local communities.

To have any such awards, appointments, or accolades announced in an upcoming issue, please send recipient names, pertinent details, and a brief account of these honours to *katiao@sta.ca*. Picture submissions are greatly encouraged.

The CRA's 2014 Distinguished Rheumatologist: Dr. Boulos Haraoui

1. Why did you become a rheumatologist? What or who influenced you along the way to do so?

During medical school and my internal medicine training, I was always fascinated by complex multisystem cases which did not rely solely on laboratory or imaging techniques for diagnosis, but required detailed medical history taking and a thorough physical exam. This narrowed my choices to endocrinology and rheumatology; rheumatology won after I met Dr. Guy Germain (who was the head of the department at the time at the Université de Montréal) during my rotation. He was passionate and dedicated to his patients, and showed me the great satisfaction I could glean from a career in rheumatology; ultimately, he suggested that I should focus on rheumatoid arthritis (RA), the big crippling disease, by pursuing a fellowship. This is how I ended up doing basic and clinical research at the National Institutes of Health (NIH) with the help of a scholarship from The Arthritis Society (TAS).

2. What do you believe are the qualities of a distinguished rheumatologist? How do you feel you embody these qualities?

A rheumatologist is by definition a compassionate physician who understands patient suffering and strives to alleviate it; at the same time, though, understanding that rheumatologic conditions have complex underlying pathophysiology. My training allowed me to better appreciate the huge unmet need in term of therapies and at the same time the big potential of immune modulation. This convinced me to focus my practice on RA and led to my involvement in multicentre collaborations through clinical trials, the Canadian Rheumatology Research Consortium (CRRC) network, the Canadian Early Arthritis (CATCH) cohort, and other initiatives aimed at improving patient care such as the Treat to Target (T2T) program.

Focused teamwork is the key to success; you need to be a team player but, at the same time, exercise leadership by bringing and developing new ideas.

3. In recent years the Canadian Initiative for Outcomes in Rheumatology Care (CIORA) has become one of the largest arthritis research-funding agencies in Canada. What was the effect of integrating with the CRA? How else do you foresee the landscape of rheumatology clinical research changing over the next decade?

One of the achievements I am most proud of is the growth of CIORA, which started as a one-company initiative and is now funded by several others. CIORA is currently the third-largest rheumatology research-funding agency in Canada. It is important for the CRA to have a say and a contribution in rheumatology research. By focusing on clinical research, CIORA complements several educational and practice management initiatives of the CRA. This allows the CRA to set priorities for research in areas of unmet needs in patient care and also to support the work of young clinical investigators.

Dr. Haraoui receiving his award from CRA President Dr. Carter Thorne and Dr. Janet Pope.

4. Your tenure within the CRA is long and storied. What do you feel is your lasting legacy within the organization?

Two legacies stand out: The first is the "French Power" contribution to the advancement of the CRA following in the footsteps of several predecessors. I hope it helps open the door to a younger generation of rheumatologists from Quebec. Another would be bringing CIORA to the CRA after it had matured as an independent organization; it fills an important mission for the advancement of patient care in Canada.

5. Your work in biologics trials in RA has shaped the landscape for research and inquiry. Why are biologics of such tremendous importance in the treatment armamentarium? What developments do you anticipate as future success and challenges?

Biologics have tremendously improved the lives of thousands of patients in Canada. Rheumatologists are now able to "promise" better tomorrows to their patients. That said, after 15 years and several available biologics, we are at a stage where we need to better strategize our treatment approaches by early detection and treatment, developing tools to identify subsets of patients and aiming to individualize therapies.

Moreover, RA is not just a "joints" disease and requires management of all the co-morbidities and extra-articular features. This will require multidisciplinary teams with nurses, allied health professionals, and pharmacists, along with collaboration with other medical specialties such as pulmonary medicine and cardiology. We need to convince our health authorities to invest in such initiatives.

6. You are trilingual and participate in rheumatology societies across the globe. What advances are being made in international forums that are shaping Canadian initiatives? How have your international sojourns shaped your perspectives on the Canadian field?

My international interactions have allowed me to see

the high esteem in which Canadian rheum-atology is held, and how we influence practice in several countries. At the same time these interactions have allowed me to appreciate the importance of collaborative work at which certain countries excel. This has convinced me that we need to have such models in Canada through national initiatives (*e.g.*, CRRC, CATCH) and, at the same time, bring Canadian expertise and contributions to international programs such as the T2T and the Evidence, Expertise, Exchange Initiative (3E).

7. What has been the most poignant observation you have realized over the course of your career?

My saddest observation is the decline of industry-sponsored clinical trials in Canada. I have witnessed the exciting times of the first biologics trials in the late 1990s and early 2000s where I could see the "miraculous" improvement of patients within weeks. Over the years, clinical trial designs did not keep pace with the changes of optimal management of RA, and it became increasingly difficult to include patients and be able to gain experience with new therapies before they become available in Canada. Moreover, the transition from in-house management of trials by pharmaceutical companies to Contract Research Organizations (CROs) has severed the ties investigators had with the medical personnel and departments within the companies. These ties are crucial in order to influence trial designs and foster other collaborations. Add to that the complexities of new legal requirements and it is almost impossible for an individual clinician to build and sustain a clinical-trial set up.

8. You are marooned on a desert island. What is the one book you want with you?

The Prophet by Khalil Gibran. It summarizes in a few pages all of the experience of humanity. I have read it at least a dozen times and always find something new to reflect upon.

9. What do you love most about living in Montreal?

For somebody coming from the Middle East with a French educational background, Montreal offers the best mix of North American culture "modulated" by European influence. It is the only city where you can seamlessly alternate in the same conversation between English and French (and sometimes a third language, Arabic in my case). Montreal has also a vibrant cultural life and great, great restaurants. Outdoor activities are easily within reach, too.

Boulos Haraoui, MD, FRCPC
Associate Professor of Medicine, Université de Montréal
Head, Clinical Research Unit in Rheumatology,
Centre hospitalier de l'Université de Montréal (CHUM)
Chair, CIORA Steering Committee
Montreal, Quebec

The CRA's 2014 Distinguished Investigator: Dr. Brian Feldman

1. What circumstances or which individuals propelled you towards investigative research? Did you anticipate your career trajectory leading in this direction?

I had been interested in clinical research, and what is now called "evidence-based medicine" since I was a high school student. My father is an academic pediatrician and was on faculty at McMaster University from the late 1960s until the mid-1980s. Our family friends were some of the leaders in the development of clinical epidemiology and, while I was a teenager, I was strongly influenced by my father and his colleagues and the exciting movement they were creating.

I sought out opportunities to participate in research—starting in high school—and took the opportunity (with the strong encouragement of my rheumatology mentors Dr. Ron Laxer and Dr. Earl Silverman) to do graduate work in the area during my fellowship. The University of Toronto was just starting their clinical epidemiology graduate program at the time, and it was a very exciting place to study. Dr. Elaine Wang, the late Dr. John-Paul Szalai, and Dr. Claire Bombardier were some of my fantastic graduate school mentors, amongst many others. I certainly did not expect to spend so much time doing science—and I did not expect my clinical practice to shrink to where it is now—but things evolved over the years (as they do) and I could not be happier.

2. You have developed investigational methods to study patients with rare disorders, which have been adopted in countless research studies. What has guided your design of clinical trials? How do you feel your contributions have altered the research landscape in Canada?

My methods have not been widely adopted; rather, I hope my work has allowed other researchers to feel comfortable looking for alternative research designs when studying therapies in difficult situations. As rheumatologists, we look after patients with a wide variety of rare disorders. Classical clinical trials often require large numbers of subjects to produce precise and definitive results. Like many other frustrated investigators I felt—and I still feel—that finding new ways to study how well treatments really work is a worthwhile goal, even when adequate numbers of research patients are not available.

The goal is, I guess, to get the best possible evidence for treatments even if classical clinical trials are not feasible. If my work has had any influence, I hope it is by encouraging investigators to be more flexible in their thinking about producing evidence, and that some evidence is better than none.

3. Through your advocacy efforts, the Canadian pediatric rheumatology agenda has advanced considerably. What do you feel is the primary obstacle in the pediatric field? What do you foresee as future successes?

As Canadians we value children, and the health of children, very highly. However, there are far fewer sick children than, say, sick elderly folks. For example, while osteoarthritis (OA) may affect 40% or more of Canadian adults, childhood arthritis (depending on

Dr. Feldman receiving his award from CRA President Dr. Carter Thorne and Dr. Claire Bombardier.

how we define it) affects only about 1 in 250 children. We love children, but Canadian funding for clinical care and research is, by necessity, directed towards the much larger health challenges. I believe our successes in the field of pediatrics have come through the foresight of some of our pediatric rheumatology leaders in developing very well organized collaborations across the country. This has allowed us to compete aggressively for research funding and develop stronger advocacy than we could have without banding together. And, there has been strong support for this in the rheumatology community in general—the CRA, The Arthritis Society (TAS), the Canadian Arthritis Network (CAN), the whole Arthritis Alliance of Canada (AAC)—these organizations have been very supportive of our efforts to improve care and research for children.

4. Your investigative approach is comprehensive, covering research into clinical manifestations, disease course and outcome, therapeutic approaches, and trial design. In what ways do you feel this inclusivity renders you a more effective researcher?

I suppose there are different ways one can develop a research career. Young researchers are often told that they need a laser-like focus in order to succeed. And there are certainly great examples of highly focused and very successful researchers. Looking back, I have done it a different way.

I had the opportunity to be able to chase down all the questions that seemed super interesting and use all the methods that seemed to have new potential as they presented themselves. This involves straying far away from rheumatology at times, for example, into blood disorders, cancer, short gut surgery, inflammatory bowel disease, and liver disorders. Probably the most common thing I hear when I meet with the graduate students and coordinators—either from me or from them—is "wouldn't THAT be cool!" I am not sure our lack of focus makes us more effective, but it certainly makes the whole process a lot of fun!

5. How and why should rheumatologists engage to a greater degree with TAS?

I got involved with TAS initially as a way of "paying back", as they funded my clinical fellowship. TAS is one of the largest funders of arthritis research in Canada, and has a potent advocacy voice representing our patients. It is also one of the main avenues through which the Canadian public interacts with the arthritis community. Over the years, I have heard many people sing the praises of TAS, but I have also heard of a few disgruntled rheumatologists complaining about the direction TAS had been taking. I think the main reason to get involved with an institution is that getting involved is how we influence the direction that institution is taking; this is certainly true for TAS.

6. You hold numerous chairs, so many in fact, I feel we should address you as the "head table". How do you manage all of your achievements concurrently? Is there some advice you can offer to your colleagues on how to balance their commitments and obligations?

I am probably not the best person to talk about "balance", but here goes: in order to get stuff done, I find it very important to continually challenge my priorities. I keep a computer database of my projects and "to-dos", and everything is in priority order. As a new task comes up I always think deeply about just how important it is, relatively. I schedule my week, usually on Sundays, so that I make time for the highest priority tasks, and so that at the end of the week I can look back and say, "I got some good stuff done this week".

It is also important, I believe, to schedule time for personal development and learning, which to me usually means reading slightly outside of the field. Finally, I think even the busiest person should make time to have some fun. I have just taken up the sport of equestrian reining—it is a blast—and it is a great way, at least for me, to get my head out of rheumatology and research so that I am fresh when I get back to work.

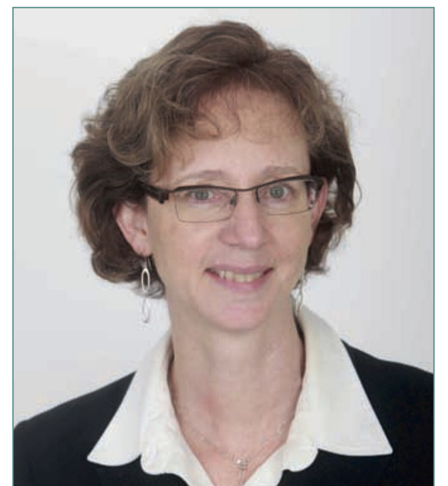
7. For those wanting to pursue rheumatology and a career in research, what is your advice?

This is a great time to get into rheumatology. There is a marked shortage of personnel and there are positions open all over the country for all types of rheumatologists, including community clinicians, academic clinicians, educators, and researchers.

For those interested in research, I would suggest two things that will really "up the game". First, do formal graduate studies, preferably a PhD, and with a great supervisor. Second, do that training at the end of your clinical training. It is pretty easy to jump back into clinical work after taking a few years off to do a PhD, as the pace of change in clinical medicine is slow—frustratingly so for many patients. It can be pretty daunting to jump back into research after taking a few years off to do a fellowship, as the pace of research is furiously fast, and it is hard to remain competitive after taking a break.

Brian Feldman, MD, MSc, FRCPC
Ho Family Chair in Autoimmune Diseases
Professor of Pediatrics, Institution of Health Policy Management & Evaluation,
University of Toronto
Senior Scientist and Head, Division of Rheumatology,
The Hospital for Sick Children
Toronto, Ontario

The CRA's 2014 Teacher-Educator: Dr. Evelyn Sutton



1. What circumstances propelled you towards teaching? Who were your educational inspirations? Did you anticipate your career trajectory leading in this direction?

I have always loved to share what I enjoy, whether it is a beautiful sunset, a new recipe, or a new experience. So teaching came naturally—I loved learning medicine and sharing it with those who were interested.

I did not anticipate my career—it found me! I did not start out with a plan; after residency I went into private practice but was happy to accept a part-time appointment with the university. I enjoyed being on the rheumatology consultation service as it gave me a chance to interact with learners and it also provided a break from the routine of the office. As time went on, I was offered opportunities to participate not only in teaching but also administration, which to my surprise I also found rewarding.

2. What have been your greatest challenges and accomplishments in your role as Assistant Dean of Medical School Admissions at Dalhousie?

The reality that the majority of people who apply to medicine will be unhappy with the Admissions Committee's decisions fueled my desire to provide practical feedback to unsuccessful applicants. The previous system of full file review did nothing to dispel myths that surrounded what made for a successful application. Although files were intensely scrutinized, the outcome was based on the Admissions Committee voting on to either accept or reject each application. Feedback to unsuccessful applicants would be vague at best.

Replacing the traditional interview of one faculty member and one medical student per applicant with multiple, timed interviews (multi-mini interviews) allowed for component and anonymized scoring. Now, unsuccessful applicants are provided with their component scores and how they compared with those who were successful; this allows them to make a more informed decision on whether to reapply and, if they do, which parts of their application need to be improved to be competitive. I do not think it eases the disappointment which unsuccessful applicants experience, but it does provide them with feedback that should allow them to strengthen their application should they choose to reapply.

In addition to providing objective feedback to unsuccessful applicants, the component scoring will allow longitudinal studies of what makes or does not make a successful medical student and doctor, and future Admissions Deans will be able to revise these criteria on the basis of that evidence.

3. You were instrumental in initiating a one-month elective in medical education for all residents at Dalhousie. This program recently celebrated its tenth anniversary and has been recognized by the Royal College as an innovation of excellence. How did this initiative come about? What was the prime motivator to push for this initiative?

The idea for a one-month elective in medical education came out of a discussion with a renowned educator, Dr. Karen Mann, whom I met while serving on our medical school's undergraduate curriculum committee. I certainly cannot take full credit. We had noted that many residents were interested in teaching, but were uncertain whether a Masters in Medical Education was the correct career path for them. This resulted in further discussions

and the recruitment of Dr. Blye Frank, then Department Head of Medical Education. The three of us worked together to develop the curriculum for the elective. The real work of implementing it was and continues to be done by Dr. Mann and her colleagues in medical education.

4. Your teaching endeavours have been recognized nationally, with your receipt of the Faculty of Medicine Community of Scholars Award for Excellence in Medical Education and Canadian Association of Medical Education (CAME) Certificate of Merit. What is your proudest achievement as an educator?

Without a doubt, to be recognized by the CRA as Teacher-Educator of the year is the most special. It was a magical week to be congratulated warmly by former and current students and colleagues. Hearing the quotes Dr. Taylor provided in her introductory speech reminded me of the film "It's a Wonderful Life". On the one hand I wondered if she was sure they were talking about me, on the other hand I recognized who must have authored some of the comments, and I was deeply moved. Truly, this is my lifetime achievement award!

5. You have held various academic roles with the Faculty of Medicine at Dalhousie University in undergraduate, postgraduate and continuing medical education. How do you feel your involvement has shaped the trajectories of your students?

I do not know that my involvement has shaped their trajectories, but I have been privileged to meet many wonderful undergraduate and graduate students. My goal has always been to help students, if needed, to discover their own path to successful career fulfillment. I have been delighted when some chose rheumatology, but equally happy when a student matched to their first choice in Canadian Resident Matching Service (CARMS), whatever the discipline.

Student Awardees: 2014 CRA Annual Scientific Meeting

Dr. Philip S. Rosen Endowment Fund Award

Glen Hazlewood

"Subcutaneous Delivery of Methotrexate is Associated with Improved Treatment Survival Compared to Oral Administration for the Initial Treatment of Patients with Early RA"

University of Calgary (Supervisor: Dr. Vivian Bykerk)

CRA Basic Science Prize

Thomas Winter

"C-reactive Protein Gene Polymorphisms and C-reactive Protein Levels in a North American Native Population that is Highly Predisposed to RA"

University of Manitoba (Supervisor: Dr. Hani El-Gabalawy)

Best Paper by an Undergraduate Student

Maurice Agha

"Risk of Cerebrovascular Accidents in Patients with SLE: A Population-based Study"

University of British Columbia (Supervisor: Dr. J. Antonio Aviña-Zubieta)

Ian Watson Memorial Award

Geneviève Genest

"Causes of Stillbirths in Women with SLE: Preliminary Data from the OSLER Cohort"

McGill University (Supervisor: Dr. Évelyne Vinet)

Best Abstract by a Rheumatology Resident

Ripneet Puar

"High Mortality in North American Natives with SLE: Looking For Solutions"

University of Manitoba (Supervisors: Dr. Christine Peschken and Dr. Carol Hitchon)

6. What type of teaching environment do you think fosters the best learning potential? Why?

Any environment where both the learner and teacher are engaged (*i.e.*, one wants to learn and the other is keen to transfer knowledge) is the best environment. It can be in a lecture hall, at the bedside, or even as one walks between buildings en route to the next consult. As a teacher it is critical to know one's audience: where are they on their knowledge acquisition journey? Do they know what they need to know, or do I need to give them some cases to open up their knowledge blind spots? I find that most people in medicine—from student to practicing physician of many years—are keen to learn what they believe to be relevant to them. As the teacher, once you know that, the next step is to determine what teaching style works best for them and try to adapt one's teaching style to reflect that.

7. What are the current challenges for those teaching in the university environment?

Time is now and always has been the biggest challenge: balancing patient care with administration, research, home life, and teaching! Learning how to incorporate teachable

moments into even the busiest clinics is something I am mindful of daily.

8. What would your advice be to some of your younger colleagues who are interested in enhancing their teaching skills in rheumatology?

I would strongly encourage them to take advantage of the courses their own universities no doubt offer, and to take advantage of workshops that help refine communication skills or even improve one's own clinical skills not just confined to rheumatology. I have learned most from observing other skilled clinicians and how they teach—Dalhousie's Department of Medicine runs "Teach the Teachers" workshops where we learn from each other. Observing a skilled neurologist teach the cerebellar exam, for example, improved not only my exam but I was able to transfer some of his techniques into my own teaching. The key to the cerebellar exam is the same as MSK exam: you have to refresh your knowledge of anatomy. Once you have that, you do not need to memorize, but can do the exams by applying logic.

9. In 2004 you authored a textbook entitled *Musculoskeletal Examination: A Primer for Medical Students*; this work has since become an instrumental reference tool for medical students and residents within Canada and beyond. Tell us about compiling this work, the importance of standardized examination techniques, and your experience with having this work available to students.

I wrote it to assist medical students who complained to me they were overwhelmed by the musculoskeletal (MSK) exam and that the recommended textbooks were bewildering because of all the named tests for each joint. I wanted to show them that competency could be achieved in the MSK exam by focusing on what was similar between regional exams, not by memorizing named tests for each joint. It really started with written text that I would hand my students weekly during their MSK block of their undergraduate curriculum. After a few years I added the pictures.

My experience has been that all levels of learners really appreciated the simplified approach. Although designed with the undergraduate medical student in mind, internal medicine residents and even rheumatology trainees expressed their appreciation for it. The text was not meant to be the definitive book on MSK examination, but rather to provide a solid base from which those interested in pursuing more detailed examination could build.

10. What is something you have lost that you have never found, or were tremendously relieved when you did find it?

I lost the only memento I had of my paternal grandmother, who I am named after. It was the diamond engagement ring my grandfather gave to her, and it was the ring his father had given to his mother. My grandparents were married for 67 years, and it still hurts that I lost this family heirloom.

11. Three things you think will become obsolete in 10 years:

Cheque books, open-ended retirement for physicians, and privacy.

12. If you could compete in the Olympics, which event would you participate in?

I would have loved to have the athleticism to compete in any Olympic sport (!) but if I could pick any I would have chosen the 1,500 meters—long enough that strategy is required and not so short that in a blink it is over.

13. What do you love most about living in Halifax?

I love being near the ocean, being able to walk to work, restaurants, and theatres and concerts. It has the advantages of a larger city but with the conveniences of a small town.

14. You are handed a plane ticket to anywhere in the world. Where are you going?

I have never been to New Zealand and would love to go hiking there.

15. What was your first paid job? How long did it last?

Apart from babysitting from the age of 12 (for 50¢/hour), my first "real job" was during he summer between my Grade 10 and 11 years as playground leader for the municipal Parks and Recreation Department. Instead of babysitting neighbour's children in their homes, I essentially babysat the neighbourhood. The park had a wading pool so someone always had to be in attendance. I did that for one summer—that was enough! I worked every summer through high school and university; jobs ranged from waitressing (the worst job), working on the railroad as a station operator (the best), to being a lab assistant.

Evelyn Sutton, MD, FRCPC
Professor of Medicine and Medical Education,
Dalhousie University
Director of Arthritis Center of Nova Scotia
Halifax, Nova Scotia

The CRA's 2014 Young Investigator: Dr. Cheryl Barnabe

1. What circumstances or which individuals propelled you towards investigative research? Did you anticipate your career trajectory leading in this direction?

I had been planning to do a rural family medicine clinical exposure during the summer between my first and second years of medical school, but the program was discontinued at the last minute. Instead, I was offered work on a mixed-methods study to define education needs in palliative care for rural Manitoba physicians. I really enjoyed the process of designing questionnaires, performing qualitative interviews, analyzing results, and then putting it together in a package that was useful to the principal investigator. This opportunity was melded with clinical exposures in palliative care at the St. Boniface Hospital in Winnipeg, where I met fabulous and dynamic staff and residents who were also involved in research. A few other projects in palliative care were carried out, but once it was clear that I would be pursuing a rheumatology residency, I began working on projects with Dr. Christine Peschken and the rheumatology group in Winnipeg. To this day that group continues to do a fantastic job of blending epidemiology, clinical, and basic science research within their clinical service mandate, providing an ideal model for a clinician-scientist to follow.

Once I moved to Calgary for rheumatology training I was encouraged to be involved in analysis of the Alberta Biologics Pharmacosurveillance Program database with Dr. Liam Martin, Dr. Susan Barr, and Dr. Walter Maksymowych. This was an immense opportunity to use cohort data to inform clinical practice and understand outcomes. I completed my MSc degree in rheumatology training, working under Dr. Barr's supervision, but in a completely different field of a new imaging technique for rheumatoid arthritis (RA) damage. This has led to my participation in an international research collaboration called the Study Group for Extreme-Computed Tomography in RA (SPECTRA), which has allowed me to work with many influential investigators from Europe and also becoming involved in Outcome Measures in Rheumatology (OMERACT) activities.

During my MSc degree I was again drawn to research the epidemiology and health-services use of rheumatic disease by Canada's Indigenous population. This area of research has been incredibly rewarding–I feel I am addressing a significant health issue that receives too little attention otherwise. I deal with complex and challenging research and clinical situations. I get to apply a variety of research methods, and blend my clinical work with my research. I am continuously learning from my network of collaborators. I feel very blessed to have this career.

2. Your work in health-services research has far-reaching impact in First Nations locales. What do you feel is the primary obstacle in providing effective rheumatology services in these communities? What do you foresee as future successes?

I personally think that we place too much importance on the role of the specialist and lose perspective of the other health and social situations patients are

experiencing. We expect patients to conform to our schedules and our expectations, and tend to discount the expertise of the primary-care providers in the communities. I think the best model is for the rheumatologist to be adaptive to community needs and requests, working closely with the primary care physicians. I think that will allow us to come closer to reaching a holistic health plan for patients.

3. What has been your proudest accomplishment in your research to date? What direction would you like to see for your future projects?

I have recently completed a pharmacoepidemiology study of the Non-Insured Health Benefits (NIHB) database. Accessing the data was an intense process of reaching research agreements with both the Regional and National branches of the First Nations and Inuit Health Branch of Health Canada, the University of Calgary legal department and ethics board, and the Alberta Grand Chiefs Caucus, facilitated through the Alberta First Nations Information Governance Centre. After the data was analyzed, I had the opportunity to give the results back to the Grand Chiefs in Alberta to act on. This process has been celebrated as a positive example of how research can benefit the community and has solidified relationships for future studies.

4. For those wanting to pursue rheumatology and a career in research, what is your advice?

I would say one of my best decisions was to choose a rheumatology residency program that had no other trainees in it—this was my experience and resulted in excellent learning opportunities, undivided attention from the Faculty, and my selection of projects to work on. Those serious about pursuing research in their careers should make sure they are continuously working on a project or a case report or something publishable, which is difficult to do in the midst of clinical training, but well worth the time invested. It is critical to get ample research elective time and optimize that time by preparing the projects well in advance; projects always take much longer than expected! Finally, it is really critical to have protected time in specific research training.

5. Please define what "culturally safe care" means to you, and how this factors into your research.

Some may have heard of terms such as "cultural competency" or "cultural safety"; these are different concepts. Cultural competency relates to knowledge of a group's culture. Few people in Canada really know and understand the history of Indigenous Peoples in Canada, and do not realize the heterogeneity between groups. It is important to understand how social determinants of health define outcomes for Indigenous populations. The most critical piece of cultural competency is that the healthcare provider also reflect on their own personal biases and stereotypes that can dominate a healthcare interaction.

Cultural safety relates more to the patient experience in healthcare, and whether services and interactions are provided in an environment free from racism.

CRA/ARF Young Faculty Award for Excellence in Research: 2014 CRA Annual Scientific Meeting

CRA/ARF Epidemiology/Health Services Research Award

Dr. Cheryl Barnabe

"Investigating Access to Arthritis Health Services for Aboriginal People: A Framework for System Reform"

University of Calgary

CRA/ARF Basic Science Award

Dr. Nigil Haroon

"ERAP1 Variants Associated with AS Alter the Unfolded Protein Response in Cells Expressing HLA-B27"

University of Toronto

CRA/ARF Young Faculty Award for Best Clinical Research

Dr. Pooneh Akhavan

"Predictive Validity of Low Disease Activity Using Patient-reported Measures on Long-Term Outcomes in Early RA: Results from Study of New Onset RA and Ontario Best Practices Initiative"

University of Toronto (Supervisor: Dr. Claire Bombardier)

CRA/ARF Best Pediatric Award

Dr. Nadia Luca

"Reliability and Responsiveness of the Standardized Universal Pain Evaluations for Rheumatology Providers for Children and Youth (SUPER-KIDZ)"

University of Toronto (Supervisor: Dr. Ahmed Bayoumi)

6. What is most rewarding about your efforts in First Nations communities? Can you share an anecdote about some time you found yourself in a learning moment within the community?
I do not go through a single clinic without being humbled at how open patients are at sharing their stories with me, particularly the difficult and traumatic stories, or how appreciative the communities are to have the service provided in their healthcare setting.

7. What do you foresee as challenges to Canadian researchers in the future? What can individual rheumatologists and the CRA do to meet these challenges?
There is such immense pressure to address the patient load—and admittedly, clinician-researchers do not primarily contribute to clinical service provision. I think that this drives research that is grounded in advancing the field of rheumatology, so working on something that will benefit many is critical. Clinician-researchers do bring such expertise on the important questions and nuances of the diseases and outcomes measures to the research table. There is a great need to be supported to continue this research work.

8. If you could compete in the Olympics, which event would you participate in?
Curling of course—what a great sport. I have been fortunate to play on Dr. Cory Baillie's medical team for the interprovincial bonspiel for the last two years; hopefully he will have me back again next year despite a less-than-stellar performance in 2014.

9. If you could live in any other time period in history, what era would you inhabit?
I am pretty positive I was meant to experience the late 1960s and early 1970s!

Cheryl Barnabe, MD, FRCPC, MSc
Assistant Professor,
Division of Rheumatology,
Department of Medicine,
University of Calgary
Calgary, Alberta

Changing Medical Marihuana Regulations: What Role for Rheumatologists?

By Mary-Ann Fitzcharles, MB ChB, MRCP(UK), FRCPC; and Peter A. Ste-Marie, BA, LL.B.

Five hundred years ago, tobacco was hailed as the panacea treatment of almost any illness, including rheumatism. Brought from the Americas to Europe by early explorers, kings and their courts sang the praises of this magic herb, initiating a lucrative business that continues to thrive today. Sadly, it has taken a few centuries to recognize the serious health consequences of tobacco. Taking into consideration current issues surrounding marihuana, perhaps the world is at a tipping point similar to that of tobacco half a millennium ago? Cannabis, popularly touted as a product with multiple medicinal effects, has been catapulted into disease management by a groundswell of public advocacy. With scant scientific evidence, regulatory bodies worldwide have proceeded to legalize this substance for medicinal use.

Why Should Rheumatologists Have an Interest in Cannabis?

Firstly, the human cannabinoid system is an important player in pain, inflammation and immunological mechanisms. Secondly, patients with rheumatic complaints are seeking information about cannabinoids, with some self-medicating or accessing cannabis via the current Canadian regulations. However, there is not a single randomized controlled trial examining dosing, efficacy or side effects of cannabis in patients with rheumatic diseases.[1] It is therefore not surprising that two-thirds of the CRA membership who answered a recent survey expressed poor confidence in their knowledge of cannabinoids, with 70% recommending against cannabis use for rheumatic complaints.[2] Similar concerns were raised by family physicians in Colorado, with less than a fifth supporting use of medical cannabis.[3]

Risks Related to Cannabis

Contrary to public belief, inhaled cannabis is not innocuous. The risks can be categorized as immediate effects on cognition, psychomotor function, cardiovascular effects and mood, and long-term risks for mental health, pulmonary function, cancer risk, and drug dependence.[4]

The essence of a therapeutic effect for persons with rheumatic complaints is symptom relief with maintained function. The immediate psychiatric effects of anxiety, suicidal ideation, and acute psychosis are the most recognized, but effect on cognition requires special attention.[5,6] Even in regular young recreational users, psychomotor impairment persisted for up to five hours following acute administration.[7] Acute cannabis use was associated with at least twice the risk of serious and fatal motor vehicle collisions.[8] Health Canada has warned that driving may be impaired for up to 24 hours following acute consumption.[9]

Long-term risks can only be extrapolated from studies of recreational users, with chronic respiratory disease and lung cancer identified. Risk for lung cancer was doubled for young cannabis users in a recent 40 year longitudinal study controlled for cigarette smoking.[10] Mental health risks include depression, unmasking of serious psychiatric disease, and true addiction, reported as a cumulative incidence of 37.2% for young recreational users.[11-13] The true motive for use requires careful scrutiny, with the possibility that some patients may be misusing a medical diagnosis to access cannabis.

New Canadian Regulations Regarding Medical Cannabis

As of April 1st 2014, Canadian regulations regarding medicinal cannabis will change with implementation of the *Marihuana for Medical Purposes Regulations*. Under the previous *Marihuana Medical Access Regulations* (*MMAR*), physicians who provided the medical justification for a patient to apply to Health Canada to possess and/or grow cannabis were required to inform the patient of risks and benefits, but did not provide a traditional prescription. The new

regulations will require physicians to take full responsibility for the prescription of cannabis, by completing a "medical document", a euphemism for a prescription, stating the daily dose and duration of use for up to one year. The new regulations do not require failure of conventional treatments, nor a specific diagnosis.

Primum non nocere echoed in The Hippocratic Oath as "abstain from doing harm" is the foundation of ethics codes that govern medical practice. This ethic is reinforced by the Canadian Medical Protective Association (CMPA) in the context of prescriptions. In simple terms: before prescribing any treatment, a physician should have sufficient knowledge of the treatment; there should be a scientific knowledge of the risks and benefits of the treatment, including what is known and unknown about the treatment. A meaningful consent discussion must occur between physician and patient and be fully documented in the medical record. Finally, it is the legal obligation of a physician to comply with the regulations of their provincial licensing body.

Advocates for easier access to medical cannabis cite legal decisions, with some claiming a constitutional right to use the product for health reasons. This is a misconception. In 2000, the Ontario Court of Appeals in *R. v. Parker* concluded that a blanket prohibition against marihuana was unconstitutional because it did not allow use by people with valid medical justification. The federal government then instituted the MMAR in 2001 to comply with this ruling. A decade later, in *R. v. Mernagh*, an Ontario Superior Court judge erred when interpreting the ruling in *Parker* to conclude that people afflicted with serious illnesses have an automatic right to medical marihuana. The Ontario Court of Appeals overruled this interpretation in 2013, reinstating the necessity for persons applying for exemptions to lead evidence that there is indeed a true medical need. As physicians will now be the only gatekeepers, these legal considerations remain pertinent. Physicians are not legally obligated to prescribe medical cannabis on patient request, nor are they violating the *Canadian Charter of Rights and Freedoms* when refusing prescription. Rather, physicians are in their rights to practice evidence-based medicine, and are obliged to adhere to their ethics codes and regulations.

What Recommendations Can Be Provided to the Rheumatology Community?

In consideration of patient needs, the law and ethics that govern medical practice, and in light of current scientific knowledge, cannabis should be reserved for those few extreme situations where a patient experiences insufferable pain not responsive to treatments currently available. In the absence of the rudiments of standard scientific evidence, without knowledge of recommended dosing, and with important concerns for maintained function and long-term effects, any prescription for cannabis is in conflict with medical ethics, unless based on compassionate grounds. As caring physicians we must not be swept away by the pressure of advocacy. Forcing physicians to adopt practices that violate the ethical codes of the practice of medicine is untenable.

References
1. Fitzcharles MA, McDougall J, Ste-Marie PA, et al. Clinical implications for cannabinoid use in the rheumatic diseases: potential for help or harm? Arthritis Rheum 2012; 64(8):2417-25.
2. Fitzcharles MA, Ste-Marie PA, Clauw DJ, et al. Rheumatologists lack confidence in knowledge of cannabinoids in the management of rheumatic conditions: a needs assessment of Canadian rheumatologists. Arthritis Rheum 2013; 65(10):S49.
3. Kondrad E, Reid A. Colorado family physicians' attitudes toward medical marijuana. J Am Board Fam Med 2013; 26(1):52-60.
4. Kalant H. Adverse effects of cannabis on health: an update of the literature since 1996. Prog Neuropsychopharmacol Biol Psychiatry 2004; 28(5):849-63.
5. Thornicroft G. Cannabis and psychosis. Is there epidemiological evidence for an association? Br J Psychiatry 1990; 157:25-33.
6. Moreira FA, Grieb M, Lutz B. Central side-effects of therapies based on CB1 cannabinoid receptor agonists and antagonists: focus on anxiety and depression. Best Pract Res Clin Endocrinol Metab 2009; 23(1):133-44.
7. Mensinga TT, de Vries I, Kruidenier M, et al. A double-blind, randomized, placebocontrolled, cross-over study on the pharmacokinetics and effects of cannabis. 2006 Nationaal Vergiftigingen Informatie Centrum, RIVM Report, 267002002.
8. Asbridge M, Hayden JA, Cartwright JL. Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis. BMJ 2012; 344:e536.
9. Government of Canada, Department of Justice. Marihuana Medical Access Regulations (SOR/2001-227). Controlled Drugs and Substances Act. Available from: *www.laws.justice.gc.ca/eng/regulations/SOR-2001-227/FullText.html*
10. Callaghan RC, Allebeck P, Sidorchuk A. Marijuana use and risk of lung cancer: a 40-year cohort study. Cancer Causes Control 2013; 24(10):1811-20.
11. Harder VS, Morral AR, Arkes J. Marijuana use and depression among adults: Testing for causal associations. Addiction 2006; 101(10):1463-72.
12. van der Pol P, Liebregts N, de Graaf R, et al. Predicting the transition from frequent cannabis use to cannabis dependence: A three-year prospective study. Drug Alcohol Depend 2013; 133(2):352-9.
13. Johns A. Psychiatric effects of cannabis. Br J Psychiatry 2001; 178:116-22.

Mary-Ann Fitzcharles, MB ChB, MRCP(UK), FRCPC
Associate Professor, Division of Rheumatology,
Alan Edwards Pain Management Unit,
McGill University Health Centre
Montreal, Quebec

Peter A. Ste-Marie, BA, LL.B.
Faculty of Law, Université de Montréal
Alan Edwards Pain Management Unit,
McGill University Health Centre
Montreal, Quebec

Reflections from the Past-President

By Carter Thorne, MD, FRCPC, FACP

Colleagues: Two years ago, I had the privilege of assuming the Presidency of the CRA, which represented my third epoch with the Association. From starting practice in 1981 through 1990, like most individuals, I had little interaction with the CRA, except to pay my annual dues. As a member of the Board from 1990 to 2004 and the Executive (as Secretary-Treasurer) from 1996 to 2004, my second epoch allowed me to experience the excitement of the "new CRA." I was instrumental in initiating the Canadian Rheumatology Research Consortium (CRRC; which I am sad to say has recently disbanded; see upcoming editorial in the *Journal of Rheumatology*), as well as the startup of the Ontario Rheumatology Association (ORA). My most recent engagement with the CRA re-establishes my faith in the future of our community and our organization.

At the 2014 CRA gala dinner, we recognized over 100 members who participate actively in the CRA on committees, review panels, and as mentors. This contradicts the common refrain that organizations do not have "grassroots support." Similar to many professional organizations, your executive and board of directors, as well as committee chairs, are a committed group of individuals who do yeoman's service; unlike other organizations, the active support of its membership differentiates the CRA.

The CRA has had many successes in the past two years. In my introductory address to members in March 2012 I identified three imperatives:

1. Improve sustainability related to industry support. All of our industry partners have embraced our new model of "corporate support", moving away from simply supporting the annual meeting.
2. Modify the governance approach of our organization. The CRA has had significant burdens placed upon it, and requires a new governance structure. Dr. Cory Baillie, our new President, will champion this evolution. We have enlisted an outside consultant to develop enhanced infrastructure support and support new roles for our volunteers in governance. This will go a long way to ensuring all voices of the membership are heard.
3. We have been successful at achieving accreditor status with the Royal College. This has enhanced our branding; we are indeed recognized as the "experts in arthritis."

Noteworthy is our new enhanced relationship with Canadian Medical Association (CMA). We were one of the organizations invited to participate in the Choosing Wisely Canada initiative championed by Dr. Shirley Chow; this is an ongoing process and will be embedded in our accreditation and needs assessments. We were also invited by the American College of Rheumatology (ACR) to participate in a made-in-Canada ethics survey. Preliminary results indicate significant engagement by our membership, with twice the percentage of respondents from the CRA versus the ACR.

At this time, we are undertaking new initiatives for enhanced First Nations care through the Non-Insured Health Benefits (NIHB), the Royal College, and the Canadian Medical Association (CMA). Additionally, we are working towards harmonization of private payers regarding consistent criteria and application procedures for medical approvals. Dr. Jane Purvis is leading a cross-Canada initiative to establish guidelines acceptable to rheumatologists, patients, and third-party payers.

Our annual meeting remains much in demand, with increasing attendance not only of members and their families but also allied health professionals, industry partners, and other interested parties.

Passing the Presidential torch.

XELJANZ™ ['ZEL-janz]

noun:

1. Tofacitinib citrate

2. Now available in Canada

Talk to your Pfizer representative to learn more.

XELJANZ TM PF Prism C.V. , owner/Pfizer Canada Inc., Licensee

® Pfizer Inc., used under license
© 2014 Pfizer Canada Inc., Kirkland, Quebec H9J 2M5

Member R&D

This remains a dynamic time for all of us. I encourage your ongoing participation. I would like to take this opportunity to thank the executive; Dr. Baillie; the thoughtful and considered approach of Dr. Jacob Karsh who has given us great counsel while steering us through the Canadian Revenue Agency concerns; and Dr. Jamie Henderson, who was a steady navigator and commentator on ongoing activities. I welcome Dr. Joanne Homik who is the new Vice-President of the CRA.

It goes without saying that this organization's success is led by our Secretariat, Virginia Hopkins, Sharon Brinkos, and Christine Charnock, who currently holds the title of Manager and will assume new responsibilities in leading the CRA in our new governance models.

Finally, I would like to thank all the chairs of committee, leads in various activities, and all members for their support over the past year. I look forward to a revitalized CRA, based on strong financial footings, a new governance structure, strong leadership, and an enthusiastic membership.

It has been my privilege to serve you.

Carter Thorne, MD, FRCPC, FACP
Past-President, Canadian Rheumatology Association
Past-President, Ontario Rheumatology Association
Medical Director, The Arthritis Program & Chief Division of Rheumatology, Southlake Regional Health Centre
Newmarket, Ontario

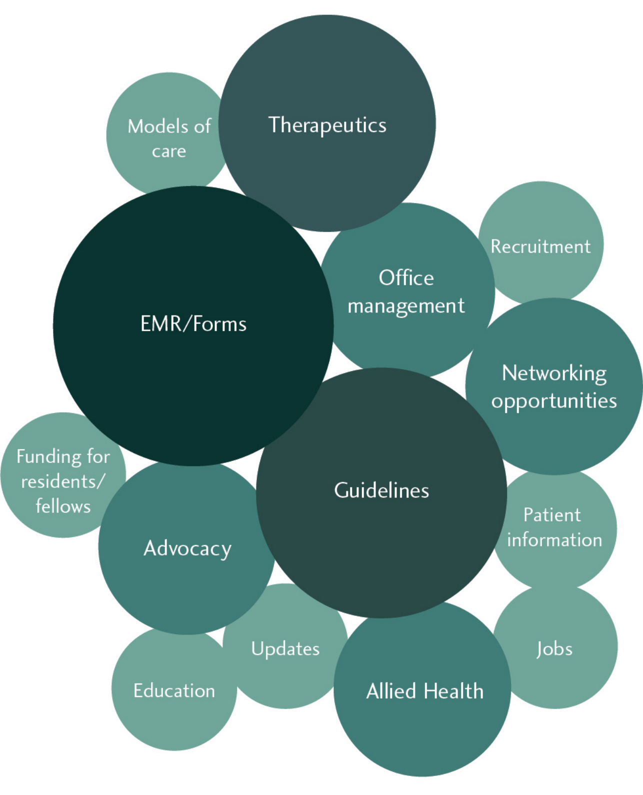
PHOTO CONTEST 2ND PLACE: "PEOPLE"
Photo by: Dr. Cheryl Barnabe

PHOTO CONTEST 3RD PLACE: "PEOPLE"
Photo by: Dr. Elaine Soucy

PHOTO CONTEST 2ND PLACE: "PLACES"
Photo by: Dr. Cory Baillie

PHOTO CONTEST 3RD PLACE: "PLACES"
Photo by: Dr. Maggie Larché

If there is one thing the CRA can do to make your job easier or better, what would it be?



Wanted — Most Wanted

Current and future members benefit from:

Supply and demand for rheumatologists

A sense of community

Learning opportunities

A unified Canadian voice for patient access to care

Networking

Advocacy for patient access

Advocacy for biologics and other treatment modalities

Opportunities to improve our practice

Increasing knowledge and awareness about rheumatology

ERASE THE PAIN

This spring The Arthritis Society launched Erase The Pain (**ThePain.ca**), a $25 million campaign focused on delivering concrete solutions to help erase the pain of arthritis in Canada.

One of the campaign initiatives seeks to recruit and inspire a future generation of frontline rheumatology clinicians and researchers. As a proud partner of The Arthritis Society, the CRA is calling on members to help lead the charge to raise $2 million over five years as part of the larger campaign.

By attracting top medical students to the field of rheumatology, you will be helping to increase access to care for over the 4.6 million Canadians living with arthritis today, and the 3 million more that are expected to develop the disease over the next 20 years.

Janet Yale, president and CEO of The Arthritis Society, presents Dr. Carter Thorne, Past-President of the CRA, with a plaque recognizing his personal contribution to the Erase The Pain campaign at the CRA's recent conference in Whistler, B.C.

To find out more and to make your pledge, please contact:

Kathryn De Carlo
The Arthritis Society
416-979-7728 x 3395
kdecarlo@arthritis.ca

Thank you for your support as we work together to Erase The Pain!

President's Letter

By Cory Baillie, MD, FRCPC

The CRA council has just completed its annual retreat which took place in Winnipeg between April 25-27, 2014. The weekend was focused on two themes: Governance and Strategic Direction for the CRA. To help achieve progress on these themes, we invited an expert on non-profit board governance, Catherine Raso, MBA, to act as our facilitator.

We began the weekend educating ourselves on a number of issues, including a review of the results of member feedback from the recent CRA focus groups and telephone interviews, along with results from the questions asked online during the membership renewal process. We then reviewed the value members receive from CRA membership; this value assessment includes skills development, information and knowledge, networking and fellowship, improved public policy, and increased public awareness. Building on these themes, we established goals for the next two years under the strategic directions of Care, Learning, Research and Representation.

We also spent significant time reviewing non-profit board governance and changes that the CRA should implement to operate more effectively. Several CRA council members, including myself, have offered to continue to work with Catherine Raso to restructure the CRA governance model. We hope to be able to present a new model for approval at the face-to-face board meeting in November during the American College of Rheumatology (ACR) conference in Boston.

Finally, the board gave direction to the chair of each existing CRA committee, about work that their respective committee should focus their efforts on.

I would like to thank the CRA council members along with Christine Charnock and Sharon Brinkos for their participation at the retreat. I am excited about my upcoming two years as President of the CRA and I am confident that the organization will continue to succeed at its mission of representing Canadian rheumatologists and promoting the pursuit of excellence in arthritis care, education, and research.

Cory Baillie, MD, FRCPC
President, Canadian Rheumatology Association
Winnipeg, Manitoba

We asked, and you told us the CRA does this well:

Conferences
The educational mission
Guidelines and Position Statements
Action-oriented Committees
The *CRAJ*
Bringing people together
Champions good science in Canada
The website
Seeking out member input
Journals
Strong organization
National advocacy
Patient resources
Studentship programs

All participants surveyed expressed support for the CRA and applauded the organization's efforts to gather member input. Participants in focus groups and one-on-one interviews said that CRA is truly a national organization, not central to any particular region. It is a strong organization with great leadership—"people feel like CRA does good things!" It is an intimate, collegial, and welcoming group. The work done by busy clinicians on the board and on committees is of great value to the rheumatology profession.

National Update 2014

By Shahin Jamal, BScPT, MD, FRCPC, MSc

Similarly to 2013, the 2014 National Update focused on clinical practice guidelines across a variety of disease spectrums including systemic lupus erythematosus (SLE), vasculitis, spondyloarthropathies (SpA), and systemic onset juvenile idiopathic arthritis (sJIA) (Still's disease). In addition, we had a presentation on the Advanced Clinical Practitioner in Arthritis Care (ACPAC) Program.

The session began with Dr. Stephanie Keeling of the University of Alberta, who gave us an overview of the Canadian Recommendations for the Management of SLE. As one can imagine, the creation of recommendations for disease management for SLE has been very challenging and complex. The group has engaged "lupologists" from across Canada and the world, along with guideline methodologists and other specialists who manage lupus (*e.g.*, nephrologists). The team is currently working on the first part of the recommendations, which will focus on diagnosis and monitoring of SLE. Systematic literature reviews are underway to address eight questions identified from a CRA survey of practice patterns in lupus across Canada. They hope to have the results of the first part of the recommendations completed for the CRA Annual Scientific Meeting (ASM) in 2015. Once these are complete, work will begin on recommendations regarding SLE therapeutics.

Our second speaker was Dr. Christian Pagnoux from the University of Toronto. He gave a very entertaining presentation on Canadian Recommendations for the Management of Anti-neutrophil Cytoplasmic Antibody (ANCA)-positive Vasculitis. Throughout his presentation, Dr. Pagnoux highlighted many of the challenges involved with guideline development, including difficulty competing for Canadian Institutes of Health Research (CIHR) funding, difficulty recruiting research fellows with interest in guideline development, and difficulty publishing manuscripts limited to Canadian data. The members of the Canadian Vasculitis Network (CanVasc) have reviewed the first draft of recommendations; they are working on the second draft, which will be distributed to other specialist societies and patient groups for review in the coming months. The completed publication will hopefully be available in the fourth quarter of 2014.

Dr. Sherry Rohekar then presented on the updated CRA/Spondyloarthritis Research Consortium of Canada (SPARCC) Treatment Recommendations for the Management of SpA. These are divided into seven themes including general management of SpA, wait times and triage, diagnosis, disease monitoring, nonpharmacologic therapy, pharmacologic therapy, and surgery. Pharmacologic therapy is further divided into nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, antibiotics, disease-modifying antirheumatic drugs (DMARDs), tumor necrosis factor (TNF) inhibitors, and non-TNF-inhibitor biologics. The recommendations are nearing completion and should be available for publication in the coming months.

Dr. Katie Lundon from the University of Toronto gave an informative presentation on the Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program. ACPAC is an interprofessional academic and clinical training program in advanced musculoskeletal/arthritis care for allied health professionals (*e.g.*, occupational therapists, physical therapists, and nurses). It is hosted at St. Michael's Hospital in collaboration with the Hospital for Sick Children and offered through the Department of Continuing Development and Professional Development, Faculty of Medicine at the University of Toronto. The program focuses on the assessment, diagnosis, triage, and independent management of musculoskeletal- and arthritis-related disorders by allied health professionals. The program began in 2005 and has trained close to 40 graduates to date. The majority of graduates are working in arthritis care in a variety of settings in Ontario. The program has been recognized nationally and internationally and has had a positive impact on

the care of and satisfaction expressed by patients with arthritis, both directly and indirectly. Moving forward, there is interest in expanding this program to the national level.

The National Update ended with Dr. Earl Silverman, a pediatric rheumatologist from the University of Toronto. He presented a commentary on novel therapies for the management of sJIA, particularly focusing on tocilizumab (IL-6 inhibitor) and canakinumab (IL-1 inhibitor). Randomized controlled trials for both agents in sJIA showing efficacy over placebo were published in the New England Journal of Medicine in December 2012; long-term safety data is needed. These therapeutic agents are very expensive and the cost of therapy may be a major barrier to access.

This year's National Update was another success. I am sure others share my pride in the depth and quality of work being produced by our Canadian rheumatology colleagues.

Shahin Jamal, BScPT, MD, FRCPC, MSc
Rheumatologist, Vancouver General Hospital
Vancouver, British Columbia

That's Debateable: The 2014 Great Debate

By Stephanie Ensworth, MD, FRCPC; on behalf of Vivian Bykerk, MD, FRCPC; Susan Humphrey-Murto, MD, FRCPC, MEd; Shahin Jamal, BScPT, MD, FRCPC, MSc; and Stephanie Keeling, MD, MSc, FRCPC

The 2014 CRA Great Debate was a standing-room-only event, attended by almost all of the adult and pediatric physician and Arthritis Health Professions Association (AHPA) attendees of the 69th CRA Annual Scientific Meeting (ASM) and accompanied by many partners, spouses, and friends. It did not disappoint! It was a terrific debate loaded with clever humour and spoofs, as well as excellently presented didactic, scientific, and educational material right up to the surprise spectacular finale!

The topic of this year's Great Debate was "Be it resolved that we are doing too much monitoring of DMARDs and biologics and doing too much screening before initiating biologic therapy." From the East came Dr. Vivian Bykerk from the University of Toronto and Dr. Susan Humphrey-Murto from the University of Ottawa. Representing the West were Dr. Shahin Jamal from the University of British Columbia and Dr. Stephanie Keeling from the University of Alberta. The team from Eastern Canada argued for the proposition, while the team from Western Canada argued against the statement.

There have been only a few, scattered CRA Annual Great Debates that have included female rheumatologists as debate participants. The 2004 Great Debate featured the first all-female debate of Dr. Claire Bombardier and Dr. Alice Klinkhoff versus Dr. Dianne Mosher and Dr. Janet Pope, all highly respected and highly regarded Canadian rheumatologists. For a trip down memory lane, their debate topic was "Be it resolved that gold is an outdated, impractical, and toxic therapy that no longer has a place in the therapeutic armamentarium for RA." Since that landmark Great Debate, there has been a dearth of female rheumatology debate participants. This year, 2014, marked the tenth anniversary of that historic 2004 all-female CRA Great Debate and we celebrated by the second ever all-female debate. Again, the participants were all highly respected and regarded Canadian rheumatologists.

The 2014 CRA Annual Great Debate was a rousing, heated, clever, entertaining, and educational event!

The Eastern Canadian team of Dr. Bykerk and Dr. Humphrey-Murto argued that we are doing too much monitoring of disease-modifying antirheumatic drugs (DMARDs) and biologics and too much screening before initiating biologic therapy with the presentation of five main points. Their first point was that demands on the Canadian healthcare system are high, yet resources are limited. A recent article[1] demonstrated a marked increase in the number of patients with rheumatoid arthritis (RA), yet no concomitant increase in the number of rheumatologists. The Choosing Wisely campaign (ABIM foundation)[2] has exploded as a direct result of the need to provide optimal yet efficient care. The team suggested that too much monitoring occurs, as evidenced by excessive monitoring for retinal toxicity of antimalarials[3] and methotrexate (MTX) bloodwork monitoring exceeding guidelines in Canada.[4] They also noted there is a lack of empirical evidence that monitoring changes outcomes. For example, increased liver enzymes occur in 50% of patients, yet are poorly predictive of histology and most enzyme elevations resolve without any dose adjustment.[5] Monitoring needs to be tailored to the individual patient, they emphasized. Patients with no other risk factors for liver toxicity can safely be monitored less frequently while receiving MTX. Lastly, the "For" team added a little humour by suggesting that too much monitoring may be the result of greater problems such as obsessive compulsive disorder or fear of litigation. Rheumatologists were reassured that they rarely were sued.

The Western Canadian team of Dr. Jamal and Dr. Keeling argued that we are not doing too much monitoring of DMARDs and biologics nor are we doing too much screening before initiating therapy. To begin, the team established that there is no good data regarding appropriate screening and monitoring of rheumatologic drug therapies. There are, however, clinical practice

The 2014 CRA Great Debate participants (left to right): Dr. Shahin Jamal, Dr. Vivian Bykerk, Dr. Stephanie Keeling, and Dr. Susan Humphrey-Murto.

guidelines, including recently published CRA guidelines on the management of RA,[6] based on available data and expert opinion that the team used as the basis of their argument. Survey results from practicing Canadian rheumatologists suggest most practice according to published guidelines. Consequences of insufficient monitoring include missing serious medication toxicity, the cost (both direct and indirect) of managing adverse events, and the risk of liability. Furthermore, rheumatologists do not have good data on appropriate monitoring of patients taking combinations of medications (rheumatologic and other). The team agreed with the Choosing Wisely campaign to provide optimal care but argued that, based on current available data, Canadian rheumatologists are doing the appropriate amount of monitoring. When using potentially toxic medications, the main goal is "do no harm." Perhaps liability rates in rheumatology are low because we are doing appropriate monitoring and therefore preventing harm.

The 2014 Great Debate ended with the Western team suddenly and surprisingly leading a Flash Mob dance; many in the audience rose from their seats and took part! The Flash Mob performed to a song by the Village People called "Go West" that the team renamed as "Vote West!" The Chair of the Debate, Dr. Stephanie Ensworth, discovered afterwards that Dr. Jamal and Dr. Keeling contacted all of the ASM attendees from Western Canada prior to the meeting, involving them in a clandestine plan for this Flash Mob. It was a stunning effort accomplished on the part of these two Western Canadian debate participants.

In the end, by rounds of applause, the audience chose the instigators of the Flash Mob and the against team of Dr. Jamal and Dr. Keeling as the winner of the 2014 Great Debate, just edging out the "For" team of Dr. Bykerk and Dr. Humphrey-Murto. A superb time was had by all.

References

1. Widdifield J, Patterson M, Bernatsky S, et al. The Rising Burden of Rheumatoid Arthritis Surpasses Rheumatology Supply in Ontario. Can J Public Health 2013; 104(7):e450-5.
2. ABIM foundation. Choosing Wisely. Available at: *www.chooseingwisely.org/*
3. Browning DJ. Impact of the revised American academy of ophthalmology guidelines regarding hydroxychloroquine screening on actual practice. Am J Ophthal 2013; 155(3):418-28.
4. Bykerk VP, Schieir O, Akhavan P, et al. Emerging Issues in Pharmacological Management of RA: Results of a National Needs Assessment Survey Identifying Practice Variations for the Development of CRA Clinical Practice Recommendations. J Rheumatol 2012 ;39(8):1555-8.
5. Visser K, van der Heijde DM. Risk and management of liver toxicity during methotrexate treatment in rheumatoid and psoriatic arthritis: a systematic review of the literature. Clin Exp Rheumatol 2009; 27(6):1017-25.
6. CRA Treatment Recommendations for RA. 2012. Available at: *www.rheum.ca/en/publications/cra_ra_guidelines*

Stephanie Ensworth, MD, FRCPC
Clinical Associate Professor, Division of Rheumatology,
University of British Columbia
Vancouver, British Columbia

on behalf of Vivian Bykerk, MD, FRCPC;
Susan Humphrey-Murto, MD, FRCPC, MEd;
Shahin Jamal, BScPT, MD, FRCPC, MSc; and
Stephanie Keeling, MD, MSc, FRCPC

AHPA in Whistler: 2014

By Leslie Soever, BScPT, MSc, ACPAC

The Arthritis Health Professions Association (AHPA) was pleased to join the CRA for the Annual Scientific Meeting in Whistler, British Columbia. This year featured our 6th annual pre-course for arthritis health professionals with 93 attendees. There was an excellent slate of speakers including Dr. Shahin Jamal (Biologics Update—What's New, What's Old, What's Coming); Dr. Maysan Abu Hakima (Update on Gout); Cheryl Koehn and Kelly Lendovy, Arthritis Consumer Experts (Patient Advocacy/Access Issues); and Dr. Linda Li, physiotherapist (Outcome Measures).

We presented a number of service and research awards. Terri Lupton received the Extraordinary Service Award, which recognizes contributions by an AHPA Board Member in advancing the mission, vision, and goals of our association. Terri has been tireless in her efforts related to the AHPA pre-course and deserves a lot of credit for it being such a success. She has been instrumental in securing funding as well as excellent speakers over the years. The pre-course is an excellent demonstration of interprofessional knowledge translation and sharing amongst arthritis health professionals across Canada.

The AHPA Clinical Innovation Award recognizes members who have designed and implemented an innovative clinical project or related initiative that benefits the lives of Canadians living with arthritis. This year's winners were Dr. Sydney Brooks-Lineker and her research team members, Dr. Elizabeth Badley, Dr. Mary Bell, Dr. Vernon Curran, Lisa Fleet, Fran Kirby, Dr. Peter Tugwell, Bob Glynn, and Anuj Charan for their project "Getting a Grip on Arthritis Online".

Through the generous support of The Arthritis Society (TAS), a $5,000 Research Award was presented to Judit Takacs for her work, "The Effect of Dynamic Balance Training and Physical Function in Those with Knee Osteoarthritis."

The Arthritis Research Foundation (ARF) also generously supported a $5,000 Movement and Mobility Award, presented to Gail Paterson for her research on "Pilot Test of a Pragmatic Randomized Control Trial of the OA GO AWAY, a Self-management Intervention to Promote Prescribed Exercise and Physical Activity for Patients with Knee and Hip Osteoarthritis."

The Carolyn Thomas Award was established in honour of Carolyn Thomas, a founding member of AHPA who supported research. It is given to the first author of the year's best scientific abstract. The recipient was Dr. Susan Bartlett for her research "Assessing Significant Flares in Rheumatoid Arthritis: Validity of the Outcome Measures in Rheumatology Preliminary Flare Questions in the Canadian Early Arthritis Cohort".

The Barbara Hanes Memorial Award was established in honour of her work as an Occupational Therapy Director at TAS, Ontario Division, and her contributions as a teacher and a contributing author to the rheumatology textbook *Physical Therapy in Arthritis*. This award was issued to Sabrina Cavallo for her research entitled "Predictors of Leisure Participation in Children and Youth with Juvenile Idiopathic Arthritis". Sabrina Cavallo also received the Best Trainee Abstract for the same research.

Congratulations to all AHPA award winners and thank you for your excellent work! I would also like to thank all members of the AHPA Board and regional representatives for their dedication and efforts in the ongoing work of AHPA.

Top: Terri Lupton receiving the Extraordinary Service Award. Middle: Judit Takacs receiving the TAS Research Award. Bottom: Gail Paterson receiving the ARF Movement and Mobility Award.

Leslie Soever, BScPT, MSc, ACPAC
President,
Arthritis Health Professions Association
Bolton, Ontario

CIORA: Research Successes and Future Directions

By Boulos Haraoui, MD, FRCPC

The Canadian Initiative in Outcomes of Rheumatology Care (CIORA) was created seven years ago to help support clinical research in rheumatology. It started as an initiative between Abbott and a group of core CRA members. It was based on the results of a survey of the CRA membership regarding the unmet need of funding small, clinically relevant projects. Indeed, no such structure existed; the only agencies one could apply to for research grants were the Canadian Institutes for Health Research (CIHR) and The Arthritis Society (TAS). The focus was on early access to rheumatology care, patient awareness, education, and multi-disciplinary approaches.

During the first three years, CIORA operated under an unrestricted grant from Abbott, which allowed the funding of several projects. With the huge success and the set-up of a CIHR-like review process under the guidance of Dr. John Esdaile, the CIORA steering committee decided to expand funding by enlisting other pharmaceutical companies. Currently, CIORA receives unrestricted funding from Abbvie, Amgen, BMS, Pfizer, Janssen, Roche, and UCB.

Three years ago, CIORA moved under the auspices of the CRA and became an official committee, managing a yearly budget of almost one million dollars. The yearly call for grant applications was completed last month and 24 projects were submitted; they are presently being assessed by a group of independent scientists and clinicians. The results were announced in mid-May.

Last year CIORA was able to fund 11 one-year and two-year projects. It also introduced the CRA(CIORA)/TAS Clinician Investigator Award in order to help young promising investigators start their career; it is managed by TAS. The first award was given to Dr. Cheryl Barnabe from the University of Calgary for her project entitled "Service Delivery Models for Triage and Targeted Treatment to Improve Patient and Health System Outcomes in Rheumatoid Arthritis".

The success of CIORA can also be measured over the years by the several oral and poster presentations of funded research projects at various medical meetings and conferences, as well as publications in peer-reviewed journals. You can view the listing by visiting the CRA website and clicking on the CIORA header (*www.rheum.ca/en/ciora/*).

CIORA still needs to grow in order to better fulfil one key component of the CRA's mission, namely research. While the topics eligible for funding were initially restricted to inflammatory arthritis (IA), we recognize the need to address the broader spectrum of diseases managed by rheumatologists.

Efforts will be deployed in the coming years to broaden the sources of funding, and collaborations will be sought with other organizations similar to our partnership with TAS.

I would like to acknowledge the tremendous administrative work done by the CRA staff, in particular Christine Charnock and Virginia Hopkins. I would like also to highlight the hard work of the Steering Committee members, Dr. Janet Pope, Dr. Carter Thorne, Dr. Michel Zummer, Dr. Alf Cividino, Dr. Maggie Larché, Dr. Regina Taylor-Gjevre, and Dr. Jamie Henderson. Finally, special thanks and gratitude to Dr. John Esdaile and all the reviewers who volunteer their time and expertise to this important task.

Boulos Haraoui, MD, FRCPC
Associate Professor of Medicine, Université de Montréal
Head, Clinical Research Unit in Rheumatology,
Centre hospitalier de l'Université de Montréal (CHUM)
Chair, CIORA Steering Committee
Montreal, Quebec

In the Beginning, it was Arthritis…

By Abdallah Alqethami, MD; and Christian Pagnoux, MD, MSc, MPH

A 20-year-old man presented with general fatigue for one month and migratory arthritis involving the metacarpophalangeal, proximal interphalangeal, elbow, and metatarsophalangeal joints associated with morning stiffness. He later showed bilateral eye redness and pain, and an ophthalmologist diagnosed bilateral iritis that rapidly improved with eye drops. The patient had no signs of urethritis and denied any prior episode of diarrhea. He had no significant personal or familial medical history. He never smoked and denied any alcohol or recreational drug use.

Laboratory investigations revealed hemoglobin level 123 g/L (normal, 140 g/L-180 g/L), leukocyte count 7.6x10^9/L (2.5x10^9/L-7.5x10^9/L), platelet count 491x10^9/L (150x10^9/L-400x10^9/L), erythrocyte sedimentation rate 33 mm/hr (< 15 mm/hr), C-reactive protein (CRP) level 86 mg/L (< 10 mg/L), serum creatinine level 66 µmol/L, alanine aminotransferase level 64 U/L (< 36 U/L) and alkaline phosphatase level 93 U/L (< 100 U/L). Rheumatoid factor (RF) was positive at 1:160. The patient was negative for antinuclear antibodies (ANA) and extractable nuclear antigens (ENA) as well as HIV and hepatitis B and C virus (HCV). Urine analysis gave normal results. Hand X-rays showed no erosions.

Diagnostic Work-up and Initial Management

The patient first sought medical care in a walk-in-clinic one month after the onset of the joint symptoms. He was given naproxen, which was initially helpful. After bilateral iritis developed, he was tested for anti-cyclic citrullinated peptide (anti-CCP) antibodies and HLA-B27, but both were negative. X–rays of the sacro-iliac joints were normal; however, because of the persistent arthritis, methotrexate (MTX) was started, with a working diagnosis of early rheumatoid arthritis (RA).

In the absence of anti-CCP antibodies, the diagnosis of early RF-positive RA was debatable. RF is not specific. Transient positivity can occur in patients with hypergammaglobulinemia or infections, including HCV infection or more sustainably, those with cryoglobulinemia or other autoimmune conditions with high titres of other auto-antibodies, such as anti-smooth muscle (autoimmune hepatitis) or antineutrophil cytoplasmic antibodies (ANCA). Almost all of these latter conditions can start with non-specific polyarthritis. Iritis is not a common symptom in ANCA-associated vasculitis but is found in a few patients. Hence, reactive spondyloarthropathy could still be considered in this patient, which was not ruled out by the absence of HLA-B27.

However, one month later, cyanotic discolouration of the toes developed with numbness and tingling in the hands (in the right ulnar and both median nerve distributions), lateral side of the legs, and dorsum of the feet, mainly around the right medial malleolus; there was similarly weakness in hands and in the left big toe extensors. Electromyography with nerve conduction study confirmed the diagnosis of mononeuritis multiplex. At that time, the serum creatinine level had increased to 220 µmol/L, with blood 4+ and protein 3+ on urine analysis, and CRP level 86 mg/L. Chest X-rays were normal.

The clinical and biological findings no longer favoured RA or spondyloarthropathy, but more likely a medium-sized vessel vasculitis (*i.e.,* polyarteritis nodosa) or small-sized vessel vasculitis (such as an ANCA-associated vasculitis [AAV]). The presence of renal involvement with hematuria and proteinuria in the absence of high blood pressure suggested AAV more than polyarteritis nodosa. The presence of erythrocyte casts in the urine, suggestive of glomerulopathy (as opposed to an ischemic renal

RA Guidelines: Practice Patterns of Rheumatologists in Canada Compared to the CRA Recommendations for RA (Part V)

By Sankalp V. Bhavsar, MD, FRCPC; on behalf of Carter Thorne, MD, FRCPC, FACP; Claire Bombardier, MD, FRCPC; Vivian P. Bykerk, MD, FRCPC; Glen S. Hazlewood, MD, FRCPC; Pooneh Akhavan, MD, FRCPC; Orit Schieir, MSc; and Sanjay Dixit, MD, FRCPC

In this installment, we present the results of survey questions pertaining to peri-operative care, treatment of latent tuberculosis infection, and vaccinations

1. A patient with rheumatoid arthritis (RA) is maintained on adalimumab and methotrexate (MTX). She is scheduled for elective cholecystectomy. Regarding peri-operative management of adalimumab, you would suggest:

Answer: Hold at least one dose of adalimumab pre-operatively and resume post-operatively if there is no evidence of infection and adequate wound healing has occurred.

Recommendation/supporting evidence: American College of Rheumatology (ACR) 2008,[1] Spanish Society of Rheumatology (SER) 2010.[2]

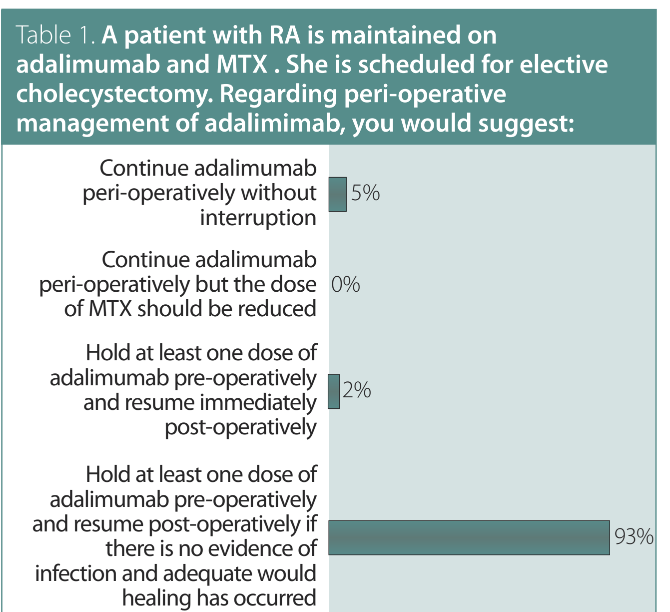


Table 1. **A patient with RA is maintained on adalimumab and MTX . She is scheduled for elective cholecystectomy. Regarding peri-operative management of adalimimab, you would suggest:**

Both ACR 2008[1] and SER 2010[2] guidelines referred to the same three cohort studies that examined risks for postoperative infections in RA patients treated with anti-tumor necrosis factor (TNF) agents. The largest retrospective cohort study of 768 RA patients underwent 1,219 elective orthopedic procedures and reported nonsignificant increased odds ratios (OR) for surgical site infections in patients who continued anti-TNF therapy (OR 1.5, 95% CI 0.43–5.2). In that study, surgical site infections were observed in 41/1,023 (4%) patients who did not use anti-TNF, 6/104 (5.8%) patients that stopped anti-TNF therapy (for > 4 half-lives), and 8/92 (8.7%) patients that continued anti-TNF therapy. A retrospective cohort study of 91 RA patients who underwent orthopedic surgery reported a higher incidence of peri-operative infections in patients treated with anti-TNF therapy relative to patients who were not treated with an anti-TNF (OR 5.3, 95% CI 1.1–24.9). A small prospective cohort of 31 RA patients who underwent orthopedic surgery did not report a significant increase in post-operative infections or healing complications associated with anti-TNF therapy.[1,2]

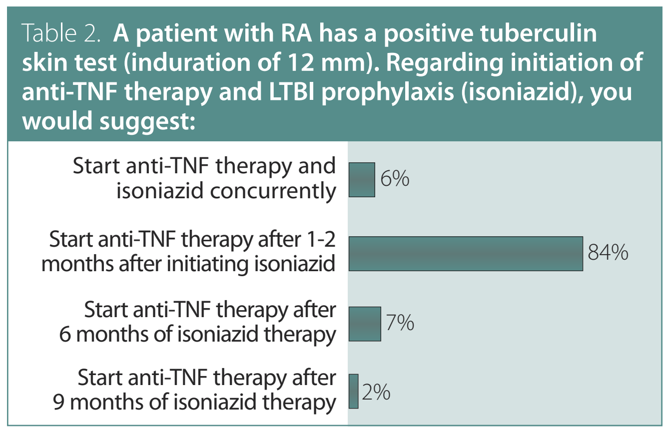


Table 2. **A patient with RA has a positive tuberculin skin test (induration of 12 mm). Regarding initiation of anti-TNF therapy and LTBI prophylaxis (isoniazid), you would suggest:**

2. A patient with RA has a positive tuberculin skin test (induration of 12 mm). Regarding initiation of anti-TNF therapy and latent tuberculosis infection (isoniazid), you would suggest:

Answer: Start anti-TNF therapy one to two months after initiating isoniazid.

Recommendation/supporting evidence: Furst 2010.[3]

Furst[3] reviewed observational evidence from Spain, which showed that RA patients who screened positive for latent tuberculosis infection (LTBI) and were treated with anti-TNF therapy following one month of tuberculosis (TB) prophylaxis had a significantly reduced risk of TB reactivation.

3. Which of the following statements regarding vaccinations in RA is false?

Answer: Herpes zoster (HZ) vaccine can be safely administered in patients 60 years or older receiving anti-TNF therapy.

Recommendation/supporting evidence: European League Against Rheumatism (EULAR) 2011,[4] the Canadian Immunization Guide 2006,[5] and US Centers for Disease Control and Prevention (CDC) 2011.[6]

Evidence for the recommendation was based on results of a recent systematic review undertaken to inform EULAR 2011 recommendations for patients with autoimmune inflammatory rheumatic diseases.[4]

Influenza. One observational study showed a reduction in infections at one year in 34 patients with RA who received influenza vaccine, compared to 20 patients who did not (instances of acute bronchitis were 22.6% vs. 4.3%, respectively; viral respiratory infections 61.3% vs. 8.7%). Two other observational studies also found a reduction in hospital admissions and mortality from influenza and pneumonia in elderly patients with rheumatic diseases who received the influenza vaccine.

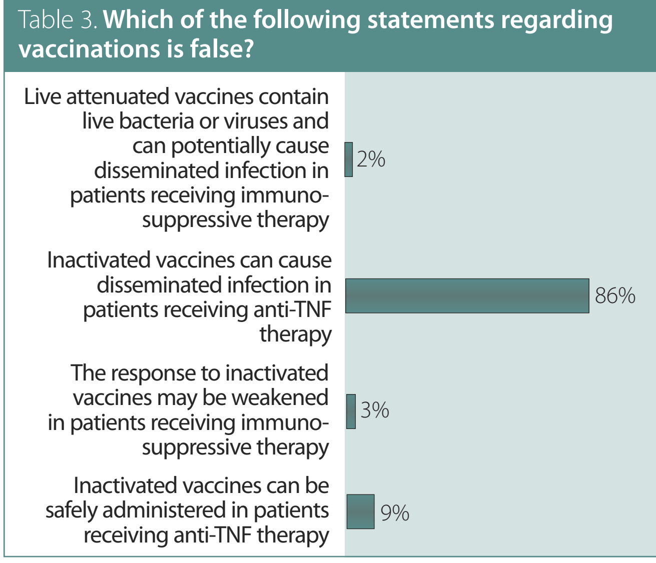


Table 3. **Which of the following statements regarding vaccinations is false?**

HZ. An increased risk of HZ has been reported in RA patients compared to healthy population controls from two administrative databases (adjusted hazard rate ratios 1.7 and 1.9, respectively). In addition, treatment with glucocorticoids, azathioprine, leflunomide, and anti-TNF was associated with increased risks of HZ.

In general, immunocompromised persons should not receive live vaccines because of the risk of disease caused by the vaccine strain. However, literature suggests that HZ vaccine can be safely administered to patients on low-dose immunosuppression, and it is reasonable to consider HZ vaccine in individuals receiving such therapy (*e.g.*, MTX ≤ 0.4 mg/kg/week). The 2014 publication of the Canadian Immunization Guide[5] states that it is reasonable to consider HZ vaccine in patients receiving anti-TNF biologics on a case-by-case basis after review with an expert in immunodeficiency. Retrospective data demonstrates the safety of HZ vaccine in people receiving anti-TNF therapy for inflammatory conditions. However, the current CRA recommendation is to avoid HZ vaccine in patients receiving biologic therapy.[6]

For further information on these recommendations and the supporting evidence of these results, please consult the CRA RA Guidelines document, available at *www.rheum.ca/en/publications/cra_ra_guidelines*.

References
1. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis [review]. Arthritis Rheum 2008; 59(6):762-84.
2. Spanish Society of Rheumatology. Update of the Consensus Statement of the Spanish Society of Rheumatology on the management of biologic therapies in rheumatoid arthritis. Rheumatol Clin 2010; 6(1):23-36.
3. Furst DE, Keystone EC, Fleischmann R, et al. Updated consensus statement on biological agents for the treatment of rheumatic diseases 2009. Ann Rheum Dis 2010;69 Suppl 1:i2-29.
4. van Assen S, Agmon-Levin N, Elkayam O, et al. EULAR recommendations for vaccination in adult patients with autoimmune inflammatory rheumatic diseases. Ann Rheum Dis 2011; 70(3):414-22.
5. National Advisory Committee on Immunization. Canadian Immunization Guide: Public Health Agency of Canada; 2006 and 2014. Available at *www.phac-aspc.gc.ca/publicat/cig-gci/*.
6. Centers for Disease Control and Prevention. General recommendations on immunization - Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2011; 60(2):1-64.

Sankalp V. Bhavsar, MD, FRCPC Vasculitis Fellow, McMaster University, Hamilton, Ontario

on behalf of Carter Thorne, MD, FRCPC, FACP; Claire Bombardier MD, FRCPC; Vivian P. Bykerk, MD, FRCPC; Glen S. Hazlewood, MD, FRCPC; Pooneh Akhavan, MD, FRCPC; Orit Schieir, MSc; and Sanjay Dixit, MD, FRCPC

Indications and clinical use

- SIMPONI® I.V., in combination with methotrexate, is indicated for the treatment of adults with moderately to severely active rheumatoid arthritis
- Specific studies of SIMPONI® I.V. in pediatric patients have not been conducted
- Caution should be used when treating the elderly as there is a higher incidence of infections in this population

Contraindications

- Severe infections such as sepsis, tuberculosis and opportunistic infections
- Moderate or severe (NYHA class III/IV) congestive heart failure
- Hypersensitive to golimumab or any other ingredient in the formulation or component of the container

Most serious warnings and precautions

- **Serious infections leading to hospitalization or death:** sepsis, tuberculosis, invasive fungal infections and other opportunistic infections have been observed with SIMPONI® I.V.
  - Treatment should not be initiated in patients with active infections, including chronic or localized infections
  - Treatment should be discontinued if a patient develops a serious infection or sepsis
- **Recurring/latent infections:** including tuberculosis, or with underlying conditions which may predispose patients to infections, or who have resided in regions where tuberculosis and invasive fungal infections are endemic
- **Tuberculosis (from reactivation or latent tuberculosis infection or new infection):** has been observed in patients receiving TNF-blocking agents
  - Before starting treatment, all patients should be evaluated for both active and latent tuberculosis
  - If latent tuberculosis is diagnosed, start with anti-tuberculosis therapy before initiation
  - Monitor for signs and symptoms of active tuberculosis
- **Lymphoma and other malignancies:** some fatal, have been reported in children and adolescent patients treated with TNF-blockers

Other relevant warnings and precautions

- Risk of bacterial, mycobacterial, invasive fungal and opportunistic infections, including fatalities
- Risk of hepatitis B virus reactivation
- Risk of malignancies, including lymphoma, leukemia, non-lymphoma malignancy, colon dysplasia/carcinoma and skin cancers
- Risk of worsening or new onset of congestive heart failure
- Concurrent use of Anakinra or Abatacept is not recommended
- Concurrent use with other biologics is not recommended
- Risk of pancytopenia, leukopenia, neutropenia, aplastic anemia and thrombocytopenia
- May affect host defenses against infections and malignancies
- Risk of allergic reactions
- Concurrent use with live vaccines/therapeutic infectious agents is not recommended
- May result in the formation of autoantibodies
- Risk of new onset or exacerbation of central nervous system (CNS) demyelinating disorders
- Closely monitor patients who have undergone surgical procedures for infections
- Contraception recommended in women of childbearing potential; and for 6 months after last treatment
- Use with caution in subjects with impaired hepatic function
- May influence the ability to drive and use machinery

For more information

Please consult the product monograph at http://www.janssen.ca/product/579 for important information relating to adverse reactions, drug interactions and dosing information which have not been discussed in this piece.

The product monograph is also available by calling 1-800-387-8781.

Reference: SIMPONI® I.V. Product Monograph, Janssen Inc., November 28, 2013.

All trademarks used under license.
© 2014 JANSSEN Inc.
19 Green Belt Drive
Toronto, ON M3C 1L9
www.janssen.ca

PAAB Member R&D

SIJA140023E

For the treatment of RA

New

SIMPONI® I.V.

Administered in 3 hours total per maintenance year

Given as a **30-minute I.V. infusion** at
Weeks 0 and 4, then every 8 weeks thereafter

RA=rheumatoid arthritis; I.V.=intravenous.

XELJANZ™ ['ZEL-janz]

noun:

1. Tofacitinib citrate

2. Now available
in Canada

Talk to your Pfizer representative to learn more.

XELJANZ TM PF Prism C.V., owner/Pfizer Canada Inc., Licensee

® Pfizer Inc., used under license
© 2014 Pfizer Canada Inc., Kirkland, Quebec H9J 2M5

Member R&D