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# CRAJ SCR

The Journal of the Canadian Rheumatology Association

## *Spotlight on:* The CRA ASM



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I have rheumatoid arthritis. But I didn't want that to stop me from having a busy life.

When it comes to choosing an RA treatment, it's true that everyone's different. Some prefer a subcutaneous treatment, while others may find an I.V. medication a suitable choice.

As a shift worker, I looked at my schedule and discussed it with my doctor before choosing a treatment option. It was good to know that I had options – and to talk about them – before choosing a therapy.

– **Jim, Fork Lift Operator***
Has had RA for 5 years; currently on I.V. medication.

* Based on a real patient. May not be representative of all patients.



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# Together We Will Stand

By Philip A. Baer, MDCM, FRCPC, FACR

**"I am strong when I am on your shoulders / You raise me up to more than I can be."**
- Josh Groban, "You Raise Me Up" (lyrics by Brendan Graham), *Closer*, 2003.

The desire to pass along one's acquired knowledge is always a strong one. Why not help others benefit from your experience, and avoid any of your mistakes? Of course, some of the best lessons are learned from making errors, and the world changes constantly, making your personal experience sometimes irrelevant to those who follow, but still the mentoring impulse is strong. "See one, do one, teach one" was the mantra during my medical training, and still carries some resonance.

Dr. Baer and Dr. Stephanie Gottheil meeting at the 2015 ASM.

I recall volunteering for very few extra activities during medical school, but I did co-edit a guide for first-year medical students traditionally put out by second year students. The edition I participated in was entitled "You Asked For It." In my fourth year, I volunteered again as a mentor to a small group of first-year students. One of my mentees was David Williams, who went on to fame as a Canadian astronaut. I take no credit for his success, but the mentoring experience was very positive overall.

Increasing the supply of future rheumatologists is a core activity for all our Canadian rheumatology organizations, from the CRA to The Arthritis Society (TAS). Personally, I have a vested interest in this as well. With a mature busy practice, it becomes more and more difficult to absorb the patients of retiring rheumatologists in my vicinity. Patients in need are accommodated, but not always easily. In Scarborough, where I practice, the referral base is on the order of 600,000 people, currently served by one rheumatologist in his eighties, four in their fifties, and one each in their thirties and forties. The three communities immediately east of us have 300,000 more people, with only one part-time rheumatologist servicing them.

So, anything I can do to encourage future doctors to become rheumatologists, I will sign up for! For CRA ASM 2015, I was invited, as were all Canadian rheumatologists, to mentor someone attending the meeting for the first time. I was thrilled to accept.

I am not superstitious, but I also find serendipity and coincidences to be positive omens. Thirty-five rheumatologists and prospective mentees were paired up for the inaugural program; when I received the name of my partner in this match, Dr. Stephanie Gottheil, I was pleasantly surprised to find that we already had a connection. I had attended college with her mother, and she had attended the same small school as my two sons. Small world!

The mentoring program was left quite informal. Dr. Gottheil and I met at the first plenary, and later at a poster I presented. We had a chance to discuss all the positives of a rheumatology career, which I am sure Stephanie observed for herself at our meeting, one of the most dynamic and educational ever. You can read more about it in this issue of *CRAJ*.

I also engaged in some unplanned mentoring on the flight from Toronto to Quebec City. By chance, I was seated with Liza Abraham, a second year medical student at the University of Toronto who was presenting a poster at her first CRA meeting. We struck up a conversation, and I hope it may positively influence her career choice as well. Her impressions of the CRA meeting are also highlighted in this issue of *CRAJ* (see page 23).

Mentors and mentees were surveyed after the meeting, and impressions on both sides were very positive. The mentoring program will run again at future CRA ASMs, and I highly recommend getting involved—the future of our specialty literally depends on it.

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

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# AWARDS, APPOINTMENTS, ACCOLADES

Dr. Earl Silverman was the 2014 recipient of the Excellence in Investigative Mentoring Award bestowed by the American College of Rheumatology (ACR). This honour recognizes his outstanding contributions and ongoing mentorship in the Division of Medicine at the University of Toronto. In his role within the mentorship program Dr. Silverman oversees trainees in their academic pursuits, guiding them towards academic productivity and success. "The longer I work in this capacity, the more mutually beneficial the role becomes," Dr. Silverman asserts. His contributions are tremendous: the program counts over 100 successful trainees from international institutions; notably, more than 50% of the fellows hold academic appointments.

When the Division began, Dr. Silverman's position was more research oriented. As the Division expanded, so too did his role, evolving into one deeply rooted in mentorship and guidance. "I would like to give especial thanks to Dr. Ronald Laxer, who was my partner in starting the Division", Dr. Silverman notes, "as well as Dr. Rayfel Schneider, who was initially responsible for trainees, and who graciously supported my own transition into the role of mentor."

Dr. Mala Joneja of Queen's University, in Kingston, Ontario, was awarded a 2015 Certificate of Merit from the Canadian Association of Medical Education (CAME). The Certificate of Merit is awarded to recognize and reward faculty for their contributions to medical education at Canadian medical schools. Dr. Joneja's contributions include promoting excellence in the training of future rheumatologists, as well as providing guidance and support for international medical graduates.

Dr. Joneja is also the recipient of the Associate Medical Services (AMS) Phoenix Project Fellowship (2012-2014). Her work with the AMS Phoenix Project highlights the use of critical-incident narratives during residency training to promote the development of compassionate physicians.

Dr. Linda Kwakkenbos is a post-doctoral Fellow at McGill University and Co-Director of the Scleroderma Patient-centered Intervention Network (SPIN). After the 2012 completion of her PhD in Social Science at Radboud University, in the Netherlands, Dr. Kwakkenbos started working with Dr. Brett Thombs at McGill University. She initially coordinated the SPIN project, and was later named Co-Director. SPIN is an international collaborative team of researchers, clinicians, and individuals with scleroderma devoted to developing and implementing patient-centered care that targets important issues related to quality of life and well-being among people with scleroderma. SPIN is currently recruiting 2,000 patients with scleroderma for an ongoing cohort, which will provide the infrastructure for rehabilitation, educational, and psychological intervention trials.

Dr. Kwakkenbos recently received the prestigious Banting Post-Doctoral Fellowship from the Canadian Institutes of Health Research (CIHR) to continue her work in scleroderma and to expand the novel cohort trial concept to rare diseases more broadly.

## AWARDS, APPOINTMENTS, AND ACCOLADES

*The Journal of the Canadian Rheumatology Association (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.

# 2015 Distinguished Rheumatologist: Dr. Carter Thorne

**1. Why did you become a rheumatologist?**

My first six months as a "straight intern" in medicine included two months on the rheumatology service at Wellesley Hospital, where Dr. Metro Ogryzlo, that "giant" of a man, was chief of Service; he was also head of the Division of Rheumatology at the University of Toronto. Dr. Ogryzlo was an exceptional man—thoughtful, compassionate, and saw not only the trees in the forest, but the forest in the country-side.

In addition, I was influenced by the other remarkable individuals who have influenced so many others, as well—Dr. Murray Urowitz, Dr. Hugh Smythe, Dr. Dafna Gladman, and Dr. Peter Lee. I also had the privilege of meeting and getting to know Mr. Edward Dunlop.

Another huge influence was the patients—the hunt was on to become part of this program, this journey…

**2. What or who influenced you along the way to do so?**

- For rheumatology as a specialty: Dr. Ogryzlo.
- For learning how to observe and count: Dr. Gladman, Dr. Smythe, and Dr. Urowitz.
- For learning about kids with arthritis: Dr. Abraham Shore.
- For teaching me about teams and the value of patient education: the Allied Health Professions staff at Wellesley RDU, especially Ros, and my two consecutive years working with them.
- For research support and encouragement: Dr. Gladman, Dr. Edward Keystone, Dr. Inman, Dr. Bombardier, Dr. Boulos Haraoui, and Dr. Pope.
- For becoming involved: Dr. Smythe, who appointed me Chief Fellow, even though I had declared that I was not inclined to the academic stream; Dr. Bill Vail, General Surgeon from Newmarket—who was President of the Ontario Medical Association (OMA) when I was first a Professional Association of Interns and Residents of Ontario (PAIRO) representative to OMA—for telling me about Newmarket, and encouraging me to apply; and Dr. Paul Davis, who had the vision to change the format and direction of the CRA and who championed the inclusion of community members in the executive of this re-born CRA.
- For counsel, advice and support: Mr. Denis Morrice.
- For my colleagues, who were always there to help whenever I had another idea. My patients for their patience.
- My wife, Jena, and our children Sarah and Daniel, who survived my long practice hours, endless meetings, and unexpected absences.

**3. What do you believe are the qualities of a distinguished rheumatologist?**

- Respected by his peers.
- Contributes to the rheumatology community through participation in education, professional organization, research, advocacy, and/or patient care.
- A "go-to" person, for care, education, and sharing.

**4. You have served in leadership roles within the CRA, the ORA, PANLAR, and as a member of the York Region District Health Council. How do you feel your work in these organizations has helped shaped the field of rheumatology in Ontario?**

Those who desire to make a meaningful difference must

look beyond their immediate environs to appreciate what indeed may be achieved. Working with different groups, interconnected as health planners, payers, and providers allows one to more easily consider and appreciate the opportunities for convergence, integration, and keeping the long view in clear focus. Clinicians are well placed to consider the latter, as we are the only ones, of those previously mentioned, who will see the fruit born of these labours.

Concepts of treat-to-target (T2T), Models of Care (MoC), and systematic musculoskeletal (MSK) assessment reflect principles that have provided a framework and platform to advocate for best practices to ensure best outcomes.

**5. What do you love most about living in Ontario?**
The seasons passing, the range of landscapes (the cottage), the opportunities, the multi-ethnicity, the shared values, and new concepts.

**6. Given your extensive work in the field of rheumatic diseases, where do you anticipate clinical research moving within the next decade?**
The time of randomized control trials (RCTs) is past—not for drug development, but as the source of knowledge of best practices. The development of clinical cohorts, such as Canadian Early Arthritis Cohort (CATCH), Ontario Biologics Research Initiative (OBRI), Spondyloarthritis Research Consortium of Canada (SPARCC), and Canadian Scleroderma Research Group (CSRG), will provide us with valuable insights as to what may make a difference in clinical care and outcomes. However, the next step will be the development and maturation of robust practical trials utilizing these cohorts and investigators to direct our care to notions of enhanced adherence, patient engagement, and continuous improvement.

**7. If you could live in any other time period in history, what era would you inhabit?**
This has been the **best** time for our profession!

**8. What is the greatest professional and organizational challenge you have faced, and how did you address/overcome this challenge?**
Professionally, it would be maintaining the concept and integrity of The Arthritis Program (TAP) at Southlake Regional Health Centre, in Newmarket. Despite its

Photo courtesy of Dr. Fred Doris, 2015.

Dr. Thorne, looking every bit the Distinguished Rheumatologist.

successes and accolades (by patients, administrators, accreditors, universities, Ministry of Health, and peers), we still face challenges, not least of which is the lack of recognition of interprofessional care, not as an add-on or "extra" but as essential to the outcome success of our patients.

From an organizational perspective, engaging the CRA to consider a new sponsorship model to ensure transparency and sustainability of the organization, and an evolution to a new administration and governance framework. This responsibility has been very ably assumed by Dr. Cory Baillie.

**9. What do you feel is your lasting legacy within the rheumatology community?**
The blurring of "town and gown" ensuring that those who work in the trenches have a voice at the table. I am attentive to the role of good clinical care in addition to thoughtful and optimal use of medications that can ensure best outcomes. Finally, the value I place on interprofessional MoC in caring for our patients.

**10. I never anticipated that** I would be so blessed with my decision to enter the field of rheumatology... until it happened. This has resulted in much success in team building, research, advocacy, and professional growth.

**11. What changes to the landscape of rheumatology have you witnessed over the course of your career?**

The evolution from RCTs as the arbiters of care and practice to the role of clinical cohorts—being more reflective of our patients and our practice—in guiding us towards best practices.

**12. How do you envision the landscape changing before you retire from service?**

That more clinicians will accept that they can combine research with clinical care and improve their practice at the same time.

Possibly the concept of "bundling" rheumatology care, as has been done to an extent in cancer care, implying a responsibility for the envelope of costs associated within our scope of practice.

**13. In 2013 you were awarded the Queen's Diamond Jubilee Medal; what did this honour mean to you?**

I was nominated for this recognition by Janet Yale at The Arthritis Society (TAS). This represented two separate but connected successes: the first, organizational, reflecting the renewed rapprochement and commitment of the CRA and TAS to work to our strengths, for our common goals; and second, the recognition of a valued member of the arthritis community, who was not my professional colleague.

**14. If you could invent a gadget, what would it be and why would we need it?**

Teleporter: save travel time!

*Photo courtesy of the CRA, 2015.*

Dr. Thorne receiving his Distinguished Rheumatologist Award from Dr. Baillie.

**15. You are known for rapidly mobilizing the rheumatology community in response to crises arising out of "left-field", such as the withdrawal of naproxen suspension, issues surrounding antimalarial eye monitoring, and Health Canada warnings about methotrexate drug interactions. How have you been so successful in getting action on these files?**

Identifying the leverage points, the responsible parties and who can make the decision. The need must be real and easily identified. It helps to ensure that there is "natural justice" to the endeavour, and that any member of the general community could identify the merit of the exercise. I would be remiss if I did not identify the major role that Mr. Morrice has played in our successes. He has worked tirelessly on behalf of patients and our members; he has kept the door ajar as we doctors attend to our other professional imperatives, and he has kept us honest, if we should waiver from our argument.

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

My cottage: comfortable, familiar, full of memories, and I'm able to share with family and friends.

**17. What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges?**

Ongoing fiscal constraints will limit our access to new therapeutics. Thus, as individuals and as a community we must make a commitment to husband our resources, engage our patients, share our care responsibilities (with allied health professionals), and measure and share our experience and knowledge.

**18. What was your first paid job?**

As a paper boy for the *Toronto Star*, when I was ten to 13. I used the money earned to buy my wife's engagement ring (it was not very large!).

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

# 2015 Distinguished Investigator: Dr. Hani El-Gabalawy

**1. You have mentioned that your mentors at McGill University influenced your interest in rheumatology. With hindsight, what have been the most rewarding aspects of going into the field of rheumatology, and what have been some of the more challenging aspects?**

For me, the most rewarding aspects of rheumatology have been, firstly, establishing long-term therapeutic relationships with patients, and observing the impact of clinical decisions on their life trajectory. This has been a source of great satisfaction, while at times teaching me important lessons in humility. Secondly, being part of the targeted therapies revolution in rheumatology has been exhilarating for me, as it has been for all rheumatologists. We have led the way in targeted biologic therapeutics and in linking treatment to disease mechanisms. Many other disciplines have been indebted to ours for their progress in therapy. All over the world, the rheumatology community is populated by nice people who collaborate well together and who value each other. Finally, it has been a privilege to work at an academic centre with a steady flow of young minds that are eager to make a difference.

As far as challenging aspects I would say being overshadowed by disciplines with larger, often higher-earning, medical communities. This also applies to their scientific communities, for "it's just arthritis after all…" Rheumatologists have had to collectively deal with this "we just don't get any respect" phenomenon for as long as I can remember. The biologic revolution has helped us a great deal in this respect. For more than a decade, rheumatology as a discipline has struggled to recruit the best young minds and talents into the field, but I believe this is finally changing.

**2. You mentioned in 2011 the possibility of maybe one day developing a vaccine for rheumatoid arthritis (RA). Has your research led you any closer to such a possibility?**

We are tantalizingly close to considering an RA vaccine, although there are several important considerations to such an initiative. I have already mentioned the need for a workable risk model. The second is having the biomedical research world bring us new insights into appropriately targeting the immune system in a highly specific, safe, and cost-effective way. Induction of immune tolerance has been the "holy grail" of this research, but it has been a tough nut to crack.

Another key challenge is having enough study subjects (power) to undertake prevention clinical trials. It is highly unlikely that we will have the ability to test several different strategies, so we need to carefully choose the studies we undertake.

Finally, we have begun to explore the ethical dimensions involved, through focus groups in the local communities. These have given us important insights into how individuals will potentially weight the risk of RA versus risk of prevention strategies.

**3. You have spent the past several years studying and providing care and treatment to First Nations people living with RA. What are some of the major breakthroughs you have had with your research? How has providing expert clinical care to treat this disease impacted these communities?**

Our research program, which is focused on RA and other rheumatic diseases in First Nations populations, has been

rewarding in many respects. It should first and foremost be acknowledged that this program would not have been possible without ten years of uninterrupted funding from the Canadian Institutes for Health Research (CIHR) for our project entitled *Early Detection of RA in First Nations*. We are truly privileged to have had this opportunity to undertake and sustain the project. As with all longitudinal cohort studies, stability of research funding is an essential ingredient. So what have we done with all this funding? Although we pride ourselves on our publication record—this being the "currency" of scientific research—arguably the most important "breakthrough" from our research has been bringing this population much closer to the prospect of disease prevention. We are now at stage where a substantial amount of translational research has provided us with a workable risk model for RA in First Nations patients, and we can begin to carefully consider the risks and benefits of various interventions that may in fact modify the probability of imminent disease onset.

From a clinical practice perspective, a key aspect of our research strategy in remote First Nations communities—such as Manitoba's St. Theresa Point and Norway House—has been bringing clinical rheumatology services to the communities in which the research is undertaken. We are particularly indebted to Dr. David Robinson for his provision of many of these services, and for engaging our rheumatology trainees in this program. Dr. Robinson is now developing new models of care for primary-care rheumatology services in these communities that rely on training local community-based healthcare providers and providing them with appropriate skills.

**4. If you had a theme song that played whenever you enter a room full of people, what song would it be?**
Jim Croce's *I Got A Name*.

**5. How does your research influence the clinical care of patients? Are there differences that you see in the way that MD researchers approach epidemiologic studies and health services research compared to PhD researchers?**
In my opinion, the best clinical research programs harness the strengths of teams that have both MD and PhD researchers. My 25-year interaction with my friend and colleague Dr. John Wilkins is a perfect illustration of this synergy.

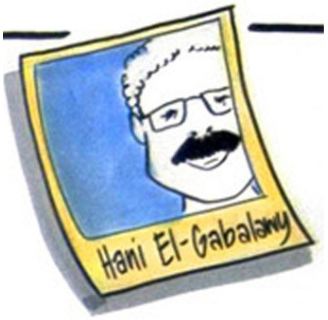
**6. If you could live in any other time period in history, what era would you inhabit?**
The classic period at the interface between ancient Egyptian and Greek culture, for this is a period that has profoundly influenced the course of mankind.

**7. What do you believe are the qualities of a distinguished investigator? Moreover, how do they apply to you?**
Passion, tenacity, and creativity are in my mind particularly important. I believe I embody these.

**8. How has your research in northern Manitoba contributed to the overall understanding of RA? How has it compared to the research conducted by similar teams in the United States and Europe?**
We have been fortunate to collaborate with some of the world's best researchers in this area. In particular, our collaborations with researchers at Leiden University in the Netherlands have been exciting and productive. In studying RA in First Nations and comparing our


Photo courtesy of Dr. Fred Doris, 2015.

Dr. El-Gabalawy standing guard over his investigative research content.




Graphics courtesy of Sara Heppner-Waldston, www.saragraffix.com, 2015.

The ever-animated Dr. El-Gabalawy in his Great Debate iteration.

Photo courtesy of the CRA, 2015.

Dr. Cory Baillie and Dr. John Esdaile presenting Dr. El-Gabalawy with his Distinguished Investigator Award.

findings to other populations around the world, we have the opportunity to examine key commonalities and differences, both of which are highly instructive. For example, we have studied the major HLA risk allele for RA in First Nations, that being HLA-DRB1*1402. This allele encodes for the "shared epitope" sequence, which is common to essentially all of the HLA risk alleles that have been identified in multiple populations. On the other hand, *1402, which is unique to Native American populations, encodes for other amino acids at a different part of the molecule that have been found to be protective for RA in other populations. Untangling this interesting paradox gives us important insights into both RA specifically in First Nations patients, and RA in general.

**9. Are there other areas of interest you would like to investigate in the future?**

Our lab at the University of Manitoba, named *The Manitoba Centre for Proteomics and System Biology*, is focused on applying new state-of-the-art proteomic technologies to the analysis of a spectrum of biological fluids. We are getting closer to being able to quantify the entire "proteome" in a similar manner to what has been achieved with the expressed genome (microarray). This is exciting as we apply it to serum samples before and after RA onset. We are also actively studying epigenetic changes in peripheral blood cells, such as lymphocytes, that may precede RA onset.

**10. If you could erase one day from history, which would it be?**

9-11.

**11. I never anticipated** leading an National Institute of Health (NIH) study in early arthritis ...until it happened.

**12. What was your first thought when you learned that you would receive this award?**

"What am I going to say to all my colleagues that would make it sound like I was actually worthy of this honour?!"

**13. What do you love most about living in Manitoba?**

Manitoba is a place where great accomplishments happen in an understated manner. Manitobans do not oversell their achievements.

*Hani S. El-Gabalawy, MD, FRCPC*
*Endowed Research Chair in Rheumatology,*
*Professor of Medicine and Immunology,*
*University of Manitoba*
*Winnipeg, Manitoba*

# 2015 Teacher-Educator: Dr. Andrew Thompson

**1. From where do you think your passion for medical education stemmed?**

I think I could probably develop a passion for almost anything that I enjoy. I have a passion for medical education because I enjoy it.

**2. Your methods of teaching and conveying information are described as "fun" and "different", often including humour and story-telling to help learners. From what or whom did you learn this approach to education, and why do you feel it is important to employ it?**

It is best to think of educating students from a marketing point of view. How do you think the marketers get us to buy things? They create something that catches our interest, keeps our interest, and makes us ponder it afterwards. Think of a memorable commercial or billboard—these are often memorable because they are either sexy, controversial, or funny. In essence, the marketers are awakening our emotions while they convey their message. Teaching is no different—you are a marketer of educational information, therefore you have to package and present the information in a way that awakens the learner's emotions. Humour is a good way to do this. Creating controversy and discussion is another. The "sexy" approach…not so good.

The other important aspect of conveying information is "less is more". It is not important to try to teach everything all at once. Use a layered approach. Build the cognitive scaffold and then start to shape it.

**3. What are your biggest pet peeves?**

Inefficiency and bureaucracy.

**4. What was your first thought when you learned that you would receive this award?**

I felt very humbled. There are so many great rheumatology educators to choose from and I felt honoured to have been chosen for this award.

**5. What was the inspiration for creating *rheuminfo.com* and *rheumtalks.com*? What is the most rewarding aspect of running the sites, and what is the most challenging aspect?**

*Rheuminfo.com* started in 2003 in Richmond, British Columbia. I had just started working with Dr. Kam Shojania and Dr. Barry Koehler. I came out of my office and asked them if they had an information sheet on methotrexate. At that time they did not, so I made one for our office. I then went on to make information sheets about other medications. Then I thought, "If we do not have these in our office, then what about other rheumatologists? I should share these online via a website." That is when *rheuminfo.com* was first born. Over the years I have learned loads about education both formally, through a Masters Degree, and informally gauging the use of information pamphlets in the clinical setting. This has changed the approach to conveying information to patients. *Rheuminfo.com* has grown beyond any of my expectations and it is now becoming more of a global resource. In January 2015 we had over 60,000 visitors to the site and the number continues to grow.

*Rheumtalks.com* began out of frustration with current online continuing medical education (CME). In the olden days we had these online CME programs that consisted of a one-hour video of a talking head. After five minutes I

would be bored out of my mind. Then I thought about *YouTube*. Most people can pay attention for three to five minutes to a *YouTube* video before they shut it down; I applied this philosophy to *rheumtalks.com*. Videos should be three to five minutes long. Each video is contained in a module that has a single learning objective. The users can pace themselves and do one or two modules at a time.

**6. What is something unexpected that has changed about you in the past few years?**

I am getting offered the senior's discounts at Shoppers and Rexall now…

**7. How do you find the time to manage a full-time academic rheumatology practice and also develop all of these educational tools?**

I do not find the time—I use my time to do these things because I thoroughly enjoy them. After 10 years in practice, I have finally stumbled upon my niche, where I fit best into the rheumatology community. My wife, Marlene, and our boys Callum and Duncan are also really supportive. It could also be that I am a little insane. My friends call me "100% Andy"; I am either full steam ahead or full stop. There is not much in between.

**8. If you had a theme song that played whenever you enter a room full of people, what song would it be?**

*Don't Stop Believin'*, by Journey.

**9. What changes to the landscape of rheumatology have you witnessed after creating these websites? What direction do you see yourself taking with the sites in the future?**

This is a great question. It reminds me of that interview question, "Where do you see yourself in five to 10 years?" It is not a favourite question of mine because so many opportunities present themselves and it is best not to plan too much. A better approach is to have a firm set of beliefs or principles by which you conduct yourself or your business, and then use these to guide your path. That was a long-winded answer to say that I have no idea where the sites will go in the future! This year we are moving *rheuminfo.com* onto a mobile platform to better deliver our content in the age of smartphones and tablets.

**10. If you could invent a gadget, what would it be and why would we need it?**

Sorry, I would need to have you sign a non-disclosure agreement to further discuss this question.

**11. What projects are you currently excited to be working on, and what projects would you like to undertake in the future?**

In the future I would love to create a full-fledged electronic medical record (EMR). The challenge with existing EMRs is that they are built on old technology and the user interfaces are not optimal. That is a huge project but infinitely interesting.

I am currently excited to be working on a new project called *clinicinfo.com*. *Clinicinfo.com* is a way to help us communicate more effectively and efficiently with our patients; it functions like a private banking website that a healthcare professional can place messages on for their patient. I have been using the system since September 2013. The system is now in 12 other medical clinics and is going really well; it really improves office efficiency. We are now looking at further expansion with potential commercialization.

*Photo courtesy of Dr. Fred Doris, 2015.*

In a blaze of coloured pixels, Dr. Thompson received his award from Ms. Janet Yale and Dr. Cory Baillie.


Photo courtesy of the CRA, 2015.

Dr. Thompson and Dr. Baillie: the future of Canadian curling!


Photo courtesy of the CRA, 2015.

Dr. Thompson, recipient of the 2015 Teacher-Educator Award from the CRA.

**12. If you could go bowling with any three people, dead or alive, who would you take and why?**
Marlene, Callum, and Duncan—that is a no brainer. If they were not available I would want to go with Steve Jobs, Warren Buffett, and Kevin Firko.

**13. If you could compete in the Olympics, which event would you participate in?**
Curling—I used to be a varsity curler at Western—it is true!

**14. If you could live in any other time period in history, what era would you inhabit?**
The future!

**15. Three things you think will become obsolete in 10 years:**
Newspapers, fax machines (maybe 20 years), and credit cards (phone pay systems).

**16. What do you love most about living in Ontario?**
I love the social aspect of Ontarians.

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

*Andy Thompson, MD, FRCPC, MHPE*
*Associate Professor of Medicine,*
*Division of Rheumatology,*
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# 2015 Young Investigator: Dr. Sindhu Johnson

**1. You had mentioned in an interview with The Arthritis Society (TAS) that it was your dream to become an arthritis medical specialist. What or who influenced you along the way to develop this dream?**

I have been lucky to have many individuals who have influenced my journey. Dr. Majed Khraishi was my neighbor in St. John's, Newfoundland, and he was the one to put the idea in my head.

During my training, I was inspired by some of the legends in academic rheumatology—Dr. Dafna Gladman, Dr. Murray Urowitz, Dr. Peter Lee, Dr. Arthur Bookman, Dr. Simon Carette, Dr. Rob Inman, Dr. Lori Albert, Dr. Cathy Dewar, Dr. Ed Keystone, Dr. Joan Wither, Dr. Adel Fam, Dr. Rachel Shupak, Dr. Louise Perlin, Dr. Laurence Rubin, and Dr. Heather MacDonald-Blumer. All of these individuals are so passionate about what they do; they are all very talented and love their job. I knew I wanted to be the same and work in this kind of environment. Dr. Gillian Hawker and Dr. Brian Feldman were my MSc and PhD supervisors, respectively. They are both brilliant people and set me on the research path of a clinical epidemiologist. Dr. Feldman taught me to view my research training as the process of collecting tools for a tool kit. When faced with a question from the clinic, there are a number of tools that can be used to find the answer. Together with Dr. Janet Pope and Dr. Claire Bombardier, these individuals currently mentor me as I transition to international collaborations. I am really glad to have my "epi" buddies in the Canadian rheumatology community, Dr. Shahin Jamal, Dr. Antonio Avina, and Dr. Marie Hudson. It is great to be able to talk about what we do, share ideas, and have fun when we see each other.

**2. Why did you decide to focus your investigation on scleroderma? What other diseases have you focused on?**

One of the reasons I love rheumatology is the opportunity to address multisystem disease, and scleroderma is the prototype. When I finished my clinical training, bosentan had just come to the market, with the potential to improve survival. I believe success begets success, so I could see that a number of exciting new therapies would become available during the course of my career. Scleroderma is now where rheumatoid arthritis (RA) was 15 years ago. It is an exciting time to be involved with scleroderma!

Since my doctoral work studied pulmonary hypertension in scleroderma, I am affiliated with the University Health Network (UHN) Pulmonary Hypertension Programme. As a result, my research has also focused on pulmonary hypertension in the rheumatic diseases, including scleroderma, systemic lupus erythematosus (SLE), RA, and mixed connective tissue disease (MCTD).

**3. What was your first thought when you learned that you would receive this award?**

Yippee! I was and continue to be thankful for this recognition.

I gave Christine Charnock a big hug. She has watched me "grow up" in rheumatology, and it was really nice to share that moment with her.

**4. What has been your proudest accomplishment in your research to date?**

My doctoral work was nominated by the Institute of Health Policy, Management and Evaluation (IHPME) at the University of Toronto for two separate awards. The Governor General's Gold Medal is awarded to the graduate student who has achieved the most outstanding academic record in the graduating class for the Doctoral degree. The Council of Graduate Schools/PROQUEST Distinguished Dissertation Award recognizes completed dissertations representing original work that makes an unusually significant contribution to the discipline. Although I did not receive either, I am proud that my work was considered.

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

*Bossy Pants* by Tina Fey. She is a great inspiration, making it to comedy's big league, *Saturday Night Live*, at a time where women were not considered capable comedians. The book is so funny and full of great life lessons. I laugh every time I read it.

**6. What are some of the hurdles that you have faced as a young, female MD researcher?**

There is still discrimination based on age and gender, which is really unfair and infuriating. I am still learning when to stand up and fight for justice, and when to keep quiet and accept it. Thankfully, grace and humour can go a long way in this regard.


Photo courtesy of Dr. Fred Doris, 2015.

Dr. Johnson's research is #1 in the eyes of the CRA (and Dr. Janet Pope).

**7. What direction would you like to see for your future projects?**

With my clinical epidemiology training, involvement in the development of the American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) Classification Criteria for Systemic Sclerosis, and current position of Co-Chair for the ACR subcommittee for Classification and Response Criteria, I am earning a reputation as a methodologist for classification and response criteria development.

I am currently the ACR lead for the EULAR-ACR Classification Criteria for SLE; this four-phase study is underway, and will likely take two years to complete. Working with Dr. Pope and Dr. Murray Baron, we have been successfully funded for the development of new Systemic Sclerosis Subset Classification Criteria. My hope is that the novel methodologic approaches in which I have developed expertise will be applied to other rheumatic diseases.

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

I was a cashier at a McDonald's in St. John's. I aspired to work drive-through, but never got that far!

*Sindhu Johnson, MD, PhD, FRCPC*
*Director,*
*Toronto Scleroderma Program*
*Rheumatology, Department of Medicine*
*Institute of Health Policy, Management and Evaluation*
*University Health Network*
*Pulmonary Hypertension Programme*
*University of Toronto*
*Toronto, Ontario*

# 2015 Innovation in Education Award: Dr. Henry Averns

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

My mother had rheumatoid arthritis (RA) so I understood something about the effects of the disease on a family. I felt I was likely to want to practice in this area when I went to medical school and, as is often the case, my final decision was confirmed by the great fortune of spending two significant blocks of time with a rheumatologist, who had by coincidence spent a lot of time in Canada. Dr. John Winfield was the inspiration who confirmed my instincts to become a rheumatologist. Even at medical school I realized the only way I could spend my weekends fly-fishing was to choose the right specialty.

**2. Please briefly describe the research project for which you won the Innovation in Education Award.**

We have tried to engage in a clinical audit project every year for the last two decades, and I have no doubts that once one gets used to learning one's weaknesses and failures, that the initial shame and self-flagellation can produce improvements in patient care. This year we reviewed how effectively we assess risk-factors in patients taking biologic therapies, and identified some clear gaps that we believe we have now addressed.

**3. Where have you provided rheumatology services to remote communities, and how has that influenced your regular rheumatology practice?**

I have run clinics in several communities on the West coast of James Bay. Sadly, I have cut down on these lately owing to ongoing organizational challenges. The many difficulties faced in providing care to these communities are well recognized. This is certainly an area where one has to accept that the pace of change is far slower than one's own ambitions; that said, the rewards of learning from these communities are immeasurable.

**4. If you could be any joint in the body, which would you be and why?**

The sphenozygomatic suture in the skull, obviously.

**5. You moved to Canada after already being a successful rheumatologist in the UK. Please contrast the two countries in terms of your experience as a rheumatologist in both.**

I think the rheumatology phenotype is the same in both countries—each has managed to foster a combination of cutting edge outcome-driven practice whilst hanging on to the real art of clinical medicine.

One of the striking differences between the UK and Canada is that in the UK almost all Consultants are employed by the National Health Service (NHS), and whatever the specialty all are paid the same (increasing with seniority). In Canada, I was surprised that some specialties appeared to be valued differently from others. The UK system has many advantages and still has ways of rewarding the most deserving. A fee-for-service model results in a very different relationship between doctors, patients and their teams, and the government, and alters the way in which negotiations can take place.

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

I tend to avoid getting my heart rate above 75 bpm so I think darts would work well.


Photo courtesy of Dr. Fred Doris, 2015.

A blur of innovative ideas, Dr. Henry Averns runs between duties as Great Debate Chair, award winner, and conference presenter.

**7. A recent *Globe and Mail* article has highlighted the issue that there is a shortage of rheumatologists in Canada, especially in rural areas. What do you think some of the steps need to be in in order to start alleviating this issue going forward?**

I do not feel there should be an expectation of where one will end up practicing. The current model has resulted in practice location being influenced by market forces as well as clinical need. We have a fairly good idea of how many rheumatologists are needed per 100,000 population. Clearly there is a reluctance to stray too far from the urban academic womb for many trainees. Perhaps there needs to be some incentive to do so—one can quickly brainstorm models which would encourage fledglings to fly further from the nest.

**8. You have recently opened a new clinic to devote more time to your patients. How has this changed your day-to-day routine? What are the benefits and challenges of this change in practice for you?**

Academic practice can be rewarding, but is also associated with barriers to clinical care. Moving to a private office allows one to escape from competitive—and sometimes sociopathic—environments and to develop efficient practice. What I had not appreciated is that not only does one have the freedom to develop teams and see far more patients, but there is still time to engage in academic activities, paradoxically more so, in my case, in the community than before.

On the other hand, I think there is the potential for younger rheumatologists who go into solo practice to quickly lose the peer support and learning opportunities that exist in academic settings. We do not focus much training on the business side of being a rheumatologist, and mentoring of younger specialists would be valuable.

**9. If you could erase one day from history, which would it be?**

The day the letter from the German art school went missing: "Dear Mr. Hitler…Your paintings are extraordinary… do not even consider any other career…"

**10. You are currently working with the Ontario Rheumatology Association (ORA) to improve uptake of EMRs and develop patient assessment tools. How do you think this project will change the landscape of rheumatology? Are there any factors that will have to change alongside the project in order to facilitate its success?**

The project has already helped us define our "data dictionary" and think more clearly about the relevance of the many data we collect. There are some familiar barriers to adoption, not the least of which is the significant variation in EMRs and the lack of a single lexicon of terms and definitions across the country. It will not be long, however, before we begin to share our outcome data with each other, and this will be a major step in informing our clinical practice.

**11. You have stated on your website (*www.rheumors.com*) that you have a longstanding interest in medical databases, electronic medical records (EMR), and outcome assessment. From where do you think that interest stems?**

I trained at the Haywood Hospital which had what was already a powerful database/EMR in the 1980s, and from there realized the potential of electronic information. Hence, I learned to code fairly early on. The Haywood also instilled in me the importance of robust collection of outcome data—I have almost complete data on every patient I have seen since 1996.

**12. Something you think will become obsolete in 10 years:**

What, other than me?

**13. If you could live in any other time period in history, what era would you inhabit?**

I would look good in a toga as I have the physique for it, but I would need to be a wealthy Roman as I am too lazy to be a slave.

**14. You are the Chair of the Optimal Care Committee for the CRA and have been involved in initiatives designed to improve the care of patients with rheumatic diseases within Aboriginal populations. What have been some of the biggest challenges in implementing these initiatives?**

Challenge is the wrong word. There is a massive interest and support for these initiatives across the country, and our ability to forge effective links with each other and with key stakeholders has resulted in small but important steps towards our goal. I cannot imagine making bigger steps until there is clear buy-in from all stakeholders, including the patients themselves and the Federal government. One needs a good imagination to picture this situation arising soon…

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

*How To Build A Doerle Short Wave Radio* by WC Doerle. I would be pretty lonely without Mrs. Averns.

**16. What do you love most about living in Ontario?**

The short, warm winters.

**17. You have previously mentioned that "prestige and money sometimes distance doctors from their deepest values" and that doctors ought to work with "financial and emotional unselfishness, and humility". What or who led you to hold this view in high regard, and how do think this belief has shaped your career?**

My father was a very successful but humble man who devoted much of his spare time to actively helping those in most need, and who truly held personal achievement above financial gain. Whenever he felt I was driven by ego, conceit, or money he would politely remind me of other values. After his death we learnt that we were indeed unaware of the true extent of his generosity to others, and I realized that I would never come close. If you judge me by my actions not my words, it turns out I am pretty shallow.

Photo courtesy of the CRA, 2015.

A jovial trio: Dr. Christopher Penney, Dr. Averns, and Dr. Cory Baillie share a laugh at the 2015 CRA ASM.

**17. If you had a theme song that played whenever you enter a room full of people, what song would it be?**

Is there a song called *Here comes that fat bald irritating English man*? That would probably work well.

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

I applied to be a male model for a fashion magazine. When they saw me they gave me £20 to go away and never come back.


Graphics courtesy of Sara Heppner-Waldston, www.saragrafix.com, 2015.

He may not have made it as a model, but Dr. Averns cuts a rare form as a cartoon!

**19. What is your biggest pet peeve?**

Conceit.

**20. If you could invent a gadget, what would it be and why would we need it?**

I would love something that made me look as if I was paying attention when bored—my attention span is about 90 seconds.

**21. What is something unexpected that has changed about you in the past few years?**

I seem to have hairier ears—my Dad had warned me about this terrible thing occurring...

**22. If you could go bowling with any three people, dead or alive, who would you take and why?**

Stevie Wonder, Ray Charles, and George Shearing. We could talk music and I think I might win.

*Henry L. Averns, MBChB, FRCP(UK), FRCPC*
*Rheumatologist*
*Kingston, Ontario*

XELJANZ (tofacitinib) in combination with methotrexate (MTX) is indicated for reducing the signs and symptoms of rheumatoid arthritis (RA) in adult patients with moderately-to-severely active RA who have had an inadequate response to MTX. In cases of intolerance to MTX, physicians may consider the use of XELJANZ as monotherapy.

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- Significant symptom reduction at 6 months in MTX-IR patients vs. placebo + MTX.[1*]

  ACR20 response rates at 6 months: 52% XELJANZ 5 mg BID or 47% adalimumab 40 mg QOW vs. 28% placebo ($p<0.0001$ and $p<0.001$, respectively).
  This study was not designed to compare XELJANZ to adalimumab.

- Significant improvement in physical functioning at 3 months in MTX-IR patients vs. placebo + MTX.[1*]

  Mean HAQ-DI decrease from baseline at 3 months: -0.56 XELJANZ 5 mg BID or -0.51 adalimumab 40 mg QOW vs. -0.25 placebo ($p<0.0001$).
  This study was not designed to compare XELJANZ to adalimumab.

# Proven tolerability profile

- The most commonly reported adverse events during the first 3 months in Phase 3 studies (≥2% of patients treated with XELJANZ) in patients treated with XELJANZ (n=1216) vs. placebo (n=681) were upper respiratory tract infection (4.4%, 3.4%), headache (4.4%, 2.2%), nasopharyngitis (3.9%, 2.8%), diarrhea (3.7%, 2.3%), nausea (2.6%, 2.6%), and urinary tract infection (2.1%, 1.8%).[1]

**Most serious warnings and precautions:**

**Risk of Serious Infections:** Patients treated with XELJANZ are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt XELJANZ until the infection is controlled. Reported infections include: active tuberculosis, invasive fungal infections, bacterial, viral, and other infections due to opportunistic pathogens.

Treatment with XELJANZ should not be initiated in patients with active infections including chronic or localized infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with XELJANZ, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

**Malignancies:** Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications.

**Other relevant warnings and precautions:**

- Risk of gastrointestinal perforation. Use with caution in patients who may be at increased risk for gastrointestinal perforation.
- Risk of viral reactivation, including herpes zoster.
- Risk of malignancies, lymphoproliferative disorder, and nonmelanoma skin cancer.
- Risk of lymphopenia, neutropenia, anemia, and lipid elevations.
- XELJANZ should not be used in patients with severe hepatic impairment, or in patients with positive hepatitis B or C virus serology.
- Use with caution in patients with a risk or history of interstitial lung disease (ILD).
- XELJANZ can increase the risk of immunosuppression. Concurrent use with potent immunosuppressive drugs is not recommended.
- Concurrent use with live vaccines is not recommended.
- Use with caution in patients with impaired renal function (i.e., CrCl <40 mL/min).
- XELJANZ should not be used during pregnancy.
- Women should not breastfeed while being treated with XELJANZ.
- The safety and effectiveness of XELJANZ in pediatric patients have not been established.
- Caution should be used when treating the elderly because of an increased risk of serious infection.
- Use with caution in Asian patients because of an increased risk of events including: herpes zoster, opportunistic infections and ILD.
- Treatment with XELJANZ was associated with increases in creatine kinase.
- XELJANZ causes a decrease in heart rate and a prolongation of the PR interval. Caution should be observed in patients with a low heart rate at baseline (<60 beats per minute), a history of syncope or arrhythmia, sick sinus syndrome, sinoatrial block, atrioventricular (AV) block, ischemic heart disease, or congestive heart failure.
- Treatment with XELJANZ was associated with increased incidence of liver enzyme elevations.

**For more information:**

Please consult the product monograph at http://www.pfizer.ca/en/our_products/products/monograph/342 for important information relating to adverse reactions, interactions, and dosing information which have not been discussed in this piece. The product monograph is also available by calling us at 1-800-463-6001.

**Reference: 1.** Pfizer Canada Inc. XELJANZ Product Monograph. April 16, 2014.

BID = Twice daily; QOW = Every other week; MTX-IR = Methotrexate Inadequate Responders
*Multicentre, randomized, double-blind, placebo-controlled study in patients ≥18 years with active RA according to ACR criteria. Patients received MTX and were randomized to receive XELJANZ 5 mg BID (n=196), adalimumab 40 mg sc QOW (n=199), or placebo (n=106). The primary endpoints were the proportion of patients who achieved an ACR20 response at month 6, mean change from baseline in HAQ-DI at month 3, and the proportion of patients who achieved DAS28-4 (ESR) <2.6 at month 6.

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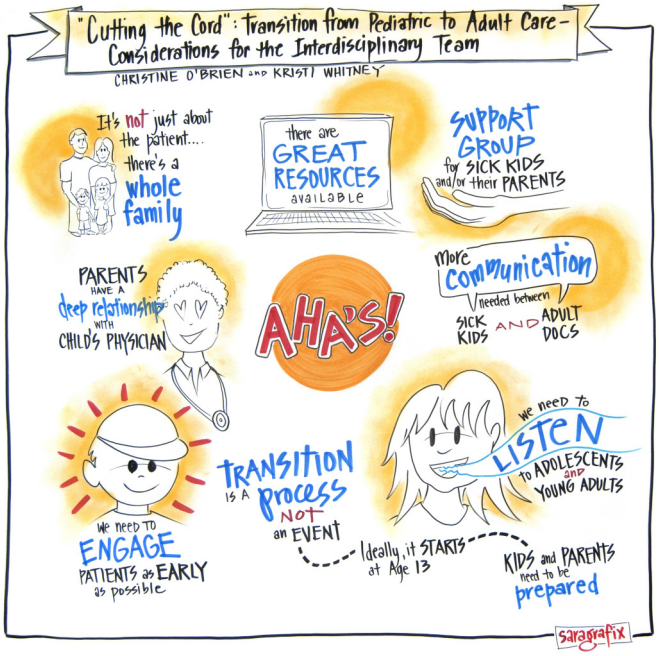
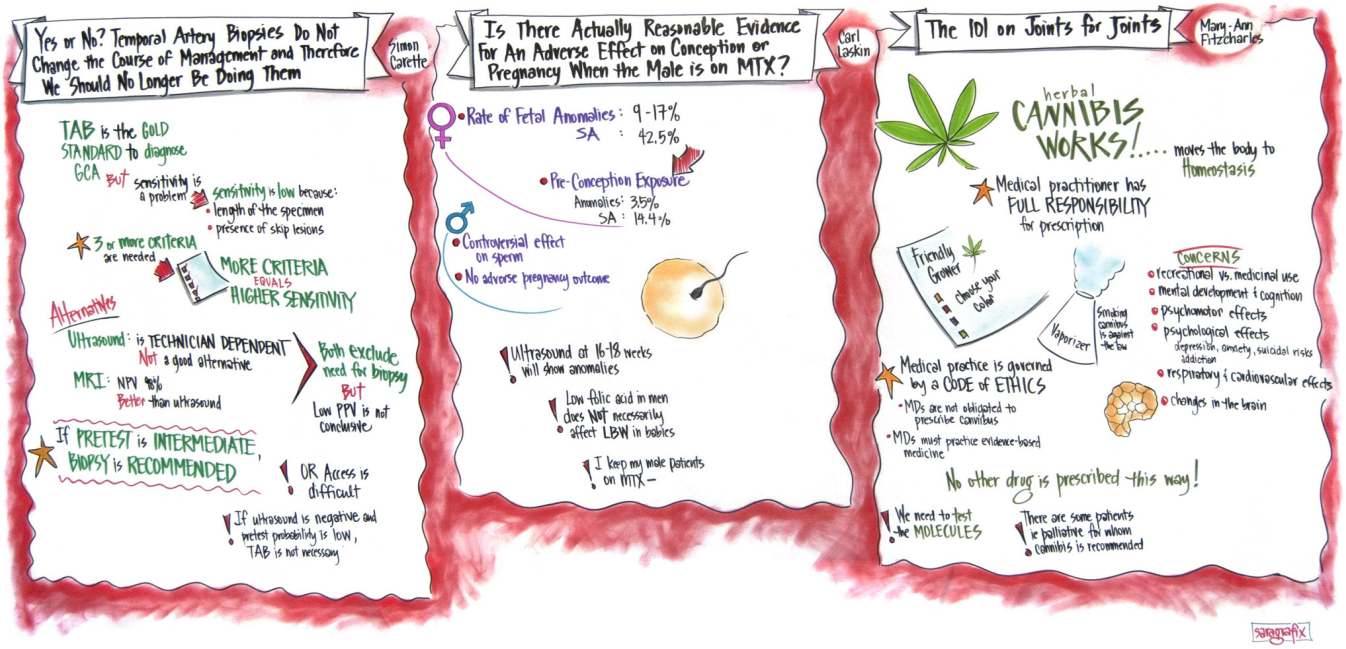



Graphics courtesy of Sara Heppner-Waldston, www.saragrafix.com, 2015.

## CRA/ARF Young Faculty Award for Excellence in Research: 2015 CRA Annual Scientific Meeting

**CRA/ARF Epidemiology/Health Services Research Award**

Dr. Evelyn Vinet

*"Increased Risk of Hematological Malignancies in Children Born to Women with Systemic Lupus Erythematosus"*

McGill University

**CRA/ARF Best Basic Science Research Award**

Dr. Carolina Landolt-Marticorena

*"Discovery and Validation of Novel Urinary Biomarkers for Lupus Nephritis"*

University of Toronto

**CRA/ARF Basic Clinical Research Award**

Dr. Glen Hazelwood

*"Treatment Preferences of Patients with Early Rheumatoid Arthritis: A Discrete-Choice Experiment"*

University of Calgary

Supervisors: Dr. Claire Bombardier and Dr. Deborah Marshall

# The Realities of Research Support, In My Experience

By Cheryl Barnabe, MD, FRCPC, MSc

In 2013 I was awarded the CRA-Canadian Initiative for Outcomes in Rheumatology Care (CIORA) and The Arthritis Society (TAS) Clinician Investigator Award. This salary award was designed to support investigation in inflammatory arthritis (IA) aligned with the research pillars of the CIORA grant program—getting more patients with IA diagnosed, utilizing multidisciplinary care teams to deliver high-quality arthritis services, and advancing educational initiatives.

During my award tenure, I have focused on how we might improve systems of access and care delivery for indigenous patients with arthritis. Indigenous populations in Canada have the highest prevalence of both osteoarthritis (OA) and most types of IA. They have severe disease outcomes, and our current healthcare system fails, for the most part, to provide an environment where optimal treatment outcomes could occur. The salary award has given me the opportunity to explore these issues, helping develop the networks and interventions to resolve the situation that exists. I am incredibly fortunate that my CRA(CIORA)/TAS salary award will now be followed by tenure of a Canadian Institutes of Health Research (CIHR) salary award, as a New Investigator in Community-Based Primary Healthcare, to make interventions based in the primary-care setting and which strengthen the primary-care provider-specialist relationship to improve outcomes.

What does a salary award give an academic? These awards afford protected time to write grants and papers, develop a research program, and supervise research students. Without this protected time, it is incredibly difficult to pursue research endeavours and achieve high-impact work. I am most grateful to the CRA and TAS for their contributions to supporting my research program over the past two years.

Suggested Reading
To learn more about CIORA and available support opportunities, please visit *www.rheum.ca/en/ciora/.*

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

## CRA/ARF Young Faculty Award for Excellence in Research: 2015 CRA Annual Scientific Meeting

**Summer Studentship Mentor Award**
Dr. Lori Albert

**Philip Rosen Award for Best Abstract for Clinical or Epidemiology Research by a Trainee**
Dr. Liam O'Neil
*"Interrupted and Delayed Care in First Nation Patients with Rheumatoid Arthritis: The Best Target for Therapy?"*
University of Manitoba
Supervisor: Dr. Christine Peschken

**Ian Watson Award for Best Abstract for SLE Research by a Trainee**
Dr. Ripneet Puar
*"High Mortality in Vulnerable Canadians with SLE"*
University of Manitoba
Supervisor: Dr. Christine Peschken

**Best Abstract for Basic Science Research by a Trainee**
Sina Rusta-Sallehy
*"A Progressive Increase in T follicular Helper Cells Marks the Transition from Benign to Symptomatic Autoimmunity"*
University of Toronto
Supervisor: Dr. Carolina Landolt-Marticorena

**Best Poster by a Medical Student**
Dennis Wong
*"Reliability of Radiographic Assessment of Psoriatic Arthritis Mutilans"*
University of Toronto
Supervisor: Dr. Dafna Gladman

**Best Abstract for Research by an Undergraduate Student**
Dr. Tristan Kerr
*"The Risk of Growth Retardation and Obesity in Children with JIA Treated with Contemporary Treatments: Results from the ReACCh-OUT Cohort"*
University of British Columbia
Supervisor: Dr. Lori Tucker

**Best Abstract for Research by a Rheumatology Resident**
Dr. Claire Barber
*"Developing System Level Performance Measures for Evaluating Models of Care for Inflammatory Arthritis"*
University of Calgary
Supervisors: Dr. Deborah Marshall and Dr. Diane Lacaille

**Best Poster by a Post-Graduate Resident**
Zainab Alabdurubalnabi
*"Cardiovascular Risk Assessment in Moderate to Severe Inflammatory Arthritis Patients"*
University of Alberta
Supervisor: Dr. Stephanie Keeling

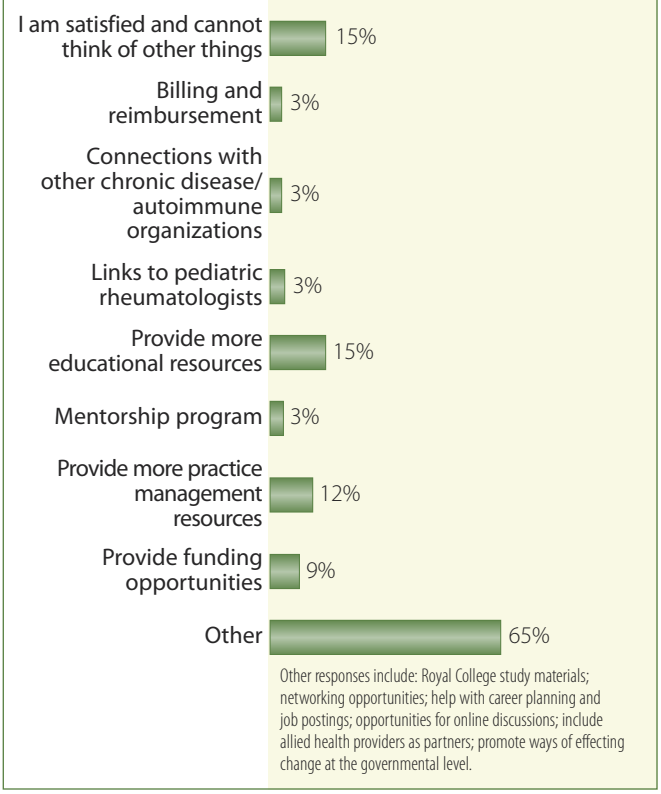
# President's Address

By Cory Baillie, MD, FRCPC

The mission of the CRA is to represent Canadian rheumatologists and promote the pursuit of excellence in arthritis care, education, and research. In order to fully represent Canadian rheumatologists, the CRA needs to understand the needs and wants of its members, as owners of the CRA. The CRA Board of Directors appreciates this and has established a membership engagement committee chaired by Dr. Trudy Taylor to pursue this goal.

The CRA has undertaken a number of membership engagement activities over the past two years to gain input on what direction the CRA should take in the future. In 2014, expert-led focus groups during the CRA Annual Scientific Meeting (ASM), as well as telephone interviews with members, were arranged. In addition, one-on-one meetings with Ontario rheumatologists took place during the Ontario Rheumatology Association (ORA) ASM.

Table 1. **How could being a member of the CRA bring more value to you?**




Other responses include: Royal College study materials; networking opportunities; help with career planning and job postings; opportunities for online discussions; include allied health providers as partners; promote ways of effecting change at the governmental level.

This year, the CRA had a teleconference with several resident members enquiring about how the CRA can best support them as they launch their careers; members were also questioned on a variety of topics during the membership renewal process. CRA board members each interviewed a representative sample of the rheumatology community attending the 2015 Quebec City CRA ASM (see table for some of the topics contained in this survey). Also during the 2015 ASM, the first ever CRA Town Hall meeting was held, allowing idea generation on key areas of CRA interest such as clinical care, research, education, and representation.

In late April, the CRA council and staff travelled to Winnipeg for our annual retreat. The results of all of the membership engagement activities were reviewed and discussed at length. The concept of the value of networking and collaboration was very prominent throughout many of the engagement activity results. Combining this information with feedback on the CRA's current activities and education about the external environment, the board worked to revise the strategic priorities of the CRA. The new strategic priorities document is lengthy and is a work-in-progress but the broad theme highlights that the CRA exists so that Canadian rheumatologists achieve excellence in clinical care, education and research. As a result:

- Members and individuals receive direct benefits;
- Partners and other organizations support the issues of rheumatologists and the field of rheumatology; and
- There is public awareness and understanding about rheumatologists and the field of rheumatology.

The CRA board is always looking for further input from its members. If you have any thoughts or suggestions regarding the future plans of the CRA, we would love to hear from you. Please contact us at *info@rheum.ca*.

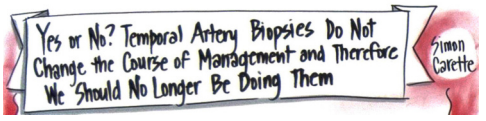
*Cory Baillie, MD, FRCPC*
*President,*
*Canadian Rheumatology Association*
*Assistant Professor,*
*University of Manitoba*
*Winnipeg, Manitoba*

# Controversies in Rheumatology

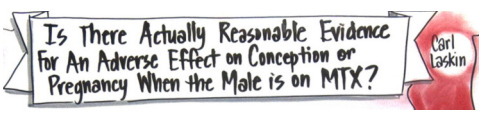
By Sherry Rohekar, MD, FRCPC

Pathology, pregnancy, and pot were hot topics at the CRA Annual Scientific Meeting (ASM) in February 2015.

Dr. Simon Carette opened the session with the following challenge: "Temporal artery biopsy does not change the course of management, and therefore we should no longer bother doing them. Yes or no?" Dr. Carette began by discussing the issue of the low sensitivity of temporal artery biopsy for giant cell arteritis (GCA), typically between 15%-40%. Low sensitivity is multifactorial, but technique and steroid exposure are important factors. He then spoke about what diseases may be present in patients with suggestive symptoms, but negative biopsy. The American College of Rheumatology (ACR) classification criteria do not include many of the classical symptoms of GCA. Dr. Carette also discussed the utility of potential alternatives to temporal artery biopsy, such as MRI and ultrasound. His takeaway message was to consider whether performing the biopsy would actually change clinical management. If the pre-test probability is high and you would still treat independently of the biopsy, he proposed that you would be justified in not performing the biopsy. In contrast, if the pre-test probability was low, why bother doing a biopsy at all? The biopsy is most useful for those in whom the pre-test probability is intermediate, wherein the results would change your management.




Dr. Carl Laskin continued the session by discussing the safety of pharmacotherapy of rheumatic disease in pregnancy. In those contemplating a pregnancy, he suggested avoiding nonsteroidal anti-inflammatory drugs (NSAIDs) and withdrawing certain disease-modifying antirheumatic drugs (DMARDs) (*e.g.*, methotrexate, leflunomide, mycophenolate mofetil [MMF], and cyclophosphamide). He also noted that sulfasalazine should be avoided in males contemplating conception. Tumor necrosis factor (TNF) inhibitors may be continued until pregnancy or during the pregnancy, while non-TNF inhibitor biologics may be used as necessary. In those who are pregnant, he advised discontinuing NSAIDs by Week 32. Many DMARDs noted above are highly teratogenic and warrant in-depth discussion with pregnant patients regarding outcomes. In those who are nursing, Dr. Laskin suggested using NSAIDs, anti-malarials, sulfasalazine, and prednisone to control flares; TNF inhibitors are also likely safe during breastfeeding. Dr. Laskin advised discussing family planning with patients at least annually. He also told us, "do that with which you are comfortable and be intellectually and emotionally honest with your patient."




Dr. Mary-Ann Fitzcharles concluded the controveries session by lecturing on "Joints for Joints 101", which focused on the use of medical marijuana in rheumatology. Dr. Fitzcharles pointed out that marijuana has been used for thousands of years in parts of the world as an excellent therapy for pain. She noted, however, that there is a dearth of evidence from clinical trials in rheumatology. She reviewed new Canadian regulations for the prescription of medical marijuana, in effect since April 2014, detailing the acquisition and method of consumption of marijuana with some humorous examples. Dr. Fitzcharles also discussed the impact of marijuana on the nervous system. Rheumatolo-gists, in particular, were found in a recent study to be in uncharted waters when it came to the use of medical marijuana in their practice. She noted that medicinal cannabis use is currently driven by a political and financial agenda, with no clear idea about the exact molecule, dose, pharmacokinetics, or safety. Dr. Fitzcharles noted, "no other drug is ever prescribed in this way", and reminded the audience that "if you have written a prescription, you are fully responsible for the well-being of your patient."


This year's Controversies in Rheumatology session was well received and thought-provoking. The speakers challenged us to critically examine our approach to pot, pregnancy, and pathology. Bravo to all.

*Sherry Rohekar, MD, FRCPC*
*Program Director,*
*St. Joseph's Health Care*
*Associate Professor,*
*Western University*
*London, Ontario*

# This House Believes that Pre-RA Should Be Treated: Report from the Great Debate

By Henry Averns, MBChB, FRCP(UK), FRCPC

As always, the Great Debate brought together four great minds from the CRA to engage in high-level academic debate on the subject of rheumatoid arthritis (RA). The question of the day was, "*Be it resolved that this house believes pre-RA should be treated.*" On the "for" side were Dr. Volodko Bakowsky and Dr. Derek Haaland, squaring off "against" Dr. Rob McDougall and Dr. Hani El-Gabalawy to discuss the concept of pre-RA and what treatment should be considered.

Dr. Bakowsky handily identified that it would be advantageous if we could actually understand the definition of pre-RA; he humbly helped us understand why he describes himself as Jack-of-all-trades and master of none.

Dr. El-Gabalawy raised some compelling arguments against treating pre-RA, though the audience could be forgiven for suggesting we should send his slides to a group of psychologists to help understand what lurks in his mind.

Dr. Haaland's rebuttal was a work of art, and largely informed by Dr. El-Gabalawy's own publication—to use one's oppenent's work against them is sheer brilliance.

Dr. McDougall wound up the debate; after realizing that there was a danger things could be lost for the "against" team, he quickly adopted the art of obfuscation and personal abuse, to the delight of the audience, who were then treated to a lesson on Scottish whisky (as opposed to beer, which should be renamed pre-whisky, apparently).

The Haaland-Bakowsky team led us in to a musical finale which will remain the stuff of legend, and which will no doubt cause future debaters to pause before accepting the challenge.

In the end, both sides put forth such compelling arguements that the debate was declared a draw, much like the fantastic artwork which accompanied this face-off.

*Henry L. Averns, MBChB, FRCP(UK), FRCPC*
*Rheumatologist*
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Graphics courtesy of Sara Heppner-Waldston, www.saragrafix.com, 2015.

# Reflections from a First-time ASM Attendee

By Liza Abraham

It is the season of scientific conferences and meetings; avid conference-goers have their schedules prepared, posters printed, and flights booked. My first conference experience would be at the 2015 CRA Annual Scientific Meeting (ASM) in Quebec City, and it promised to be a memorable one. I was attending this national meeting to present a poster on the triage of rheumatology referrals by an advanced practice physiotherapist to facilitate wait-time benchmarks.[1] As a second-year medical student, I was nervous about having to present my research findings to a room filled with leading researchers and clinicians. Adding to this, I was scheduled to write a massive exam upon my return to Toronto. My flight to Quebec City was thus spent cramming for my exam and wondering to myself how I would get through the next few days.

Upon my arrival at the Fairmont Chateau Frontenac, I immediately noticed the ambient intellectual chatter around me. Old friends and colleagues were reconnecting since meeting a year ago. I headed into the large conference room where a networking session was being held, and introduced myself to the first person that I saw, Dr. Frances Leung. She turned out to be a community rheumatologist practicing in Toronto, so we chatted about my summer CRA studentship at Women's College Hospital. I was later joined by Dr. Dana Jerome, my summer clinic supervisor, who referred me to the new *Sli.do* app implemented by the conference organizers this year. The app connected me with other attendees on social media and provided useful information about keynote presentations and workshops.

Over the course of the CRA Annual Scientific Meeting (ASM), I had wonderful opportunities to network with practicing physicians and establish connections with students from medical schools across Canada. Each shared their personal reasons for choosing to practice rheumatology. It was refreshing to participate in such candid discussions about career choice and residency. From the moment I began medical school, I have been asked what specialty I am interested in, but much of a medical student's time is spent on finding the jugular venous pressure (JVP) or memorizing the anatomy of the brain. With such limited clinical experience, career decision-making can be a daunting process. Attending the ASM allowed me to reflect on my understanding of the nature of the rheumatology specialty, and consider if these aligned with my own goals for residency and future medical practice.

On the day of my poster presentation I was incredibly nervous. I had spent the previous evening rehearsing in my room, thinking about how embarrassing it would be if I could not answer the attendees' questions. After throwing on my best suit, I headed down to the conference area and was relieved to see my supervisor waiting for me. She could tell I was nervous, but she reassured me that this audience would welcome my work. And she was right. There was a great deal of interest in the triage process utilized to improve access to care by patients; I was excited to share my findings and discuss opportunities for collaboration with others interested in health systems solutions and equity of access. It was a truly meaningful experience that allowed me to create new mentoring relationships with researchers and clinicians across Canada.

When we spend so much time in our first few years in medical school in a classroom learning to be medical experts, it can be very difficult for students to remember our CanMEDS roles of collaborator, scholar, and professional; however, these roles are all-important in ensuring an evidence-based approach is used to advance medical practice. Attending the CRA ASM offered a unique opportunity to share new innovations in research and practice, and create new mentoring relationships. Moreover, the career advice offered by both academic and community-practicing rheumatologists was invaluable.

Conferences are a great way to develop potential partnerships, build new relationships, and strengthen old ones. The CRA attendees are all experts in their field and were eager to teach me about their specialty. I took the time to ask questions, meet my colleagues, and explore the city that I was visiting. It was truly a memorable experience and I look forward to attending next year's ASM in Lake Louise, Alberta.

Suggested Reading

1. Gakhal N, Farrer C, Jerome D, et al. Triage of Rheumatology Referrals by an Advanced Practice Physiotherapist Facilitates Wait Time Benchmarks. Poster presented at the CRA ASM: 4-7 February 2015; Quebec City, Quebec. Available at: *www.womens-collegehospital.ca/assets/pdf/CRA%20poster%20v2%20Jan%2029%2020151.pdf.*

*Liza Abraham*
*Medical Student,*
*University of Toronto*
*Toronto, Ontario*

# AHPA in Quebec City

By Leslie Soever, BScPT, MSc, ACPAC

The Arthritis Health Professions Association (AHPA) was pleased to join the CRA for the Annual Scientific Meeting (ASM) in Quebec City, Quebec. This year featured our 7th annual pre-course for arthritis health professionals with 86 attendees. An excellent slate of speakers included Dr. Boulos Haraoui (*Biologics and Small Molecules: 2014 in Review*), Dr. Annette Wagner (*Kidney Involvement in Different Rheumatic Diseases*), Dr. Heather McDonald-Blumer (*Osteoporosis: Overview of the Latest Evidence*), Dr. Dharini Mahendira (*Safety of Pharma-cotherapy of Rheumatic Disease in Pregnancy – Update*), Occupational Therapist Karine Toupin April (*Complementary and Alternative Therapy [CAM] – Evidence in Inflammatory Arthritis*), Pharmacist Carolyn Whiskin (*Review: Drug/Therapies Utilized in Inflammatory Arthritis and Side Effect Profiles/Interactions*), and Physiotherapist Chandra Farrer (*Osteoarthritis – Review of Updated Published Guidelines*).

This meeting also saw the introduction of an Interprofessional Role Play enacting an inflammatory arthritis case. Dr. Andy Thompson played the role of the rheumatologist; Jane Cottrell, the nurse; Karen Gordon, the physiotherapist; Carolyn Whiskin, the pharmacist; and Marlene Thompson, the patient.

Jennifer Burt received the Extraordinary Service Award, which recognizes contributions by an AHPA Board Member in advancing the mission, vision, and goals of our association. Jennifer has served on the Board of Directors of AHPA since 2007, initially as Provincial Representative for Newfoundland and Labrador, then as President (2011-2013), and more recently as Past-President. Her many achievements include her capable leadership of AHPA through the process of incorporation, representation on the Arthritis Alliance of Canada (AAC), and overall advocacy of our organization to the broader arthritis community.

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 winner was Dr. Katie Lundon for her project *"Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program."* The Arthritis Society Research Award was presented to Dr. Lucie Brosseau for her work, *"Development and Dissemination of Ottawa Panel Clinical Practice Guidelines on Self-Management and Rehabilitation Interventions for Juvenile Idiopathic Arthritis (JIA)"*.

The Carolyn Thomas Award was established in honour of a founding member of AHPA who supported research; it is given to the first author of the year's best scientific abstract. Carol Kennedy received it for her research *"Effectiveness of a Telemedicine Education Program for Adults with Inflammatory Arthritis*

Ms. Leslie Soever presenting Ms. Jennifer Burt with Extraordinary Service Award.

*Living in Rural and Remote Communities in Ontario"*. The Barbara Hanes Memorial Award was established in honour of her work as an Occupational Therapy Director at TAS and her contributions as a teacher and a contributing author of the rheumatology textbook *Physical Therapy in Arthritis*. This award was presented to Lorna Bain for her research entitled *"Identifying and Addressing Real and Perceived Barriers to Therapeutic Education Programs to Inform a New Model of Care"*.

Congratulations to all award winners and thank you for your excellent work that contributes to improved care for individuals with arthritis! I would also like to thank all members of the AHPA Board of Directors for their dedication and efforts in the ongoing work of AHPA.

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

Mr. Sameer Chunara presenting Dr. Katie Lundon with Clinical Innovation Award.


Ms. Janet Yale presenting Dr. Lucie Brosseau with TAS Research Award.

# Who's That Homunculus?

By Auntie Inflammatory, on behalf of The Arthritis Society

A strange, silent being paid a visit to Quebec City this February, courtesy of The Arthritis Society (TAS). No, not *Bonhomme*, but a real, live arthritis homunculus which took to the stage at the CRA's 2015 conference and interacted with attendees. Featuring rheumatoid arthritis (RA)-affected joints on the front and osteoarthritis (OA) on the back, the homunculus brought this common educational tool to life, and helped inject a little fun into the day's proceedings.

But what to call it? The Society turned to the CRA's members for help, and your suggestions poured in.

Prizes were awarded to the submitters of the three finalists. The runnersup—one for *Ossie Arthuritis*, and two for *Bonhomonculus* (fitting for Carnival)—each received TAS swag. The top prize of an iPad Mini was awarded to the winning entry, *Auntie Inflammatory*! Special thanks to TAS's own Benoit Duhamel for his courageous performance as Auntie.

One other name was submitted no less than six times: *Andy Thompson*, in honour of the winner of the CRA's Teacher/Educator Award. In the highlight of the day, Dr. Thompson went up to claim his award and then, *à la* Clark Kent, pulled open his shirt to reveal the homunculus suit underneath. Well played, Andy!

Of course, TAS also had some serious business to attend to, as president and CEO Janet Yale presented the Phil Rosen Award for Best Abstract for Clinical or Epidemiology Research by a Trainee to Dr. Liam O'Neil, for his study of interruptions and delays in RA care among First Nations patients and their impact on outcomes. Ms. Yale also awarded an Arthritis Health Professions Association (AHPA) research grant to Dr. Lucie Brosseau for the development and dissemination of clinical practice guidelines for self-management and rehabilitation interventions for JIA. Congratulations Dr. O'Neil and Dr. Brosseau!

These research awards, selected by the CRA's review committee and funded annually by TAS, are just one of the many ways that TAS invests in the recruitment and development of the next generation of arthritis researchers and clinicians. We continue to work together with the CRA through the **Every Member** campaign to ensure that the rheumatology community has the capacity to meet the needs of Canadians now and into the future.

Auntie Inflammatory takes time out for a quick photo with Ms. Janet Yale at the 2015 CRA Conference

For information about **Every Member** or to make your pledge, please contact Sandra Dow at *sdow@arthritis.ca*, or by phone at 416-979-7228 ext. 3343.

The Arthritis Society

# Dr. Cy Frank

By Gillian Hawker, MD, FRCPC; and Dianne Mosher, MD, FRCPC

1950 - 2015

Dr. Cy Frank, colleague, mentor and friend to many of us in rheumatology, passed away suddenly on March 5, 2015. He was a truly outstanding individual—a mensch. His legacy will live on.

Dr. Frank was an ardent supporter of a publicly funded healthcare system. He believed wholeheartedly that savings could be found through greater efficiency and effectiveness in our healthcare system. Most importantly, he believed that any dollars saved needed to be reinvested to improve health care for all Canadians. He was a passionate advocate for implementation of quality-of-care metrics: "We cannot fix the system unless we measure it!" He could not fathom—or tolerate—the notion of finding solutions without people with arthritis at our sides. He believed meaningful engagement of people with arthritis to be integral to the solution and insisted on their involvement in advocacy, research, development, and implementation of care-delivery models.

Some of us would tease Cy, noting that he behaved more like a rheumatologist than an orthopedic surgeon! Either way, he was a steadfast friend to rheumatology. As the first appointed scientific director of the Institute of Musculoskeletal Health and Arthritis (IMHA) in 2000, Dr. Frank attended our CRA meeting with Mr. Denis Morrice, then President and CEO of The Arthritis Society (TAS). He wanted to ensure that rheumatology researchers were at the IMHA table. He was instrumental in the formation of the Arthritis Alliance of Canada (AAC) and was the wise advisor to Dr. John Esdaile, Ms. Cheryl Koehn, and ourselves in the mammoth undertaking that led to the Summit on Standards of Care for Arthritis. At the time of his death, he was co-chair for both the inflammatory arthritis (IA) and osteoarthritis (OA) models of care (MOC) working groups at the AAC. At 6 am every other Wednesday, he was on a conference call for the IA MOC group with Dr. Vandana Ahluwalia, Dr. Michel Zummer, Dr. Anne Lydiatt, Dr. Jaime Coish, and Dr. Mosher, gently pointing them in the right direction. This was despite the fact he was CEO of Alberta Innovates Health Solutions (AIHS), on the Federal Minister of Health's task force on innovation in health care, still performing surgery, all while serving on countless other committees.

As an orthopedic surgeon, Dr. Frank was the first to perform arthroscopic surgery in Calgary. He was a great technical surgeon, but also a caring physician who always made time for his patients and would squeeze in that extra patient when you were concerned. He had a special interest in ligament repair and has fixed a few of us! Knowing that ligament repair did not prevent the development of OA, he set out to better understand this disease. He was successful in leading an OA team grant from AIHS for the past decade. Among his many accomplishments was the establishment and evaluation of standardized care pathways for hip and knee replacements, including the implementation of centralized intake clinics for people seeking hip or knee replacement surgery. These health system innovations were shown to improve patient outcomes and reduce health care costs. Dr. Frank was internationally recognized for this pioneering work. Indicative of his far reach, upon learning of his death, Dame Sally Davies, Chief Medical Officer for England, called Dr. Frank's longtime assistant Judy to express her disbelief and sympathies.

Dr. Frank's accomplishments were many. He was founding Director of both the McCaig Bone and Joint Institute and the Alberta Bone and Joint Health Institute. He did this with support from business leader and philanthropist J.R. McCaig.

Dr. Frank was a modest man. In 2014 he received the Order of Canada, which he did not even tell his sons about until two weeks later, never wearing his pin. He was a proud Albertan and loved the mountains and his cabin in Kananaskis. He had a passion for fixing old cars, especially Mustangs! One of his proudest moments was when he was able to perform surgery with his son Tym, an orthopedic resident in Vancouver.

He has guided many of us in our career decisions. We all felt that he was personally invested in our success. He had all the time in the world to talk to us and have a coffee, for which he always paid. Papa Cy, we will miss you!

*Gillian Hawker, MD, FRCPC; and*
*Dianne Mosher, MD, FRCPC*

# AB

**Cheryl Barnabe** @drcherylbarnabe

The future is so bright you gotta wear shades! Since the summer 2012 update, we have welcomed the following rheumatologists to practice in our city: Dr. Paul MacMullan, Dr. Corisande Baldwin, Dr. Frank Jirik, Dr. Ann Clarke, Dr. Heather Waymouth, Dr. Svetlana Stajkovic, Dr. Elzbieta Kaminska, Dr. Hector Arbillaga, Dr. Susa Benseler, Dr. Tommy Gerschman, and Dr. Nadia Luca. We also have acknowledged the retirements of Dr. Norma Jibb and Dr. Paul Ryan.

**Stephanie Keeling** @drstephaniekeeling

The University of Alberta is proud to announce the addition of Dr. Alison Clifford to the Division of Rheumatology. She completed her rheumatology fellowship at Dalhousie and a vasculitis fellowship at the Cleveland Clinic. We are excited to see her expand the vasculitis clinic and her family!

**Mercedes Chan** @drmercedeschan

Dr. Janet Ellsworth has two new colleagues, Dr. Mercedes Chan and Dr. Dax Rumsey, joining the pediatric rheumatology division at the University of Alberta/Stollery Children's Hospital. Together they have introduced a pediatric MSK physical examination (pGALS) workshop to medical students during their pediatrics clerkship and hope to start a transition clinic in the foreseeable future!

**Cheryl Barnabe**
@drcherylbarnabe

Dr. Susan Barr and Dr. Liam Martin: the model of train the trainer. Who taught who to shape gnocchi? (Photo courtesy of @melissaweibe)

**Christopher Lyddell** @drchristopherlyddell

Despite missing nursing support, and in addition to monthly one-week clinics in Grande Prairie, Dr. Chris Lyddell has started an Edmonton musculoskeletal (MSK) Ultrasound clinic to help GPs with diagnosis of soft tissue problems, as well as scanning inflammatory joint disease patients for early diagnosis and to access treatment response. Long way to go to get broader acceptance and funding—a work in progress.

**Cheryl Barnabe** @drcherylbarnabe

Dr. Paivi Miettunen, pediatric rheumatologist at the Alberta Children's Hospital, and Ms. Jaymi Taiani, public education officer for the McCaig Institute for Bone and Joint Health, have created a program for juvenile idiopathic arthritis (JIA) patients called *Expressions of Arthritis: Giving Children a Voice Through Art*, wherein patients are using art to manage chronic pain, cope with emotional stress, increase self-esteem, as well as enhance their ability to communicate their symptoms to their healthcare providers.

**Stephanie Keeling** @drstephaniekeeling

The Department of Medicine at the University of Alberta held its first annual Percy-Russell Lectureship for Medical Grand Rounds in April, welcoming Dr. Gillian Hawker as the first speaker to a packed house. This lectureship honours the pioneering work in rheumatology in Alberta by Dr. Anthony Russell and the late Dr. John Percy.

**Cheryl Barnabe**
@drcherylbarnabe

Dr. Gary Morris, of the University of Calgary, was the recent winner of the Dr. Tom Enta Award for Clinical Excellence (Community Practice), courtesy of the University of Calgary Department of Medicine Awards.

**Joanne Homik**
@drjoannehomik


Dr. Paul Davis has partially retired, spending some of his time on Vancouver Island reacquainting himself with the ocean, and some of his time still seeing patients in Edmonton. We miss his wit, humour, and clinical pearls. His patients will be sad when the island pulls him completely into its grasp.

# Top Ten Things Rheumatologists Should (And Might Not) Know About Hip and Knee Arthroplasty

By Michael J. Dunbar, MD, FRCSC, PhD; and C. Glen Richardson, MD, FRCSC, MSc

Hip and knee arthroplasty are extremely successful surgical procedures for end-stage arthritis with predictable improvements in pain relief, mobility, and overall quality of life. Recent innovations have had mixed results, resulting in the need for some clarity in the discussion of what constitutes current state-of-the-art procedures for arthroplasty. Patients sent from our rheumatology colleagues for arthroplasty are a unique population that often requires special consideration. The following list addresses these issues.

1. **The incidence of hip and knee arthroplasty** for patients with rheumatoid arthritis (RA) has fallen dramatically over the last two decades, likely as a result of better medical management.[1] Patients with end-stage and joint mutilating RA are now rarely seen in the operative theatre. In contradistinction, the incidence of arthroplasty for osteoarthritis (OA) over the same time period has increased severalfold.

2. **Patients with inflammatory arthropathies are at an increased risk** for periprosthetic joint infection after arthroplasty. Disease-modifying immunosuppressive agents are generally stopped in a "wash-out" fashion in an effort to reduce infection risk. Recent evidence suggests that such practice may not in fact lower the infection risk. The outcomes of an infected arthroplasty can be devastating, and unfortunately, the incidence of joint infection is increasing internationally.[2]

3. **Cemented fixation** of arthroplasty components to host bone continues to demonstrate superior survivorship in patients with inflammatory arthropathies, despite advances in uncemented fixation.[3] Using cement provides immediate fixation in vulnerable bone and allows for the addition of antibiotics that elute into the joint over time, reducing the incidence of infection.

4. **Long-term revision rates** for hip and knee replacement are similar or slightly higher in patients with RA compared to those with OA. Increased risk for failure associated with ongoing inflammatory processes and infections are balanced by, in general, lower body mass and reduced activity levels.

5. **Metal-on-metal total hip replacements (THR)** have been a failure and are largely being abandoned. Several designs of such implants have led to high levels of serum and urine cobalt and chromium that can result in local toxic effects, including periarticular muscle necrosis.[4] Such complications can be profound in scope. Metal-on-metal THR should not be used in patients with inflammatory arthropathies.

6. **Resurfacing arthroplasty** of the hip also uses a metal-on-metal bearing, but unlike a total hip replacement, the femoral head and neck are retained and milled to accept a capping prosthesis. Some types of resurfacing arthroplasty have also had associated metal ion issues and, at best, these prostheses match the outcome of conventional hip replacement in males with OA. The host bone needs to be strong and vital to support the femoral prosthesis, so resurfacing arthroplasty should not be used in the face of inflammatory arthropathies.

7. **Ceramic-on-ceramic bearings** in total hip arthroplasty adds significant additional cost to the procedure but national registry data from many countries fails to show superiority compared to the gold standard of metal femoral heads articulating on cross-linked polyethylene. Ceramic bearings can fracture, necessitating the need for complex revision. Some series on ceramic bearings report an incidence of "squeaking" of the bearing with activity in more than 10% of patients.[5]

8. **Resurfacing of the patella** in total knee arthroplasty with a plastic button to articulate against the metal femoral component is generally recommended in inflammatory arthropathies.[6] An unresurfaced patella increases rates of anterior knee pain and decreases rates of overall satisfaction, but decreases the rates of long-term complications due to failure of the supporting patellar bone stock and subsequent fractures. The situation is complicated by the fact that most patients with inflammatory arthropathies have the posterior cruciate ligament resected and substituted for at the time of knee arthroplasty, which increases the sagittal shear on the patella-femoral joint.

9. **Computer-assisted total knee arthroplasty** has been shown to reduce outliers in component positioning and overall limb alignment, and has subsequently been shown to improve survivorship.[7] It is likely that computer-assisted surgery will continue to evolve into robotic surgery, with more future procedures being allocated to robotic preparation. The role of the future surgeon will be to instruct the patient-specific implantation plan and then manage the robotic systems, much like occurs in aviation.

10. **National joint replacement registries** have improved the outcomes of joint replacements around the world, disseminating implant-specific results to surgeons both nationally and internationally.[8] Because the incidence of failure, especially in the short term, is low in arthroplasty, large numbers of patients are required to be studied over decades in order to provide meaningful insight. Randomized clinical trials are generally not practical for such outcome metrics. The Canadian Joint Replacement Registry (CJRR), under the umbrella of the Canadian Institute of Health Information (CIHI), oversees the registration of implanted hip and knee prostheses in Canada and is part of the International Society of Arthroplasty Registries (ISAR).


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## UPDATE: STAND UP AND BE COUNTED!

The CRA launched a national rheumatology workforce survey called **Stand Up and Be Counted** in March 2015. The objective of the survey is to determine the current workforce capacity for rheumatology care in Canada and to map the geographic distribution of rheumatologists. This work will help us estimate our current workforce capacity to care for our patients, plan for the future, inform model of care development, and support advocacy efforts for our specialty.

To date, more than 325 rheumatologists have responded to the survey. Your participation is critical in ensuring the success of this work. It is not too late to **Stand Up and Be Counted**! The survey will remain open until August 2015. Please contact *claire@rheum.ca* to receive your link to complete the survey.

## Indication and clinical use

- SIMPONI® I.V., in combination with methotrexate, is indicated for the treatment of adults with moderately to severely active rheumatoid arthritis
- No studies have been performed in pediatric patients
- 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 (TB) 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, TB, 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 TB, or with underlying conditions which may predispose patients to infections, or who have resided in regions where TB and invasive fungal infections are endemic
- **TB (from reactivation or latent TB 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 TB
  - If latent TB is diagnosed, start with anti-TB therapy before initiation
  - Monitor for signs and symptoms of active TB
- **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
- Latex sensitivity
- 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 CNS demyelinating disorders
- Closely monitor patients who have undergone surgical procedures for infections
- Women must not breastfeed during and for 6 months after last treatment
- 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
- Potential for medication errors

## 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 25, 2014.


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