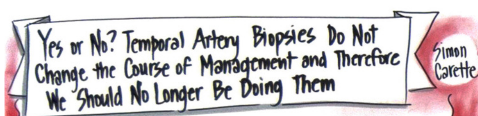
Controversies in Rheumatology

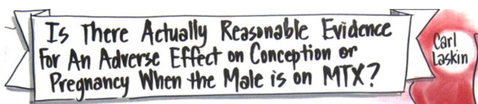
By Sherry Rohekar, MD, FRCPC

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."



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Dr. Mary-Ann Fitzcharles concluded the controversies 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.

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