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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on:

Working Behind the Scenes Supporting Rheumatology in Canada

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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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Choosing Unwisely

By Philip A. Baer, MDCM, FRCPC, FACR

"You can only fall in love six times in your life. Choose wisely."

- Douglas Coupland

Changing behaviour is difficult. One of my favourite examples relates to Vitamin C and scurvy. It took 42 years from the time that scurvy was identified as being preventable by ensuring an adequate intake of citrus fruit until the British navy mandated that each sailor receive a ration of fresh oranges and lemons daily.[1]

Adult education talks about achieving a zone of mastery, where patterns are recognized and actions taken semi-automatically without great mental effort. The concepts of muscle memory and "ten thousand repetitions" or "ten thousand hours" in sport and the performing arts have a similar background.[2] I appreciate this daily, as my 20 km commute to and from work happens without my consciously recalling each traffic light or turn en route. The drive seems so much longer in bad weather, when more concentration is required.

In the office, we benefit as well. For simple conditions, we can almost predict the patient's answers to our questions before they are uttered. Physical examination findings in these situations are usually not surprising, and are anticipated based on the history. One develops a set of mental speeches that can be unspooled and recited to cover the basics of the diagnosis and treatment plan.

Problems arise when new medical information becomes available, requiring a change in what we do. It is hard to overcome learned habits and inertia unless the information is clear-cut and compelling; even in those cases, knowledge translation remains a challenge. In other situations, physicians may never have learned the correct approach in the first place—a particular challenge in rheumatology, which I believe does not receive an adequate allotment of instruction time in undergraduate and post-graduate medical training. This applies particularly to physicians who will staff the front lines of primary care, where musculoskeletal conditions are so prevalent.

The results unfurl in my office daily. Most of my referrals come from family physicians and general practitioners, who seem to have been taught that a rheumatology referral requires ordering a battery of tests I would never ask for, such as rheumatoid factor (RF), antinuclear antibodies (ANA), anti-double stranded DNA (dsDNA) and complement studies in routine cases of knee osteoarthritis (OA) or low back pain. This has been repeatedly documented in the clinical literature.[3,4] Similarly, the desire to order knee and spine MRIs seemingly cannot be overcome easily, even when plain knee X-rays demonstrate abnormalities, and when there is no spinal surgery in view.

What will it take to really make a difference? Pressure on healthcare budgets will make an impact eventually. We are already experiencing freezes and cuts to physician fees in Ontario, with offers to restore funding if physicians can propose system-savings initiatives which would reduce spending on unnecessary lab testing and imaging. I have great hopes for **Choosing Wisely Canada**, spearheaded nationally by Dr. Wendy Levinson, and for the CRA's **Choosing Wisely** initiative (*www.rheum.ca/en/the_cra/choosing_wisely_canada1*), led by Dr. Shirley Chow. The matrials and evidence are compelling. Knowledge translation and dissemination will be critical. Perhaps increasing patient

knowledge will lead them to question and educate the medical practitioners they encounter. Personally, I am taking every opportunity to present this material when I am given a choice of continuing medical education (CME) topics, including at journal clubs, at cruise CME conferences, and at events such as *Primary Care Today* (*www.pri-med.ca/pct/home.html*).

I remain hopeful that the next generation of electronic medical records (EMRs) will integrate testing guidelines at the point-of-care, as well as dashboards to optimize care as it happens. Perhaps a pop-up will appear on a general practitioner's screen when they order a "rheumatology panel" of labs on a patient with simple hip or knee OA. Maybe it will stop the ordering of anti-dsDNA and extractable nuclear antigens (ENA) panels when the ANA status has not yet been determined. One can only hope.

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AWARDS, APPOINTMENTS, ACCOLADES

The Sunnybrook Health Sciences Centre (SHSC) Department of Medicine *Pre-clerkship Teaching Award* recognizes exemplary teaching in the first two years in medical school. As the most recent recipient of this award, I was prompted to reflect on the role rheumatologists played in my own education. As a student, I was inspired by excellent role models such as Dr. Dafna Gladman, Dr. Lynn Russell, and Dr. John Sibley.

I became even more appreciative of their efforts when I transitioned into a medical teacher myself. I will strive to repay my mentors by passing on knowledge, skills, and dedication to patient care to the next generation of physicians.

Dr. Mary Bell received the Ontario Rheumatology Association (ORA) *Rheumatologist of the Year Award* presented at the ORA Annual General Meeting in May 2015. This award is given to an Ontario rheumatologist who has made a significant and meaningful contribution to the ORA in keeping with its pillars of engagement. She suggested that the association embark on an EMR journey that has resulted in the highest rate of EMR adoption in any specialty. She has been active in the Models of Care Committee supporting all aspects of our work, and an advocate for Allied Health Professionals working in community and hospital environments. She has also diligently supported our work with the Ontario Pharmacists Association with dissemination of the Medscheck Programme. Dr. Bell has been a great supporter of the ORA: "I think that more has been done for rheumatology in Ontario by the ORA in the past 10 years than by any other group over the past 30 years!"

Dr. Bell has an MD from the University of Toronto and an MSc in Clinical Epidemiology and Biostatistics from McMaster University. She served as the Head of the Sunnybrook Hospital Division of Rheumatology and was the Director of Continuing Education and Knowledge Translation for the University of Toronto. She has led and has been awarded for her work on several successful national projects, including *Getting a Grip on Arthritis* and the *Patient Partners in Arthritis Programme*. She continues her research at the Arthritis Community Research and Evaluation Unit (ACREU).

Dr. Dafna Gladman was awarded the Royal College of Physicians and Surgeons 2015 Mentor of the Year. The regional *Mentor of the Year Award* was established to recognize Fellows of the Royal College in good standing who have had a significant impact on the career development of students, residents, and/or Fellows. The nominee must have demonstrated their ability to be an excellent role model in demonstrating the qualities or competencies of a "professional" as described in the CanMEDS framework. Dr. Gladman is a recognized, international leader in both systemic lupus erythematosus and psoriatic arthritis (PsA) with emphasis on database development, prognosis studies, genetic markers for disease susceptibility and expression, assessment instruments, and quality-of-life measures.

This scholarly work is complemented by an extraordinary track record mentoring student learning and experience. She served as Program Director for the University of Toronto rheumatology program between 1992 and 2003, overseeing the training of approximately 40 rheumatologists, many of whom have gone on to become community and academic leaders. She has supervised research projects for a staggering number of students of different levels including 13 core medical resident projects, 68 rheumatology fellow projects, 64 undergraduate student projects, and 19 graduate (MSc and PhD) projects.

AWARDS, APPOINTMENTS, AND ACCOLADES

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

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

Who Is Behind That Email Address?

Name: Sharon Brinkos

Role at the CRA: Executive Assistant

How long have you been kicking around? Almost 2.5 years!

What has been your funniest moment working at the CRA? There is not any one particular moment but when Christine, Virginia, Claire, and I get together, there is usually something that we all have a good laugh over.

Have you experienced a real eye-opener while in your position? Working with doctors gives a real appreciation for what they do and how they are trying to make things better for the future.

How many ASMs have you attended? Two: Whistler (2014) and Quebec City (2015).

At 5 pm on a Friday I can be found either packing up to head to the cottage or cooking dinner.

Personal interests? Cooking, spending time at the cottage, crafts, and my volunteer jobs.

Why do you love working for the CRA? Meeting everyone that I deal with on a daily basis at the ASM and working from home allows for flexibility with my kids' schedules.

Do you have any pets/personal mascots? Yes, his name is Oskar.

Name: Claire McGowan

Role at the CRA: Project Coordinator

How long have you been kicking around? I have been kicking around for quite some time, specifically a year at the CRA.

What has been your funniest moment working at the CRA? We have had some funny times on flights…although perhaps my colleagues spend more time laughing *at* me.

How many ASMs have you attended? One so far…Quebec City (2015).

At 5 pm on a Friday I can be found kicking off the weekend with the ones nearest and dearest to me.

Personal interests? Photography, travelling, kayaking, and hiking.

Why do you love working for the CRA? I work with good and wonderfully dedicated individuals who all channel their energies towards a common goal.

Do you have any pets/personal mascots? No pets, no plants. I am only good at keeping people alive and well!

Name: Virginia Hopkins

Role at the CRA: Research & Technology Coordinator

How long have you been kicking around? Four years.

Have you experienced a real eye-opener while in your position? The amount of knowledge that is required to do this job and understand rheumatology is endless!

How many ASMs have you attended? Four: Victoria (2012), Ottawa (2013), Whistler (2014) and Quebec City (2015).

At 5 pm on a Friday I can be found driving my kids somewhere…

Personal interests? Reading, volleyball, and ball hockey.

Why do you love working for the CRA? I love working from home and the range of responsibilities.

Do you have any pets/personal mascots? We have a Netherland Dwarf rabbit named Coco.

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CIORA Summation: 2015

By Boulos Haraoui, MD, FRCPC

The CRA Research Committee has been busy in 2015. CIORA held its eighth grant competition and this year broadened funding criteria to support projects related to all rheumatic diseases. CIORA awarded three one-year grants and six two-year grants for a total of just over $740,000! CIORA also sponsored the second *CRA (CIORA) TAS Clinician Investigator Award* which funds a young investigator with $60,000 per annum for two years which will allow them the opportunity to initiate and pursue independent research of clear relevance to arthritis. This year's recipient is Dr. Bindee Kuriya from the University of Toronto.

CIORA's contribution to the advancement of rheumatology research in Canada is made possible by the unrestricted financial contributions of many industry partners. Over the years, they have realized the importance of supporting such initiatives, thus making CIORA the third-largest funding agency of rheumatology research in Canada. We would like to acknowledge their continuous support.

A special thank you to Dr. John Esdaile for his contribution to CIORA as the Review Panel Chair. Dr. Esdaile has served as Chair since 2006 and has provided valuable guidance and direction to the review process. We would like to welcome Dr. Paul Fortin as our new Review Panel Chair.

CIORA-funded research is being presented worldwide, with several poster and oral presentations made at recent meetings of the European League Against Rheumatism (EULAR) and the American College of Rheumatology (ACR). For example, at EULAR 2015, CIORA support aided:

- *Using Patient Relevant Variables to Describe the Disease Course in Children with Juvenile Idiopathic Arthritis: Results from the REACCH-OUT Cohort* (Poster); and
- *Creating New Rheumatologists: The Canadian Experience* (Poster).

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Similarly, at ACR 2014, CIORA was involved with:

- *A Novel Approach to Assess Wait-Times to Rheumatologists* (Poster);
- *Creating New Rheumatologists: The Canadian Experience* (Oral); and
- *Increasing Access to Inflammatory Arthritis Education in Rural and Remote Communities using Telemedicine* (Oral).

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Montreal, Quebec

CIORA: Call for Grants

CIORA is Issuing Another Call for Grants in 2016!

CIORA Online Grant Application System opens January 25, 2016.

Letter of Intent must be submitted by February 29, 2016.

CIORA Online Grant Application submission deadline is March 30, 2016 at 23:59 Pacific Time.

Please visit *www.rheum.ca/en/research/CIORA* for more information.

Any questions can be directed to Virginia Hopkins at *virginia@rheum.ca*.

University of Toronto Community Rheumatologist Award

By Claire Bombardier, MD, FRCPC

Community rheumatologists play key roles in the advancement of rheumatology; as such, the *University of Toronto Community Rheumatologist Award* was created in 2009 to honour these individuals and celebrate their achievements. The award is given to a community rheumatologist "in recognition of outstanding and sustained leadership in rheumatology in Ontario." Recipients serve as role models for our trainees and faculty, contribute to our academic mission, and effectively advocate for the rheumatology profession and for the improvement of patient care.

Every May, the call for nominations for the Community Rheumatologist is announced. The winner of the award must meet the following criteria:

1. Be a community rheumatologist in Ontario;
2. Show evidence of outstanding contribution to Ontario rheumatology at large and to the University of Toronto faculty, graduates, and undergraduates;
3. Demonstrate their contribution has been sustained over many years; and
4. Display leadership in the following areas: advocacy, creative professional activity, education, research, and patient care.

Two letters of support must accompany each nomination; any faculty member or trainee within the University of Toronto's Rheumatology Division can make nominations. The review committee will consist of the Division Director, Program Director, Chief Resident, and one other member of the program committee. The letter of nomination should describe the rationale for the nomination, outline the recipients' outstanding contribution and their impact on the rheumatology community, and provide evidence of their sustained contribution over many years.

To exemplify how highly community rheumatologists are thought of, excerpts taken from nomination letters used to describe previous winners include: "has gone beyond the call of duty to contribute to the betterment of patient care, research, and rheumatology practice in Ontario," "there is not a rheumatologist in this province who remains untouched by the creative efforts, political savvy, financial foresight, hard work and contributions," "has a long history of leadership in community rheumatology at the provincial, national, and international levels," "provides an excellent rheumatology experience for residents who participate in seeing patients at his clinical site. Feedback from the participating residents indicates that this is an extremely valuable learning experience, both in terms of the rheumatology they learn and the practice insights which they gain," and "an excellent role model for future community-based rheumatologists."

The name of the recipient of the *University of Toronto Community Rheumatologist Award* is announced at the Annual Ogryzlo Research Day dinner during the after-dinner proceedings. This award is not necessarily given out every year. For more information, please visit: *www.rheumatology.utoronto.ca/aah_page82/aae_page201/Annual_Ogryzlo_Research_Day_June_24th_2014/Nominations_for_the_Community_Rheumatology_Award.htm.*

Community Rheumatologist Award

Award Year	Recipient
2012	Dr. Vandana Ahluwalia
2011	Dr. Philip A. Baer
2009 (inaugural)	Dr. J. Carter Thorne

Claire Bombardier, MD, FRCPC
Professor of Medicine, University of Toronto
Director, Division of Rheumatology, University of Toronto
Senior Scientist, Toronto General Research Institute, University Health Network Canada Research Chair in Knowledge Transfer for Musculoskeletal Care
Past Co-scientific Director, Canadian Arthritis Network
Toronto, Ontario

Rheumatoid Arthritis Biologic Criteria for All Canadians

By Jane Purvis, MD, FRCPC

The treatment of rheumatic diseases has changed dramatically in the last 15 years with the advent of new, effective therapies and the reassessment of older medications, leading now to the concept of treating patients to target and working to avoid disability and deformity. Along with this revolution in treatment has come a significant increase in the direct costs of therapy, especially as related to the expense of biologic medication. This reality has resulted in payers and prescribers attempting to rationalize or strategize the use of these therapies; such strategies have included requiring various older medications to be used first, or selecting only patients with certain levels of disease activity to be given access to the biologics. This had led to situations where patients with similar diseases, but different insurance companies, were not able to access the same medication. The provincial criteria for biologic access in the rheumatic diseases are also very different, so that current portability of coverage across insurers and provinces is uneven and not particularly equitable.

To proactively address this situation, the Third Party Payer Committee of the Ontario Rheumatology Association (ORA), with the blessing of the CRA, entered into discussions with the Canadian Life and Health Insurance Association (CLHIA), who were also interested in bringing more standardization to the system. For the first effort, it was decided to address biologic access for adults with rheumatoid arthritis (RA), as there are published treatment criteria from the CRA that have been well-accepted, and the disease is well characterized and relatively common. Given that the number of rheumatologists across the country is fairly small, it was felt that this was a reasonable first target for attempting to create pan-Canadian criteria for biologic access for private insurers.

Early on, it was decided that the specific biologic drug name was not as important as gaining access to biologics as a class. This was an important decision to allow the insurers to proceed further with the discussions. As a result, all the biologics approved for RA as of January 2014 were considered as a group, excluding rituximab, which is approved as a second-line drug after a first biologic in most cases. The criteria were derived from the evidence-based guidelines available, especially the CRA guidelines for RA.[1,2] The CLHIA helped facilitate the discussion with its member insurance companies through meetings with industry, as well as a teleconference with the ORA/CRA committee members. The ORA/CRA team included Dr. Jane Purvis (Committee lead), Dr. Arthur Karasik, Dr. Philip Baer, Dr. Carter Thorne (ORA Past-President, CRA Past-President, CRA Therapeutics Committee lead), Mr. Denis Morrice, Ms. Dawn Richards (Canadian Arthritis Patient Alliance [CAPA] representative), with consultations with Dr. Cathy Flanagan and Dr. Jason Kur (British Columbia), Dr. Cory Baillie (CRA President, Manitoba), Dr. Jamie Henderson and Dr. Peter Docherty (New Brunswick), Dr. Frédéric Morin, Dr. Boulos Haraoui, and Dr. Denis Choquette (Quebec), and Dr. Janet Pope, Dr. Vandana Ahluwalia, Dr. Henry Averns, Dr. Nikhil Chopra, and Dr. Felix Leung (Ontario). Supportive and dissenting opinions were all carefully considered by the committee.

The final accepted criterion is as follows:

- A minimum 12-week trial of methotrexate plus one other disease modifying anti-rheumatic drug (DMARD).
  - Where combinations of non-biologic DMARDs are impossible (a rare situation), three consecutive non-biologic DMARDs would be acceptable.

The agreement with the insurers is that, going forward, unless a plan sponsor instructs otherwise, private insurance plans will adhere to this standard criteria across the country. This initial step—reached with much discussion and consideration—is only our starting point on this journey, with plans to review the functionality of the criteria after their use for a few months. Input from prescribers, insurers and patient groups will be welcomed. The CLHIA along with the ORA/CRA team will meet to assess any

modifications that may be required. It is hoped that this simple criterion, applied across all insurers across the country, could lead to similar standardized outcomes with provincial formularies for RA patients. We will be speaking with each province over the coming months to see if there is a willingness to move in this direction.

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Therapeutic Updates: Where We Stand

By Carter Thorne, MD, FRCPC, FACP

The CRA is undergoing a transformation in order to better serve its members and fulfill its mission. As part of the reorganization, we have made changes to the Secretariat—we now have a CEO position—and have reviewed committees, both regarding their accountability and mandates. We now have "Board" committees and "Operational" committees, the former overseeing the mission of the CRA, and the latter tasked with implementation.

The "old" Therapeutics Committee has now been spilt into the Guidelines Committee whose mandate is review, development and implementation of guidelines; chaired by Dr. Shahin Jamal, their activities are more often than not reflective and proactive. The "new" Therapeutics Committee is tasked with the review of issues that may present themselves, including requests from members, agencies, and payers, which are often reactive.

Recent examples include the success the CRA had in securing access to naproxen suspension; see "An Advocacy Success Story", in the Winter 2014 *CRAJ* for more details. In that case, the CRA was able to facilitate a process that was expected to take two years and complete it within only 10 months.

More recently, our pediatric colleagues identified another care gap, notably the absence of triamcinolone hexacetonide (TH) from the retail market; this agent is particularly favoured for young patients. Though the Drug Identification Number (DIN) was still held by a Canadian company, we were unable to generate any interest from that source. Contacts developed by members of the committee were identified and a strategy meeting was held in Newmarket in July 2015, which included Dr. Deborah Levy, Christine Charnock, Denis Morrice, Ken D'Entremont of Medexus, and myself. Ken was able to identify an European Medicines Agency (EMA)-approved manufacturing source in Europe, secured a commitment for supply, and made application to Health Canada through the appropriate regulatory pathway. At the same time, the CRA contacted individuals at Health Canada to provide background and garner their commitment to this project. Within one month, we had received Health Canada approval for a Special Access Program (SAP) for TH, and product "landed" in Canada for distribution in August 2015 – a remarkable timeline of less than six weeks!

Projects under development include a response to pharmacists regarding drug interactions with methotrexate, and addressing ophthalmology concerns about hydroxychloroquine.

Any members interested in participating in the action-oriented Therapeutics Committee: please contact myself or Christine Charnock.

Carter Thorne, MD, FRCPC, FACP
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News From the Scientific Committee

By Evelyn Sutton, MD, FRCPC

The CRA ASM is going back to beautiful Lake Louise! *Optimizing Quality in Rheumatology Care* is the theme for our meeting, so bring your families and plan to ski, skate, toboggan, or hike in the beautiful Rockies as you reflect on the fabulous workshops and plenaries at the meeting.

Guest speaker Dr. James Maas will kick off the meeting and present the 2016 State of the Art Lecture on the evidence on the importance of sleep (for you and your patients). We are delighted to announce that the 2016 Dunlop-Dottridge lecturer is Dr. Berent Prakken, who will present on new paradigms for inflammatory arthritis. Dr. Kaveh Shojania will speak on engaging rheumatologists in quality improvement and patient safety in this era of expanding therapies, diagnostics, and costs, drawing on his keen experience translating evidence into practice.

Need Category 3 credits for Maintenance of Certification (MOCOMP)? Dr. Henry Averns will lead you through the ins and outs of performing your own chart audit. Stay tuned for emails from the CRA for pre-meeting information.

In addition to these features, we have a wide variety of other workshops planned with our own CRA experts, in addition to guest experts in respirology, gastroenterology, and a presentation by the Canadian Medical Protective Association (CMPA). In addition to the workshops, a special Meet the Expert session was designed to allow you to meet several experts within an hour to discuss your problem cases.

Our planning committee is especially excited to bring game-based learning to the meeting; Dr. Philip Baer is busy compiling questions for *RheumJeopardy*, a game that will involve all attendees in the session. Thanks to technology, we will be able to divide the room into two massive teams, so plan on participating. This is guaranteed to be fun and educational!

Clear your calendar, book your flights, and plan on having a great time in Lake Louise. I look forward to seeing you there.

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

Education's Holy Grail

By Christopher Penney, MD, FRCPC

The Holy Grail of continuing medical education (CME) is to prove that an educational activity leads to a favourable change in physician practice, which in turn leads to improved patient outcomes. The first step to that end is a chart audit that you do on patients in your own practice. Chart audits are a way for you to discover what you are really doing, rather than what you think you are doing. After completing the initial audit and reflecting on the results, you may have to close the loop by changing your practice and then prove to yourself that you have done so with a second audit.

Why bother with all this? Why not just continue attending the usual group learning (Section 1) activities as you have done in the past? The answer is simple—the rules have changed! Per Royal College standards, we are now required to complete self-assessment (Section 3) activities.

The question then is would you rather have such programs designed and administered by the CRA, or by some bureaucratic governmental or regulatory agency?

Designing and implementing effective chart audits is difficult to do on your own. That is where the CRA will help. Dr. Henry Averns has volunteered to lead pilot chart audit workshops at the upcoming Annual Scientific Meeting (ASM) in Lake Louise. Lessons learned from this workshop will be used to perfect similar workshops open to the general membership at future meetings.

Rheumatology trainees are invited to submit their rheumatologic images for a chance to win a possible travel bursary to the 2017 ASM. Winning images will be selected over the next 12 months; if your image is selected, it may end up in the permanent CRA collection and be used for educational purposes for years to come. Please visit the Education section of the CRA website (*www.rheum.ca/en/education/trainee_image_contest*) for more information.

If you have developed a CME self-assessment or practice-reflection program that can be shared with your colleagues, please review the terms of reference for the *Practice Reflection Award* on the CRA website (*www.rheum.ca/en/the_cra/practice_reflection_award*). You may qualify for one of three awards given annually. The deadline for submissions is December 31, 2015.

The CRA is partnering with Meducom to develop multi-sponsor medical publications for self-directed learning activities (Section 2). Money generated from this venture will be used to support educational activities such as chart audits for the CRA membership.

Christopher Penney, MD, FRCPC
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WELCOME TO THE RHEUM & FAREWELL AS YOU LEAVE

Welcome to the following new members:

Dania Basodan, Montreal, QC
Maysoon Eldoma, Calgary, AB
Mikameh (May) Kazem, West Vancouver, BC
Taneisha McGhie, Toronto, ON
Bahar Moghaddam, Vancouver, BC
Liam O'Neil, Winnipeg, MB
Valerie Nadon, Montreal, QC
Ruud Verstegen, Toronto, ON

Congratulations are offered to:

Dr. Jamie Henderson as he embarks upon his retirement. The CRA, and your former *CRAJ* Editorial Board colleagues, wish you the very best!

So long and thanks for all the fish.

Abstract Committee: Reviews & Reports

By Maggie Larché, MBChB, MRCP(UK), PhD

As chair of the Abstract Committee, I have been working with Virginia Hopkins and Christine Charnock on streamlining the submission and review process.

Having adapted the score sheet to be more in line with the CIORA review process, we now have a 10-point scale for several questions pertaining to factors such as hypothesis, design, methods, results, and conclusions. With an increase in the number of abstract reviewers, we are able to have two or three reviewers assessing each abstract. This allows for more rigorous assessment of each abstract and will enable enhanced selection of podium presentations and prize-winners.

For the 2015 meeting we had 255 abstracts to review. This year, we have had 277 abstracts submitted, the best of which will be considered for one of 11 potential prizes, of which four are specifically aimed at young faculty—Basic Science, Clinical Research, Epidemiology/Health Services Research (especially cohorts), and Pediatric. Other prize categories are:

- Best Abstract on Clinical or Epidemiology Research by a Trainee: *Phil Rosen Award*
- Best Abstract on SLE Research by a Trainee: *Ian Watson Award*
- Best Abstract on Basic Science Research by a Trainee
- Best Abstract on Research by a Rheumatology Resident
- Best Abstract on Research by an Undergraduate Student
- Best Abstract by a Medical Student
- Best Abstract by a Post-Graduate Resident

Based on high scores, abstracts will be selected for podium presentations. We are looking forward to an interactive poster session, with wine and cheese, and cutting-edge podium presentations.

For more informations on these awards, and others, please visit *www.rheum.ca/en/the_cra/awards*.

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More Communications!

By Stephanie Keeling, MD, MSc, FRCPC

The CRA Communications Committee is actively seeking candidates interested in sharing their expertise.

If you are interested in joining the committee or contributing to the monthly CRA newsletter, *Rheum To Go*, please contact Claire McGowan at *claire@rheum.ca*.

Stephanie Keeling, MD, MSc, FRCPC
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Guidelines Committee: Update 2015

By Shahin Jamal, BScPT, MD, FRCPC, MSc

Over the past few years, the CRA Therapeutics Committee has been very active with clinical practice guidelines. As a result, in 2014, the CRA Guidelines Committee was founded to focus specifically on clinical practice guidelines, consensus statements, and disease-management-related position statements. We have been working with Dr. Peter Tugwell and a group at McMaster University to streamline the guideline development process and ensure our methodology is up to date.

Over the past year, our Committee has been very active across many diseases and management spectrums. In the spring, the 2014 Update of the CRA/SPARCC Treatment Recommendations for the Management of Spondyloarthropathy (SpA) were published in two parts in the *Journal of Rheumatology*.[1,2] The CanVasc Recommendations for the management of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitides were accepted for publication in the *Journal of Rheumatology* and published in October 2015. These were both huge undertakings and I commend Dr. Sherry Rohekar, Dr. Christian Pagnoux, and their groups on their hard work and perseverance. Dr. Stephanie Keeling continues to lead a group of Canadian lupologists towards the development of management guidelines for lupus. There was meeting in September 2015 in Toronto, and we are excited to see their findings published within the coming year. The pediatric section of the CRA has developed a Canadian position statement on management of juvenile arthritis. This too will be submitted for publication soon.

Dr. Mary-Ann Fitzcharles has done an excellent job advocating and educating on the use of medicinal marijuana in rheumatic diseases. In the summer of 2014, she published data from a survey of CRA members detailing rheumatologists' lack of confidence with prescribing cannabinoids.[3] This was followed up in January 2015 with an editorial on expanding medicinal marijuana access in Canada for rheumatic disease.[4] We have recently submitted a systematic review of randomized controlled trials of the efficacy, tolerability, and safety of cannabinoid treatments in the rheumatic diseases. This will hopefully be published in *Arthritis Care and Research* in the coming months.

Subsequent entry biologics (SEBs) have arrived in Canada and the CRA has had some involvement in this process. We submitted a position statement to Health Canada in fall 2014, and worked with a group of pharmacology colleagues to disseminate and publish on Canadian rheumatologist attitudes towards SEBs.[5] Work in this area continues, and more information can be found at *www.rheum.ca/en/the_cra/drug_updates*.

We have many projects ongoing: There was a needs assessment circulated to the CRA membership over the summer, focused on management of giant cell arteritis. In the coming months, a similar needs assessments will be distributed on management of inflammatory arthritis in pregnancy; another needs assessment on management of Takayasu's arteritis (TAK) was recently completed. Based on the results, researchers will be developing clinical practice guidelines in these areas. The groups who developed the rheumatoid arthritis (RA) and fibromyalgia guidelines published in 2011 will be evaluating uptake of these guidelines and working on updates for the future.

Finally, the CRA has supported the Canadian Institute of Health Research (CIHR)-Institute of Musculoskeletal Health and Arthritis (IMHA) James Lind Alliance (JLA) which is looking at priority-setting in fibromyalgia. There has been a recent survey of our membership to determine the top-10 unanswered research questions in the management of adult fibromyalgia. This priority-setting exercise could be used in other areas of research by the major research funding charities.

I have had the great privilege of chairing the Therapeutics (and now Guidelines) Committee since 2011. I will be stepping down in February 2016 and Dr. Glen Hazlewood will be taking over. I have no doubt that he will do an excellent job! We are very lucky to have such enthusiastic colleagues that continue working hard to improve rheumatology in Canada. I would like to thank all of the passionate members of my Committee and the CRA Board for their time, expertise, support, and dedication. I would particularly like to thank Christine Charnock, without whom none of us could do what we do.

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Can You Tell Me What CanREAL Really Is?

By Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE;
Susan Humphrey-Murto, MD, FRCPC, MEd; Christopher Penney, MD, FRCPC

Can What? CanREAL stands for Canadian Rheumatology Education and Learning. This subcommittee of the CRA Education Committee was founded on the premise of "promoting scholarship in rheumatology education." About 15 years ago, Dr. Lori Albert originally convened a small nucleus of educators as an informal group. At the 2012 CRA Annual Scientific Meeting (ASM), the group met and formed this working group subcommittee. At the 2013 CRA ASM, the CRA provided official subcommittee status.

What do we do? **The purpose of CanREAL is to:**

- Promote exchange of ideas and best practices for rheumatology education at the undergraduate and postgraduate level.
- Promote scholarship in rheumatology education in Canada.

Can Who? The CanREAL membership structure is an open committee membership of individuals interested in undergraduate and post-graduate medical education. A special welcome is extended to rheumatology trainees considering a career in medical education. Those interested in getting involved can contact:

- Dr. Raheem B. Kherani, Chair: *raheem.b.kherani@gmail.com*
- Dr. Susan Humphrey-Murto, Vice-Chair: *shumphrey-murtomd@toh.on.ca*
- Dr. Christopher Penney, Secretary and Chair, CRA Education Committee: *penney@ucalgary.ca*

Can When and Where? Face-to-face meetings are held at the CRA ASM each year. Teleconferences have been set up as needed throughout the year with the support of the CRA.

Can Why? CanREAL provides a national forum for collaboration in rheumatology education, innovation, and scholarship. Early collaborations are developing with shared projects and connections that the CRA fosters through support of organizations such as CanREAL. There have been discussions reviewing a potential new award, entitled the *Medical Education Innovation Project Award* to complement the recently developed *Practice Reflection Award*. Future directions include ongoing round-table discussions amongst rheumatology educators nationally to share best practices and innovations, and to provide a platform for the development of scholarship across institutions. Through collaborations within the CRA there is opportunity for the development of more web resources and enhancing the educational delivery of the CRA ASM.

Can **YOU** engage with medical education in rheumatology nationally? Absolutely. Join us for the next CanREAL meeting in Lake Louise.

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- 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.

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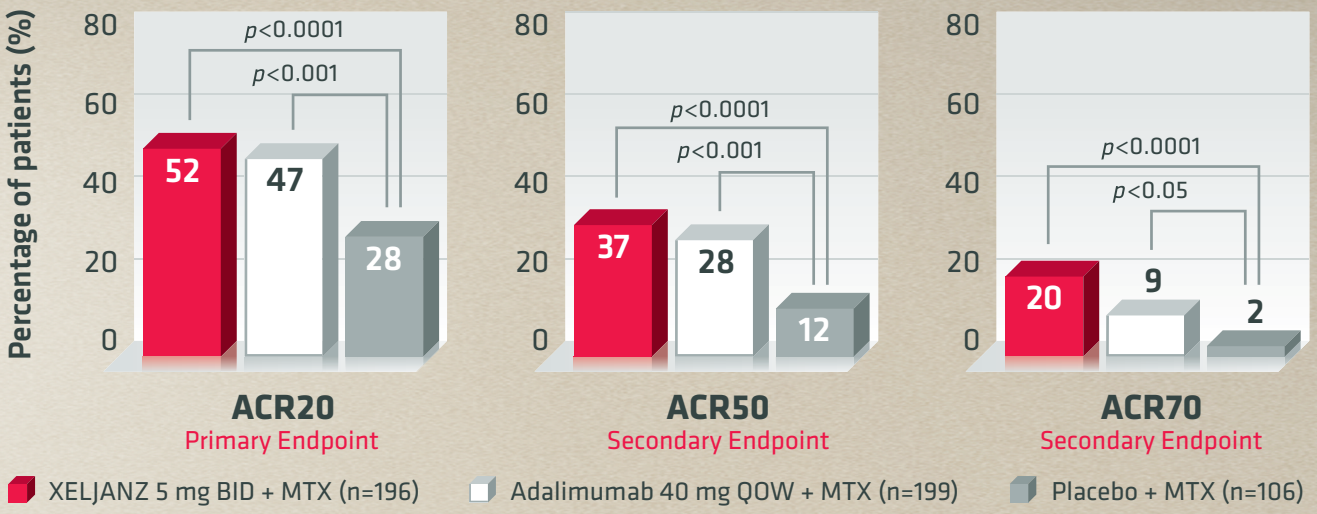
Significant symptom reduction was shown at 6 months in MTX-IR patients treated with XELJANZ + MTX vs. placebo + MTX.[1*]

This study was not designed to compare XELJANZ to adalimumab.

ACR response rates at 6 months



Significant improvement in physical functioning at 3 months was achieved in MTX-IR patients treated with XELJANZ + MTX 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.

- 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. **2.** Arthritis Society. June 2014 Impact - Ease of Use. Available at http://www.arthritis.ca/page.aspx?pid~7650. Accessed July 22, 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 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.

†The Arthritis Society's Ease-of-Use Commendation recognizes products, like the XELJANZ bottle cap, that have been independently tested for easy use and handling for people living with arthritis. The Arthritis Society does not determine the therapeutic value of products and the designation is not intended as a general product endorsement that are designed for ease of use in patients with arthritis.

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The XELJANZ bottle cap was awarded The Arthritis Society's Ease-of-Use Commendation.[2†]

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Optimal Care Committee

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

I have continued my role as Chair, aware that such joy should be shared with others, and keen therefore to pass on the honour to someone new. Please form an orderly line up at the next CRA meeting or email me if you are interested.

The Optimal Care Committee—formerly Access to Care—continues to focus on our relationship with the Non-Insured Health Benefits Program (NIHB); to this end I have continued to meet with them twice a year to discuss issues raised by our members and to offer advice on future guidelines and processes. Our relationship is a good one. Occasionally I have to hear pharmacists report on less satisfactory phone calls with our colleagues, and perhaps this is an opportunity to remind you that I am happy to be a conduit for your frustrations. I met recently with them to help with the process of developing guidelines for the use of biologic therapies in patients with psoriatic arthritis (PsA). We also discussed which outcomes are reasonable to expect to be recorded when requesting access to these agents; I chose to steer more towards robust outcomes such as swollen joint count, and to try to avoid scores requiring access to lab work, which is often challenging on the day of the consultation with the patient.

The NIHB continues to request information specifically to inform their policies regarding the pediatric population and I repeat my request for members to offer any advice or examples of issues to be shared with the Optimal Care Committee. Meanwhile Dr. Brent Ohata is developing some educational tools for improving the knowledge of fellows, and ultimately members, on the unique challenges and needs of our indigenous population.We look forward to hearing more from him at the next CRA meeting.

It is with a heavy heart that I must announce that the Wait Time Alliance (WTA) members have not met this year, and have enjoyed a period of hibernation and reflection. Many of you are aware that this is a meeting that I keenly anticipate each year. Of course, our commitment to defining benchmarks for reasonable waits remains strong, but at present our role is to develop more robust frameworks allowing collection of reliable and meaningful data.

While a specific release date has not yet been decided, the WTA plans to provide the new Minister of Health with a report card in the early days of the new government. Wait-time data were taken from provincial wait-time websites in spring and early summer of 2015. Those provinces that did well in 2014 continue to be the best performers in 2015, namely, Saskatchewan, Ontario, and Newfoundland and Labrador. In terms of specific rheumatology data, we have a series of question marks and no data at all at present, which I think gels pleasingly with many of my consultations. One suspects that in Ontario, trying to persuade rheumatologists to balance a 6% fee cut with better wait times might not receive universal acclaim. So it is with a tear falling to the page that I dip my quill for a final time.

Henry L. Averns, MBChB, FRCP(UK), FRCPC
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Pediatric News 2015

By Deborah Levy, MD, MS, FRCPC; Lori Tucker, MD;
Mercedes Chan, MBBS, FRCPC, MHPE; Janet Ellsworth, MD, FRCPC

Pediatric Committee

The Pediatric Committee of the CRA represents all Canadian pediatric rheumatologists. Current membership is approximately 55, with an additional 10 trainee members. We also welcome adult rheumatologists who see a significant number of pediatric patients in their practice. Although we are a small group, we are cohesive and have had an active and successful year! The current Executive includes Dr. Rosie Scuccimarri (Past Chair), Dr. Deborah Levy (Chair), Dr. Ronald Laxer (Vice-Chair), and Dr. Roberta Berard (Secretary). We have three active subcommittees that liaise with other CRA Committees, and an *ad hoc* Subcommittee that tackled Canadian management guidelines for juvenile idiopathic arthritis (JIA).

Advocacy Subcommittee

The Advocacy Subcommittee, chaired by Dr. Lori Tucker, takes on issues of importance to patient care identified by our Committee members. Over the past year, we have focused on issues of access to therapies for children with JIA. Naproxen liquid was unexpectedly discontinued in late 2013, leaving no approved nonsteroidal anti-inflammatory drugs (NSAIDs) for treatment of JIA available in liquid form. Strong advocacy efforts via an *ad hoc* group that included representatives of the Pediatric Committee as well as the CRA Therapeutics Committee, the Ontario Rheumatology Association (ORA) and The Arthritis Society (TAS) led to renewed availability of naproxen suspension in Canada earlier this year. See "An Advocacy Success Story", in the Winter 2014 *CRAJ* for more details.

Following success with naproxen we turned to triamcinolone hexacetonide (TH), the preferred steroid preparation for intra-articular use in pediatric rheumatology. This medication has been available only via the Special Access Program (SAP) for the past several years, until the recent discontinuation of supply in the late spring of 2015. Quick work by a similar *ad hoc* Committee has led to reinstitution of access via a new SAP supplier and together we are working on a permanent solution, outlined in greater detail on page 10 of this issue of the *CRAJ*.

Lastly, our Committee has begun the process of identifying barriers to rheumatology care for children and youth of First Nations background. The CRA Optimal Care Committee, chaired by Dr. Henry Averns, is working with the federal Non-Insured Health Benefits (NIHB) program to bring rheumatology care issues into the open and work collaboratively to try to address them. We have begun to discuss issues such as limited biologic medication access for diagnoses other than JIA, and transition access issues for teens.

Education Subcommittee

The Education Subcommittee, chaired by Dr. Mercedes Chan, continues to strive to fulfill our mandate to equip all doctors who interact with children with rheumatic disease with resources to enhance knowledge and management of pediatric rheumatologic conditions. Some of the steps being taken include formally exploring representation at the level of the Canadian Pediatric Society (CPS), as well as encouraging and supporting rheumatology teaching at CPS annual meetings. We are also proactively reviewing the CRA's website with the aim of increasing pediatric content and linking resources between the CRA and CPS.

Human Resources Subcommittee

The Human Resources Subcommittee, chaired by Dr. Janet Ellsworth, conducts regular surveys of the pediatric members regarding manpower, clinical and academic activities, and allied health resources. These surveys are a valuable resource to our community, providing a snapshot of what is happening in pediatric rheumatology centres across the country. In 2015, we participated in the design of **Stand Up and Be Counted** to include relevant pediatric data. We had an excellent response, with completion of the survey by over 90% of the Pediatric Committee members, and await analyses of these data to help plan for a full pediatric survey next year.

JIA Management

An *ad hoc* Subcommittee, chaired by Dr. Ross Petty, has prepared a position paper on the management of JIA in the Canadian context. It builds on the guidelines of the British Society for Pediatric and Adolescent Rheumatology (BSPAR) and those of the American College of Rheumatology (ACR). Many members of the Pediatric Committee participated in

subcommittees chaired by Dr. Tania Cellucci and Dr. Jaime Guzman; all members had the opportunity for input into the development of the guidelines which deal with access to care, and appropriate institution of second- and third-line pharmacologic treatment. Following approval by the Guidelines Committee of the CRA, the manuscript will be submitted for publication in the fall.

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AMRQ: It Is The Same Old Story…

By Frédéric Morin, MD

On this very date last year, I wrote that we were in forced negotiations with the Quebec government. At that time, balancing the provincial budget was the number one priority.

All medical specialists were expected to do their part by reopening the agreement signed years earlier, which provided for a salary increase over seven years to reduce the gap between Quebec and the other Canadian provinces. In spite of all this, we came out of negotiations fairly well, without cuts and having preserved the promised increase, albeit postponed to a later date. The irony of this "imposed amount" is that Quebec's current health minister is the same person who negotiated the agreement when he was president of the Fédération des médecins spécialistes du Québec (FMSQ). Politics can sometimes turn people into false friends…

We now find ourselves swept up in the same maelstrom! In a few weeks, the Quebec government will adopt Bill 20, which dictates, among other things, the conditions for accessing specialized medicine. If applied, a physician who fails to meet the objectives set out in the bill could be penalized (10% per quarter). For example, 90% of consultation requests by first-line caregivers will need to be fulfilled on a priority basis determined by a central office. Imagine implementing this kind of monitoring: "Big Brother is watching you." Obviously, we are attempting to extract ourselves from this mess by negotiating realistic and unified objectives. Implementation of this bill is planned for January 2016. The hope is that an agreement will be signed shortly that makes Bill 20 obsolete.

To end on a happier note, the Association des médecins rhumatologues du Québec (AMRQ) held its 2015 annual convention at the beginning of October in the picturesque region of Estrie. The convention was a resounding success with record participation from our members. Dr. Anne St-Pierre ably guided an amazing team. Kudos for a job well done. Congratulations also to Dr. Alessandra Bruns, the recipient of the 2015 Merit Scholarship!

Frédéric Morin, MD
President,
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News From SOAR: Atlantic Update 2015

By John Hanly, MD, FRCPC

The 32nd annual meeting of the Society of Atlantic Rheumatologists (SOAR) took place at the Algonquin Resort in beautiful Saint Andrews, New Brunswick from June 19-21, 2015. An enthusiastic group of SOARites—with representation from all three Maritime provinces and Maine—gathered for the event. The members renewed personal and professional friendships, garnered new scientific knowledge from excellent presentations, and enjoyed the beautiful weather at that time of year. Some even managed to squeeze in a round of golf!

This year's guest speakers were of the usual high caliber for SOAR meetings. Dr. Boulos Haraoui from the Université de Montréal gave the second David Hawkins lecture in rheumatology on *Applying T2T in Daily Clinical Practice: Choice and Interpretation of the Target*; followed by a presentation on *The Biosimilars: Myths and Facts*. The following day we were joined by Dr. Jan Dutz, from the University of British Columbia, who addressed the group on *The Skin as a Marker of Immunodeficiency in Dermatology and Rheumatology* and *New Concepts in Cutaneous Vasculitis*. The scientific program was completed with presentations from SOAR members.

At our gala dinner SOAR thanked Dr. Jamie Henderson for his 32 years of service as Treasurer/Secretary. Jamie, who retired from clinical practice this year, was one of the founding fathers of the organization and attended all of the annual meetings over a 32-year span, a record unlikely to be matched! We wish him an active and happy retirement and look forward to seeing him and Barb at many more SOAR meetings.

Dr. Jamie Henderson.

At the invitation of Dr. Sylvie Ouellette, several members participated remotely in an event organized in Moncton to honour the memory of three RCMP officers killed in the line of duty in that city in June 2014. As the inaugural event occurred on Father's Day, it was appropriately called **3 kms for 3 Fathers** to bring the community together in honour of these avid runners. It is now intended to be an annual event with aims to create a scholarship fund available to Moncton area high schools.

Overall, 2015 was another terrific meeting; the group is already looking forward to next year's SOAR meeting in Fox Harbour, Wallace, Nova Scotia on June 17-19, 2016.

John Hanly, MD, FRCPC
Professor of Medicine and Pathology,
Director of Research and CME,
Division of Rheumatology, Department of Medicine,
Capital Health and Dalhousie University
Past-President, Society of Atlantic Rheumatologists
Halifax, Nova Scotia

Forever SOARing to new heights: SOAR members and guests.

3 kms for 3 Fathers, a walk/run/jog in honour of three men who gave their lives for their community.

Sometimes: Notes from the ORA President

By Arthur Karasik, MD, FRCPC

"Sometimes, you may have to get lost first, to really find yourself."
- Anonymous

Admittedly, when I first started my new role I had, as people had warned me, a feeling like a deer in the headlights. There have been struggles of course, and tremendous challenges, but I take pleasure in what the ORA has accomplished. There is no association apathy or myopia. It has been anything but boring!

I applaud our supporters, who have helped us maintain our financial health. This solid financial standing means we have the resources and reserves to be effective in our service to our membership and all arthritis stakeholders. For 2016, we will re-examine, prioritize, and lay the groundwork for our new business plan.

There are many committee initiatives. I have observed our committee leads, executive, and project managers, and I can say that the pleasure is not in accomplishing an initiative; rather the pleasure is in planning it. Most of you already realize that the foundation of success at the ORA is a strong team of committees and their leads. Some of the executive are seasoned veterans, still skillfully guiding us; I have relied on and invested in their talents in order to maintain advocacy, relevancy, and strategic direction. They have brought creative thinking that leads to a more powerful, unified voice.

For 2015-2016, we will continue to work with the surge in the way we interact with technology (electronic medical records [EMR], dashboards, registries, patient education), shape healthcare debates (Exceptional Access Program [EAP] access, private payers, subsequent entry biologics [SEBs], national Pharmacare), and work to redesign our website communications to target continuous improvement. We will continue Models of Care work, particularly current key projects and knowledge translation. We hope to expand the Ontario Rheumatology Association Development and Education (ORADE) initiative to more members and international destinations in order to enhance our vision going forward. We will continue to represent issues of national interest, such as manpower, private payers, and the Arthritis Alliance of Canada (AAC).

In the last year it has been enjoyable to learn that the president of an association or a doctor does not have unquestioned authority; this role has shifted towards being an effective and respectful team player. No hierarchy, just welcoming full participation of all interdisciplinary healthcare stakeholders who can help to achieve optimal health outcomes, especially for patients with chronic diseases. New realities, involvement, and energies are continuously required to succeed. I encourage all of you, and you know who you are, to just jump right in and take a chance.

"My heart is pounding," I said.
"That's how you know you're having fun," Margo said.
- John Green, Paper Towns

Arthur Karasik, MD, FRCPC
President, Ontario Rheumatology Association
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Martinis & Musings: Notes from WAR

By Paul Davis, MD, FRCPC

The sun shone brightly and, while sipping martinis on the patio of the Manteo Resort hotel, it was difficult to remember that one was attending a serious clinical meeting. A fundamental premise of the Western Alliance of Rheumatology (WAR) meeting is that it could and should be fun. The opportunity to blend good medicine with social interaction with family and colleagues has been a major reason for its continued success.

The scientific component of the meeting is dictated by the participants themselves who are all invited to give a 15-minute clinical presentation. No visiting firemen, trials, or rats and enzymes at this meeting! Participants take pride in presenting challenging cases to their colleagues and presentations are all of high calibre, ranging from the sublime to the ridiculous. One notable feature has always been the involvement of trainees during the scientific program; their presentations are of the highest quality and their sartorial elegance unmatched by all, save for Dr. John Esdaile. This meeting is often the first chance these trainees have to give presentations to an audience outside their own educational centre. It is gratifying to see that rheumatology in Canada is in good hands for the future.

A continued extra value for trainees has been the mock rheumatology objective structured clinical examination (OSCE) supported by an industry grant. Here, trainees can ply their clinical skills against the best rheumatologic minds of western Canada and obtain confidential feedback on their performance. This has been, and we hope will continue to be, a key component of the weekend's events.

And now back to my martini! Real estate agents will tell you it's about location, location, location and the Okanagan valley offers much for attendees, not least of which include the local wineries. We continue to encourage attendees to participate in the social events of the weekend, such as wine and cheese gatherings and a BBQ supper. Somebody once said—or maybe I just invented it—that "a relaxed mind is a fertile mind".

Finally I would be remiss not to mention that this meeting would not be possible without our industry colleagues. We encourage their active participation in all activities and hope that they also obtain valuable benefit for their own continuing professional development (CPD) needs.

See you all in 2016.

Paul Davis, MD, FRCPC
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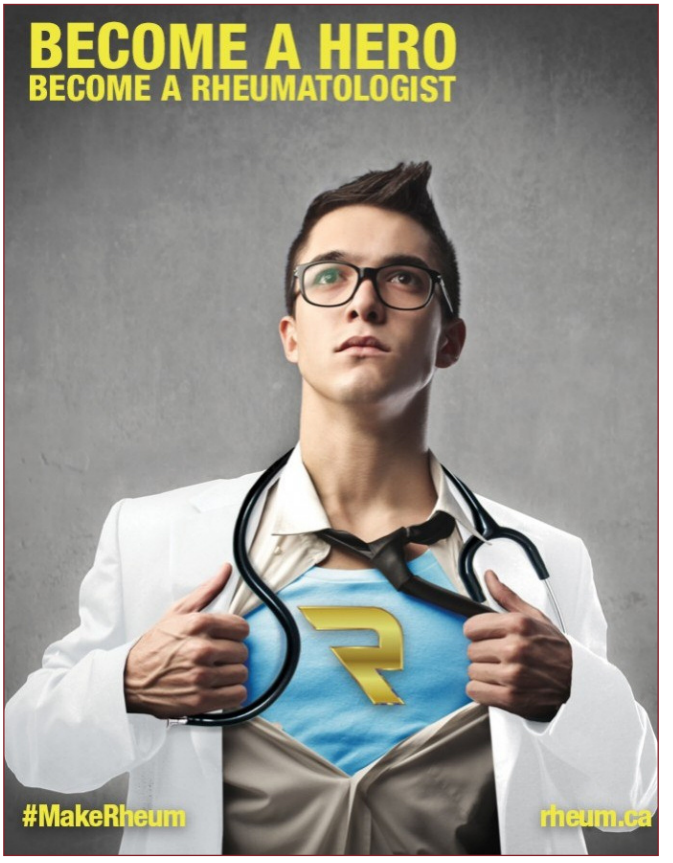

Tales of the City: ACR 2015

By Philip A. Baer, MDCM, FRCPC, FACR

"The glory that was Rome is of another day / I've been terribly alone and forgotten in Manhattan / I'm going home to my city by the Bay / I left my heart in San Francisco."

– Tony Bennett, "I Left My Heart In San Francisco" (lyrics, Cory/Cross), *I Left My Heart in San Francisco,* 1962.

I have heard this song many times, but not all the lyrics were familiar. How very appropriate it turns out to be for rheumatology in 2015, with European League Against Rheumatism (EULAR) meeting in Rome and the American College of Rheumatology (ACR) in San Francisco.

"Getting there is half the fun," they say, but modern travel is not familiar with the adage. I booked my hotel within 15 minutes of the ACR website opening for reservations in June, and managed to snag my first choice. A prior check of Trivago, TripAdvisor, and Expedia had confirmed that the ACR hotel rates were a great deal compared to the standard online offers. Flights worked out well, with numerous seat sales, and I even managed to upgrade to business class for the outbound leg.

Air Canada likes the collapse in oil prices, but the negative impact on the Canadian:US exchange rate that resulted made the rest of the trip pricier by the day. Air Canada also likes last minute aircraft changes; my return flight was altered three times. One day before departure, I received a mysterious email from Air Canada refunding my fee for a preferred seat. No indication of which flight it was for, but prior experience told me this was not good. By then, I had also tried to check-in online for the flight to San Francisco, and been rejected three times. A call to Air Canada confirmed what I had already deduced: I had been randomly selected for special security screening, which meant I would have to check in at the airport. We also worked out that my coveted aisle seat had disappeared; I now had a "preferred" middle seat instead, proffered at no cost, hence the fee refund.

Up early to get to Pearson airport. I breezed through US customs, avoiding the dreaded "holding pen", but security screening was another story. I expected the rotating X-ray scanner treatment, but not having to unpack my entire carry-on for inspection and swabbing. Every electronic device had to be turned on, every power cord checked and every bag strap examined in a fashion akin to a surgeon "running the bowel". Fortunately I had charged everything the night before. Everyone was very polite, and I even reached the lounge for a few minutes.

Meeting so many colleagues travelling on the same flight was a pleasure, especially some I only seem to meet in these situations once or twice a year. Leaving slightly late raised my pulse, as I had only about an hour between landing and my first meeting, and I loathe being late.

I planned to work en route, including on this article, after enjoying some on-board entertainment. Problems again: My touch screen was singularly unresponsive. I heard the flight attendants muttering about problems with the entertainment system; however, they resolved my issue by bringing me a large alcohol swab. Cleaning the screen restored it to normal function—one wonders how much dirt there must have been on it before. The crew could not fix the next issue: The in-seat power outlets were all dead. This was a known issue, apparently, but not something worth Air Canada's while to fix if it meant taking the plane out of service. Also not something anyone mentioned to us; my seatmate had purchased inflight WIFI for five hours, before finding out she did not have enough juice in her computer to actually use it.

We all ♥ San Francisco.

Despite everything, the actual flight arrived on time and I narrowly made my first meeting. The weather was fine for exploring the city, and walking to and from the conference centre daily. I frequently found myself near the iconic Transamerica pyramid, which had special meaning for me as a long-time medical consultant at Transamerica Life Canada. Interestingly, the adjacent "Flatiron" style building was the original Transamerica head office, now housing the Church of Scientology. With the sale of Transamerica Life Canada to the Canada Pension Plan Investment Board, the company name is now the not-yet-infused-with meaning *ivari*, and my efforts there might contribute a small amount to the maintenance of all of our government pension benefits.

Outside the conference itself, I enjoyed multiple breakfast, lunch, coffee, and dinner meetings while struggling to avoid overeating. The CRA Council and *CRAJ* Board meetings were particularly interesting and productive.

I presented one poster on minimal disease activity and patient-related outcomes in psoriatic arthritis (PSA; abstract 676), and was very surprised when we ended up as an impromptu stop on the spondyloarthropathy (SpA) poster tour. That poster also found me meeting a number of other 1-L "Philip's" attending the conference. Dr. Philip Mease had a PsA poster around the corner, Dr. Philip Helliwell stopped by, and Dr. Filip van den Bosch led the poster tour which visited our poster. Nice to see so many agreeing Philip really should be spelled with one L, not two. For fans of Ogden Nash, I did not see any 1L, 2L or 3L lamas/llamas/lllamas at ACR.

I was a free agent the rest of the time. Of course, I attended the ACR Knowledge Bowl in preparation for my role creating questions for and moderating *RheumJeopardy* at the CRA ASM in Lake Louise. The repeat winners were the University of Iowa Hawkeyes, defeating teams from Massachusetts General Hospital and the University of Texas at Galveston by a wide margin in a very fact-focused competition.

I also found intriguing presentations on my interests *du jour*, including biosimilars, JAK and IL-17 inhibitors, smoking cessation in rheumatic diseases, bispecific antibody drugs, and non-radiographic axial SpA. The Great Debate on low-dose steroid therapy in rheumatoid arthritis (RA) ended up a draw between Dr. Ruderman and Dr. Boers, and was quite entertaining. I now know the difference between non-alcoholic fatty liver disease (NAFLD), non-alcoholic fatty liver (NAFL), and non-alcoholic steatohepatitis (NASH) when discussing fatty liver. Dr. Bevra Hahn's update on aspects of systemic lupus erythematosus (SLE), including arthritis, bone disease, pregnancy, and nephritis was also very educational.

ACR 2015 broke attendance records with over 16,800 registrants. Canadian content was as strong as ever; the best coverage of the conference is provided by Dr. Andy Thompson and his team of intrepid reporters at *www.rheumreports.com/*. In addition to great medical coverage, I also learned that Yerba Buena was San Francisco's original name (meaning "Good Herb;" while nothing to do with marijuana, the odour of that controversial herb was highly prevalent on the streets around the Moscone Centre), and that St. John's and San Francisco have many things in common.

Canadian scientific content I noted with particular interest included the results of the **Stand Up and Be Counted** survey of rheumatology manpower in Canada (abstract 1269), delays in rheumatology consultation and treatment (abstract 1031), tumour necrosis factor (TNF) inhibition of radiographic progression in ankylosing spondylitis (AS) (abstract 975), some of the papers on underuse of triple therapy (abstracts 1044, 2106, 2107), and papers on the improving survival of RA patients (abstracts 1999 and 3240). Dr. Glen Hazlewood probably set a record with three podium presentations within a single session (abstracts 1041, 1043, and 1044).

The progress in rheumatology continues to amaze, driven by a new generation of clinician scientists and basic researchers. As that other famous song about San Francisco says:

"In the streets of San Francisco […] / People in motion.
There's a whole generation / With a new explanation."

ACR 2015 was a nice break from the daily office routine, though just as or more tiring in its own way. In 2016, for the first time in years, I will not be physically attending the ORA, EULAR, or ACR meetings. I hope to be a virtual presence at the *CRAJ* Board meeting at ACR through teleconferencing, assuming Air Canada gets me home on time from my overlapping event next November. So I am issuing another call for prospective authors who want to cover EULAR and/or ACR 2016 for *CRAJ* in my place: Please contact me to express your interest.

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

Top Ten Things Rheumatologists Should (And Might Not) Know About Detection and Treatment of Hemochromatosis

By Justin Cottrell; and Paul Adams, MD, FRCPC

This brief report summarizes some common issues related to hereditary hemochromatosis (HH) and its impact on patients with comorbid rheumatic diseases.

1. **HH screening.** Individuals with HH and iron overload without related complications benefit from early diagnosis and treatment. Population screening is not recommended.[1] A serum transferrin saturation and ferritin concentration is appropriate for initial diagnosis and for screening first-degree relatives of patients with HH.

2. **HH and iron overload diagnosis.** Homozygosity for the C282Y mutation in the *HFE* gene is typical. Iron overload is suspected by a ferritin > 300 µg/L in men or > 200 µg/L in women. Transferrin saturation is often elevated but has significant biological variability.[2]

3. **Genetic testing.** In most provinces, genetic testing for the C282Y and H63D mutations of the *HFE* gene is done in provincial laboratories without charge. Genetic testing for rare iron genes (*e.g.*, ferroportin, hemojuvelin, hepcidin, transferrin receptor 2) is available but not recommended; you can find out more at *www.invitae.com*. Due to stigmatization, genetic testing of children is not recommended.

4. **False positive elevations in iron tests.** Serum ferritin commonly rises with inflammation; other causes of an elevated ferritin include daily alcohol use, obesity, and fatty liver.[3] Extreme elevations of serum ferritin can be seen in histiocytosis and Still's Disease. None of these conditions have iron overload.

5. **HH treatment.** Phlebotomy (500 mL) once a week until iron levels return to normal is the primary treatment for HH and serum ferritin levels should be checked monthly or bi-monthly.[4] Maintenance phlebotomy is not always required, particularly in women. Avoidance of iron supplements, vitamin C supplements, and uncooked shellfish is also recommended.

6. **HH arthropathy distribution.** Chronic, indolent pain and joint stiffness of the joints, including the wrists, knees, hips, feet, shoulders, and ankles may be observed. Arthropathy is generally symmetrical and polyarticular. Acute bilateral destruction of the metacarpophalangeal joints (Figure 1) may resemble rheumatoid arthritis (RA); however bony swelling may occur which is indistinguishable from pyrophosphate-associated arthropathy. Disease-specific changes include subchondral radiolucency of the femoral head with atypical stripping of the cartilage from subchondral bone, and hook-like osteophytes on the second and third metacarpal heads.

7. **HH arthropathy findings.** Histological changes include abnormal iron deposits, minimal synovial inflammation,

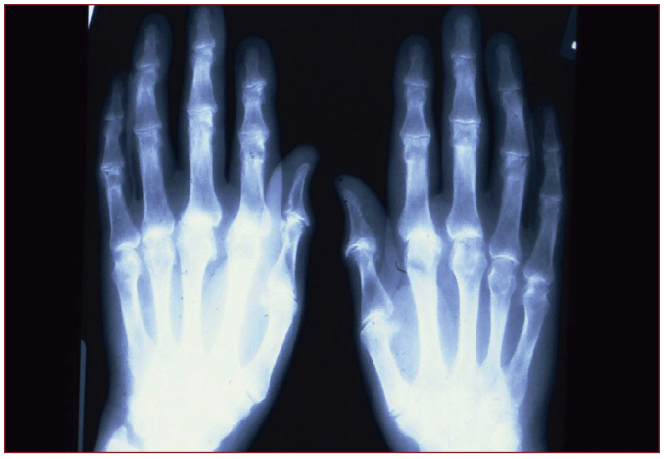

Figure 1. X-rays of the hands of a surgeon with hemochromatosis, who could not operate because of pain in the knuckles.

and calcium pyrophosphate dihydrate (CPPD) deposition, particularly in the knees and triangular cartilage. Synovial histology in HH arthropathy resembles osteoarthritis (OA) but increased neutrophils are present.

8. **HH arthropathy treatment.** Control of symptoms using analgesics, nonsteroidal anti-inflammatory drugs (NSAIDs), and acetaminophen is beneficial. In severe cases, joint replacement is warranted and is more frequent in hemochromatosis patients.[5]

9. **Other HH symptoms.** End organ damage can lead to liver enlargement, fibrosis, cirrhosis, liver failure or death and increased risk for developing liver cancer. Weakness, lethargy, darkness of the skin, diabetes mellitus, heart disease, thyroid disease, and reproductive problems due to pituitary abnormalities leading to impotence, loss of libido, amenorrhea and generalized osteoporosis may be present.

10. **Other iron overload syndromes.** Other iron overload syndromes include transfusional iron overload, juvenile hemochromatosis, aceruloplasminemia, African iron overload, neonatal, or perinatal iron overload.

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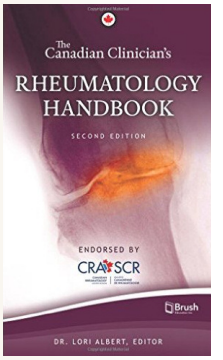
Book Review



The Canadian Clinician's Rheumatology Handbook, 2nd Edition

Editor: Lori Albert
Publisher: Brush Education Inc.
Date: 2015

This book is the second edition of a handbook written to support a national rheumatology curriculum for internal medicine trainees in Canada. Dr. Lori Albert is the lead author and editor of this volume which comprises chapters written by academic rheumatologists from across Canada. The comprehensive and well written chapters reflect the expertise of each author.

Each chapter provides a logical and comprehensive approach to major clinical presentations of rheumatic conditions. The chapters are introduced with a list of "key concepts," followed by important questions to ask during history taking as well as the clinical features to assess during the physical examination. A discussion of the recommended lab investigations, differential diagnosis, and treatment possibilities makes each chapter a complete overview of the topic.

In addition to very thorough coverage of the major clinical problems in rheumatology, a separate chapter addresses the clinical assessment and management of certain "rheumatologic emergencies".

Not only are the basics of the musculoskeletal (MSK) examination described, there is also a detailed joint examination complete with illustrations. Techniques for joint aspiration and injections are likewise detailed. Separate chapters discuss an approach to selection and interpretation of laboratory tests used in rheumatology, plus interpretation of imaging used to assess the MSK system.

The *Canadian Clinician's Rheumatology Handbook* is an excellent, comprehensive resource geared to residents in rheumatology, internal medicine, and family practice, and would be a useful asset for practicing physicians or allied health professionals working in rheumatology.

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David Robinson @drdavidrobinson

The Rheumatology Interest Group (RIgG) brings together rheumatologists and internal medicine trainees interested in rheumatology for informal evenings of food, wine, and occasionally journal articles. Best journal club ever!

Photo credit: Travel Manitoba/Robyn Hanson.

#awaywego! #Manitoba

Kerstin Gerhold @drkerstingerhold

Winnipeg welcomed two new pediatric rheumatologists, Dr. Lily Lim and myself, who are teaming up to fill the substantial vacancy left by the retirement of Dr. Kiem Oen. The team looks forward to bringing new visions to the Manitoba area.

#drlilylim

#drkerstin gerhold

#UniversityofManitoba

Photo credit: Travel Manitoba/Robyn Hanson.

#paintedwolves #SpiritWay #Manitoba

Liam O'Neil @drliamoneil

Everyone here is very excited to welcome three new rheumatology fellows, who will begin training in July 2016. An expanding program will improve many domains, including collaboration and structured learning.

Photo credit: Travel Manitoba.

#birdsofafeather #flytogether

Cory Baillie @drcorybaillie

The University of Manitoba rheumatology team is excited to welcome Dr. Amber Cogar, Dr. Mai Nguyen, and Dr. Ceri Richards as incoming PGY4 residents in July 2016!

Should Canada Night Head to Europe?

CRA members overwhelmingly indicate that one of the key reasons they belong to the CRA is for networking and connecting with Canadian colleagues. In our quest to expand opportunities, the CRA surveyed members about the ACR and EULAR meetings, and the possibility of hosting a Canada Night during future EULAR events. We queried our members on their thoughts about a European adventure. The survey was sent to the entire membership, of which 130 provided their input.

Starting locally, North American attendance rates are consistently high, with the vast majority of those polled "always" (43%) or "sometimes" (40%) attending the annual ACR meeting (Table 1). Canada Night remains a solid draw with three-quarters of participants "always" (54%) or "sometimes" (21%) attending the event while at the ACR meeting (Table 2).

Broadening the horizon, we noted a decline in attendance rates, with less than half of those surveyed (42%) regularly attending EULAR meetings (Table 3). When queried on their thoughts regarding a potential Canada Night at future EULAR meetings, we received a range of responses (Table 4). The cost of attending EULAR meeting was the most common concern; as a consequence, numerous members do not attend the meeting, and the offer of a Canada Night would not influence their attendance. Among members who do attend EULAR meetings, many noted they would prefer to use the evening to network with European colleagues, or visiting the host city during downtime.

Canada Night at the ACR meeting continues to grow and be a very successful event for networking with your Canadian colleagues. Let us know how you think we can make it even better.

Table 1. **Do you attend the ACR meeting?**

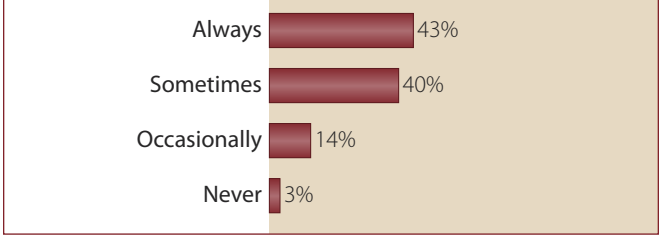


Table 2. **When you attend the ACR meeting, do you attend Canada night?**

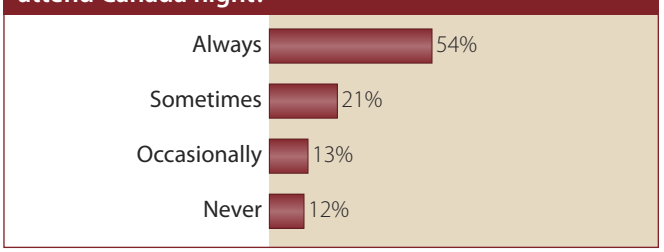


Table 3. **Do you attend the EULAR meeting?**

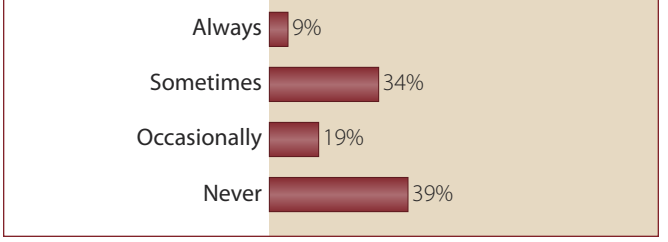
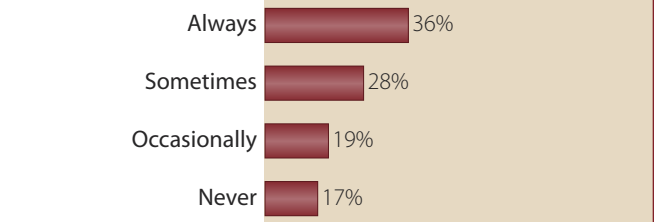


Table 4. **If the CRA was to organize a Canada Night at the EULAR meeting, would you attend?**



Other responses included: Nice idea, depending on how many CRA members attend; may be too busy with "side" activities; many members stay off-site; cost likely too high; do not really think we need it; I rarely attend EULAR. It is a very expensive meeting for us to attend, and academically, we still have to attend the ACR so its an extra meeting; this is a chance to meet with our Europeans colleagues and every evening counts. I would prefer not to have a Canada night; not sure such a meeting is added value since we all keep different schedules during conferences.

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- Reduction of signs and symptoms and improvement in physical function in patients with active ankylosing spondylitis (AS) who have responded inadequately, or are intolerant, to conventional therapies
- Reduction of signs and symptoms, induction and maintenance of clinical remission and mucosal healing and reduction of corticosteroid use in adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response to a corticosteroid and/or aminosalicylate; REMICADE® can be used alone or in combination with conventional therapy
- Reduction of signs and symptoms and induction and maintenance of clinical remission in pediatric patients with moderately to severely active CD who have had an inadequate response to conventional therapy (i.e., corticosteroid and/or aminosalicylate and/or an immunosuppressant)
- Treatment of fistulizing CD in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment
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- Reduction of signs and symptoms, induction and maintenance of clinical remission and induction of mucosal healing in pediatric patients with moderately to severely active UC who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant)
- Reduction of signs and symptoms, induction of major clinical response, inhibition of the progression of structural damage of active arthritis and improvement in physical function in patients with psoriatic arthritis (PsA)
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Please consult the product monograph at http://www.janssen.ca/product/183 for important information on conditions of clinical use, contraindications, warnings, precautions, adverse reactions, drug interactions and dosing information, which have not been discussed in this piece.
The product monograph is also available by calling 1-800-567-3331.

References: 1. Data on file, Janssen Inc. **2.** REMICADE® Product Monograph, Janssen Inc., September 26, 2014.

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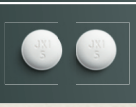

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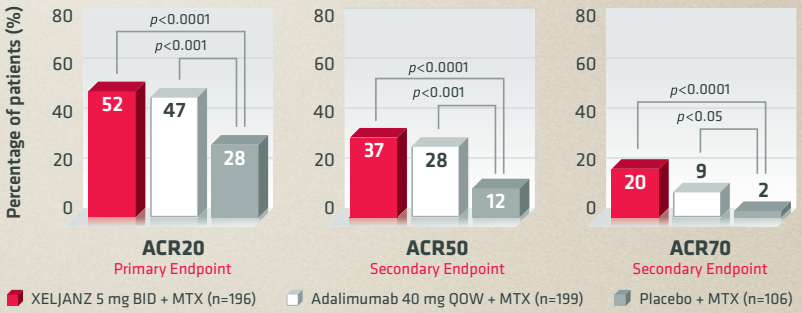
ACR response rates at 6 months



Significant improvement in physical functioning at 3 months was achieved in MTX-IR patients treated with XELJANZ + MTX 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.

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- XELJANZ should not be used during pregnancy.
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- 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.
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- 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:

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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 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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