Winter 2020, Volume 30, Number 4

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on:
CRA Committee & Regional Association Reports

olumiant®
(baricitinib) tablets

An estimated 95,100 patients have received baricitinib worldwide since launch.§

CONSIDER OLUMIANT IN THE MANAGEMENT OF RHEUMATOID ARTHRITIS (RA)[1]

In adults who inadequately responded to one or more conventional disease-modifying anti-rheumatic drugs (cDMARDs), Olumiant demonstrated:[1*]

- Significant improvement in ACR20 response rate vs. placebo at Week 12: 66%† vs. 39% (95% CI: 17.6, 35.3; $p \leq 0.05$)[1]
- Improvements in disease activity scores (DAS28-hsCRP <2.6) vs. placebo (type I error not controlled) (secondary endpoints)[1]:
  - Week 12: 26% vs. 9% (95% CI: 10.2, 23.7; $p \leq 0.05$)
  - Week 24: 31% vs. 11% (95% CI: 12.9, 27.2; $p \leq 0.05$)
- Significant improvement in mean change from baseline in HAQ-DI score vs. placebo at Week 24: -0.24† (95% CI: -0.35, -0.14; $p \leq 0.05$) (secondary endpoint) [1,2]

Convenient once-daily dosing[1]

- Recommended dose: **2 mg once daily**, in combination with MTX
- May be used as monotherapy in cases of intolerance to MTX
- Can be taken any time of the day, with or without food

Olumiant is a selective and reversible inhibitor of Janus kinase (JAK)[1‡]

Indications and clinical use:
- Olumiant (baricitinib), in combination with methotrexate (MTX), is indicated for reducing the signs and symptoms of moderate to severe rheumatoid arthritis (RA) in adult patients who have responded inadequately to one or more disease-modifying anti-rheumatic drugs (DMARDs).
- Olumiant may be used as monotherapy in cases of intolerance to MTX.
- Use of Olumiant in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine is not recommended.
- Geriatrics (≥65 years of age): Use with caution.
- Pediatrics (<18 years of age): Olumiant should not be used in this patient population.

Contraindications:
- Patients with known hypersensitivity to baricitinib or any of its components.

Most serious warnings and precautions:
- **Serious infections:** Patients treated with Olumiant are at risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt Olumiant until the infection is controlled. Reported infections include: active tuberculosis – patients should be tested for latent tuberculosis before initiating Olumiant and during therapy and treatment for latent infection should be initiated prior to Olumiant use; invasive fungal infections including cryptococcosis and pneumocystosis; bacterial, viral and other infections due to opportunistic pathogens. Do not initiate treatment with Olumiant in patients with active infections, including chronic or localized infection. Monitor closely for signs and symptoms of infection during and after treatment with Olumiant.
- **Malignancies:** Lymphoma and other malignancies have been observed in patients treated with Olumiant. Consider the risks and benefits of Olumiant prior to initiating treatment in patients with a known malignancy other than a successfully treated non-melanoma skin cancer, or when considering continuing Olumiant in patients who develop a malignancy.
- **Thrombosis:** An increased incidence of thrombosis, including deep venous thrombosis (DVT) and pulmonary embolism (PE), has been observed in patients treated with Olumiant. In addition, there were cases of arterial thrombosis. Patients with symptoms of thrombosis should be promptly evaluated.

Other relevant warnings and precautions:
- Use with caution in patients who may be at increased risk of gastrointestinal perforations.
- Patients presenting with new-onset abdominal symptoms should be evaluated promptly for early identification of gastrointestinal perforation.
- Evaluate liver enzymes before initiating Olumiant and thereafter according to routine patient management. If increases in alanine transaminase (ALT) or aspartate transaminase (AST) are observed and drug-induced liver injury (DILI) is suspected, interrupt Olumiant until diagnosis is excluded.
- Olumiant has not been studied in patients with severe hepatic impairment and is therefore not recommended.
- Combined use of Olumiant with potent immunosuppressants is not recommended.
- Not recommended for use with live vaccines.
- Avoid use of Olumiant in patients with an active infection, including localized infections.
- Closely monitor patients for the development of signs and symptoms of infection during and after treatment with Olumiant.
- Interrupt Olumiant if a patient develops a serious infection, an opportunistic infection, or sepsis.
- Use with caution in elderly and diabetic populations.
- Use with caution in patients with a history of chronic lung disease.
- Patients should be evaluated for latent or active tuberculosis infection prior to administration of Olumiant; the product should not be given to patients with active tuberculosis.
- If herpes zoster develops, Olumiant treatment should be interrupted until the episode resolves.
- Risk of increase in creatine phosphokinase (CPK) within one week of starting Olumiant.
- Avoid initiation, or interrupt Olumiant if hemoglobin <80 g/L.
- Avoid initiation, or interrupt Olumiant if absolute lymphocyte count (ALC) <0.5 x 10^9 cells/L.
- Avoid initiation, or interrupt Olumiant if absolute neutrophil count (ANC) <1 x 10^9 cells/L.
- Assessment of lipid parameters should be performed approximately 12 weeks following initiation of Olumiant and as needed thereafter.
- CPK levels should be checked in patients with symptoms of muscle weakness and/or muscle pain for evidence of rhabdomyolysis.
- Not recommended in moderate and severe renal impairment, including end-stage renal disease (ESRD).
- Use with caution in patients with risk factors for, or a history of, interstitial lung disease (ILD).
- Special populations: Should not be used during pregnancy. Women of reproductive potential should take appropriate precautions to avoid becoming pregnant during treatment, and for at least 1 week after the final treatment. Breastfeeding is not recommended during Olumiant treatment.
- Monitoring and laboratory tests: Assess lipid parameters prior to starting Olumiant therapy, approximately 12 weeks after initiation, and periodically thereafter. Liver enzyme tests are recommended. If drug-induced liver injury is suspected, interrupt therapy until this diagnosis has been excluded. Assess renal function prior to starting Olumiant therapy, approximately 4–8 weeks after initiation, and periodically thereafter. Assess lymphocytes, neutrophils and hemoglobin count at baseline, approximately 4–8 weeks after initiation, and periodically thereafter.

For more information:
Please consult the Product Monograph at http://pi.lilly.com/ca/olumiant-ca-pm.pdf for important information relating to adverse reactions, drug interactions and dosing that has not been discussed in this piece.

The Product Monograph is also available by calling 1-888-545-5972.

ACR = American College of Rheumatology; CI = confidence interval; DAS28-hsCRP = Disease Activity Score 28-high sensitivity C-reactive protein; HAQ-DI = Health Assessment Questionnaire-Disability Index.

* Phase 3, double-blind, 24-week study of 684 biologic DMARD-naïve patients with moderate to severe RA and inadequate response or intolerance to ≥1 cDMARDs. Patients were assigned 1:1:1 to placebo (n=228) or baricitinib 2 mg (n=229) or baricitinib 4 mg (n=227) once daily. The primary endpoint was American College of Rheumatology 20% response (ACR20) at Week 12 for baricitinib 4 mg.[2] Baricitinib 4 mg is not an approved dose in Canada.[1]

† Type I error controlled.

‡ **Clinical significance unknown.**

§ Estimated patient exposure for baricitinib based on cumulative sales. Clinical significance is unknown.

References: 1. Olumiant (baricitinib) Product Monograph, Eli Lilly Canada Inc., August 14, 2018. **2.** Dougados M, van der Heijde D, Chen Y-C, *et al*. Baricitinib in patients with inadequate response or intolerance to conventional synthetic DMARDs: results from the RA-BUILD study. *Ann Rheum Dis* 2017;76:88-95. **3.** Data on file. Eli Lilly Canada Inc.

olumiant® (baricitinib) tablets

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Core and Explore: A Sequel to *What is a Rheumatologist?*[1]

By Philip A. Baer, MDCM, FRCPC, FACR

"What's past is prologue."
– *The Tempest* by William Shakespeare

How do past patterns of rheumatology practice affect the rheumatologists of today?

At a recent large primary care continuing medical education (CME) event, I was mingling with attendees after presenting a review on osteoporosis. A stranger approached proffering his business card and started discussing his research/business venture in the field of fibromyalgia (FM). What was "the ask": Could I please review the protocol and business plan and provide advice? I replied that, while I was flattered to be considered, fibromyalgia was no longer a core interest of rheumatologists, including myself. I referred him to the websites of the CRA and Canadian Pain Society to find someone more suitable.

That started me thinking about the evolution of rheumatology as a discipline. At the core, everyone agrees on the primacy of the inflammatory arthritides and the poorly named "connective tissue diseases." However, while gout is the most common inflammatory arthritis, particularly in men, it is clearly not part of the holy trinity of rheumatoid arthritis (RA), psoriatic arthritis (PsA) and axial spondyloarthritis (axial SpA).

Osteoporosis (OP) as a primary diagnosis is treated only by a minority of rheumatologists. Low back pain is an orphan but ubiquitous condition. Orthopedists and neurosurgeons certainly don't want to see unselected patients with this condition, nor do rheumatologists. Could this explain the relative absence of ankylosing spondylitis (AS) patients in my practice (prevalence 0.5-1% of the general population, similar to RA, but underrepresented in my practice versus RA by a factor of 5:1), as well as the commonly cited delay in AS diagnosis of five-to-nine years? In Ontario, we are expanding Inter-professional Spine Assessment and Education Clinic (ISAEC) sites to attempt to deal better with low back pain sufferers.[2] European attempts to enrich the likelihood of finding inflammatory back pain patients among the masses of chronic low back pain patients under age 45 also come to mind.

Some rheumatologists are happy to see simple conditions such as tendinitis, bursitis, rotator cuff syndrome, epicondylitis and trigger finger. Others have no time for anything but our core conditions. "These conditions should be managed in primary care" is the refrain. The issue, of course, is the limited training most primary care practitioners have in musculoskeletal (MSK) conditions such as these, as well as osteoporosis and gout, which should also ideally be handled in their offices. The limited availability of physiatrists, and their focus on complex rehabilitation and trauma/neurologic conditions, also leads to these patients being referred to rheumatologists.

Having dispensed with spinal osteoarthritis (OA) and degenerative disc disease (DDD), what about peripheral OA of the hands, hips and knees? After all, the American College of Rheumatology (ACR) and European League Against Rheumatism (EULAR) continue to produce guidelines on this topic, most recently the draft ACR/Arthritis Foundation guidelines presented at ACR 2019. This is the most common arthritis of all, but is it core to any discipline, let alone rheumatology? Tom Appleton and Gillian Hawker are prominent Canadian researchers focused on OA, but my peers certainly aren't. At the two journal clubs which I regularly attend, I can't remember the last time anyone chose to present an article about OA. Vasculitis as a topic is far overrepresented at these events, in contrast to its low prevalence. Should every patient with hip/knee OA see a rheumatologist before being directed to an orthopedic surgeon, to ensure medical management has been fully exhausted before total joint replacement? Impossible in the current Canadian context. Again, Ontario is experimenting with central assessment of such patients at dedicated Rapid Access Clinics, with triage by trained physiotherapists or nurse practitioners as the initial step.[3] Likely, these approaches are in existence or being considered elsewhere in our balkanized Canadian healthcare system.

Artie Kavanaugh made a telling comment at the ACR 2019 Rheumatology Roundup session covering the highlights of the meeting. While he did not note the draft guidelines on OA and gout presented there, he did comment on the presence of fibromyalgia research at the meeting,

Continued on page 5

CRAJ EDITORIAL BOARD

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Core and Explore: A Sequel to *What is a Rheumatologist?*[1]

Continued from page 3

including posters and concurrent sessions, as well as the guidelines on FM promulgated by various rheumatology organizations (including the CRA). Perhaps tongue-in-cheek, he opined that if rheumatologists do not want to be considered as experts in FM care, maybe such research should not be part of our meetings. Of course, if we don't create these guidelines, who will? The intended audience are the primary care practitioners to whom we want to offload gout, OA, FM and osteoporosis, not rheumatologists.

Can we learn a lesson from the legendary Warren Buffett to help resolve these dilemmas? As do many investment gurus, he advocates that non-professional investors should "buy the market" by buying and holding broad stock and bond index exchange-traded funds (ETFs) at low cost: the core. At the same time, all investment companies recognize the desire of retail investors to hit a home run, rather than accept plodding returns compounded over decades. Hence, "core and explore": Put 80-90% of your money in the core ETFs, and use 10-20% as "mad money" to find the next Apple, Alphabet or Amazon, while staying away from the crashing cannabis sector, Uber/Lyft, and others not for the faint of heart.

You are probably wondering what any of this financial information has to do with rheumatology? Well, we can practice "core and explore" in two ways. First, we can educate our non-rheumatology colleagues and the general public that the core of rheumatology has shifted. While we may have previously accepted referrals on anything within the broad field of MSK medicine, we have now refined our core to the immune-mediated inflammatory arthritides, and whatever we choose to call "collagen-vascular diseases." Gout, peripheral OA and osteoporosis may be in the outer reaches of the core for many of us, but chronic pain, FM, non-inflammatory spinal conditions and regional soft-tissue conditions clearly are not.

Secondly, we can maintain practice variety and our competence in these common conditions which now lie at the fringes of rheumatology, but which our patients with the core conditions frequently complain of secondarily. We can choose to explore these conditions by accepting selected patients for one-to-two visits to confirm diagnoses, provide treatment plans and perhaps provide intra-articular therapies, for which we are the acknowledged experts.

Comments, kudos and criticism on this topic are welcome next time you see me.

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

References:
1. Baer PA. What is a Rheumatologist? CRAJ. Winter 2019. Available at *www.craj.ca/archives/2019/English/Winter/Editorial.php*
2. Interprofessional Spine Assessment and Education Clinics. Available at *www.isaec.org/*.
3. Rapid Access Clinics for Musculoskeletal Care. Available at *www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/Rapid-Access-Clinics-for-Musculoskeletal-Care*.

WELCOME TO THE RHEUM

Welcome to the following new members:

Aos Aboabat, Toronto, ON
Salman Anwar, Winnipeg, MB
Angela Arisz, Toronto, ON
Heather Bannerman, Hamilton, ON
Omar Benryane, Québec, QC
Jean-Philippe Bergeron, Montréal, QC
Maude Bouchard Marmen, Quebec, QC
Raffaella Carlomagno, Toronto, ON
Brett Catton, Kingston, ON
Raymond Chu, Ottawa, ON
Marie-May Collin-Castonguay, Quebec, QC
Gemma Cramarossa, Toronto, ON
Chelsea DeCoste, Toronto, ON
Siobhan Deshauer, Toronto, ON
Irena Doubelt, Mississauga, ON
Hajar El Kamouni, Laval, QC
Evelyne Gendron, Québec, QC
Anick Godin, Kelowna, BC
Ksenia (Xenia) Gukova, Calgary,
Elliot Hepworth, Ottawa, ON
Melissa Holdren, London, ON
Samer Hussein, Sherbrooke, QC
Mehul Jariwala, Saskatoon, SK
Jehanya Jegatheeswaran, Kingston, ON
Gabriel Jeyasingham, London, ON
Andrea Johnson, Edmonton, AB
Mats Junek, Oakville, ON
Tristan Kerr, Vancouver, BC
Justine Lafleur-Careau, Montréal, QC
Geneviève Lagacé-Lavoie, Montréal, QC
Francisca Lambert-Fliszar, Montréal, QC
Delansie Lawrence, Toronto, ON
Ellen MacDonald, Edmonton, AB
Jayne MacMahon, Toronto, ON
Javier Marrugo, Sherbrooke, QC
Jeanine McColl, Toronto, ON
Manisha Mulgund, Hamilton, ON
Myat Tun Lin Nyo, Saskatoon, SK
Charles Pagé, Sherbrooke, QC
Maria Powell, Calgary, AB
Kristina Roche, Halifax, NS
Samantha Segal, Rossland, BC
Dale Seguin, Ottawa, ON
Ramandip Singh, Winnipeg, MB
Mohan Stewart, Vancouver, BC
Julia Tan, Vancouver, BC
Justine Turmel-Roy, Montréal, QC
Caroline Vo, Montréal, QC
Stephanie Wong, Vancouver, BC
Denis Yahiaoui, Montréal, QC
Roger Yang, Montréal, QC

Dr. Ciarán Duffy – ACR Master

It is our great pleasure to announce that CRA member, Ciarán Duffy, is the 2020 recipient of an ACR Master Award.

The Master Award is one of the highest honours bestowed by the American College of Rheumatology (ACR) and honours outstanding scholarly contributions to the field of rheumatology through clinical care, education, research and leadership over the course of an entire career. In addition, the recipient must have made substantial contributions to the ACR, and/or other national and international bodies devoted to rheumatology.

Dr. Duffy is Professor and Chair, Department of Pediatrics, University of Ottawa and Chief of the Department of Pediatrics at the Children's Hospital of Eastern Ontario. He exemplifies the contributions to the field of rheumatology that are being honoured by the ACR Master Designation throughout his career. He has made substantial contributions to clinical care, education and research in pediatric rheumatology and has helped to establish Canadian pediatric rheumatologists as international leaders in research.

Dr. Dafna Gladman – Fellow of the CAHS

Induction into the Canadian Academy of Health Sciences (CAHS) as a Fellow is considered one of the highest honours within Canada's academic community. Dr. Dafna Gladman, was recently inducted into the CAHS based on her work in psoriatic arthritis (PsA), which has changed the way rheumatologists manage this condition. She found that PsA is more common and more severe than previously thought, identified factors that lead to the development of PsA among patients with psoriasis, and factors that are associated with more severe PsA. She also alerted the medical community to the fact that PsA was associated with important comorbidities including coronary artery disease, diabetes, obesity and depression.

2020 CIORA Grant Awards

CIORA ICORA
CANADIAN INITIATIVE FOR OUTCOMES IN RHEUMATOLOGY CARE | INITIATIVE CANADIENNE POUR DES RESULTATS EN SOINS RHUMATOLOGIQUES

The Canadian Rheumatology Association (CRA) is pleased to announce that CIORA will be funding five two-year grants for a total of $509,203 CAD to projects that will enhance access and innovation for rheumatology care. Congratulations to the 2020 grant award recipients!

This was the 13th annual grant competition and since 2006, CIORA has funded 103 projects and provided $7,378,703 CAD in research funding.

CIORA provides funding based on various pillars; this year's grants include projects that promote:

- Awareness/Advocacy/Education (1)
- Multi-Disciplinary Care Teams (1)
- Health Economics/Sustainability of Health Care/Quality Improvement (3)

A special thanks to our sponsors for their continued support.

Janet Pope, MD, MPH, FRCPC
Professor of Medicine,
Division Head,
Division of Rheumatology,
Department of Medicine,
St. Joseph's Health Care,
Western University
London, Ontario

Pillar	Title	Principal Investigator	Award
Awareness/Advocacy/ Education	Improving the care of cancer patients receiving immunotherapy who develop rheumatic immune-related complications, and those with pre-existing rheumatic disease, through online education with health care providers: An Initiative of Ca-nadian Research Group of Rheumatology in	Roberts, J.H. Ye, C.	$77,148
Health Economics/ Sustainability of Health Care/Quality Improvement	Health economic evaluation of the manda-tory switching policy for biosimilars in patients with rheumatoid	Bansback, N.	$96,984
Health Economics/ Sustainability of Health Care/Quality Improvement	Measuring quality of heart failure care in inflammatory arthritis – are we making the mark?	Kuriya, B. Eder, L.	$104,000
Health Economics/ Sustainability of Health Care/Quality Improvement	Safety and effectiveness of biosimilar anti-TNF agents in British Columbia – exploiting a natural experiment from a change in health policy	Lacaille, D.	$114,000
Multi-Disciplinary Care Teams	Work disability and function in systematic lupus erythematosus: a national mixed-methods sequential explanatory study	Nowrouzi-Kia, B. Tourna, Z.	$117,098

CIORA is issuing another call for grants in 2021!

- CIORA Online Grant Application System opens **January 25, 2021**.
- Letter of Intent must be submitted by **February 19, 2021**.
- CIORA Online Grant Application submission deadline is **April 9, 2021 at 17:00 (Pacific Time).**
- Grant notifications will be sent out in **June 2021**.

Who's in the Rheum? CRA Staff Edition (Part 2)

Welcome to the second part of our *Who's in the Rheum? CRA Staff Edition* series! We hope to share some of the personalities behind the CRA who work hard to support our members.

	 Kevin Baijnauth	 Virginia Hopkins	 Claire McGowan
Please describe your role at the CRA in one sentence.	I am the Communications and Marketing Coordinator at the CRA; my role is essentially to support our team and committees on the amazing work they do.	As Manager, Research and Innovation, I am responsible for managing our research programs (CIORA, abstracts) and our technology platforms (website, mobile app, virtual conference, association management system, etc.).	I work with CRA Education and Program Committees to ensure comprehensive educational programs are developed and delivered to the CRA membership.
How long have you been with the CRA?	Since October 2018.	Since October 2011.	Since December 2014.
What is your favourite CRA memory to date?	Definitely the CRA's Gala at the Annual Scientific Meeting. I've worked several events and concerts before, but nothing prepared me for the Gala!	There are too many to choose from but the Gala dinners and Great Debates are at the top of the list.	Favourite recent memory: a sea of colourful blinking party glasses on the dance floor in Victoria.
How has COVID-19 impacted your day-to-day operations?	My regular day-to-day operations were minimally impacted. However, I work a lot with external organizations who were affected, so I've had to adjust in working with other parties who are not accustomed to working from home.	I've been very fortunate to have very little impact on my day-to-day operations.	Programs and planning have been altered by COVID-19 (and my internet has struggled with a full house at home!).
What were your summer plans this year pre-COVID?	I was planning to go to Korea and Japan this year!	My daughter and I were going to take a graduation trip to New York City.	Lots of cottaging and a road trip to the east coast.
Where is your next destination once it's safe to travel?	I've never been to an all-inclusive resort before! If anything, this pandemic has taught me to spend more me time on myself, so that's my next destination for sure.	Italy for a wedding (fingers crossed).	Portugal.
If you were shipwrecked on a deserted island, what two items would you want to have with you (excluding basic necessities)?	Simple, satellite internet connection and a gaming laptop that is solar powered!	My cell phone and a solar charger for my cell phone.	A camera and EarPods (. . . and a little bit of chocolate).
Can you share any of your hidden talents or hobbies?	I was really into muay thai and boxing a few years ago. Now I'm interested in karate, though I'm still a white belt!	I love to organize everything and anything. I also enjoy reading and playing sports.	My latest pastime: furniture makeovers.
What are you watching or reading these days?	My good friend Louisa Onome is a contemporary YA writer from Toronto and is releasing her debut novel, *Like Home*, in early 2021. I love supporting my friends, and I know this story was a labour of love. It deals with a lot of heavy-hitting social issues but is full of charm and wit! I hope you can all check it out!	I just finished reading *In Five Years* by Rebecca Serle, and I'm watching *Schitt's Creek* on Netflix.	Book: *If You Want to Make God Laugh* by Bianca Marais TV show: *The Queen's Gambit*
What's your favorite '80s or '90s jam?	*No Scrubs* by TLC. It's also my go-to karaoke song!	Duran Duran, Culture Club, Depeche Mode (to name a few).	Far too many to choose from. Top picks include Queen, REM, The Hip and Cat Stevens (he's timeless).

Who's Who in Postgraduate Rheumatology Training

Who's Who in Postgraduate Rheumatology Training is a new, recurring section where we'll introduce you to the individuals who serve as leaders in this area.

Dr. Raheem Kherani – Adult Rheumatology Program Director, University of British Columbia

Dr. Raheem B. Kherani, a Clinical Associate Professor at the University of British Columbia (UBC), has training in pharmacy, medicine and health professions education. He provides leadership in education with a focus on postgraduate and interdisciplinary education, as well as continuing professional development (CPD), and rheumatology care. As the new UBC Adult Rheumatology Program Director, he hopes to continue to foster collaboration and empowerment of his trainees and faculty. "It is a privilege to serve in our health care profession and in the education of the future leaders of tomorrow in rheumatology," says Dr. Kherani. Leading the CRA Education Committee, coordinating the National Written Rheumatology In-Training Examination (NWRITE) and serving on the Royal College Specialty Committee are avenues to further these aspirations and facilitate ongoing engagement.

Dr. Kim Legault – Program Director, McMaster University

Dr. Kim Legault is a clinician-educator at McMaster University and was appointed the Rheumatology Residency Program Director in July 2019. Dr. Legault's clinical and research interests are in systemic lupus erythematosus and antiphospholipid syndrome. She has previously held the Geoff Carr Lupus Fellowship Award from the Arthritis Society/Lupus Ontario and has a Masters' in Health Research Methodology. However, above all, she enjoys teaching residents.

Dr. Legault's initiation into the ranks of program directorship has been eventful. She started as Program Director on the day of transition to Competency by Design in rheumatology, and shortly thereafter oversaw her program's internal review. Several months thereafter, there was a surprising and swift transition to virtual care, and hence virtual residency education. However, the strong team of her colleagues and fellow educators, the powerhouse McMaster Rheumatology Program administrator, and the hardworking and dedicated Rheumatology Fellows have made the transition both reasonably smooth, and certainly fun! Dr. Legault's educational interests are in education in the virtual care setting and in development of a supportive learning environment.

Dr. Elana Murphy – Adult Rheumatology Program Director, Dalhousie University

Dr. Elana Murphy became involved in postgraduate education in 2016 as the Regional Representative with the Royal College Subspecialty Committee. She worked with committee members from across the country in developing the framework for Rheumatology Competence by Design (CBD). She became Program Director at Dalhousie in January 2019 and has enjoyed helping residents navigate this new educational model. She is appreciative of her supportive colleagues and staff at Dalhousie and is also thankful for the collegial group of Rheumatology Program Directors and Subspecialty Committee members from across Canada with whom she shares this work.

News from the ASM Program Committee

By Vinod Chandran, MBBS, MD, DM, PhD

We look forward to "seeing" you at the CRA's first virtual Annual Scientific Meeting (ASM)! It is shaping up to be an exciting and dynamic offering that can be enjoyed from the comfort of your own home. In 2021, as we celebrate the 75th anniversary of the CRA, our meeting will showcase the strengths of our extended rheumatology community, aptly captured by the theme of our meeting: Collaboration, Resilience and Advancement.

Dr. Daniel Kastner

Dr. Michael Libman

Dr. Danielle Martin

Oh, what a difference a year can make…. clinical care, research and meetings have all been transformed by technology and are much different than what we were accustomed to when we last met in Victoria. While a virtual conference will undoubtedly also be a different experience from years past, what will NOT change is the exciting lineup of speakers and workshops you expect, as well as the opportunities to network that you enjoy.

The meeting will run from Wednesday, February 24th to Friday, February 26th, 2021. Each day will offer a full day of formal, interactive programming and adequate time for networking plus, you will have the opportunity to watch on-demand sessions afterwards! Although the sessions are shorter in duration than at CRA's in-person conference, they will deliver practical, clinically applicable learnings from leading experts from Canada and around the world.

The ASM keynote lectures include:

- Dunlop-Dottridge, delivered by Dr. Daniel Kastner, NIH Distinguished Investigator, Inflammatory Disease Section, National Human Genome Research Institute (NHGRI). Dr. Kastner will speak on the advances made in understanding autoinflammatory diseases.
- State-of-the-Art, delivered by Dr. Michael Libman, Director of the J.D. MacLean Centre for Tropical Diseases at McGill University. Dr. Libman will be speaking to us about vaccinations and rheumatic diseases.
- Non-Medical Expert, delivered by Dr. Danielle Martin, family physician and Executive Vice-President and Chief Medical Executive of Women's College Hospital in Toronto. A highly regarded health system leader, Dr. Martin will speak to us about inequities in health care delivery in the current times.

Additionally, we will feature abstracts and poster tours for trainees and investigators to showcase their research activities; state-of-the-art and crowd-sourced workshops; satellite symposia; as well as the not-to-be-missed crowd favourites including Clinical Pearls and Mysterious Cases, RheumJeopardy and The Great Debate! Opportunities to celebrate our award-winning colleagues will be featured throughout the meeting, and satellite meetings will feature the Residents' Pre-Course, CRA Review Course, Arthritis Health

Professions Association (AHPA) Pre-Course, and the Canadian Arthritis Research Conference.

We welcome all CRA and AHPA members, as well as interested stakeholders, and colleagues around the word to join us for this exciting and memorable Annual Scientific Meeting. We look forward to reconnecting, sharing, and celebrating with you in February!

Vinod Chandran, MBBS, MD, DM, PhD
Chair, CRA ASM Program Committee
Associate Professor, Department of Medicine,
Division of Rheumatology, University of Toronto,
Affiliate Scientist, Krembil Research Institute,
University Health Network, Toronto, Canada
Adjunct Professor, Memorial University, St. John's, Newfoundland

Abstract Review Committee Update

By Marinka Twilt, MD, MScE, PhD

The abstracts have been submitted and the CRA Abstract Review Committee has begun the hard work of reading and scoring the abstracts, ably supported by Virginia Hopkins, Manager, Research & Innovation. The committee selects the abstracts worthy of poster presentation. Our meeting will be converted to a virtual meeting this year, and the Annual Scientific Meeting team supported by Claire McGowan (Manager, Educational Programs and Events) together with the CRA Abstract Review Committee have worked hard to retain the multiple opportunities the CRA & AHPA ASM offer on an ongoing yearly basis. Our meeting continues to garner interest from researchers, clinicians, trainees and industry. Even during these unprecedented times, more than 200 abstracts were submitted. Each abstract will be scored by three reviewers, and the best in each category are chosen based on the average score; the chair will break any tie for a spot on the virtual poster tour. Thank you reviewers!

There will be six poster tours during which the top-ranked abstracts will be presented. There will also be interactive poster sessions where attendees will be able to "discuss" posters with the presenters. The top 5 abstracts in each award category will be judged during the poster session for the following awards:

- Best Abstract on Quality Care Initiatives in Rheumatology
- Best Abstract on Research by Young Faculty
- Best Abstract on Pediatric Research by Young Faculty
- Best Abstract on Basic Science Research by a Trainee
- 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 by a Medical Student
- Best Abstract by a Rheumatology Resident
- Best Abstract by an Undergraduate Student
- Best Abstract by a Post-Graduate Research Trainee
- Best Abstract by a Rheumatology Post-Graduate Research Trainee

We look forward to seeing you all during the first virtual CRA & AHPA ASM!

Marinka Twilt, MD, MScE, PhD
Chair, CRA Abstract Review Committee
Pediatric Rheumatologist, Clinician Scientist,
Alberta Children's Hospital
Associate Professor, Department of Pediatrics,
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Calgary, Alberta

Report from the Human Resources Committee

By Jessica Widdifield, PhD; and Claire Barber, MD, PhD, FRCPC

A sustainable rheumatology workforce is essential to achieving the mission of the CRA. This past year, the Committee has prepared a technical report on the Canadian rheumatology workforce. Several activities were undertaken to develop this working technical report.

First, we ascertained data profiles on the number of rheumatologists, residents, trainees and fellows in Canada using national databases. The quantitative data were derived from four data sources, including the Canadian Medical Association and the Canadian Institute of Health Information Scott's Medical Database for number of rheumatologists; the Canadian Post-M.D. Education Registry for trainee and fellow counts; and the Canadian Resident Matching Service data for applicants to postgraduate rheumatology training programs. From these data sources, several important rheumatology workforce trends were identified. The first notable trend is the growth in the number of rheumatologists in Canada over the past decade, though overall this fails to meet the target benchmark of 1 rheumatologist per a population of 75,000 (Barber et al., 2014), and rheumatologist distribution is not equal across Canada. Another notable trend is the continued growth in the number of female and foreign-trained rheumatologists entering the workforce. There is also an increasing number of available rheumatology residency positions being offered and fewer unfilled training positions over time. As a result of the increase in available rheumatology residency positions, the numbers of trainees and fellows in adult and pediatric rheumatology training programs have significantly increased between 2000 and 2018 and, as of 2018, there were 82 residents and 27 fellows in Canada. Twenty percent of these were visa trainees (who are expected to return to their country of origin after training).

Second, we further curated the evidence base (via a scoping review) to identify Canadian rheumatology workforce research to examine the extent, range, and nature of research activities related to the rheumatology workforce, and to identify research gaps in the existing literature. Studies evaluating components of Canada's rheumatology workforce, including the supply, demand, and medical education aspects, have revealed many noteworthy findings. While the overall supply of rheumatologists has increased, changing workforce demographics and other factors may be negatively impacting the clinical capacity to meet the demands of the increasing volume of patients. Increasing early exposure to rheumatology is vital to attracting new trainees to rheumatology. Although there is widespread literature on the Canadian workforce, many fundamental questions remain unanswered, including accurately understanding the current full-time equivalent (FTE) supply and forecasting the future rheumatology workforce supply needs.

Third, we conducted an environmental scan to identify current rheumatology evidence-based clinical practice guidelines or recommendations that specifically state the role for rheumatologists in the care of patients with rheumatic and musculoskeletal diseases (RMDs). Twenty-five national and regional guidelines for RMDs were reviewed. Eleven guidelines and two white papers contained 21 recommendations describing the central role for rheumatologists in the care of patients with rheumatic diseases. However, only three Canadian guidelines explicitly stated the role of rheumatologists in the care of RMDs.

The workforce technical report (which will be posted on the CRA website [*rheum.ca/about-us/leadership-committees/human-resources-committee/*] in early 2021) was undertaken to inform the CRA's Workforce Position Statements (currently being prepared by the Committee).

Finally, the launch of the 2020 Rheumatology Workforce and Wellness Survey was delayed until Fall 2020. This new launch timeline has permitted the addition of questions to better understand the impact of the pandemic on rheumatology practices including the use of virtual care. All rheumatologists are encouraged to complete the electronic survey being distributed by the CRA via email to CRA members.

Reference:
Barber C, Marshall D, Mosher D, et. al. Developing System-Level Performance Measures for Evaluation of Models of Care for Inflammatory Arthritis Framework. 2014. Retrieved from *www.arthritisalliance.ca/images/PDF/Final%20Background%20MOC_Nov6.pdf*

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Communications Committee Update

By Dax G. Rumsey, MD, MSc, FRCP(C)

The year 2020 has been an interesting year for everyone (to say the least) and the Communications Committee is no exception to this!

Our major initiative this year has been launching the official podcast of the CRA, *Around the Rheum*. We took advantage of what may prove to be the last in-person meeting for some time by recording several episodes of the podcast at the Annual Scientific Meeting (ASM) in Victoria back in February (which seems like years ago now)! We have been releasing these episodes throughout the year. With the support of the Canadian Medical Association, Scotia Bank, and MD Management, we have also been working on a special COVID-19 series of episodes. We have had excellent feedback on the podcast so far and have had over 1,700 listens to date! A big thank you goes out to the *Around The Rheum* team, which include Kevin Baijnauth (Marketing and Communications Coordinator of the CRA), David McGuffin (Producer from Explore Podcast Productions with extensive experience), Dr. Daniel Ennis (adult rheumatologist based in Vancouver and our host), and Aaron Fontwell (Producer from Fontwell Estate Creative Agency, who has been helping us with the final mixing).

Another one of our initiatives has been improving the social media presence of the CRA. We have been actively using our Twitter account (@CRASCRRheum) to promote events happening within our community and to share major/interesting rheumatology publications and guidelines.

We have also launched "Rheum for Growth," an accounting column aimed at both practicing rheumatologists and rheumatology trainees who are about to enter the workforce. This column is written by Peter Simpson, CPA, CMA, the Chief Financial Officer (CFO) of the CRA, based on topics that our committee thinks will be of interest to the membership.

In addition, we continue to interview members of the community for our "Who's in the Rheum?" column. The Communications Committee also performs several other formal and informal communications functions, including the vetting of surveys, liaising with outside organizations who wish to communicate with our membership, and other related tasks.

We are open to new and fresh ideas/input and encourage any CRA members interested in joining our committee to drop us a line! You may contact me at *dax.rumsey@ahs.ca* or Kevin Baijnauth at *kbaijnauth@rheum.ca*.

Dax G. Rumsey, MD, MSc, FRCP(C)
Chair, CRA Communications Committee
Zone Section Chief, Paediatric Rheumatology,
Alberta Health Services – Edmonton Zone (Stollery Children's Hospital)
Division Director, Paediatric Rheumatology,
Assistant Professor, University of Alberta
Edmonton, Alberta

Education Committee Report

By Elizabeth M. Hazel, MD, FRCPC; and Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE

"Zooming" towards on-line learning for all!

The CRA Education Committee is embracing the challenges of delivering high quality education to our membership during a pandemic. In 2017, the committee was restructured, and the subcommittees have continued to improve productivity. The CRA conducted an educational audit this year and identified goals for continuous improvement of our educational offerings. The audit's recommendations will help to guide the subcommittees in their future projects, along with expanded leadership of the committee.

Undergraduate Subcommittee

This committee has taken on an ambitious project to define important components of the undergraduate medical school curriculum, as they pertain to rheumatology. In developing the National Undergraduate Rheumatology Curriculum (NURC), they have consulted stakeholders from across the country. They are in the midst of conducting Delphi exercises to analyze their data, and their plan is to have a report available for dissemination in 2021.

Postgraduate Subcommittee

With ongoing changes in residency training, including Competence by Design (CBD), the postgraduate subcommittee is developing shared educational resources to supplement university residency programs' current academic curricula. Peer-reviewed resources will be uploaded onto the CRA website and made available to the target audiences. The first set of resources includes immunology videos, musculoskeletal radiology videos and physical exam resources. They have found a way to appropriately acknowledge the authors. Their longer-term project is to create a national immunology curriculum.

The National Written In-Training Exam (NWRITE) subcommittee has revised their timeline to reflect the advancement of the Royal College Exam to the end of trainees' R5 year. This practice exam provides trainees and program directors with valuable information on how to best prepare for their final exams.

CanREAL Subcommittee

Our experts in medical education scholarship continue to share their expertise with CRA members of our rheumatology community through collaboration with ongoing projects. CRA members are encouraged to reach out to this advisory subcommittee when there is expertise or consultation required on medical education matters.

Continuing Professional Development Subcommittee

While the CRA used to concentrate educational offerings at our in-person Annual Scientific Meeting, the Continu-

ing Professional Development (CPD) Committee is exploring alternative educational offerings. They continue to provide accreditation of Section 1 and 3 activities, as well as assist CRA members and committees in the development of CRA-accredited activities. The over-arching goal is to review input from the membership to respond to their needs. For example, at the start of the global COVID-19 pandemic, they helped to coordinate a Webinar series to address the needs of the membership. They are addressing the changing landscape to move to assist the virtual delivery of content through podcasts, webinars, and educational offerings throughout the year. The committee also plans to scan the patient perspective to ensure patient/stakeholder involvement in CPD development and continue to work with other CRA committees. We look forward to post-pandemic education that will build on virtual and in-person collaboration.

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Clinical Associate Professor,
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Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE
Chair, CRA Education Committee
Clinical Associate Professor,
Program Director, Adult Rheumatology
University of British Columbia, Vancouver, British Columbia

Quality Care Committee Update

By Amanda Steiman, MD, MSc, FRCPC

Writing about the Quality Care Committee's 2020 year in review demands reflecting on a year that has fundamentally changed the fabric of our society and the way we live. The pandemic has upended the way we interact, practice medicine, learn, and teach. I both marvel and cringe at how close we were to the edge of the pandemic precipice as we socialized, celebrated and learned together at the CRA Annual Scientific Meeting (ASM) in Victoria.

Winston Churchill is credited with saying that one should "never let a good crisis go to waste." Indeed, this sentiment has never rung more true, as members of the Quality Care Committee have worked to simultaneously usher pre-pandemic initiatives through a changed world, and pivot to others that focus on virtual care delivery in the context of the traditionally high-touch/low-tech specialty that we love.

I want to take a moment to laud Cheryl Barnabe's outstanding and sustained leadership as past Quality Care Committee Chair, and her ongoing work as the Equity Subcommittee Chair. She wears impossibly big shoes to fill with both exceptional poise and measured tenacity, and we have all benefitted from her vision and determination. Claire Barber and Shirley Chow continue to lead the Quality and Resource Stewardship Subcommittees, respectively, and I continue to lead Access.

It has been a year that has highlighted the power of collaboration on many fronts, with continued delivery of Indigenous Health Education sessions, continued work on generation of a Quality Report Card for rheumatologic care, and collaboration on rheumatoid arthritis guideline development with a focus on equity for marginalized/at-risk patient populations. Collaborations with the Education Committee have resulted in pragmatic guidance, shared with members via the CRA COVID portal and through presentations on return-to-work strategies in the setting of COVID-19. Finally, in collaboration with the Pediatrics Committee, we have embarked on work to improve awareness and bolster support for transition to adult care, with a publication outlining the results of a needs assessment exercise and next steps forward, in press. We look forward to fruitful multi-committee collaboration in building a Telemedicine Working Group, born out of collaboration between the Quality Care and Pediatrics committees, which will strive to deliver pragmatic and, to the extent possible, evidence-based guidance and support to CRA members in care delivery through these unprecedented times.

We will continue to work and grow and learn in the setting of this most unwelcome global turn of events, with a steadfast commitment to the quality of care we deliver – under any circumstances – to patients with rheumatic diseases.

Amanda Steiman, MD, MSc, FRCPC
Chair, CRA Quality Care Committee
Assistant Professor of Medicine,
University of Toronto
Clinician in Quality and Innovation
Rheumatologist,
Sinai Health System/University Health Network
Toronto, Ontario

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JAK = Janus kinase; PsA = Psoriatic arthritis; QD = Once daily; RA = Rheumatoid arthritis; UC = Ulcerative colitis

* Comparative clinical significance is unknown
† Patients enrolled in the formerly known eXel™ Patient Support Program, which was exclusive for patients taking XELJANZ and not XELJANZ XR. The eXel™ program has now been replaced with PfizerFlex.
‡ Prescription and physician data were obtained from eXel™ support program enrollment forms collected from June 2014 to November 2018

References:
1. Pfizer Inc. Data on file. 2019.
2. Pfizer Canada ULC. XELJANZ/XELJANZ XR Product Monograph.
3. XELJANZ XR Notice of Compliance information.
4. XELJANZ RA Notice of Compliance information.
5. XELJANZ PsA Notice of Compliance information.
6. XELJANZ UC Notice of Compliance information.

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Update from the Therapeutics Committee

By Rosie Scuccimarri, MD, FRCPC

The last nine months have been very busy for the Therapeutics Committee with many requests and tight deadlines responding to the COVID-19 pandemic. The committee drafted and approved a number of position statements for the CRA, including one endorsing the ACR statement on COVID-19, another on practical recommendations and finally one on hydroxychloroquine supply. We supported a letter penned to Minister Patty Hajdu with regard to the hydroxychloroquine shortage. The committee endorsed a Canadian Paediatric Society (CPS) practice point on the paediatric inflammatory multisystem syndrome temporally associated with COVID-19. We continue to monitor ongoing issues related to the COVID-19 pandemic.

Conjointly with the CRA Pediatric and Stakeholder Committees, the Therapeutics Committee drafted and approved the CRA position statement on access to citrate-free adalimumab, and we continue to actively follow this issue. A cannabidiol addendum was made to the Medical Cannabis position statement, which was approved by the CRA Board. The committee drafted a Medical Cannabis information sheet for patients and allied health professionals. It is currently being edited to the appropriate reading level for patients by an outside agency. Our committee is still working on a position statement on stem cell therapy for osteoarthritis. We have currently drafted and approved a position statement on the safety of hydroxychloroquine in the treatment of rheumatic diseases, which should be circulated shortly.

I would like to thank the Therapeutics Committee members for their dedication over a particularly challenging year dealing with COVID-19. They have been engaged and responsive to a number of emerging and urgent issues in 2020, and their guidance and advocacy has benefitted not only CRA members but the wider rheumatology community.

Rosie Scuccimarri, MD, FRCPC
Chair, CRA Therapeutics Committee
Associate Professor, Department of Pediatrics,
McGill University
Pediatric Rheumatologist, Montreal Children's Hospital
Montreal, Quebec

New Resources for Patients

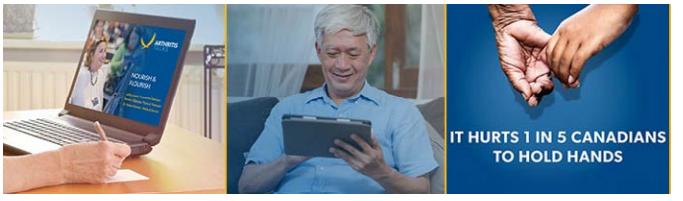
By Trish Barbato, President and CEO, Arthritis Society

Throughout 2020 and the challenges it has brought to all of us in the arthritis community, the Arthritis Society has never wavered in its commitment to support people affected by the disease.

At a time when many health charities have had to scale back their research efforts, we are continuing to meet our funding commitments, and making new ones.

Our Arthritis Talks education webinars, now taking place monthly, are reaching thousands more Canadians than ever before. And, we are steadily adding to our collection of evidence-based online information for people with arthritis.

We invite you to visit our website, *arthritis.ca*, to check out our comprehensive overview of emerging treatment and research, our guide to drug-free pain management options, a detailed biologics and biosimilars portal and lifestyle supports such as our "Life Hack" video series.



As Canada's voice for the six million Canadians with arthritis, the Arthritis Society is also continuing our campaigns aimed at shining a light on the disease. This holiday season, we're focusing our messaging on how arthritis takes away the simple joys of life.

Holding hands, playing in the snow and getting dressed shouldn't hurt.

Thank you for being among the Canadians helping to diminish the pain of arthritis. We encourage you to share our new resources with your patients and networks.

Pediatrics Committee News

By Ronald M. Laxer, MDCM, FRCPC

The CRA Pediatrics Committee, comprised of all CRA pediatric rheumatologists and trainees, is a large, diverse and active community within the CRA. The COVID-19 pandemic has challenged us all in myriad ways, and I am proud of how our members responded by educating their colleagues on COVID-related hyperinflammation in the pediatric population through hosting a CRA webinar, as well as collaborating with the Canadian Pediatrics Society on a Practice Point to assist pediatric colleagues with the diagnosis and initial management of patients with possible pediatric inflammatory multisystem syndrome (PIMS)/multisystem inflammatory syndrome in children (MIS-C).

Despite the personal and professional challenges posed during this ongoing pandemic, our dedicated committee members still managed to make significant headway on many of our 2020 goals, including development of the following:

- Uveitis Guidelines, led by Drs. Deb Levy and Bobbi Berard with the help of CRA pediatric members, ophthalmologists and patient/family representatives. The group is working through an "adolopment"[1] process of the ACR Uveitis Guidelines, published in 2019, to provide a Canadian context and incorporate patient values, preferences and equity. The goal is to publish a manuscript by year's end with endorsement from both the CRA and the Canadian Ophthalmological Society.

- Pediatric Choosing Wisely Recommendations, led by Dr. Nadia Luca and a working group comprised of pediatric rheumatologists and patient/parent representatives. After completing three rounds of Delphi Surveys and identifying the top 15 items for consideration, a survey was sent to CRA members to rate their agreement with and the impact of each item. Once the data and literature review are concluded, a manuscript will be submitted with the top five recommendations.

Keep an eye out for these publications as well as updates on other pediatric initiatives, to be highlighted in a future *CRAJ* article.

We also want to extend our warmest wishes to Janet Ellsworth on the occasion of her retirement. Janet has been a giant in our field, having created successful academic programs in both Halifax and Edmonton, and has left a wonderful legacy. We wish her safe travels on her new journey!

Pediatrics Committee members at the last in-person meeting in Victoria, BC, in February 2020.

To close, I would like to leave you with a photo of those members who attended the Pediatric Committee meeting at the 2020 CRA Annual Scientific Meeting in beautiful Victoria, BC. (photo above). Little did we know it would be our last in-person event! Thanks to all for your hard work and leadership.

Ronald M. Laxer, MDCM, FRCPC
Chair, CRA Pediatrics Committee
Professor,
Departments of Pediatrics and Medicine,
University of Toronto
Staff Rheumatologist,
The Hospital for Sick Children
Toronto, Ontario

References
1. The "GRADE-ADOLOPMENT" approach to guideline production combines adoption, adaptation, and, as needed, de novo development of recommendations. DOI:https://doi.org/10.1016/j.jclinepi.2016.09.009

Update from the Guidelines Committee

By Glen Hazlewood, MD, FRCPC

Over the past year, the Guidelines Committee has continued to work towards developing and updating CRA treatment recommendations, driven by our membership.

Highlights in the past year include:

- The JIA-Uveitis group, led by Drs. Bobbi Berard and Deb Levy, met over the summer to develop CRA treatment recommendations, adapting those from other organizations to a Canadian context. The Zoom meetings went well, with excellent engagement from the panel. Guidelines are now being written and should be published in early 2021.
- Recommendations for rheumatoid arthritis are underway, with the guideline panel meeting monthly to vote on recommendations, which will be published in a 'living' fashion, starting in early 2021.
- Spondyloarthritis Guidelines, led by Dr. Sherry Rohekar, are ongoing, with plans to also use an adapt/adopt approach from other guidelines, with updated literature searches.
- Our ongoing equity initiative, led by Dr. Cheryl Barnabe, has led to a draft Equity Framework, which will be incorporated into CRA Guidelines, starting in 2021.
- We have continued to foster and build relationships with other international rheumatology and guidelines associations to harmonize efforts, including Cochrane, GRADE, ACR and the Australian Rheumatology Association.

Thank you to everyone for their hard work over the past year, despite the challenging times. I think I speak for everyone when I say we're looking forward to 2021!

Glen Hazlewood, MD, FRCPC
Associate Professor,
Departments of Medicine and Community Health Sciences,
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University of Calgary,
Calgary, Alberta

B.C. Society of Rheumatologists (BCSR) – Update from the Pacific

By Jason Kur, MD, FRCPC

On the political front, our representatives have been extremely busy. This past year we once again successfully argued for rheumatology disparity funding through a lengthy process at the Doctors of B.C. Extra funding will be targeted to the creation of a complex modifier code, similar to ones that already exist in general internal medicine. In addition, we have been negotiating the transition of our Labour Market Adjustment fee codes (i.e., our nursing model of care) from the budget of the Specialist Services Committee to the General Medical Services Plan. We have also been working closely with B.C. Pharmacare on the transition to biosimilars as their mandated policies continue to roll out (now to include rituximab after the initial etanercept and infliximab changes in 2019).

COVID-19 has brought many challenges to clinical practice, and our leaders have helped ensure the transition to virtual care has gone as smoothly as possible. This has included some outstanding representation by Dr. Tommy Gerschman to ensure community specialists have support for everything from personal protective equipment (PPE) to adequate virtual billing codes. Dr. Kam Shojania has also been our fearless leader in coordinating the rheumatology response for the COVID medicine ward at Vancouver General Hospital.

The 15th annual British Columbia Rheumatology Invitation Educational Series (BRIESE) conference moved content online in September but was no less well attended. Speakers included Dr. Janet Pope, Dr. Jan Dutz, Dr. Anna Postolova and Dr David Fajgenbaum. Dr. Fajgenbaum shared his unique and inspiring story of battling Castleman disease as both a patient and a scientist. Without a doubt, it was one of the most impactful sessions that has ever been presented at BRIESE.

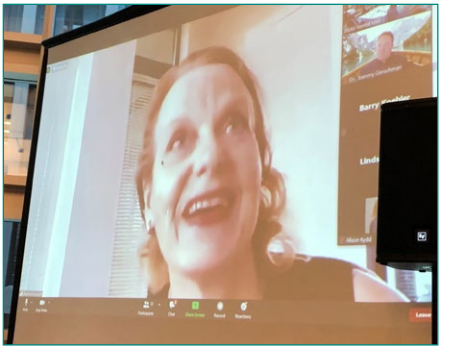
The BCSR managed to host a hybrid Zoom/dinner celebration for the Annual BCSR/University of British Columbia (UBC) award winners in September. The Innovation Award was jointly given to Dr. Kun Huang and Dr. Fergus To for their creation of the B.C. myositis clinic. The Advocacy Award resulted in a tie for the first time and was given to two extremely deserving winners. Dr. Tommy Gerschman has brought his confident leadership style to the BC Society of Specialists and has represented his rheumatology colleagues exceptionally over many years through some challenging times, most recently advocating for community specialists in the time of COVID. Dr. Stephanie Ensworth was also feted for her outstanding leadership role with Pharmacare as the Chairperson of the Rheumatology and Autoimmune Disease Adjudication Advisory Committee (RADBAAC). B.C. rheumatologists are extremely fortunate to have her at the table as a patient and physician advocate when dealing with biologic access concerns. Dr Fergus To was awarded the UBC Medicine Honor Roll Recipient for Clinical Teaching Excellence – both for undergraduate and postgraduate inpatient teaching, and Dr. Brent Ohata was awarded the UBC BCSR Teaching Award.

I would also like to congratulate Dr. Raheem Kherani on his new role as the UBC Rheumatology Training Program Director and extend gratitude to Dr. Shahin Jamal for her tireless work on behalf of the Training Program as she exits the role.

We are truly fortunate to have such accomplished and supportive colleagues in B.C.

Dr. Brent Ohata, winner of the UBC BCSR Teaching Award.

Dr. David Collins – socially distancing himself from all the other guests.



Dr. Stephanie Ensworth, accepting her award via Zoom.

Jason Kur, MD, FRCPC
Artus Health Centre
University of British Columbia
President,
B.C. Society of Rheumatologists
Vancouver, British Columbia

AMRQ Update

By Nathalie Langlais, MD, FRCPC

The fall of 2019 will be remembered for tight and sometimes difficult negotiations between the *Fédération des médecins spécialistes du Québec (FMSQ)* and the Ministry of Health and Social Services. You will recall that the Ministry, wanting to achieve large, one-off savings, wanted Quebec specialists to agree to substantial fee reductions, which did not happen. Instead, as a result of these negotiations, *l'Institut de la pertinence* was born, a truly unique platform where all medical associations now have the opportunity to present their views on potential recurring savings in their respective practices. For example, some may want to reduce their fee schedule or eliminate procedures that have become superfluous or obsolete, while others may want to propose changes to clinical measures, such as their frequency and/or relevance, target patients, etc., based on the increasingly widespread principle of "Choosing Wisely." For the *Association des médecins rhumatologues du Québec (AMRQ)*, this is a welcome exercise that will allow us to put forward innovative ideas and solutions aimed at providing the best possible care for our patients. The objective here is therefore twofold: to improve efficiency of care while taking part in this exercise. This is a great opportunity to present our views on measures that we believe will be welcomed by both the Ministry and our colleagues.

In the spring of 2020, the COVID-19 pandemic struck Quebec, which nobody had expected. Quebec was the worst-affected province in Canada with a high rate of infections, 25% of which were among healthcare professionals. Quebec's residential and long-terms care centers or *centre d'hébergement et de soins de longue durée (CHSLDs)* were hit hard, and specialist physicians were called in to assist this particularly vulnerable population. In rheumatology, our practice then changed completely and, overnight, telemedicine became the new way of doing things. Most of our activities continued with this new reality. We were less affected by the offloading of clinical activities compared to physicians in other specialties. During the first wave of the pandemic, many activities had to be suspended, including surgeries and endoscopies, and many radiology examinations. These disruptions in service and the postponement of operations and examinations will impact our healthcare system for years to come. During this same time period, many rheumatologists assisted by working COVID units and provided care to hospitalized patients; we are grateful to them. For about six weeks at the beginning of the pandemic, Quebec's Public Health Department requisitioned the majority of hydroxychloroquine reserves for COVID cases with the result that only certain patients, including lupus patients, were able to continue their treatment. Our association made every effort to ensure that they would continue to have access to the drug. Unfortunately, our efforts were unsuccessful until Public Health finally changed its ruling and allowed patients who had been deprived of their medication to resume treatment.

We are now in the second wave of the pandemic and this time the virus is circulating throughout the community and is now affecting a younger population. Given this sad state of affairs, Public Health has unfortunately had to make the decision to impose new restrictions on the public with the hope of limiting the spread of the virus, especially with winter at our doorstep, and the season of flu, colds and other viruses that could complicate matters.

In keeping with our Hippocratic oath, we must observe government directives and guidelines, and show our support for our patients.

In closing, I wish you all the best in staying healthy and keeping your spirits up during these difficult times.

Nathalie Langlais, MD, FRCPC
President,
Association des médecins rhumatologues du Québec

Report from the ORA

By Philip A. Baer, MDCM, FRCPC, FACR

Ontario Rheumatology Association

We are six-plus-months into the pandemic in Ontario, with all the challenges that has entailed. ORA members pivoted immediately to virtual care in mid-March 2020. We ran five ORA Town Halls throughout April and May 2020 to update members on the evolving situation. All of these are archived on the ORA website *www.ontariorheum.ca* (via the members-only portion), where we also house links to multiple COVID-19 resources, including financial and infection control information.

Unfortunately, our ORA Annual Scientific Meeting (ASM) scheduled for mid-April 2020 fell victim to the pandemic and had to be cancelled. We will definitely be holding our 2021 ORA ASM from May 28-30, 2021, either virtually or in a hybrid format. Our entire star-studded roster of speakers confirmed for the 2020 event has agreed to participate. They include Drs. Joseph Smolen, Maya Buch, Michelle Petri, Jeffrey Curtis, Christopher Ritchlin, Robert Inman, Shahin Jamal, Robert Bell and Jason Lee. Full details can be found on our website.

In the background, all ORA committees continue to function and deal with their mandates. Drug shortages, biosimilars, virtual medicine and transitions in and out of practice are key areas we continue to focus on. The Informatics Committee has officially launched phase 1 of the ORDER project, aiming to create a dashboard for a rheumatology elecronic medical record (EMR), which will allow participants to view their own practice outcomes, and compare themselves to the aggregate of participating rheumatologists within the province. The ultimate goal is to develop an enhanced EMR experience, while improving patient outcomes in a measurable fashion. Also, a new Northern Ontario committee has been created from our RheumOpportunities Committee, chaired by Sahil Koppikar.

Our new ORA Board and Executive took over their roles as of May 25, 2020. Special thanks to our three departing board members for their hard work on behalf of our members: Drs. Vandana Ahluwalia, Rick Adachi and Vinod Chandran. We welcomed to the ORA Board Drs. Shelly Dunne, Raman Rai and Faiza Khokhar. All of us are working hard advocating on behalf of the ORA membership and our patients during these challenging times. Other transitions include the retirement of our long-time Executive Director, Denis Morrice, who was instrumental in leading the ORA to its current strong position, well-known to all stakeholders in the arthritis space. Sandy Kennedy, previously our ORA Project Manager, has taken over Denis' position.

The ORA board at a past meeting:

From left to right; **Back row:** Dr. Carter Thorne, Dr. Tom Appleton, Dr. Henry Averns, Dr. Rick Adachi, and Dr. Imtiaz Khan; **Middle row:** Mr. Denis Morrice, Dr. Vinod Chandran, Dr. Art Karasik, Dr. Felix Leung, Dr. Philip Baer, Ms. Sandy Kennedy, Dr. Nikhil Chopra, and Dr. Deborah Levy; **Front Row:** Dr. Thanu Ruban, Dr. Janet Pope, Dr. Jane Purvis, Dr. Vandana Ahluwalia, and Dr. Julie Kovacs

There are always opportunities for ORA members to participate in ORA activities and committees. Check out our website for more information.

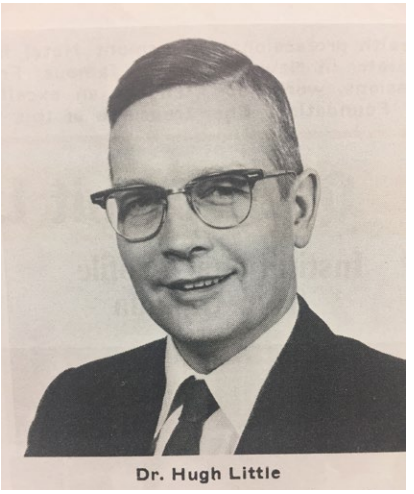
Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
Scarborough, Ontario

Hugh's Legacy
Reflections from the Northern Ontario Outreach Clinic

By Laurence Rubin, MD, FRCPC

In October 1992, Hugh Little died suddenly. He was 58.

The previous spring, I had accepted the offer of Division Head, Rheumatology, at Women's College Hospital. I had discussed this with him at length, and despite the impact it would have on the Sunnybrook Rheumatology Division, he strongly encouraged me to apply and supported my move. He was my mentor, my friend and an invaluable support during my post-doctoral years. He had recruited me to Sunnybrook, my first staff position. He was a leader, with a demanding academic and personal standard, but also a generous heart and an acute sense of humour.


Dr. Hugh Little

And while I had performed limited clinical activities in my years at Sunnybrook, one that I enjoyed immensely, was our semi-annual visit to Timmins for the Arthritis Clinic.

Hugh had started this program in the early 1970s as a travelling Arthritis Society program in Northeastern Ontario, with Timmins as the natural hub. In those days, rheumatoid arthritis (RA) management consisted of prescribing aspirin and injectable gold, along with the judicious use of steroids.

Many of the rheumatology residents who passed through Sunnybrook accompanied Hugh on these trips; a Thursday night arrival, check in and dinner at "The Senator," the preferred (and really only) hotel in town, frequented by mining executives. The restaurant had a well-earned reputation for its menu and wine list. The dinner was both liquid and filling, but the next day at 7a.m. it was time for a quick breakfast and heading, by foot, to clinic. The late Bill Bensen told me several times about the rigours of his frozen trudge up the hill to St Mary's.

In the late 80s, Hugh asked if I would be willing to join him. The Sunnybrook rheumatology fellow at the time had a mortal fear of flying and refused the offer. I immediately said yes.

Following that visit, and at my request, I became a regular. Thus my 30-plus-year relationship with Timmins began.

When Hugh died suddenly, I was, by default, in charge. The hospital was grateful for my willingness to carry on and provide what they had felt was an important and critical service. This longstanding commitment and relationship has served us all well.

With a local population and catchment area totalling 60,000, and a focus on inflammatory rheumatic disease, predominantly RA, we developed an effective, efficient and sustained model of care. This has been the result of multiple contributions, and in particular our partnership with the Arthritis Society. After Timmins local and long-tenured Arthritis Society therapist Geraldine Carlier moved to Beirut, we were incredibly fortunate to recruit Mary Ellen Marcon from Sault Ste Marie. Mary Ellen was an inaugural graduate of the Advanced Arthritis Practitioner Program (developed by Rachel Shupak). I participated in the training program in Toronto; it was there that I met Mary. Both on site as well as through remote involvement, and with a deep first-hand knowledge of the region, she has been critical to our success over the years.

In 2000, Simon Carette joined the program. Simon had a very close association with Hugh Little during his training at Sunnybrook and beyond. In 1983, he co-authored a classic paper on the natural history of ankylosing spondylitis. Simon had participated in remote clinics while in Quebec City, and I knew him to be a skilled clinician with a keen sense of humour – an absolute requisite for Timmins, and he was fluent in French!

In 2000, we moved to the new Timmins and District Hospital (TADH). Over these past two decades, we have been extremely fortunate to have skilled clinic nurses, coordinators and volunteers, with whom we have established meaningful relationships, despite our intense quarterly two-day visits. We have sufficient space, the full spectrum of technologies

Mary Ellen Marcon (on the left) and Denise Marin (on the right) from the Arthritis Society.

The Timmins team. Pictured from left to right: Drs. Laurence Rubin, Simon Carette, Bahar Moghaddam, Sahil Koppikar, and Lynn Richards.

and laboratory services, and all the needed pathways for excellent rheumatologic patient care in the 21st century. We have continuously engaged the primary care physician groups directly and through continuing medical education (CME). We even stayed for many years in an old mining executive house converted to a bed and breakfast, owned by one of the town's longest serving family doctors. We have eaten at almost all the reputable, and some less so, dining establishments in town. Casey's remains our diner of choice, as Simon can always count on his favourite peanut butter/brownie dessert!

In 2013, we began accepting patients from Kapuskasing, after the sudden departure of the previous visiting rheumatologist. Simon initially wanted to make separate day trips there, but I reminded him it was 150 km away, on a two-lane highway, and in the winter, we might encounter the occasional moose! We have also received referrals from remote Indigenous communities along James Bay, and met recently with the local ophthalmologist to collaborate on the management of uveitis.

Two and a half years ago, Simon and I agreed to offer an elective for rheumatology fellows in Timmins. With the support of the Rheumatology Disease Unit (RDU) Education Director, Dr. Dana Jerome, we brought our first senior trainees, Dr. Sahil Koppikar and then Dr. Bahar Moghaddam. In typical Timmins' experience, we even celebrated Bahar's birthday last December with champagne, "chilled" in the hospital parking lot snow drifts!

And now, we have both stepped away. My last visit was in June, virtually, of course, courtesy of the pandemic, but Simon made it up to Timmins in early October. Mary Ellen, after her more than two decades of dedicated service, retired in 2018. We were fortunate again, with the support of the Arthritis Society, to recruit Lynn Richards from Kingston, who has now been thoroughly inculcated in the "Timmins way."

Sahil expressed a keen interest in the program and excelled from his first visit. I am very pleased that this past July, he assumed my role as Director of the TADH Arthritis program. Simon and I have every confidence in his skill and vision. He will also recruit to replace Simon's position.

These thirty-plus years have passed quickly. I am very proud of what we have accomplished. We built and sustained a model of inflammatory arthritis care, expanding educational opportunities, and most importantly developing a viable succession plan in a remote Northern community. Sahil and his colleagues will undoubtedly evolve and improve this program, and I look forward to watching the changes.

We have been incredibly fortunate to be rheumatologists in this golden age of our specialty. The Timmins clinic is a microcosm and a living laboratory to effect and observe the results of these advances in a unique and grateful community.

And finally, thank you, Hugh, for asking me to join you; and thank you also to the anonymous resident whose fear of flying opened an incredible and gratifying life experience for me.

Laurence Rubin, MD, FRCPC
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Passing the Baton of Arthritis Research Canada's Scientific Leadership – Celebrating the Legacy of a Visionary Leader

By Diane Lacaille, MD, FRCPC, MHSc

Dr. Diane Lacaille

Dr. John Esdaile

On July 1st, after 21 years at the helm, Dr. John Esdaile retired as Scientific Director of Arthritis Research Canada/Arthrite-recherche Canada (ARC). I am deeply honoured to have been handed over the scientific leadership of this amazing organization. Dr. Esdaile was a visionary leader who leaves behind an incredible legacy, not only from his own personal research achievements, but also because of what he built.

From its roots in 1999 as a single centre with himself, one scientist, one graduate student, and an administrative staff member, Arthritis Research Canada has evolved into a leading arthritis clinical research organization, with a team of more than 100 research scientists, trainees, and staff. Our centres are located across three provinces, British Columbia, Alberta and Quebec, with scientists affiliated with five major universities, University of British Columbia, Simon Fraser University, University of Calgary, Université Laval, and McGill University. Dr. Esdaile assembled a team of research scientists with a breadth of expertise to conduct research across the disciplines relevant to arthritis. Our team of 41 scientists spans the disciplines of rheumatology, orthopedics, physiotherapy, occupational therapy, pharmaceutical sciences, biostatistics, epidemiology, health services research, public health, health psychology and behavioural change, health economics, health systems assessment, and knowledge translation. Beyond what can be measured by numbers, Dr. Esdaile created a culture of scientific rigour and excellence, of innovation, pushing boundaries for new discoveries, and fostered an environment of collegiality and collaboration, which has been key to Arthritis Research Canada's success.

Dr. Esdaile has always been a strong advocate of supporting the next generation of arthritis researchers, making supporting trainees and mentoring new scientists one of Arthritis Research Canada's top priorities. The many established scientists, previously mentored by him, who contribute to advancing rheumatology research across Canada and the U.S. are another important part of his legacy. I, myself, have had the privilege of benefiting from his mentorship over many years, from the time he supervised my summer studentship as a medical student, through being a graduate student when Arthritis Research Canada was founded, until today as I am following in his footsteps as the newly appointed Scientific Director. I can speak first-hand to the amazing mentor that he is!

Dr. Esdaile has also been a champion of meaningful engagement of patients in research well over a decade before it became popular. He had the vision of ensuring the patient voice is represented in all facets of our organization and that patients are engaged in all aspects of research. Instrumental to this was the creation of Arthritis Research Canada's Arthritis Patient Advisory Board. His commitment to ensuring the patient voice be heard has always been at the forefront of all we do. At Arthritis Research Canada, we will continue to work for and with patients to make sure our research is relevant, meaningful and helpful.

I look forward to leading the organization over the next decade. I deeply value the research conducted at Arthritis Research Canada/Arthrite-recherche Canada because of the impact it has on the everyday lives of people with arthritis. I am inspired by the incredible resilience of arthritis patients, the dedication of the research scientists and staff, the innovative ideas of my colleagues, and the sharp inquisitive minds of our trainees. I am excited at the thought of the future discoveries that will transform how health care is delivered and change how people with arthritis live their lives. These are exciting times. At Arthritis

Research Canada, we will continue to expand the breadth of expertise of our research team in order to respond to the evolving needs of patients, and to harness the opportunities that arise from new trends, such as big data, artificial intelligence, and smart technologies. We will also continue to tackle health inequities affecting people living with arthritis, especially Indigenous peoples, so that all Canadians regardless of race, ethnicity, or social circumstances, have access to the care they need and the best care available. And of course, we will continue to invest in the future of arthritis research by training and mentoring the next generation of arthritis research scientists.

Diane Lacaille, MD, FRCPC, MHSc
Mary Pack Chair in Rheumatology Research
Professor of Rheumatology,
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Burnout and the Rheumatologist

By Lester Liao, MD, MTS

Rheumatology is not often thought of as a particularly busy or stressful specialty. When we think of burnout, our mind jumps to high stress, acute disciplines that afford less control. Emergency medicine. Critical care. So, it may seem unusual to consider the problem of burnout for the rheumatologist. Are we not, after all, the best discipline?

For what it's worth, the annual Medscape Rheumatologist Lifestyle Happiness and Burnout Report suggests we tend to be less happy than the average physician at work, happier than the average physician outside of work, and roughly 40% of us are burned out.[1] By far the biggest contributor is bureaucratic tasks, which include charting and paperwork. The data aren't perfect, but they provide a springboard for at least two brief observations for rheumatologists.

First, we are not immune. This would seem obvious (no less because we pride ourselves on our understanding of immunology), but it is worthwhile to emphasize since we have a tremendous capacity for self-deception.[2] Low stress does not effectively mitigate burnout because the suspected etiology is unrelated. And we deal with an unusual batch of drugs and diseases. Our consults and charting are perhaps a touch more detailed, and from one Exceptional Access Program to the next, we have our fair share of forms. At the most superficial level, reducing tasks of this nature would be a fine place to start.

But second, and more importantly, clinical interest is not enough to banish burnout. I presume many of us joined the ranks of rheumatology due to genuine curiosity. We attract a particularly cerebral group. But that earnestness, which I see persists in many colleagues even over decades, provides little drive to continue with the paperwork, the meetings, the electronic medical records (EMRs). We need something more riveting. And this lies in the humanity of any practice. A disease is interesting, but a person is inestimable. This is of particular relevance for the rheumatologist, whose orientation toward medicine is at least mildly skewed toward a fascination with pathophysiology. The orthopedic surgeon has a different tendency on her hands. But for us, we must be mindful of this pitfall. If our goal is in satisfying curiosity, in gathering data, or even in the cure, we have missed the mark. This makes the patient a means to an end.[3] And when the patient is subservient to another goal, the heart atrophies. Chronic pain becomes a nuisance, paperwork a drag. These issues become impediments to the thing we want or need. And this, in my mind, is the deeper issue at hand.

The process, of course, is subtle. But it is inevitably present, and I recognize it in myself. Yet if my child were ill and needed paperwork, it'd be completed in a flash. The human element is overpowering. Certainly, we must take other measures to reduce burnout. But there are things the surveys have trouble capturing. The totality of our work resides in the patient before us. Lose this vision, and our work will always leave us numb and disenchanted. Remember it, and we may know we've changed a life forever.

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Canadian Liaison,
International Doctor as a Humanist Association
Toronto, Ontario

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News from Saskatchewan

By Regan Arendse, MD, FRCPC

Our plans for rheumatology practice in 2020 in Saskatoon were totally flipped by the COVID-19 pandemic. It started off on a high with a trip to the beautiful city of Victoria, B.C. for the Canadian Rheumatology Association (CRA) Scientific Meeting in February 2020. No sooner had we returned to the Prairies, we found ourselves in complete lockdown.

With an increasing number of in-person consultation cancellations in March 2020, it was clear that our normal practice of rheumatology was not going to be possible for much longer. Our Ministry of Health's early COVID-19 predictions were for 150K to 400K infections in the province, and an anticipated 3,000 to 8,000 deaths. So, after a flurry of consultative meetings with various stakeholders, many rheumatologists in Saskatchewan agreed to a pandemic agreement. This provided us with a monthly salary for three months and allowed us to practice virtual care while being available to be redeployed as required by the province at a time of need.

The learning curve with regard to providing virtual care in rheumatology was steep. From a predominantly tactile practice, examining people up close, we had to transition to assessing joint activity telephonically, which was not without its challenges. We also had to field many questions about this novel disease and its unique implications for our immuno-compromised population. Fortunately, there was excellent support from the CRA and many pharmaceutical companies for extremely informative WebEx learning sessions. These allowed us to learn from the COVID-19 experiences of rheumatologists in other parts of the world that were further along the pandemic curve. Much of the information was reassuring when faced with the anxiety of prescribing immunosuppressive therapy to immuno-compromised individuals in the midst of a pandemic. Many thanks to all those involved in making these learning opportunities possible.

At least five rheumatologists were called at various time periods during the pandemic agreement to work in internal medicine. During this time, we cancelled our community-based office work and took up duty in internal medicine. For rheumatologists with less experience in internal medicine, this was a humbling experience, with a return to managing medical conditions we had not seen in a while. Similar to the huge advances in management in the field of rheumatology, there were apparently similar advances in the management of complex internal medical conditions. Fortunately, the very competent residents were there to guide us through this adventure. However, their comments on our evaluation sheets indicated that we should keep our day jobs.

Our pandemic agreement ended with the month of June 2020 and thereafter we slowly saw a trickle of patients for in-person consultations. Fortunately, the province has continued to support our practices by maintaining the virtual consultation billing codes. At present we have approximately 60% in-person consultations and provide virtual care to about 40% of our patients. This split is driven purely by patient preference. We found that many out-of-city patients and those with co-morbidities prefer virtual care due to concerns about visiting the city of Saskatoon, where we continue to have a small but steady number of positive COVID-19 cases. The fewer in-person contacts have allowed us to stagger consultations and provide the necessary disinfection between patients. It also allows us the time required to discuss the merits of wearing a mask or other suitable face covering with some of our less enthusiastic patients.

We undoubtedly live and practice rheumatology in interesting times. With determined Prairie optimism, we continue to be hopeful that 2020 will end off on a better note than it started.

Regan Arendse, MD, FRCPC
Assistant Clinical Professor,
University of Saskatchewan
Saskatoon, Saskatchewan

By Bindu Nair, MD, MSc, FRCPC

Greetings from Saskatchewan! 2020 has certainly ushered in plenty of surprises for all of us, and our rheumatology community has banded together to meet the challenges. There was a quick learning curve for some of us, but now a hybrid of both virtual appointments and safe in-person consultations as needed are provided to Saskatchewan patients. Earlier in the pandemic, our colleagues on hospital services required help and we had some amazing rheumatologists answer the call by working as attending physicians for the medicine inpatient teams. This fall saw the successful delivery of our undergraduate musculoskeletal foundations course by virtual teaching, which was received well by the medical students. Our provincial rheumatology group continues to remain connected and have lively discussions with weekly videoconferenced grand rounds.

We are pleased to welcome our colleague, Dr. Cairistin McDougall, who is practicing in Regina, and now brings the number of rheumatologists looking after adult patients in Saskatchewan to fourteen. We are also very excited to have Dr. Kate Neufeld and Dr. Hon Yan Ng join the Division of Pediatric Rheumatology at the Jim Pattison Children's Hospital in Saskatoon.

Bindu Nair, MD, MSc, FRCPC
Professor of Medicine, Division of Rheumatology
University of Saskatchewan, Saskatoon, Saskatchewan

NEW INDICATION IN ANKYLOSING SPONDYLITIS

WE'RE PROUD OF OUR COMMITMENT TO OUR CLINICAL TRIAL PROGRAM IN RHEUMATOLOGY*

ACTIVE PSORIATIC ARTHRITIS TRIALS

BIOLOGIC-NAÏVE SPIRIT-P1

TNFi-EXPERIENCED SPIRIT-P2

PRIMARY ENDPOINT

Percent of patients achieving ACR20 at week 24

SELECTED SECONDARY ENDPOINTS

ACR50 at week 24
ACR70 at week 24
Leeds Enthesitis Index score at week 24
Modified total Sharp score at week 24 (SPIRIT-P1)

Indications:

Taltz is indicated for the treatment of:

- Adult patients with active psoriatic arthritis who have responded inadequately to, or are intolerant to one or more disease-modifying antirheumatic drugs (DMARD). Taltz can be used alone or in combination with a conventional disease-modifying antirheumatic drug (cDMARD) (e.g., methotrexate).
- Adult patients with active ankylosing spondylitis who have responded inadequately to, or are intolerant to conventional therapy.

Relevant warnings and precautions:

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- Immunizations
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- Fertility
- Geriatrics

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>1,400 PATIENTS TOTAL†‡

ACTIVE ANKYLOSING SPONDYLITIS TRIALS

COAST-V **BIOLOGIC-NAÏVE**

COAST-W **TNFi-EXPERIENCED**

PRIMARY ENDPOINT

Percent of patients achieving ASAS40 at week 16

SELECTED SECONDARY ENDOPINTS

ASAS20 at week 16

BASDAI50 at week 16

MRI spine SPARCC at week 16

Percent of patients achieving ASDAS <2.1% (low disease activity) at week 16

CONTACT YOUR TALTZ REPRESENTATIVE OR VISIT LILLY.CA/CONTACT TO LEARN MORE

ACR20/50/70=20%/50%/70% improvement in the American College of Rheumatology criteria; ASAS40=Assessment of Spondyloarthritis International Society 40 response; ASDAS=Ankylosing Spondylitis Disease Activity Score; BASDAI=Bath Ankylosing Spondylitis Disease Activity Index; MRI spine SPARCC=Spondyloarthritis Research Consortium of Canada Magnetic Resonance Imaging Scoring of the Spine (23 discovertebral unit scale); TNFi=tumour necrosis factor inhibitor.

* Clinical significance has not been established.

† Total patient number includes all patients randomized to Taltz, placebo, or adalimumab active control arm (in SPIRIT-P1 and COAST-V).

‡ SPIRIT-P1, N=417; SPIRIT-P2, N=363; COAST-V, N=341; COAST-W, N=316.

Reference: 1. Taltz Product Monograph. Eli Lilly Canada Inc., February 4, 2020.

Lilly

XELJANZ: The first JAK inhibitor in RA, PsA and UC[1]*

PrXELJANZ®
(tofacitinib citrate)

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

Use of XELJANZ/XELJANZ XR in combination with biological disease-modifying anti-rheumatic drugs (bDMARDs) or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

PSORIATIC ARTHRITIS

PrXELJANZ® (tofacitinib) in combination with methotrexate (MTX) or another conventional synthetic disease-modifying antirheumatic drug (DMARD), is indicated for reducing the signs and symptoms of psoriatic arthritis (PsA) in adult patients with active PsA when the response to previous DMARD therapy has been inadequate.

Use of XELJANZ in combination with biological disease-modifying anti-rheumatic drugs (bDMARDs) or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

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PrXELJANZ® (tofacitinib) is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis (UC) with an inadequate response, loss of response or intolerance to either conventional UC therapy or a TNFα inhibitor.

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For more information, contact your Pfizer representative.

JAK = Janus kinase; PsA = Psoriatic arthritis; RA = Rheumatoid arthritis; UC = Ulcerative colitis
* Comparative clinical significance is unknown

References: 1. Pfizer Inc. Data on file. 2019. **2.** Health Canada. XELJANZ Notice of Compliance information. **3.** Pfizer Canada ULC. XELJANZ/XELJANZ XR Product Monograph.

PP-XEL-CAN-0480-EN