

# CRA S C R

The Journal of the Canadian Rheumatology Association

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# UNCOVER A NEW INDICATION FOR TREMFYA® IN ACTIVE PSORIATIC ARTHRITIS<sup>1</sup>



ACR20 responses<sup>\*,†</sup> at Week 24  
with TREMFYA® 100 mg q8w vs. placebo<sup>1,3,‡</sup>

## DISCOVER-2 TRIAL (Biologic-Naïve Patients):<sup>1,2,¶</sup>

**64%** OF TREMFYA® PATIENTS  
(159/248)

VS.

**33%** OF PLACEBO PATIENTS  
(81/246) ( $p < 0.0001$ )

## DISCOVER-1 TRIAL:<sup>1,3,§</sup>

**52%** OF TREMFYA® PATIENTS  
(66/127)

VS.

**22%** OF PLACEBO PATIENTS  
(28/126) ( $p < 0.0001$ )

Demonstrated improvements in HAQ-DI and SF-36 PCS from baseline with TREMFYA® 100 mg q8w at Week 24 vs. placebo<sup>1-3,\*†</sup>

- Mean change in HAQ-DI score: -0.32 vs. -0.07 (DISCOVER-1) and -0.37 vs. -0.13 (DISCOVER-2) ( $p < 0.001$ , both trials)
- Mean change in SF-36 PCS: 6.1 vs. 2.0 (DISCOVER-1;  $p < 0.0001$ ) and 7.4 vs. 3.4 (DISCOVER-2;  $p = 0.011$ )

### Indications and clinical use:

TREMFYA®/TREMFYA ONE-PRESS™ (guselkumab injection) is indicated for the treatment of adult patients with active psoriatic arthritis. TREMFYA®/TREMFYA ONE-PRESS™ can be used alone or in combination with a conventional disease-modifying antirheumatic drug (cDMARD) (e.g., methotrexate).

TREMFYA®/TREMFYA ONE-PRESS™ is also indicated for the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

### Relevant warnings and precautions:

- Do not initiate treatment in patients with any clinically important active infections until the infection resolves or is adequately treated
- Discontinue treatment if patient develops a serious infection or is not responding to standard therapy for infection
- Evaluate patients for tuberculosis infection prior to therapy and monitor for active tuberculosis during and after treatment
- Consider completion of all immunizations prior to treatment
- Concurrent use with live vaccines is not recommended
- Discontinue treatment in cases of serious hypersensitivity reactions, including anaphylaxis, urticaria and dyspnea, and institute appropriate therapy
- Women of childbearing potential should use adequate contraception

- Use during pregnancy only if clearly needed
- The benefits of breastfeeding should be considered along with the mother's clinical needs
- Effect on human fertility has not been evaluated
- Safety and efficacy in pediatric patients have not been evaluated
- Data in patients  $\geq 65$  years of age are limited

### For more information:

Please consult the Product Monograph at [www.janssen.com/canada/products](http://www.janssen.com/canada/products) for important information regarding adverse reactions, drug interactions, and dosing and administration that has not been discussed in this piece.

The Product Monograph is also available by calling 1-800-567-3331.

HAQ-DI=Health Assessment Questionnaire-Disability Index; SF-36 PCS=Short Form (36-item) Physical Component Score; qw8=every 8 weeks; ACR20=American College of Rheumatology 20% improvement from baseline; TNF $\alpha$ =tumour necrosis factor alpha; CI=confidence interval.

\* Patients with  $< 5\%$  improvement from baseline in both tender and swollen joint counts at Week 16 were qualified for early escape and were permitted to initiate or increase the dose of concomitant medications, including NSAIDs, oral corticosteroid, and cDMARD, and remained on the randomized study treatment. At Week 16, 19.0% and 3.1% (DISCOVER-1) and 15.4% and 5.2% (DISCOVER-2) of patients in the placebo and TREMFYA® 100 mg q8w groups, respectively, met early escape criteria.

† Patients with missing data at Week 24 were imputed as non-responders. Patients who initiated or increased the dose of cDMARD or oral corticosteroids over baseline, discontinued study or study medication, or initiated protocol-prohibited medications/therapies for PsA prior to Week 24 were considered treatment failures and non-responders. At Week 24, 16.7% and 5.5% (DISCOVER-1) and 6.9% and 4.8% (DISCOVER-2) of patients in the placebo and TREMFYA® 100 mg q8w groups, respectively, met treatment failure criteria.

‡ DISCOVER-2: Multicentre, double-blind, randomized, placebo-controlled phase 3 study in biologic-naïve adults with active psoriatic arthritis (PsA) ( $\geq 5$  swollen joints,  $\geq 5$  tender joints, and a C-reactive protein [CRP] level of  $\geq 0.6$  mg/dL) who had inadequate response to standard therapies (e.g., conventional disease-modifying antirheumatic drugs [cDMARDs], apremilast, or nonsteroidal anti-inflammatory drugs [NSAIDs]), a diagnosis of PsA for  $\geq 6$  months, and a median duration of PsA of 4 years at baseline. Patients were randomly assigned to receive subcutaneous injections of TREMFYA® 100 mg at Weeks 0, 4, then q8w, or placebo. Primary endpoint was the percentage of patients achieving an ACR20 response at Week 24.

§ DISCOVER-1: Multicentre, double-blind, randomized, placebo-controlled phase 3 study in adults with active psoriatic arthritis ( $\geq 3$  swollen joints,  $\geq 3$  tender joints, and a CRP level of  $\geq 0.3$  mg/dL). Eligibility criteria also included inadequate response to standard therapies (e.g., cDMARDs, apremilast, or NSAIDs), a diagnosis of PsA for  $\geq 6$  months, and a median duration of PsA of 4 years at baseline. About 30% of study participants could have received one or two anti-TNF $\alpha$  agents. Patients were randomly assigned to receive subcutaneous injections of TREMFYA® 100 mg at Weeks 0, 4, then q8w, or placebo. Primary endpoint was the percentage of patients achieving an ACR20 response at Week 24.

¶ Treatment differences, 95% CIs and  $p$ -values were based on Cochran-Mantel-Haenszel test stratified by baseline non-biologic cDMARD and either prior CRP ( $< 2.0$ ,  $\geq 2.0$  mg/dL) (DISCOVER-2) or prior anti-TNF $\alpha$  agents (DISCOVER-1).

**References:** 1. TREMFYA®/TREMFYA ONE-PRESS™ (guselkumab injection) Product Monograph. Janssen Inc. September 4, 2020. 2. Mease PJ, Rahman R, Gottlieb AB, et al. Guselkumab in biologic-naïve patients with active psoriatic arthritis (DISCOVER-2): a double-blind, randomized, placebo-controlled phase 3 trial. Published online March 13, 2020 [https://doi.org/10.1016/S0140-6736\(20\)30263-4](https://doi.org/10.1016/S0140-6736(20)30263-4). 3. Deodhar A, Hellmich PS, Boehncke W, et al. Guselkumab in patients with active psoriatic arthritis who were biologic-naïve or had previously received TNF $\alpha$  inhibitor treatment (DISCOVER-1): a double-blind, randomised, placebo-controlled phase 3 trial. Published online March 13, 2020 [https://doi.org/10.1016/S0140-6736\(20\)30265-8](https://doi.org/10.1016/S0140-6736(20)30265-8).



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# A Century of Progress?

By Philip A. Baer, MDCM, FRCPC, FACP

*"History doesn't repeat itself, but it often rhymes."*

– Quote attributed to Samuel Clemens (Mark Twain)

The pandemic we are all tired of continues to fatigue us physically and mentally. Numbers spew out hourly from the information firehose: cases, hospitalizations, intensive care unit (ICU) admissions, deaths, percent vaccinated, testing backlog, and more. Each number comes with many flavours: municipal, public-health unit level, provincial, national, and international. Even within the span of reasonable debate, one can find incredibly diverse and conflicting sets of views covering essentially all possibilities: we are doing too much or too little; we are acting too late or prematurely; we should or should not follow the example of some other place "X".

So, what can one do? Minimize exposure to conventional media, such as television, radio, and newspapers, to start. Of course, social media is flooded with memes, GIFs, and posts, so turn that off as well. Good luck trying to stop family, friends, and colleagues from discussing the number one concern of the day.

Perhaps a more promising escape is to history and to fiction. Pandemics are richly represented in movies and books. Modern takes such as "Contagion," "28 Days Later," "Outbreak," "I am Legend," "The Hot Zone," and the Canadian film "Pontypool" may be too closely linked to current events to provide relief. A classic like "The Plague" might be better.

I found what I was looking for in "The Pull of the Stars" by Emma Donoghue, who now lives in London, Ontario. In 2018, she decided to write a book centred on the events of the "Spanish flu" pandemic of 1918, and its particular impact on pregnant women and those caring for them at a hospital in Dublin. My wife volunteered us to moderate a discussion on the book at our local book club, populated by many retired English teachers and professors, so we had to parse the manuscript much more carefully than those reading casually.

In doing so, striking parallels emerge with our current situation. Progress in technology and in science has been dramatic in the last century, but human behaviour and our reaction to crisis is not that different. Viruses were unknown in 1918, so theories abounded as to the cause of the pandemic, including World War One and various toxins. Spain was open in its reporting of the pandemic, hence the "Spanish flu" name, though it apparently originated in the U.S. This time around, we had initial names like "Wuhan flu" and equally speculative origin stories involving lab experiments gone wrong, wet markets, human

incursions into the wilderness, and others. Blaming South Africa for Omicron rather than lauding scientists there for identifying this variant is another example.

Crisis as opportunity is another theme common to both eras. In the book, doctors are in short supply, giving nurses and midwives more agency than they would normally have been allowed to exercise. Similarly, we currently have leveraged the expertise of pharmacists to deliver vaccines far more than they usually do, and we have created teams to extend the reach of our small cadre of ICU and infectious disease physicians to deliver care to all who require it.

Other similarities abound: "Health care heroes" is a familiar label currently, often applied by our leaders to those who pre-pandemic were toiling away in difficult and precarious jobs for low pay, but whose value has belatedly been realized. Similarly, the novel highlights the efforts of those toiling with little recognition in the pandemic trenches: volunteers, junior nurses, midwives, and orderlies.

Equity issues have been highlighted in our current pandemic, with marginalized and racialized workers who must work in congregate settings at the highest risk of infection. A century ago, food insecurity and poverty were rampant, and outcomes were equally skewed.

"Patient first, hospital next, self last" is a quotation from the novel which resonated with me. That is definitely a recipe for burnout, and unsustainable beyond the initial response to a pandemic or any other crisis.

Gender bias in 1918 was not surprising. The book features male orderlies lording it over better trained female nurses, and male doctors of any specialty exercising clinical authority over trained midwives. Today, we still have an embedded gender pay gap in medicine in Canada, and a recent profile on the fate of the first female head of cardiac surgery at McMaster shows we have not come as far as we thought.<sup>1</sup>

Masking controversies and unconventional remedies (onions and garlic vs. ivermectin) are well-represented as well in both eras.

Finally, my research for this article revealed that Edvard Munch was a survivor of the Spanish flu and painted a self-portrait at the time. No, it was not "The Scream," which was painted in 1893, but rather "Self Portrait with the Spanish Flu," painted in 1919, and viewable

*Continued on page 5*



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## A Century of Progress? *continued from page 3*

at the link referenced below.<sup>2</sup> If that intrigues you, you can learn more about using art to manage the stress of medical practice in the final reference below, featuring a program pioneered at Harvard and now offered in Canada by the Art Gallery of Ontario.<sup>3</sup>

Do whatever works for you and stay safe.

*Philip A. Baer, MDCM, FRCPC, FACP  
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2. "Self Portrait with the Spanish Flu." *Metmuseum.org*. Available at [www.metmuseum.org/art/collection/search/668328](https://www.metmuseum.org/art/collection/search/668328). Accessed March 8, 2022.
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## WELCOME TO THE RHEUM

Welcome to the following new CRA members:

Shahad Al-Matar, Toronto, ON  
Danya Alnujaidi, Vancouver, BC  
Michael Buchanan, Prince George, BC  
Matthew Chan, Saskatoon, SK  
Daksh Choudhary, Vancouver, BC  
Thaisa Cotton, Verdun, QC  
Evelyne Gendron, Québec, QC  
Genevieve Gyger, Montreal, QC  
Thomas Hahn, Vancouver, BC  
Angela Hu, Surrey, BC  
Matthew Jesome, Hamilton, ON  
Fares Kalache, Montreal, QC  
Hengameh Kheirkhah, Calgary, AB  
Adam Kovacs-Litman, Toronto, ON  
Dalal Mohammad, Vancouver, BC

Oscar Mwizwerwa, Toronto, ON  
Yuan Qi, Montreal, QC  
Wen Qi, Québec, QC  
Patricia Remalante-Rayco, Toronto, ON  
Micol Romano, London, ON  
Teresa Semalulu, Hamilton, ON  
Zachary Shaffelburg, Halifax, NS  
Ali Shams, Calgary, AB  
Tara Swami, Ottawa, ON  
Simone ten Kortenaar, Kingston, ON  
Karine Toupin April, Ottawa, ON  
Michael Vernon, Kingston, ON  
Stefanie Wade, Vancouver, BC  
Ashley Yip, Edmonton, AB

## CRAF Update

By Ahmad M. Zbib, MD, CPHIMS-CA

Significant progress continues on establishing the Canadian Rheumatology Association Foundation (CRAF).

We are pleased to announce the launch of the CRAF Fund through a partnership with the Community Foundation of Greater Peterborough (CFGP). Through this partnership, CFGP is now positioned to accept, receipt and hold donations on behalf of the Canadian Rheumatology Association Foundation as we wait for charitable status approval.

We are pleased to share that we have already received several donations. Donations through the CRAF Fund will help to support research, education and care delivery by rheumatology professionals for people with rheumatic diseases. Funds raised will advance activities which align with the mission of the Canadian Rheumatology Association (CRA) such as the Canadian Initiative for Outcomes in Rheumatology care (CIORA), a unique granting opportunity that is a catalyst for improving the care of Canadians living with all rheumatic diseases. Gifts received and designated to the CRAF Fund are eligible for a charitable tax receipt.



If you would like to make a donation to the CRAF Fund, you can do so directly through the CFGP Foundation at [www.cfcp.ca/project/craf-fund](http://www.cfcp.ca/project/craf-fund).

If you have any questions or would like to know how to get involved with the Foundation, please contact me directly at [executivedirector@crafoundation.ca](mailto:executivedirector@crafoundation.ca). (Our other big news...we now have an official email!)

Ahmad M. Zbib, MD, CPHIMS-CA  
CEO, Canadian Rheumatology Association  
Executive Director,  
Canadian Rheumatology Association Foundation



### Canadian Rheumatology Association Receives Award of Excellence

The Canadian Rheumatology Association is pleased to share that it is the recipient of an Award of Excellence from the Canadian Society of Association Executives (CSAE) for the work and planning behind its COVID-19 Response Series.

Since the onset of the pandemic, CRA members, the Board of Directors, Committee Chairs, staff, volunteers, community partners, sponsors, and supporters were all instrumental in coming together to support the rheumatology community during this unprecedented time.

Thank you to all for your efforts and contributions!



# CIORA Grant: Work Disability and Function in SLE



By Janet Pope, MD, MPH, FRCPC

There were eight CIORA-funded abstracts presented at the 2022 CRA & AHPA Annual Scientific Meeting which included six posters, two poster tours and one podium presentation. Dr. Behdin Nowrouzi-Kia presented his CIORA grant on work disability and function in SLE, which is summarized below.

Visit [www.rheum.ca](http://www.rheum.ca) for more details on all CIORA abstracts.

## Work Disability and Function in Systemic Lupus Erythematosus (SLE): A National Mixed-Methods Sequential Explanatory Study

**Authors:** Behdin Nowrouzi-Kia, Janet Pope, Catherine Ivory, Paul Fortin, Antonio Avina-Zubieta, Derek Haaland, Jiandong Su, Kathleen Bingham, Murray Urowitz, Dafna Gladman, Jorge Sanchez-Guerrero, Nathalie Rozenbojm, Stephanie Keeling, Amanda Steiman, Earl Silverman, Jennifer Reynolds, Lily Lim, Mary Fox, William Shaw, Maggie Ho, Patricia Katz, Zahi Touma

**S**LE is a multisystem autoimmune disease associated with significant Work Disability (WD) requiring a multidisciplinary approach to its management. SLE significantly impacts functional performance, engagement, and self-esteem, and decreases function. Moreover, SLE is one of the leading causes of WD. We hypothesize that the creation of a functional profile will enhance our understanding of the impact of SLE on patients' everyday functioning, allowing us to optimize interdisciplinary interventions.

The overall objective of this proposed project is to understand the determinants of WD and function and define how a multidisciplinary patient-centred collaborative intervention will support the delivery of care. Specifically, the study findings will support the creation of a functional profile of WD of patients with SLE in Canada; identify factors associated with WD in patients with SLE in Canada; and explore the lived experiences of SLE patients during their return-to-work journey.

A significant strength of this proposal is that our team's expertise, experience and perspectives align with CIORA's pillar of "Multidisciplinary Care Teams." Studies report that multidisciplinary teamwork in healthcare is associated with improved patient engagement and participation in the care processes in work rehabilitation. Moreover, our national team and the participation of different centres across Canada are essential to provide insight into the breadth and depth of WD and function in SLE and to enhance the external validity of this project's findings. The preliminary analysis on 91 confirmed cases with high level of WD found that WD was associated with several factors including treatment and the presence of other comorbidities (based on patient-reported outcomes: fatigue, fibromyalgia and depression). It is anticipated that the creation of a first-ever functional profile of WD will provide opportunities for a multidisciplinary team approach to deliver improved care and management of WD and functional outcomes.

# ACR Canada Night

By Brian Feldman, MD, MSc, FRCPC; Nigil Haroon, MD, PhD, DM, FRCPC; and Evelyn Sutton, MD, FRCPC, FACP

On Wednesday October 6th, 2021, the Canadian Rheumatology Association (CRA) held its annual Canada Night event, returning for the first time since 2019. Canada Night has traditionally been held at the site of the American College of Rheumatology (ACR) Convergence meeting; however, it was cancelled in 2020 due to the COVID-19 pandemic. This night was typically intended to bring together all Canadian rheumatologists who were meeting at ACR, as it is a great opportunity for a night of networking and entertainment. In 2021, the decision was made to hold Canada Night virtually to bring together all members of the CRA.

The pandemic caused many to pause and reflect, which was one of the reasons why “The Future of Rheumatology” was selected as the theme of Canada Night. To set the stage, Dan Trommater, who is an illusionist, was invited to kick off the event. Dan Trommater engaged attendees with an interactive presentation to challenge assumptions and boost communication, as well as provide opportunities to have everyone virtually “sit” in a group to discuss difficult topics.

Following this, an accredited session on the future of rheumatology began, led by Drs. Evelyn Sutton, Nigil Haroon, and Brian Feldman. This session was focused on questions, impending challenges, and opportunities that would most impact the future of rheumatology in Canada. All three presenters provided different angles on the topic, including a review of the evolution of rheumatology practice over the years, the major advances in the science and practice of rheumatology, and an exploration of how these trends may influence clinical care in the future.

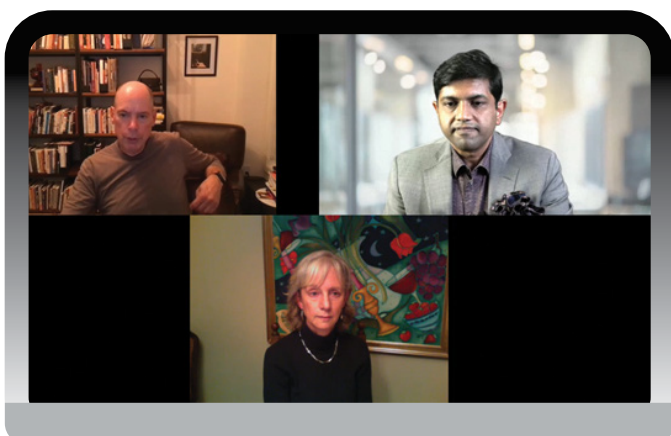
The session closed with an engaging question and answer period with the audience, which included lively discussions on other related topics, such as artificial intelligence; equity, diversity and inclusion (EDI); and environmental awareness; all critical areas that will affect the way we practice rheumatology in the future.

The CRA thanks all who were involved in the planning of this event, including our speakers, staff, vendors, and supporters. We look forward to seeing our members at the next (hopefully in-person) Canada Night event.

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Clockwise (from top left): Dr. Brian Feldman, Dr. Nigil Haroon, and Dr. Evelyn Sutton.



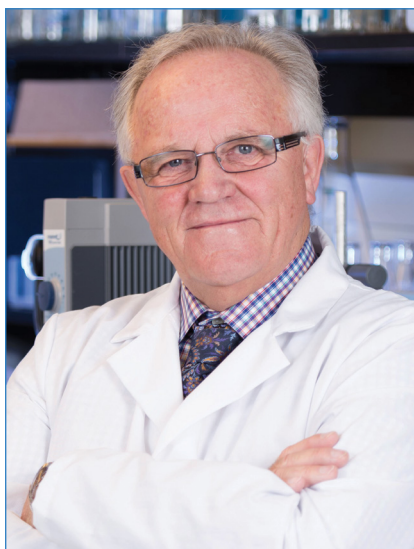
# Reflections on Retirement

By Marvin J. Fritzler, PhD, MD

I recently retired from the University of Calgary after 50 years in academia. Retirement has been a time for reflection and “post-mortem” evaluations. In considering the many people that impacted my formative years and introduced me to academic rheumatology, I remember with gratitude the wisdom and encouragement of Ian Watson, Bob Church, Doug Kinsella, Phil Gofton, Manfred Harth, Henri Menard, Dave Bell, Earl Decoteau and Dave Hawkins (a legend in his own time). Since I didn’t set goals or have a mission statement for my academic career, I have no checklist that reassures me that I accomplished anything. I recently started to clean out my university office, a physical and mental purging of momentous proportions. I amassed hundreds of books and thousands of research files and notebooks that included projects that I thought would be important some day: 99.9% have been thrown away! I reflected on this in a recent article I co-authored: Autoantibody Discovery, Assay Development and Adoption: Death Valley, the Sea of Survival and Beyond.<sup>1</sup> Sure, there are research files that are still interesting to me, but I’ll bet not to you. I doubt that anyone will ask me “what happened to your research on “LINES” (long-interspersed nuclear elements), anti-sense ERCC1, or (my favorite) kappaphredon (aka ‘dimethylchickenwire’)?”

Because it provides a tincture of healing, there are two things I didn’t throw away. First is a collection of letters, cards and emails from former patients or their family members who thanked me for the clinical care I provided. The second is a plaque that my children gave me quoting Albert Einstein: “If we knew what it is we were doing, it wouldn’t be called research.” The pandemic has allowed ample time for reflection on scientific research. An important “lesson” came from a colleague while several of us were embroiled in an email debate about certain published COVID-19 data. He said, “It is important to remember that science is provisional”; or, as I often said, “the data never speak for themselves, they have to be interpreted.” Hence, the oft used aphorism today “we follow the science” bears witness that many people do not understand science.

Over my career I had the fortune to serve on numerous agencies, boards, consultancies, and committees. Some



continue, some do not. I think the most valuable committees were those that could disband having accomplished what they set out to do. Many others persist in peeling the proverbial onion.

What have I learned, and what are my take-home messages? First a paradox, progress is only seen by looking in the rear-view mirror. The bugs on the windshield only serve as a distraction from the scenery and the dashboard is only a reference for that specific moment. Second, what is intuitive (particularly in academia) rarely happens. Third, the rumours (today on social and even mass media) are rarely true or accurate.

What are my concerns? 1) our young academics are overburdened with legalistic, risk-averse institutions that are swamping them with minutiae; 2) peer review is on the cusp of failure (it has become “political review”) and if it continues its current trend, it will take science to irrelevance (try following it then); 3) what will post-pandemic health care or academic research look like?

I leave these concerns in the hands of a very capable new generation who I am confident will effect needed course corrections. They are much brighter and more dedicated to equitable, diverse, and inclusive patient care and research than I was when I started. Through all of this, the Canadian Rheumatology Association has been, and I expect will continue to be, a vibrant and reassuring anchor of leadership and collegiality. I consider it an honour to be one of you.

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# The Future of Rheumatology

By Reza Mirza, MD, FRCPC

Rheumatology is among the most rapidly advancing specialties. Though oncology rivals us, we reserve the pleasure of routinely attaining remission. As we approach the 75th year since the discovery of cortisone, the *Journal of the Canadian Rheumatology Association (CRAJ)* asked me to opine: What do the next 75 years hold?

Rheumatologists will secure the holy grail of personalized therapy. We have the means to modulate specific cellular, protein, or nuclear targets at will. The shot-gun, “inhibit-everything” approach employed glucocorticoids may work short-term but is not tenable in the long run. The burning question is what to target and in whom.

We know clinical phenotypes are insufficient to predict biochemical response. Small Japanese trials give us a taste of how to predict, using lymphocyte flow cytometry patterns.<sup>1</sup> We must continue to stratify our patients into more meaningful groups, as doctors have always done. We have the resolution: long-read sequencing, -omics, mass cytometry. We simply need to offer this data with high quality longitudinal treatment-response data to the altar of machine intelligence.

We are already experts at measuring and extrapolating phenotypes associated with the B-cell receptor, particularly in its soluble antibody form (we are ever grateful, Marv). We must proceed beyond the anti-cellular antibodies that define modern day rheumatology.

Our characterization of the innate arm is scanty, and we have less than half the lymphocyte story. Like Alice in Wonderland, we are blind to the wizard behind the curtain, the T-lymphocyte and its receptor. Unlike B-cells, T-cells can survey intracellular processes, can induce apoptosis where they stand, and their repertoire is estimated to be an order of magnitude more diverse.

The first hurdle we must overcome — to achieve the phenotyping required for personalized therapy — is characterization of the innate arm’s molecular signaling patterns and the T-cell receptor. “Reactive lymphadenopathy” will go the way of the dodo. Instead, embrace this type of lab report: “Activated, proliferating cytotoxic T-lymphocytes present. Sequencing of these T-cells reveal a T-cell receptor with specificity for an unknown target.” It will be so, until our knowledge is more refined.

Once we have completed our measuring, we can begin predicting. Virtual simulations of biology (“in silico”) will continue marching endlessly forward towards the asymptotic perfect prediction. Many philosophers will give up on the age-old conundrum of whether free will exists. (Sadly, it does not exist beyond our own perception.) The unknown, activated T-cells in your pathology sample will

be submitted to the clinical bioinformaticist to have its receptor topology predicted by AlphaFold, bellowing in the server for his next puzzle.<sup>2</sup> In silico evaluation will determine the T-cell receptor’s target-based affinity matching against all known and unknown proteins. Mind you, technically this isn’t futuristic. All these tools exist; the future simply holds application and refinement (Do reach out if interested).

In 75 years, we will have the capacity to measure the vast data contained in blood using multi-sensory physicochemical properties, far beyond the two-dimensions of mass-spectrometry (mass and quantity). Imagine “The Array” (“The Matrix” was taken) where each constituent is evaluated by its response to a distribution of non-destructive wavelengths, allowing for unique fingerprinting. This vast expanse of data would eclipse our working memory by thousands of orders of magnitude. The machine would interpret and draw us a cartoon of the immune system with helpful red and bold lines at upregulated pathways leading us to the most proximal source of inflammation.

There will be no serotype-phenotype discordance, and diagnostic labels will be redefined using serotype-first approaches. Lines between specialties will blur when your rheumatoid patient has a profound signal for peripheral ulcerative keratitis or interstitial lung disease.

We will become well-read in genotypes, and their non-coding grammar. Gene editing will continue to boom-and-bust. Its current boom-cycle will bust once off-target effects are measured. The careful will advocate for reversible, non-curative treatments that consistently work and, crucially, do not spill over into gametes and forever perpetuate. There will be a push for ex-vivo genetic editing of cells, à la CAR-T cells.

The world will be starkly different in 75 years. Our power to dispel disease will grow dramatically, paralleling the existential threat we pose to ourselves. We have yet to shed our beast.

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# Evolution of the Canadian Rheumatology Workforce

By Stephanie Kulhawy-Wibe, MSc, MD

The future of rheumatology in Canada will undoubtedly be shaped by the feminization of our workforce. Our specialty is already more than half female, but this female predominance will become even more pronounced, as women now account for 75% of rheumatologists under 45 years of age.<sup>1</sup> This has implications for workforce planning, but also has the potential to evoke positive change in how rheumatology is practiced. This trend also exists in the United States, but we are about 10 years ahead in Canada, which presents us with the opportunity to become leaders in supporting women in the workforce in novel and bold ways.<sup>1,2</sup> Below are a few areas where we might better support women in the rheumatology workforce:

- Gender inequity is still an issue in our field: women make less money, publish fewer first- and last-author publications, get less grant funding, and are less likely to be promoted to associate or full professor than their male counterparts.<sup>3,4</sup> So, how can we rethink remuneration for services? How can we better support women to publish and attain grant funding? What are the barriers to promotion?
- Half of rheumatologists in Canada report burnout, and women are disproportionately more affected. Women are also less likely to perceive their workplace as supportive.<sup>5</sup> Historically, rheumatology prided itself on being a happy specialty, but we now report among the highest levels of burnout of all medical specialties.<sup>6</sup> What are the modifiable drivers of burnout? How can we address this critical issue to protect and retain our current workforce?
- Female rheumatologists have different work patterns. They are more likely to work part-time, and even when working the same number of hours per week, they see fewer patients.<sup>3,5</sup> This could affect our ability to keep up with the already high demand for rheumatology services. Are there creative ways to meet service demands without necessarily working more hours?
- Women are more likely to take leaves of absence.<sup>7</sup> How can we help with transitions around leaves? And how can it not penalize their long-term goals and future career trajectory?
- Similarly, taking a maternity leave during residency has become more acceptable and common in recent years. However, some residents may not be able to afford to defer their staff salary any longer. Furthermore, each year your salary is deferred, you are giving up not your first, but your last earning year which typically accounts for a greater proportion of lifetime income. With the introduction of competency by design, could there be some flexibility for earlier advancement if competency standards are met?

Rheumatology in Canada is not yet equitable, but the feminization of our workforce provides an impetus for change. Together we can shape a future that provides equitable opportunity for professional advancement, compensation, and wellness for all members of our diverse workforce.

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# Characterization of the Rheumatologist-Extended Role Practitioner Model of Care in an Inpatient Tertiary Care Network

Lena Nguyen; Marie-Andree Brosseau, PT; Nancy Granger, MScPT, MSc; Julia Ma, MPH; Andrew Chow, MD, FRCPC; and Stephanie Tom, MD, FRCPC

## Introduction:

Models of care (MOC) have become crucial to address rheumatologist workforce shortages and increasingly complex patient needs. In Canada, leveraging the involvement of extended role practitioners (ERP) in outpatient rheumatology settings has been shown to decrease wait times.<sup>1-2</sup> The first Canadian rheumatologist (MD)-ERP MOC for inpatients was introduced at Trillium Health Partners (THP) in 2015. Our ERPs are physiotherapists who completed the Advanced Clinician Practitioner in Arthritis Care (ACPAC) program.

## Methods:

We undertook a retrospective, cross-sectional chart review of all patients referred to the rheumatology inpatient consultation service at THP, which includes the Mississauga Hospital (MH) and Credit Valley Hospital (CVH) sites, to characterize the modern inpatient rheumatology consultation service where they were assessed by the ERP-MD team from January 1, 2015 to December 31, 2019. A retrospective chart review was conducted using the hospital's electronic medical records system and descriptive analyses performed.

## Results:

A total of 2,361 patients were seen by the MD-ERP team between January 2015 and December 2019. The overall cohort had a median age of 72 and included more females (59%) than males (41%). The majority of rheumatology referrals (96%) came from wards (hospitalist, internal medicine, surgery); only a few were from intensive care or coronary care units (3%). Most consults were new patients with no prior rheumatology contact (69%). The most common reason for hospitalization was a musculoskeletal (MSK) diagnosis (30%), which included possible rheumatologic or orthopedic etiology, followed by neurologic (19%) and infectious (16%) admission diagnoses (Table 1).

Table 1:

### THP Rheumatology Consultation Population

<b>Number of patients</b>	<b>2,361</b>
<b>Patient age (median, [IQR])</b>	<b>72[52,82]</b>
<b>Patient sex, Number (%)</b>	
Female	1,397 (59.2)
Male	964 (40.8)
<b>Referral service, Number (%)</b>	
Internal Medicine	2,254 (95.5%)
Intensive/Cardiac/Neurosurgery Critical Care	69 (2.9%)
Other	38 (1.6%)
<b>Rheumatology care prior to admission</b>	
No previous rheumatologist	1,637 (69.3%)
Already has rheumatologist	724 (30.7%)
<b>Number of admission diagnoses</b>	
1	2,277 (96.4%)
2+	84 (3.6%)
<b>Type of admission diagnosis, Number (%)</b>	<b>2,445</b>
MSK	738 (30.1%)
Neurologic	453 (18.5%)
Infectious	381 (15.6%)
Cardiovascular	248 (10.1%)
Abdominal/GI	180 (7.4%)
Renal	121 (4.9%)
Respiratory	104 (4.3%)
Undifferentiated	101 (4.1%)
Hematology/Endocrinology	69 (2.8%)
Malignancy	50 (2.0%)
<b>Patient status at discharge</b>	
Alive	2,213 (93.7%)
Deceased	148 (6.3%)



Table 2:

**Rheumatology Inpatient Consultation Service**

Number of patients		2,361
Number of rheumatologic diagnoses		
0		258 (10.9%)
1		1,934 (81.9%)
2		169 (7.2%)
Rheumatologic diagnoses		
Crystal Disease		646 (28.4%)
MSK pain/OA		622 (27.3%)
Systemic Autoimmune Rheumatic Disease		347 (15.2%)
Inflammatory Arthritis		309 (13.6%)
Vasculitis		262 (11.5%)
Infectious		87 (3.8%)
Number of Interventions		
0		49 (2.1%)
1		719 (30.5%)
2		791 (33.5%)
3		695 (29.4%)
4+		107 (4.5%)
Interventions		
Bloodwork		1,622 (68.7%)
Medication		1,329 (56.3%)
Imaging		1,097 (46.5%)
Injection		675 (28.6%)
Non-pharmacologic		89 (3.8%)
Referrals		
Medicine specialty		146 (6.2%)
Surgery		145 (6.1%)
Allied Health		25 (1.1%)
Radiology		26 (1.1%)
Other		5 (0.2%)
Outpatient follow-up required		
No		1,360 (57.6%)
Yes		1,001 (42.4%)

The most common rheumatologic diagnoses were crystal disease (28%) followed by osteoarthritis (OA)/MSK-related pain (27%). Less common were systemic autoimmune rheumatic diseases (15%), inflammatory arthritis (14%), vasculitis (12%), and infection (4%). Of the 169 patients with concurrent diagnoses, the most common concomitant diagnoses were crystal disease and OA/MSK-related pain (50%). Nearly all rheumatology consultations

Supplementary Table A:

**Patients Requiring Follow-up According to Rheumatologic Diagnoses**

Number of Patients	Follow-up	
	Yes	No
Crystal disease	167 (16.7%)	479 (35.2%)
MSK pain/OA	94 (9.4%)	528 (38.8%)
Systemic Autoimmune Rheumatic Disease	279 (27.9%)	68 (5.0%)
Inflammatory arthritis	269 (26.9%)	40 (2.9%)
Vasculitis	200 (20.0%)	62 (4.6%)
Infectious	32 (3.2%)	55 (4.0%)

required interventions (98%), which included bloodwork (69%), medication (56%), imaging (47%), and/or intra-articular injection (29%), with most requiring more than one intervention (Table 2).

Of all the consulted patients, 42% required outpatient follow-up (Table 2), particularly those with systemic autoimmune rheumatic disease (28%), inflammatory arthritis (27%), and vasculitis (20%) (Supplementary Table A).

**Discussion:**

With the goals of addressing unmet inpatient needs and sustainability of hospital-affiliated community practice, THP implemented the first Canadian inpatient MD-ERP MOC. Most patients had no previous contact with rheumatology and only required intervention during their hospitalization. The most common rheumatologic diagnoses were crystal disease and OA/MSK-related pain which corresponds to their prevalence in the general population.<sup>3</sup>

Although it is important to have rheumatologic management in high acuity inpatient situations (i.e. life-threatening vasculitis), the modern rheumatology service also includes OA/MSK-related pain and crystal disease management. Crystal disease was the most common rheumatologic diagnosis, an observation that aligns with studies reporting gout and pseudogout as the main causes of hospitalizations related to crystal arthropathies.<sup>4-6</sup> Notably, several studies draw links between deficits in pre-hospital care<sup>7-9</sup> and lack of urate-lowering therapy among hospitalized patients.<sup>10-12</sup> OA was another common reason for rheumatologic consultation likely due to comorbidity (i.e. the impact of OA on gait safety and discharge planning). Due to many rheumatologists' practice scope being focused on inflammatory conditions to cope with human resource shortages,<sup>13</sup> OA/MSK-related issues and crystal disease are typically managed by primary care providers pre-and post-admission.

# Characterization of the Rheumatologist-Extended Role Practitioner Model of Care in an Inpatient Tertiary Care Network

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## Conclusion:

With the increasing burden of rheumatic diseases and too few rheumatologists, ERPs are integral to supporting inpatient rheumatology care. Our study provides a benchmark for future implementations of similar MOCs and highlights an opportunity to improve outpatient management of chronic conditions to mitigate future disease burden. More research is required to evaluate the economic impact of rheumatology consultation and inpatient MD-ERP MOC.

## Acknowledgements:

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## Declaration of Interest Statement:

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. This research was completed for quality improvement purposes to evaluate our current MOC.

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# Truth and Reconciliation and the Arthritis Community: A Call for Collective Action

By Terri-Lynn Fox, PhD; and Cheryl L. Koehn, President, Arthritis Consumer Experts

The theme of the recently held 2022 Canadian Rheumatology Association and Arthritis Health Professions Association Annual Scientific Meeting was “Towards Equity: Rheum for Everyone.” To move towards equity in arthritis, the community must take meaningful action beyond working to provide equitable care. It must come together and take meaningful and respectful action on Truth and Reconciliation.

Arthritis affects Indigenous peoples more significantly and more severely than non-Indigenous populations. Specifically, Indigenous peoples in Canada experience:

- Higher rates of inflammatory arthritis such as lupus, rheumatoid arthritis and ankylosing spondylitis;<sup>1</sup>
- Higher rates of death from lupus and its complications compared to non-Indigenous patients;<sup>2</sup>
- Worse disease outcomes in early rheumatoid arthritis compared to white patients. This means slower improvements in pain and swelling and less likelihood of achieving remission;<sup>3</sup>
- Fewer visits to specialists than the non-Indigenous population as well as significantly more hospitalizations due to arthritis complications;<sup>4</sup> and
- Lower rates of evidence-based inflammatory arthritis therapies being used among Indigenous people despite the disease being more severe;<sup>4</sup>

Yet today, the path to appropriate, timely care for an Indigenous person dealing with debilitating symptoms of inflammatory and non-inflammatory arthritis continues to be rooted in systemic racism, implicit bias and geographical challenge.<sup>4,5</sup> To address this, the arthritis community — rheumatology researchers, healthcare professionals, and patient organizations and their members — needs to start at the beginning by learning about and understanding the historical and intergenerational trauma and pain Indigenous peoples with arthritis survived and continue to deal with because of policies such as the Indian Act (1876) and Indian residential and day schools.

The Truth and Reconciliation Commission was formed to address and reckon with the horrific legacy of forced assimilation and abuses brought on Indigenous peoples by the residential school system. The Commission's final report contained 94 Calls to Action that Canadians must take for Truth and Reconciliation to truly occur. Calls to Action #18 to 24<sup>6</sup> are specifically related to Indigenous peoples' health.

Call to Action #22 requires us — those who can effect change within the Canadian healthcare system — “to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal leaders and Elders, where requested by Aboriginal patients.” Bridging academic/institutional medical practice with Indigenous healing practices and belief — the intentional and respectful merging of two worldviews — will facilitate bringing together mainstream society and Indigenous peoples' paths in unity, equity, fairness and harmony, and begin to address harmful gaps in arthritis models of care.

The Truth and Reconciliation Commission Calls to Action are a starting point to guide our arthritis community that numbers six million-plus in Canada. If we work and act together on Call to Action #22, we can meaningfully contribute to efforts towards “Reconcili-ACTION” and the design and delivery of healthcare that is knowledgeable of, and supports, Indigenous approaches to health and wellness.

The Truth and Reconciliation Commission's Final Report is a testament to the courage of each survivor and family member who shared their story, which continue to resonate today six years after the report's release.

The time for arthritis community action is now. Walk with us.

*Dr. Terri-Lynn Fox is an Indigenous Scholar and Indigenous Person living with rheumatoid arthritis.*

*Cheryl L. Koehn is the president of Arthritis Consumer Experts and a settler-colonial living with rheumatoid arthritis*

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# Spotlight on the 2022 CRA Abstract Awards

## BEST ABSTRACT ON SLE RESEARCH BY A TRAINEE – IAN WATSON AWARD

*Sponsored by the Lupus Society of Alberta*

Winner: Maher Banjari, University of Toronto

Abstract Title: Evaluating COVID-19 Vaccination in Patients with Systemic Lupus Erythematosus

Supervisor: Dr. Dafna Gladman

## BEST ABSTRACT ON CLINICAL OR EPIDEMIOLOGY RESEARCH BY A TRAINEE – PHIL ROSEN AWARD

*Sponsored by the Arthritis Society – Phil Rosen Memorial Award*

Winner: Molly Dushnicky, McMaster University

Abstract Title: Impact of the COVID-19 Pandemic on Juvenile Idiopathic Arthritis Presentation and Research Recruitment: Results from the CAPRI Registry

Supervisor: Dr. Michelle Batthish

## BEST ABSTRACT BY A RHEUMATOLOGY RESIDENT

*Sponsored by the CRA*

Winner: Wen Qi, Université Laval

Abstract Title: Characteristics and Evolution of Patients with Difficult-to-Treat Rheumatoid Arthritis

Supervisor: Dr. Laëtitia Michou

## BEST ABSTRACT ON BASIC SCIENCE RESEARCH BY A TRAINEE

*Sponsored by the CRA*

Winner: Omar Cruz Correa, University Health Network

Abstract Title: Prediction of Psoriatic Arthritis in Patients with Psoriasis Using DNA Methylation Profiles

Supervisor: Dr. Dafna Gladman

## BEST ABSTRACT BY A POST-GRADUATE RESEARCH TRAINEE

*Sponsored by the CRA*

Winner: Holly Philpott, Western University

Abstract Title: Rethinking the Role of the Synovium in Late-Stage Knee Osteoarthritis: Ultrasound Imaging and Histopathological Features of Synovial Inflammation and Damage

Supervisor: Dr. Tom Appleton

## BEST ABSTRACT ON QUALITY CARE INITIATIVES IN RHEUMATOLOGY

*Sponsored by the CRA*

Winner: Michael Zeeman, University of Alberta

Abstract Title: Characterization of patients with normal inflammatory markers in giant cell arteritis

Supervisor: Dr. Alison Clifford

ABSTRACT AWARDS	WINNERS
Best Abstract on Basic Science Research by a Trainee Award	OMAR CRUZ CORREA
Best Abstract on Clinical or Epidemiology Research by a Trainee – Phil Rosen Award	MOLLY DUSHNICKY
Best Abstract by a Medical Student Award	SAMIR MAGDY ISKANDER
Best Abstract on Pediatric Research by Young Faculty Award	CHELSEA DECOSTE
Best Abstract by a Post-Graduate Research Trainee Award	HOLLY PHILPOTT
Best Abstract on Quality Care Initiatives in Rheumatology Award	MICHAEL ZEEMAN
Best Abstract on Research by Young Faculty Award	NANCY MALTEZ
Best Abstract by a Rheumatology Post-Graduate Research Trainee Award	JENNIFER LEE
Best Abstract by a Rheumatology Resident Award	WEN QI
Best Abstract on SLE Research by a Trainee – Ian Watson Award	MAHER BANJARI
Best Abstract on Spondyloarthritis Research Award	VANESSA OCAMPO
Best Abstract by an Undergraduate Student Award	DANIEL ONWUKA

## BEST ABSTRACT BY A MEDICAL STUDENT

*Sponsored by the CRA*

Winner: Samir Magdy Iskander, Western University

Abstract Title: JAKi inhibitors have higher long-term durability of treatment in rheumatoid arthritis compared to other bDMARDs in a real world two-center Canadian Cohort study

Supervisor: Dr. Janet Pope

## BEST ABSTRACT BY AN UNDERGRADUATE STUDENT

*Sponsored by the CRA*

Winner: Daniel Onwuka, University of British Columbia

Abstract Title: Diagnostic Testing in IgG4-related Disease

Supervisor: Dr. Mollie Carruthers

## BEST ABSTRACT BY A RHEUMATOLOGY POST-GRADUATE RESEARCH TRAINEE

*Sponsored by the CRA*

Winner: Jennifer Lee, University of Toronto

Abstract Title: The Long-Term Cardiac Prognosis of Kawasaki Disease: Results from a Retrospective Matched Data Linkage Study

Supervisor: Drs. Brian Feldman and Jessica Widdifield

## BEST ABSTRACT ON RESEARCH BY YOUNG FACULTY

*Sponsored by the CRA*

Winner: Nancy Maltez, University of Ottawa

Abstract Title: Improvement in Overall Survival, Skin Fibrosis and Lung Function with Autologous Hematopoietic Stem Cell Transplantation in Systemic Sclerosis

## BEST ABSTRACT ON PEDIATRIC RESEARCH BY YOUNG FACULTY

*Sponsored by the CRA*

Winner: Chelsea DeCoste, IWK Health Centre

Abstract Title: High Adolescent Health Needs and Relationship to Disease in Patients with Childhood-Onset Systemic Lupus Erythematosus

## BEST ABSTRACT ON SPONDYLOARTHRITIS RESEARCH AWARD

*Sponsored by the Canadian Spondylitis Association*

Winner: Vanessa Ocampo, University of Toronto

Abstract Title: Prevalence, Incidence and Predictors of Uveitis in Spondyloarthritis in a Canadian Cohort

Supervisor: Dr. Dafna Gladman

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# Dispatches from the COVID Ward at Vancouver General Hospital

By Kam Shojania, MD, FRCPC

## Vancouver General Hospital COVID-19 Rheumatology Volunteers:

Alice Mai, Ann Marie Colwill, Antonio Avina, Brent Ohata, Daniel Ennis, David Collins, Diane Lacaille, Fergus To, Hyein Kim, Jason Kur, Jennifer Corpuz, Jennifer Reynolds, Jonathan Chan, Kam Shojania, Kun Huang, Mohammad Bardi, Natasha Dehghan, Neda Amiri, Raheem Kherani, Shannon Galway, Shahin Jamal, Wendy Wong

In March 2020, and for the next 23 months (and still ongoing), there has always been at least one rheumatologist working on the Vancouver General Hospital COVID-19 ward. Think back to March 2020, when we were all worried about COVID. How was it transmitted? What would happen here? Would we end up like New York or Italy? What was the COVID ward going to look like? I had visions of hallways full of sick and dying people, limited oxygen supplies, and scarce personal protective equipment. Vaccines were only a dream. During this uncertain and frightening time, these 22 rheumatologists collectively answered a call for help from the internists and administration at Vancouver General Hospital (VGH). For a week at a time, we worked alongside internists, other subspecialists, nurses, and other allied health members taking care of very sick COVID-19 patients.

At the beginning we were sifting through online sources but eventually we were able to develop our own treatment algorithms and we published papers on COVID-19 cytokine storm treatment. Some of us even had to “borrow” tocilizumab from private offices and bring supply to the intensive care unit (ICU). Seeing the rheumatologists as the first group to step up was an inspiration to other specialists in the hospital who also subsequently volunteered. A few of us were infected with COVID-19 — but all recovered. In addition to working on the COVID-19 ward, some of us also sat on the COVID-19 therapeutics committee, and others provided advice and wrote provincial directives on COVID-19 vaccines in immunosuppressed patients.

In retrospect, our biggest fear was that our internal medicine skills would be too rusty and that our care would be



Raheem Kherani (left) and Kam Shojania (right) in the “air lock” behind the VGH COVID ward (December 2020).

sub-par. The opposite turned out to be true as we each realized that we were more than capable of treating these patients. It is true that to be a good rheumatologist you need to be a good internist. All of us were comfortable taking care of unstable patients with multiple medical problems including COVID-19. Dare I say that it was actually energizing to work closely with internists, infectious disease specialists, respirologists and intensivists. It was difficult to manage the emotional toil of caring for sick and sometimes dying patients without their families present. We participated in many difficult bedside video conferences with distraught family members who could not attend in person due to emergency

isolation requirements.

On October 26th 2021, there was an appreciation dinner for these brave physicians. We received letters of gratitude from our Premier, our Minister of Health, the Mayor of Vancouver and the VGH CEO. There were lots of laughs and a few tears as we talked about how working on the COVID ward changed us. As I looked around the table, I knew that I would never forget how immensely proud I am of my wonderful colleagues who, in the early months of the pandemic, heroically “ran towards the fire” to help when there was so much uncertainty.

*Kam Shojania, MD, FRCPC  
Head, Division of Rheumatology, Vancouver General Hospital  
Medical Director, Mary Pack Arthritis Program  
Clinical Professor, UBC Division of Rheumatology  
Vancouver, British Columbia*



# Optimizing Virtual Care During the COVID-19 Pandemic and Beyond

By Sahil Koppikar, MD, FRCPC; and Brent Ohata, MD, CM, FRCPC

With the resurgence of the COVID-19 omicron variant, we have been forced again to attend the CRA Annual Scientific Meeting online in our living rooms, and many of us have transitioned back to seeing patients virtually. After two years, an end to the pandemic remains elusive. It is therefore increasingly likely that our current practice patterns — a blend of in-person and virtual encounters — will become the “new normal.” As our practice patterns evolve, it is incumbent on us as a community to develop strategies to deliver the best possible care virtually. Below are several tips to improve the care you deliver virtually:

## 1. Book video appointments instead of telephone appointments.

Video appointments not only allow for a modified physical exam, but they also facilitate interpersonal interactions. For patients who struggle with technology, successful video appointments can still occur with the assistance of family/friends, in local health clinics when home internet speeds are slow, and after test runs with your staff.

## 2. Develop strategies with your administrative staff to improve the virtual care connection and environment.

An optimized virtual environment facilitates better clinical care. Struggling with poor connectivity, poor audio/video quality, and inappropriate appointment locations waste time and detract from clinical data quality. Actions taken by your staff to improve the likelihood of a successful appointment will reduce your stress. Helpful strategies include:

- a. Appointment reminders that include preferred devices and web browsers, suggestions for improving internet speed, ideal locations and clothing, and lighting tips.
- b. Collecting telehealth consent forms and patient-reported outcome measures prior to the visit.
- c. Having patient sign in 15 minutes prior to the appointment, so administrative staff can troubleshoot any technical challenges before you enter the virtual encounter.
- d. Entering pharmacy, lab and imaging department fax numbers into the electronic medical record prior to the visit.

## 3. Become more comfortable and creative conducting a physical examination over video appointments.

Although many virtual physical exam maneuvers are not validated yet, they still provide invaluable information that impacts clinical decisions. These techniques have often been developed by health care providers who are comfortable with virtual care in various populations. Several good resources are available, including Bone and Joint Canada,<sup>1</sup> the Mayo Clinic,<sup>2,3</sup> and from evidence-based practical frameworks for the MSK exam.<sup>4</sup> The CRA has also developed accredited interactive modules to help with rheumatological virtual visits and physical exams, to be released this spring.

## 4. Virtual care is ideal when integrated within a holistic model of care (MOC).

As rheumatologists, we still rely heavily on in-person assessments, especially if the virtual examination does not allow for decision-making. Virtual care should be viewed as a complement to, not a substitute for, in-person care. Virtual care may improve access to and continuity of specialist care, especially for patients with sporadic access to rheumatology. It allows for collaboration with extended-role practitioners (i.e. Advanced Clinician Practitioners in Arthritis Care [ACPACs]) in underserved areas to enhance care and outcomes. Creative models utilize virtual care in between appointments to support patients in various ways, including self-monitoring applications, educational courses, biologic injection classes, and rapid access “hotlines.” With creativity and innovation, we can leverage virtual care moving forward to provide better care to our patients within a comprehensive and inter-disciplinary MOC.

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# Incidence of the SARS-CoV-2 Infection Amongst Patients with Rheumatological Conditions: A Single Centre Study

By Amirsadegh Yazdani; and Ramin Yazdani, MD, MRCP (UK), FRCPC

The SARS-CoV-2 pandemic has affected the lives of many individuals, directly or indirectly. Patients with rheumatological conditions have felt the effects of the pandemic more so than healthy individuals, either due to their assumptions of being immunosuppressed, either because of their underlying conditions or their treatments. This fear may lead to the discontinuation of their treatments, avoidance of doing their drug monitoring tests, or failure to attend their appointments.

To assess the effects of the pandemic on rheumatological patients, multiple efforts have been undertaken. The greatest one is the Global Rheumatology Alliance, in which any rheumatologist can register their patients who have been affected by the SARS-Cov-2 infection.<sup>1</sup>

Several factors have been reported to be associated with the worst outcomes regarding SARS-CoV-2 infection, including systemic lupus erythematosus (SLE), high disease activity, high-dose steroids, rituximab, abatacept, and JAK inhibitors.<sup>2</sup>

However, presenting local data to patients might have more impact in alleviating patients' concerns, and providing them with the answers they seek. We present the individuals who have been affected by SARS-CoV-2 infection in a community rheumatology center in Ottawa, Canada, between March 2020 and October 2021.

The number of patient visits between March 2020 and October 2021 was about 4,800 (virtual and in-person). Infections were self-reported by the patients during their consultations. Thirty-one individuals were affected

by the SARS-CoV-2 infection, nine of whom were males and 22 were females. The age of these patients ranged from 25-86 years, with a median age of 58 years. The BMI of patients ranged from 19-51 with a median BMI of 30.75. Nine individuals were born outside of Canada. Thirty individuals had an autoimmune rheumatic condition. One had gout and metabolic syndrome. Twenty-seven individuals were taking either conventional disease-modifying antirheumatic drugs (csDMARDs), or biologic DMARDs, or both (see Table). Six patients were hospitalized due to the SARS-CoV-2 infection and were treated according to local guidelines. Only one patient died due to SARS-CoV-2 infection. She was 86 years old with gout, diabetes mellitus, hypertension, stage 3 chronic kidney disease (CKD3), and had a BMI of 43 (she was not on DMARDs or biologics). In our centre, we did not observe increased mortality in rheumatological patients who are taking csDMARDs or bDMARDs.

The following table (see next page) summarizes the patients' characteristics and outcomes.

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Table:  
**Patient Characteristics and Outcomes**

Gender	Age	Diagnosis	DMARD Therapies	BMI	Hospitalization	Death due to SARS-CoV-2
F	55	PsA	Certolizumab pegol	29	No	No
F	57	RA, Sjogren's Disease	Etanercept, MTX	25	No	No
M	62	RA	MTX, HCQ	30	No	No
F	64	RA, Osteoporosis	HCQ	30	No	No
F	50	RA, Depression	MTX, CQ	33	No	No
M	51	PsA, Fatty Liver	MTX, leflunomide, adalimumab	26	No	No
F	57	RA	MTX, HCQ	28	No	No
F	41	PsA	MTX, adalimumab	51	No	No
M	58	RA	Etanercept	38	No	No
F	47	UCTD	No DMARDs	30	No	No
F	60	RA	MTX, HCQ	33	No	No
F	55	Discoid Lupus, Fibromyalgia	No DMARDs	27	No	No
F	70	SLE, Fibromyalgia,	MTX	29	No	No
F	68	Erosive Seropositive	Abatacept, MTX	30	No	No
M	52	Seropositive RA, Hyperuricemia	HCQ	31	No	No
M	59	Seropositive RA, Gout	Leflunomide, HCQ, Prednisone	45	No	No
M	56	AS	Apremilast, Sulfasalazine,	25	No	No
M	50	RA, Crohn's Disease	Ustekinumab, Colchicine,	33	No	No
F	64	RA	MTX, HCQ	23	No	No
F	48	AS	Secukinumab	29	No	No
F	76	RA	MTX, HCQ	35	No	No
M	55	AS	Etanercept	40	No	No
F	67	RA	SSZ, Prednisone	27	No	No
F	25	Early RA	No DMARDs	19	No	No
F	58	Sjogren's Disease	HCQ	31	No	No
M	67	Dermatomyositis, ILD	MMF, Prednisone	26	Yes	No
F	82	PsA	MTX, Secukinumab	32	Yes	No
F	58	RA	MTX	25	Yes	No
F	65	GPA, RA	RTX, MTX, Prednisone	19	Yes	No
F	63	RA	MTX	31	Yes	No
F	86	Gout, HTN, DM, CKD3, High BMI	No DMARDs	43	Yes	Yes

PsA, psoriatic arthritis; RA, rheumatoid arthritis; MTX, methotrexate, HCQ, hydroxychloroquine; CQ, chloroquine; UCTD, undifferentiated connective tissue disease; DMARDs, disease-modifying antirheumatic drugs; SLE, systemic lupus erythematosus; AS, ankylosing spondylitis, SSZ, sulfasalazine; MMF, mycophenolate mofetil; ILD, interstitial lung disease; GPA, granulomatosis with polyangiitis; RTX, radiotherapy; HTN, hypertension; DM, diabetes mellitus; CKD3, stage 3 chronic kidney disease; BMI, body mass index



# Highlights from ACR Convergence 2021

By Philip A. Baer, MDCM, FRCPC, FACR

*This information is brought to you by the Journal of the Canadian Rheumatology Association and is not sponsored by, nor a part of, the American College of Rheumatology.*

I did not leave my heart in San Francisco, where the American College of Rheumatology (ACR) 2021 was originally scheduled to occur, as the pandemic forced a pivot for a second year to the all-virtual format known as ACR Convergence. Programming was extended from November 1st-10th, including a Global Rheumatology Summit, Basic and Clinical Research Conference and the ACR Review Course, as well as a jam-packed meeting. From mid-December to mid-February, there will also be post-conference weekly sessions on Fridays with poster tours and debriefs highlighting the more common rheumatic diseases.

The platform was robust, including pre-recorded lectures on VIMEO with live Q&A sessions thereafter. Study Groups and Community Hubs on every conceivable rheumatology topic were sprinkled through the conference. Community Hubs included Meet-the-Expert sessions, as well as abstract presenter lightning rounds and difficult case discussions. Multiple streams catered to areas such as pediatric rheumatology, the business of rheumatology, interprofessional care and early career issues. It was possible to attend from 7:30 am to 7:00 pm every day, though not recommended either physically or mentally.

Almost every poster and abstract presentation could be downloaded in PDF format, and short audio synopses of the posters were virtually universal. The ORAL-Surveillance study was featured in at least four presentations (0831, 1684, 1940, 1941) and the FDA Update session, though the full study remains unpublished. Late breaker posters focused of course on COVID-19, as well as cardiovascular issues with hydroxychloroquine, gout, and new therapies such as avacopan for antineutrophil cytoplasmic antibodies (ANCA) vasculitis, pirfenidone for rheumatoid arthritis-associated interstitial lung disease (RA-ILD) and sequential biologics for systemic lupus erythematosus (SLE) (BLISS BELIEVE study). A positive phase 2 trial of secukinumab in giant cell arteritis (GCA) (LB19) also caught my interest. Other key studies with interesting acronyms were presented, including VITAL, KEEPSAKE, STOP-JIA, and GLORIA. Social media and interactivity were prominent, with #ACR21 Tweet Ups, polls, and lots of activity in the chat and Q&A functions of most presentations.

There were 2,500 speakers and presenters involved, which may be a new record. More than 2,000 abstracts were presented. Official attendance was 14,000 people

from 110 countries. Canadians were prominent as usual, many moderating key sessions, as well as presenting original research based on Canadian cohorts and registries. I attended the adult Thieves Market session (9T115), where two of the four presenters were Canadian rheumatology fellows: Jehanya Jegatheeswaran from Queen's (A Bone to Pick) and Maria Powell from the University of Calgary (The Disease that Cried Wolf). All the cases were fascinating, with a key take-home message that infectious diseases can masquerade as rheumatic conditions (SLE is not the only disease with protean manifestations). As the winning presenter noted, "TB can cause anything except pregnancy".

We were also well-represented in the ACR and Association of Rheumatology Professionals (ARP) awards, which included ACR Masters John Hanly (also a plenary session presenter on functional connectivity in neuro-SLE) and Rayfel Schneider, ACR Distinguished Clinical Investigator awardee Brian Feldman, and ARP award winners Debbie Feldman (Addie Thomas Service Award), Catherine Backman (Lifetime Achievement Award) and Monique Gignac (Ann Kunkel Award). Many of them are individually featured in this issue's Awards and Accolades section.

Issues around equity, diversity and inclusion were prominently featured, as they will be at the upcoming CRA ASM 2022 as well. The ACR Rheumatology Image Bank solicited new slides featuring cutaneous manifestations of diseases in patients with various skin colours, for example.

The opening keynote speaker, Dr. Seema Yasmin, spoke informally as part of a conversation with ACR President Dr. David Karp. Dr. Yasmin is both a physician epidemiologist and a journalist, having trained at the Dalla Lana school at the University of Toronto, and now based at Stanford. She spoke on vaccines and medical myths, amongst other topics. I plan to read her latest book, "Viral BS: Medical Myths and Why We Fall for Them," when I have the opportunity.

The Great Debate featured Dr. Michelle Petri and Dr. Brad Kovic debating the merits of belimumab versus voclosporin, the latter developed by a Canadian company, for the treatment of lupus nephritis. Dr. Petri was the winner with 70% of the votes.

There were excellent named lectureships, including the Gluck lecture on "The Role of Bone in OA" by Dr. Marc Hochberg, the Arend lecture by Dr. Gary Firestein on "The Disease Formerly Known as RA," the Klemperer lecture by Dr. Peter Gregersen on "Forty Years of Working on a Changing Research Landscape from RA to Endometriosis", and the Dubois lecture by Dr. Aimee Hersch on "Defining

Research Priorities in Pediatric Lupus". Who knew that tumour necrosis factors (TNFs), IL-1 and IL-6 were involved in the pathogenesis of endometriosis? That was only one of the fascinating facts I picked up.

The Year in Review was traditional in format, with basic science and clinical segments. The Closing Session was different, with a moderator and four discussants chatting without slides. The participants highlighted new information presented on polymyalgia rheumatica (PMR)/giant cell arteritis (GCA), multisystem inflammatory syndrome in children (MIS-C) related to COVID-19 infection in pediatric patients, rehabilitation and employment in the rheumatic diseases, environment-genetic interactions affecting disease pathogenesis, the microbiome, dietary supplements such as fish oil, Vitamin D, and omega-3s, geriatric rheumatology, and the impact of climate change and pollution on autoimmunity.

Other highlights: The ACR Knowledge Bowl, the ACR's counterpart to *RheumJeopardy*, was won by the Gulls of Galveston, based in Texas. More information was presented from the Accelerating Medicines Partnership (AMP) which is working to develop novel therapies in rheumatology. Dr. Kenneth Saag was formally installed as the 85th ACR President.

The plan is for ACR 2022 to be live in Philadelphia, but a hybrid meeting with a virtual component remains quite likely.

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

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## If You Ask for Innovation It Will Come

By Trish Barbato  
President and CEO, Arthritis Society

In the last issue, I talked about how arthritis needs innovation. Well, it turns out there are a lot of innovators who want to help people living with arthritis.

Whether it's researchers, entrepreneurs or clinicians, the number of creative minds working on solutions that could make life better for people living with arthritis is inspiring.

Our new **Ignite Research Grants** program attracted almost 50 applications in its first year, and we are delighted to have been able to fund nine of them. The projects range from investigating if tiny particles in the blood could predict response to methotrexate, to studying bone marrow lesions in people with osteoarthritis to better understand the disease — and all could yield tremendous results.

Similarly, in December, we were overwhelmed by the number and quality of submissions to both our **Social Impact Program** and our **Arthritis Ideator Program**. The submissions came from across the country and ranged from apps to assistive devices to screening programs.

To support this work, we recruited more than 30 "Innovation Ambassadors." Our Ambassadors, who live with arthritis, have been testing products and technology, meeting entrepreneurs and lending their voice to the assessment of submissions. The Arthritis Ideator Program will



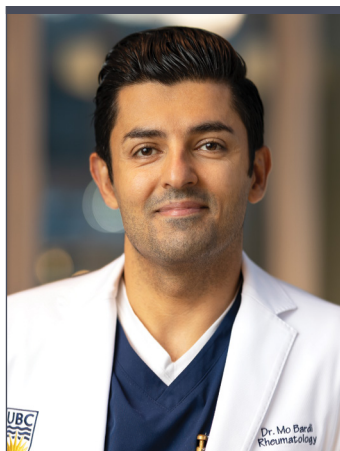
culminate with four finalists — including a People's Choice Award — being selected for funding at our exciting Arthritis Ideation Awards event on April 21, 2022. Join us for this energizing presentation of innovation. We're uncovering and fueling ideas that will change the future! More information is available at [www.arthritis.ca/innovation](http://www.arthritis.ca/innovation).



### **Dr. Catherine Backman – ACR/ARP Lifetime Achievement Award**

The American College of Rheumatology/Association of Rheumatology Professionals (ACR/ARP) Lifetime Achievement Award is presented to an ARP member who has made lasting contributions to the field of rheumatology. Catherine Backman, PhD, FCAOT, received the award at the November 2021 ACR Convergence meeting. She is currently Professor, Department of Occupational Science & Occupational Therapy, at the University of British Columbia, and Senior Scientist at Arthritis Research Canada.

In a career spanning four decades, Catherine has especially enjoyed the teamwork inherent in rheumatology practice, education, and research, inclusive of patient collaborators and graduate students. Her research examines the impact of arthritis on participation in paid and unpaid work and qualitative and mixed methods studies on occupational disruption, occupational balance, and the effect of rehabilitation interventions.



### **Dr. Mo Bardi – UBC/BCSR Innovation Award**

Dr. Mo Bardi is a rheumatologist and a member of the Division of Rheumatology at the University of British Columbia (UBC). He completed training in the use of ultrasound through the Ultrasound Society of North America Rheumatologists (USSONAR) program, and trained in Norway and the United Kingdom to use vascular ultrasound in giant cell arteritis (GCA).

The British Columbia Society of Rheumatologists (BCSR) awarded him the Innovation Award for introducing ultrasound assessments in diagnosing GCA as part of a Fast Track Clinic. Through this work, patients with GCA are seen quickly and provided a timely diagnosis that ultimately leads to improved care.



### **Dr. Daniel Ennis – UBC/BCSR Teaching Award**

I am very thankful for such an honour from the University of British Columbia (UBC) and the British Columbia Society of Rheumatologists (BCSR). If I have developed any skill as a teacher, it is because I am part of a department and community with so many exceptional colleagues who have shown me how it is done.

I am sincerely grateful to our outstanding trainees for allowing me to participate in their education. They challenge me to reflect on my own clinical reasoning and to aim to do better. I look forward to continuing our education together.

*Dr. Daniel Ennis is a rheumatologist and vasculitis clinician at Vancouver General Hospital and St. Paul's Hospital. He is a past Chief Medical Resident at St. Paul's Hospital.*



### **Dr. Debbie Ehrmann Feldman – ARP Addie Thomas Service Award**

Debbie Ehrmann Feldman, PT, PhD, Professor in the School of Rehabilitation, Faculty of Medicine, *Université de Montréal*, received this year's Association of Rheumatology Professionals (ARP) Addie Thomas Service Award. Dr. Feldman conducts health services research in musculoskeletal disease and arthritis, investigating access to care in rehabilitation and optimal ways of prioritizing care for patients with chronic musculoskeletal conditions and arthritis. Her contributions include research and advocacy in both pediatric and adult rheumatology. Dr. Feldman has mentored many graduate students and trainees who have contributed to rheumatology research and have gone on to university faculty positions in physiotherapy and occupational therapy.



### **Dr. Monique Gignac – ARP Ann Kunkel Award**

It is our pleasure to announce that Monique Gignac is the 2021 recipient of the Association of Rheumatology Professionals (ARP) Ann Kunkel Award. ARP is a division of the American College of Rheumatology. The Ann Kunkel Award is presented to an ARP member providing extraordinary service to advocate for patients with arthritis and rheumatic diseases.

Dr. Gignac is Scientific Director and a Senior Scientist at the Institute for Work & Health and a Professor at the Dalla Lana School of Public Health at the University of Toronto. From 2008-2014, she was Co-Scientific Director of the Canadian Arthritis Network, a Network of Centres of Excellence comprising over 200 arthritis researchers and people living with arthritis. She was Chair of the Advisory Board of the Institute of Musculoskeletal Health and Arthritis (IMHA) at the Canadian Institutes of Health Research (CIHR) from 2011-2016 and 2017-2020. She has been a member of the Scientific Advisory Committee at the Arthritis Society since 2011. In 2018, she was a witness before the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities in the Canadian House of Commons.



### **Dr. John G. Hanly – ACR Master Award**

In November 2021, Dr. John Hanly was recognized as an American College of Rheumatology (ACR) Master, one of the highest honours that the ACR bestows on its distinguished members, and which honours outstanding scholarly contributions to the field of rheumatology through clinical care, education, research and leadership over an entire career. Dr. John Hanly, former Head of the Division of Rheumatology at Dalhousie University and the Queen Elizabeth II Health Sciences Center in Halifax, is a respected clinician, teacher and clinical investigator. He is currently a Professor of Medicine and Pathology at Dalhousie University.

His research focus has been the study of pathogenic mechanisms of systemic lupus erythematosus and their clinical outcomes, in particular the effects of lupus on the brain and other parts of the nervous system. Dr. Hanly is a Past Chair of the Systemic Lupus International Collaborating Clinics (SLICC) and has received several awards in recognition of his achievements in lupus research, including the ACR Edmund L. Dubois Memorial Award and the Ira Goldstein Honoree Award from New York University.



## AWARDS, APPOINTMENTS, ACCOLADES



### **Dr. Nigil Haroon – Appointed Head of Division of Rheumatology, UHN**

Following an open search, Dr. Nigil Haroon has been selected as the new Head of the Division of Rheumatology for Sinai Health System and University Health Network (UHN) as of April 1st, 2022, for a 5-year term.

Dr. Haroon is a Clinician-Scientist based at UHN. He is an Associate Professor of Medicine at the University of Toronto and a Senior Scientist at the Krembil Research Institute and the Schroeder Arthritis Institute, with his clinical and renowned translational research focused on ankylosing spondylitis. Dr. Haroon completed his medical school and residency in India, and his Rheumatology Fellowship and PhD at the University of Toronto. He recently completed an MBA at the University of Toronto's Rotman School of Business. Nigil is the President of the Canadian Rheumatology Association, and holds leadership positions with the Association of Kerala Medical Graduates and the Spondyloarthritis Research and Treatment Network.



### **Dr. Rayfel Schneider – ACR Master Award**

It is our great pleasure to announce that CRA member, Dr. Rayfel Schneider, is a 2021 recipient of an American College Rheumatology (ACR) Master Award. The Master designation is one of the highest honours bestowed by the American College of Rheumatology and honours outstanding scholarly contributions to the field of rheumatology through clinical care, education, research and leadership over an entire career.

Dr. Schneider has been Program Director and Head of the Division of Paediatric Rheumatology at the Hospital for Sick Children and the University of Toronto, and most recently Vice-Chair (Education) of the Department of Paediatrics. Under his leadership the training program established a substantial international footprint. He has made important contributions to the care of patients with systemic juvenile idiopathic arthritis (JIA), with studies of prognosis and the development of international clinical trials and treatment guidelines. He has served on the ACR Special Committee on Pediatric Rheumatology, as Vice-Chair of the Canadian Paediatric Rheumatology Association, was a founding member of the AMIGO Mentorship Program, and was a member of the Advisory Committee of the Pediatric Rheumatology Collaborative Study Group (PRCSG).



### **Dr. Stuart Seigel – UBC/BCSR Advocacy Award**

I am honoured to be recognized by the University of British Columbia (UBC)/ British Columbia Society of Rheumatologists (BCSR) for helping to grow rheumatology in Kelowna. At meetings, I promoted our region. I encouraged electives by providing a positive, educational experience. Our medical office assistants (MOAs) pitched in to make trainees feel at home. The result — three Fellows returned to stay after their electives. Lessons learned? Adjust your clinic to accommodate a trainee. Make them feel welcome. A great experience will get the word out. There is now funding for rheumatology electives in underserved cities via BC Rheum2Grow. I commend my colleagues for taking rheumatology recruitment to the next level, and where it is needed.

## AWARDS, APPOINTMENTS, AND ACCOLADES

The *CRAJ* would like to recognize the contributions of its readers to the medical field and their local communities. To have any such awards, appointments, or accolades announced in an upcoming issue, please send recipient names, pertinent details, and a brief account of these honours to [Jyoti Patel at JyotiP@sta.ca](mailto:JyotiP@sta.ca). Picture submissions are greatly encouraged.

# Survey Results: Reflections on Rheumatology

In light of the CRA's milestone 75th anniversary, this issue's survey asked our members for their personal reflections on rheumatology.

The first question respondents were asked was "Why is rheumatology important to you?" Many of the responses mentioned meaningful patient connections combined with stimulating medicine.

One respondent wrote, "It provided me with a stimulating career in an evolving and close-knit specialty, and the opportunity to work longitudinally with patients to improve their lives. The rheumatology sphere in Canada is collegial, supportive, and welcoming."

Another said, "The humble lens under which rheumatology sees the world is inclusive, broad, respectful and mindful of all the contributing cogs and wheels within the human body, unparalleled in any other specialty."

And another commented, "It is an art and a science; it is absolutely fulfilling in that we see the results of our therapeutic efforts in great outcomes for our patients."

This question was followed by "What is the biggest breakthrough in rheumatology you have experienced firsthand?"

Responses included the following:

- The advent of biologics (mentioned in several responses)
- Treat-to-target approach in rheumatoid arthritis (RA)
- Improved description of phenotypes of myositis
- Advancements in diagnostic imaging and laboratory testing
- The development and evolution of the Canadian Rheumatology Association
- Development of agreed outcome measures
- Deconstruction of pain and its attribution

One respondent summed up the biggest breakthroughs as follows: "1) Biologics and other advanced therapies: revolutionized patient care and enhanced the appeal of rheumatology as a specialty and; 2) Treat-to-target approach in RA; Even though all our target measures are flawed, they ensure a better therapeutic strategy. This is exemplified by quotations from the eminent physicist Lord Kelvin 'If you cannot measure it, you cannot improve it,' and the management guru Peter Drucker 'You can't manage what you can't measure.'"



The last question asked members, "What do you see in store for the future of rheumatology?"

Responses included the following:

- More team-based care
- Narrowing scope of rheumatology practice towards inflammatory diseases
- Improved pathways to care for patients
- Increased use of virtual and asynchronous care where appropriate
- Precision medicine
- Personalization of care and customization of treatment regimens
- More rheumatologists and greater diversity
- More understanding of the conditions we treat
- Quality improvement measures to use our existing resources wisely with awareness of resource limitations
- More ultrasound use in rheumatology
- Better understanding of therapeutic targets
- Wider acceptance of models of interprofessional care to provide optimal, cost-effective outcomes/remission
- An effective treatment for osteoarthritis

As one commenter put it, "The future of rheumatology is the ruralization of rheumatology care. We need to work with nurses, physiotherapists, occupational therapists, pharmacists, and family physicians stationed in rural Canada to deliver the same excellence of care being provided in urban areas. We will need remote data gathering devices, upcoming ultrasound technologies that scan and report by artificial intelligence techniques, and all the tools telemedicine can muster to achieve this."

The CRA would love to hear your reflections on rheumatology. For any questions and feedback on the survey, please reach out to Kevin Bajjnauth at [Kbajjnauth@rheum.ca](mailto:Kbajjnauth@rheum.ca).

# Tribute to Dr. Tom Hunter

By Barry Koehler, MD, FRCPC

Thomas Hunter (1943-2022) died on January 11, 2022. A lifelong bachelor, Tom is survived by his brother Alec, Alec's wife, Trish, and niece Linsey, all of Newtonhill, Scotland.

Tom was born in Scotland. He graduated from Charing Cross Hospital, University of London in 1967. He completed his residency training at the University of Toronto, as well as a year at the National Spinal Injury Unit, Stoke-Mandeville Hospital. He became a Fellow of the Royal College of Physicians and Surgeons of Canada in Internal Medicine in 1973 and in Rheumatology in 1974.

After completing his training, he joined the Division of Rheumatology at the University of Manitoba. He was appointed Director of the Rheumatic Diseases Unit in 1982. His particular research interest was in ankylosing spondylitis. He moved to the University of British Columbia (UBC) in 1986, where he continued to pursue his interests in research, clinical care and teaching. During this time, he acted as an Examiner in Rheumatology for the Royal College (1994-1997). In Manitoba, he established, with Dr. Ross Petty, a clinic to facilitate the transition of patients moving from pediatric to adult care for their arthritis. Upon his move to Vancouver, he and Ross established a similar clinic.

Tom retired from his medical career in 1997, returning to Scotland to be the caregiver for his aging parents. Never one to remain idle nor to be completely removed from medicine, he enrolled in the University of Edinburgh and completed his MBA in 1998, his dissertation topic being "An Analysis of the Procedures used by Hospital Managers in the National Health Service to Manage the Complaints of Patients." He also started — and completed — a novel of detective fiction. His frustration was the failure to find a publisher.

Following his parents' deaths, he elected to return to Vancouver in 2013, with plans to continue his writing career. He completed the Simon Fraser programme in Creative Writing in 2015 and was well into the drafting of his second novel. Unfortunately, Mother Nature threw him a curve, with the development of a gastro-oesophageal junction malignancy in the summer of 2016. Despite chemotherapy and resective surgery, the tumour spread continued over the ensuing years. Fatigue markedly curtailed his writing. Despite this, he accomplished another of his ambitions, visiting China. He did so in 2018 as a member of the UBC Division of Rheumatology yearly teaching programme in rheumatology for medical students at



1943–2022

Zhongshan School of Medicine, Sun Yat-sen University, along with his colleagues, Simon Huang and Ian Tsang. Despite Tom's devotion to a truly English diet, he adapted to, and enjoyed, both the different culture and its cuisine.

Tom is remembered by his colleagues for his strong ethical sense and for his commitment to his patients. His life led him along branching pathways which he trod with persistence and with a twinkle in his eye.

*Barry Koehler, MD, FRCPC  
Clinical Professor Emeritus,  
Division of Rheumatology  
Department of Medicine  
University of British Columbia*



## News from Newfoundland & Labrador

By Dr. Sean Hamilton

We are in the dead of winter like most of Canada, epitomized by my snowy naturally carved backyard donut. Our Rheumatology Health Unit (RHU) presses on, frequently adjusting to the whims of COVID-19 and more recently to a straight-on cyberattack at our institution.

When I gave my last commentary from Newfoundland in November 2019, little did I or anyone else know what was coming. First, we had Snowmageddon in St. John's in January 2020 which at the time was one of our worst snowstorms ever – over a hundred centimetres of snow necessitating calling in the Army. Looking back, Snowmageddon was just a snowflake on a shovel compared to the goings on of COVID-19.



The pandemic has interfered with patient care, mainly by prolonging waiting times and necessitating virtual visits. I've come to realize the telephone call – an invention from the 1800's – as unsatisfactory as it is, is still the most practical method of the virtual visit, as video visits, which “sound” great on paper, are impractical given logistics and the volume of patients needing to be assessed.

I shall digress no more.

Our RHU here at Eastern Health covers the entire province of Newfoundland and Labrador. We have three rheumatologists, along with our physiotherapist, occupational therapist, two rheumatology nurse practitioners, a clinical pharmacist, our research staff and our very helpful office and secretarial staff. We operate a Central Rheumatology Triage with a Standardized Referral Form, which has proven to be a very successful addition. Unfortunately, our waiting list remains too long. Fortunately, we do have two full-time private practice rheumatologists in St. John's, highlighted on this page.



Snowmageddon 2020

Our own Dr. Proton Rahman has played a major role as the person in charge of modelling for the province in the battle against COVID-19. His time-consuming work in this role has been indispensable in allowing Newfoundland and Labrador to achieve as good a response to the pandemic as you would find anywhere. Dr. Rahman is to be thanked and congratulated for his efforts.

Before closing, our RHU is recruiting for one and hopefully two rheumatologists. It's unlikely I'll be around for the next CRAJ Newfoundland update as retirement beckons. As we go through the regular recruitment channels, I very humbly put a plug in for recruitment here at Eastern Health/Memorial University. I can honestly say Newfoundland has been a great place for me to practice rheumatology over the past 35 years. It has had its challenges like every other place in this wide, wide world, but its positives have far outweighed its negatives.

Sean Hamilton, MD, FRCPC  
Divisional Chief of Rheumatology  
Eastern Health/Memorial University  
St. John's, Newfoundland

## By Dr. Natalia Pittman and Dr. Shaina Goudie

Dr. Natalia Pittman and Dr. Shaina Goudie are currently practicing together in St. John's in a community-based adult rheumatology clinic. Dr. Pittman has a special interest in rheumatic diseases in pregnancy, and Dr. Goudie is doing a regular combination dermatology-rheumatology clinic. They take part in undergraduate and postgraduate medical education. Outside of work, both are mothers to two active children. Dr. Pittman is involved with competitive synchronized skating, and Dr. Goudie keeps busy at the cabin.



Dr. Goudie (right) and Dr. Pittman (left)

Shaina Goudie, MD, FRCPC  
Rheumatologist,  
Grace Medical Specialists  
St. John's, Newfoundland

Natalia Pittman, MD, FRCPC  
Rheumatologist,  
Grace Medical Specialists  
St. John's, Newfoundland



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##### Malignancy:

- Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which golimumab is a member.

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- Risk of hepatitis B virus reactivation
- Risk of malignancies

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**Reference:**

1. SIMPONI<sup>®</sup> Product Monograph. Janssen Inc. June 20, 2019.

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