Winter 2013, Volume 23, Number 4

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on
CRA and Regional Committee Reports

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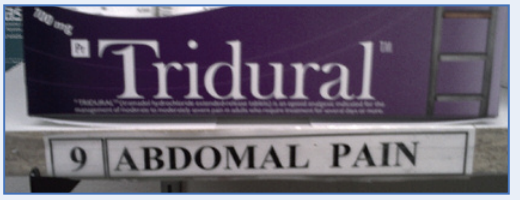
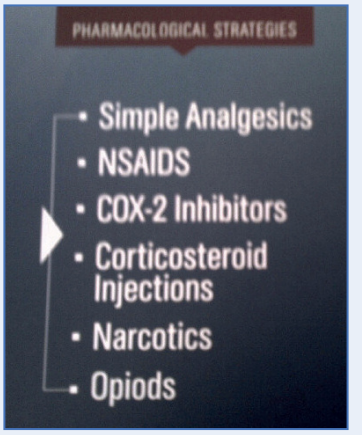
Can't Anyone Spell R-H-E-U-M-A-T-O-L-O-G-Y?

By Philip A. Baer, MDCM, FRCPC, FACR

Observations from the field.

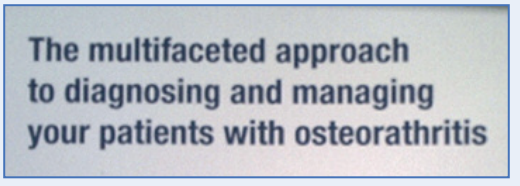


ABDOMINAL pain is so abominable.

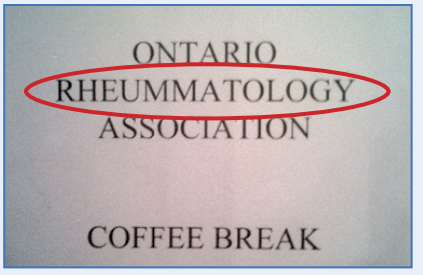


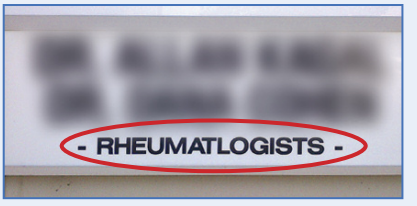
OPIOIDS: Do not take them before composing advertising text!

Heartening news: **ARTHRITIS** is not the only word they can't spell.



My next career: Proofreader for the pharmaceutical and advertising industries.





Can't anyone spell **R-H-E-U-M-A-T-O-L-O-G-Y?**

At these meetings, we are generally **GENIAL**.

Dr. S. Batarseh	Gynaecology
Dr. Y. Brill	Gynaecology
Dr. M. Chang	E.N.T.
Dr. J. Donsky	Allergist
[redacted]	Rheumotology
Ms. G. Lee-Dube	Dietician
Dr. M. Dutil	Dermatology

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Mission Statement. The mission of the *CRAJ* is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.

The editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.

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AWARDS, APPOINTMENTS, ACCOLADES

Everyone recognizes Dr. Carter Thorne's exceptional contributions to the field of rheumatology. In addition to his own work as a respected rheumatologist and researcher, his work with the CRA has given Dr. Thorne the opportunity to support high standards for clinical and research practice, to build bridges and partnerships within the arthritis community, to champion development of the profession, and to raise awareness of the disease and of the expert role rheumatologists play in its management.

Dr. Diane Thériault is known to everyone at Osteoporosis Canada (OC) as a volunteer par excellence, with boundless energy and enthusiasm, and a selfless passion and commitment to OC that is unrivalled. She has been a member of the Scientific Advisory Council since 2005 and is National Co-Chair of the Advocacy Committee. She was instrumental in developing and launching Towards a Fracture-Free Future, a key document in OC's commitment to achieving its vision of a Canada without osteoporotic fractures.

A retired Canadian diplomat and leading arthritis consumer advocate, Mr. Gordon Whitehead is active in volunteer work and arthritis advocacy. He served with Patient Partners in Arthritis, an organization that then did demonstrations of musculoskeletal examinations to health care providers. He has since become a member of the Canadian Arthritis Patient Alliance (CAPA), a Consumer Advisory Board (CAB) Member, and served as the Co-Chair of the Arthritis Alliance of Canada (AAC). He believes strongly that we Canadians have both the collective will and the capacity to make the Canadian healthcare system the best and most responsive in the world for persons afflicted with arthritis and other chronic conditions.

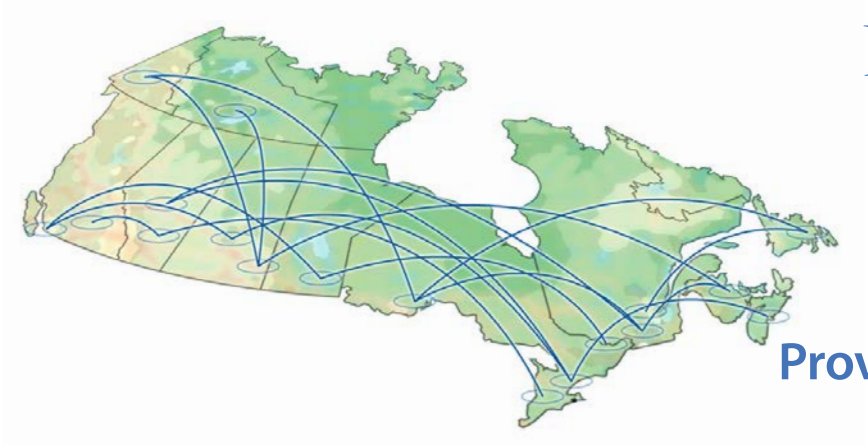
The Jonas Salk Award is presented annually to a Canadian scientist or physician who has made a new and outstanding contribution in science or medicine to prevent, alleviate, or eliminate a physical disability. This lifetime achievement award is presented jointly by Sanofi Pasteur and March of Dimes. The 2013 recipient was Dr. John M. Esdaile, Scientific Director of the Arthritis Research Centre of Canada (ARC), and Professor of Medicine at the University of British Columbia.

For more than 60 years, the March of Dimes has been on the forefront of the disability movement, dedicated to helping Canadians with disabilities lead more independent and empowered lives. It serves more than 50,000 children and adults each year and is committed to creating a society inclusive of people with physical disabilities.

AWARDS, APPOINTMENTS, AND ACCOLADES

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

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



FROM COAST TO COAST:

Reports from the CRA Committees & Provincial Rheumatology Associations

Provincial Association Committee

By Jane Purvis, MD, FRCPC; and Denis Choquette, MD, FRCPC

In February 2013, a new committee was started at the Canadian Rheumatology Association (CRA) meeting in Ottawa to bring all the various provincial rheumatology associations together, with the goal of sharing best practices and ideas. Dr. Shahin Jamal and Dr. Vandana Ahluwalia started this initiative, after they realized that the provinces were working on various, often similar projects, but had never had the opportunity to compare notes. The inaugural meeting was held with representation from British Columbia, Manitoba, Ontario, Quebec, and New Brunswick. Information and facts were exchanged on subjects such as drug access and physician remuneration.

One issue currently facing the country is insurance reimbursement for biologic agents; the work that the provincial groups are carrying out with will be shared to all regions.

Our plan now is to increase member representation from all the provinces; we will communicate via quarterly emails, plus a yearly face-to-face meeting at the CRA, to continue the dialogue on what matters to Canadian rheumatologists. A central matter is addressing economic issues that face rheumatologists, including the gross revenue of rheumatologists being grossly under the mean average income of other medical subspecialties. Similarly, we hope to discuss a fee adjustment to practice fees across Canada.

We aim to use the successes in one region to try and gain momentum in others. Current members of this committee are: Dr. Jason Kur, British Columbia; Dr. Kam Shojania, British Columbia; Dr. Dianne Mosher, Alberta; Dr. Joanne Homik, Alberta; Dr. Sharon LeClercq, Alberta; Dr. Wojceich P. Olszynski, Saskatchewan; Dr. David Robinson, Manitoba; Dr. Cory Baillie, Manitoba; Dr. Vandana Ahluwalia, Ontario; Dr. Jane Purvis, Ontario (co-chair); Dr. Denis Choquette, Quebec (co-chair); and Dr. Peter Docherty, NewBrunswick.

If you are interested in participating or notice that your province is not represented, contact Dr. Jane Purvis at *president@ontariorheum.ca* and we would be happy to include you. Any skills and competencies that could be shared to improve the way we practice are most welcome.

Jane Purvis, MD, FRCPC
President, Ontario Rheumatology Association
Rheumatologist, The Medical Centre
Peterborough, Ontario

Denis Choquette, MD, FRCPC
Professor of Medicine, Division of Rheumatology,
Université de Montréal
President, Quebec Rheumatology Association
Montreal, Quebec

CIORA Committee

By Boulos Haraoui, MD, FRCPC

The Canadian Initiative in Outcomes in Rheumatology Care (CIORA) has matured since its inception in 2006, when Abbott Canada (now AbbVie) pledged to support CRA members in the pursuit and conduct of clinically relevant research projects which would not be otherwise funded by major granting agencies.

After three years with Abbott as the sole supporter and more than $1 million of funded studies, all the major pharmaceutical companies were invited to participate, expanding the scope of funded research. The vast majority realized the importance of such an initiative and pledged to support the growth of CIORA. Currently, we receive funding from AbbVie, Amgen, Bristol-Myers Squibb, Janssen, Pfizer, Roche, and UCB.

Two years ago a major change occurred when CIORA ceased to function as an independent entity and became an integral part of the CRA, established as a committee responsible for advancing rheumatology clinical research in Canada.

Since the beginning, the grant review process was conducted by an independent panel of reviewers chaired by Dr. John Esdaile. The highest standards were applied; I would like to especially thank John and the many reviewers over the years who have volunteered their time and expertise. At the last round in the fall of 2012, six one-year grants and three two-year grants were funded, totaling $715,892! This makes CIORA the third-largest arthritis-research funding agency in Canada.

CIORA has recently created the CRA-The Arthritis Society (TAS) Clinician Investigator Award, to be managed by TAS. The first recipient is Dr. Cheryl Barnabe, for her contributions to rheumatology research. This is an investment in future leaders in clinical research in rheumatology.

The next call for grant applications will be conducted in the spring of 2014. For more information about CIORA and the grant application process, you can visit the CRA website at *rheum.ca*. You can also view posters and publications from past funded projects.

I would like also to thank the steering committee of CIORA for their guidance: Dr. Carter Thorne, Dr. Alfred Cividino, Dr. Jamie Henderson, Dr. Janet Pope, Dr. Michel Zummer, Dr. Maggie Larché, and Dr. Regina Gjevre, as well as Virginia Hopkins and Christine Charnock for their invaluable administrative skills in the management of CIORA.

Boulos Haraoui, MD, FRCPC
Associate Professor of Medicine, Université de Montréal
Head, Clinical Research Unit in Rheumatology,
Centre hospitalier de l'Université de Montréal (CHUM)
Chair, CIORA Steering Committee
Montreal, Quebec

Education Committee

By Christopher Penney, MD, FRCPC

The CRA became an accreditor of continued professional development (CPD) for the Royal College in 2011. We will be re-applying for accreditor status over the course of 2014. This is a very necessary but time-consuming and expensive process.

During 2013, the CPD subcommittee provided accreditation reviews for the CRA Annual Scientific Meeting (ASM) as well as for the Society of Atlantic Rheumatologists (SOAR), the Ontario Rheumatology Association (ORA), the Sjogren's Society, and Credit Valley Rheumatology. Online programs were co-developed with mdBriefcase on clinical trial appraisal, the CRA RA guidelines, and current trends in RA. At the ASM this year, a workshop on accreditation was held by the Royal College and attended by members of the CRA Education Committee.

As of the fall of 2013, the Education section of the CRA website is now open. This is a work in progress; if you have any educational materials that you wish to share with

your colleagues nationally, please contact Christine Charnock at *christine@rheum.ca*.

The CRA has established a Practice Reflection Award to encourage CRA members to develop CPD self-assessment/practice reflection programs that can be used to improve rheumatology practice in Canada. If you are interested in applying for the Award, please go to the Awards section on the CRA website for further information (*www.rheum.ca/en/the_cra/Awards*).

The Patient Partners In Arthritis subcommittee continues to search for a way to fund Patient Partners at the national level. The CRA turned down our request for support. We are currently negotiating with The Arthritis Society (TAS). If you have any suggestions, please contact me at *penney@ucalgary.ca*.

We welcome any CRA member with a special interest in CPD or other aspects of rheumatology education to join the committee. Dr. Jodie Reis, Dr. Aurore Fifi-Mah, and Dr. Dharini Mahendira have joined us this past year. We especially need members from Quebec. The CRA will pay your out of pocket expenses for training if you choose to become an accreditation reviewer. If you have a special interest in undergraduate or postgraduate education, you can join the CanREAL subcommittee. Please email me for further information.

Christopher Penney, MD, FRCPC
Associate Clinical Professor, University of Calgary
Rheumatologist, Richmond Road Diagnostic & Treatment Center
Calgary, Alberta

Therapeutics Committee

By Shahin Jamal, BScPT, MD, FRCPC, MSc

The CRA's Therapeutics Committee has had another busy and productive year. We have been actively involved in the development of guidelines and consensus statements across therapeutic areas. We currently have groups working on dissemination and translation of rheumatoid arthritis (RA) and fibromyalgia (FM) guidelines, development of consensus statements for vasculitis and systemic lupus, and updates on guidelines for management of spondyloarthropathies. There is also discussion on the development of Canadian guidelines for pregnancy in rheumatic diseases and osteoarthritis (OA). Through the Therapeutics Committee, the various groups have been able to work together to share resources, methodology, and manpower. In September 2013, we held a successful stakeholders meeting to discuss development of a unified framework for disseminating and measuring uptake of guidelines in rheumatology; this was funded by a Canadian Institutes of Health Research (CIHR) small-group-meeting grant and chaired by Dr. Claire Bombardier. We have also approached expert Canadian epidemiologists from McMaster University to assist in the development of unified guideline development methodology.

The CRA RA guidelines were published in the *Journal of Rheumatology* (*JRheum*) in August 2012. These are currently in the process of translation into French. An E-Recommendations Program has now been developed in conjunction with mdBriefcase. There are also multiple dissemination activities underway including a question-and-answer series in the *CRAJ*. A slide deck is available through the CRA to any individuals interested in presenting the guidelines to their local colleagues.

The Canadian Systemic Lupus Erythematosus (SLE) Consensus Working Group had their first face-to-face meeting following the CRA Annual Scientific Meeting (ASM) in Ottawa in February 2013; this too was funded by a CIHR small-meeting grant. The meeting was very successful and brought together rheumatologists and lupologists from across Canada. Priority topics and questions were identified based on a needs assessment that was distributed to the CRA membership in December 2012. The SLE Working Group is now conducting a systematic literature review, hoping to be completed in early 2014. With this, they will develop a Canadian Consensus statement on SLE management.

The Canadian Vasculitis Research Network (CANVASC) is working on recommendations for the management of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis. A needs assessment of the CRA membership was completed in spring 2013, followed by a systematic literature review and production of a first two drafts of recommendations. The final draft, with involvement of a broad spectrum of specialists, should be completed by the second quarter of 2014.

The genial members of the Therapeutics Committee.

The Canadian FM Guidelines (endorsed by the Canadian Pain Society and CRA) have received great international interest and accolade. They are available in both English and French. Multiple manuscripts have been prepared and submitted, including a publication in the *Canadian Medical Association Journal* (*CMAJ*) in May 2013. Dr. Mary-Ann Fitzcharles presented the FM guidelines at the American College of Rheumatology (ACR) Meeting in San Diego in October 2013. There is a slide kit available for use by any individuals interested in presenting the guidelines to their local colleagues.

The Spondyloarthritis Research Consortium of Canada (SPARCC) held a meeting in May 2013 to begin the process of updating the CRA/SPARCC Treatment Recommendations for the Management of Spondyloarthritis, which were published in 2007. The group identified topics for update and is currently engaged in a systematic literature review. They are hoping to have a completed manuscript in early 2014.

In addition to guidelines, the Therapeutics Committee has been engaged in acquisition of data to improve patient access to appropriate therapeutics. Over the past few years, there has been increasing difficulty accessing subcutaneous methotrexate due to its listing as a cytotoxic agent, particularly in institutional environments. A systematic review was conducted on the safety of subcutaneous methotrexate administration at the low doses common in rheumatology. The results were presented in poster form at the CRA ASM and full paper publication is in progress. At our meeting in Ottawa in February 2013, we were fortunate to have a special guest, Agnes Klein from Health Canada, in attendance. With her guidance and expertise, we continue to work towards changing the listing for low-dose methotrexate at the Health Canada level. We are also actively engaging other relevant professional societies, such as nursing, pharmacy, and occupational health.

The Therapeutics Committee has been involved in multiple other emerging issues. We are working with the Pediatrics Committee of the CRA to try to improve access to triamcinolone hexacetonide for intra-articular injection. We have been actively involved in defining the role of cannabinoids in rheumatic diseases. A needs assessment was distributed to the membership in spring 2013, which has since been summarized; a policy/consensus statement is in progress. We have also been keeping up to date with the progress of subsequent-entry biologics and their potential arrival in Canada.

Based on activities of the past year, I have no doubt that Therapeutics will continue to be an exciting and interesting committee to chair. I feel fortunate to have such amazing and enthusiastic colleagues who continue working hard to improve rheumatology in Canada. Sincere thanks to all of our passionate members for their time and dedication; I would also like to thank Christine Charnock, the CRA Board, and the Executive for their support. We are always looking for new members to become involved. Please email me at *shahin.jamal@vch.ca* if you are interested.

Shahin Jamal, BScPT, MD, FRCPC, MSc
Rheumatologist, Vancouver General Hospital
Vancouver, British Columbia

Nominations Committee

By Jamie Henderson, MD, FRCPC

The Nomination Committee is composed of Past-Presidents of the CRA. It is chaired by the immediate Past-President, a role I presently occupy. Its traditional role has been to identify prospective board members and invite them to join the board of the CRA. Every two years the Committee must identify an individual to join the executive committee as Vice-President for a two-year term. This individual would assume the presidency in

two years and the serve another two years as Past-President.

In recent years the Committee has expanded its role to nominate members it feels deserving of awards offered by the Canadian Medical Association (CMA), the American College of Rheumatology (ACR), and national organizations. We were successful in obtaining the Queen's Jubilee Medal for several of our members in the past year.

The tasks performed are not onerous but are extremely important for ensuring that we have fresh, enthusiastic, and talented members from all parts of the country representing diverse styles of practice to keep the CRA vibrant and relevant as we move forward.

James Henderson, MD, FRCPC
Past-President, Canadian Rheumatology Association
Chief, Internal Medicine, Dr. Everett Chalmers Hospital
Teacher, Dalhousie University
Fredericton, New Brunswick

Scientific Committee

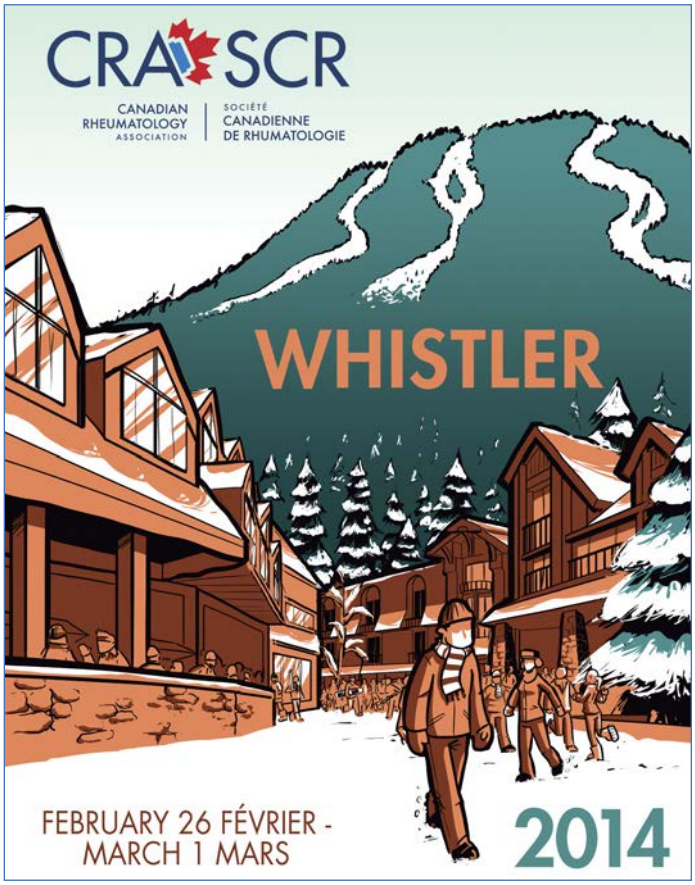
By Joanne Homik, MD, MSc, FRCPC

The CRA returns to a premier Canadian ski location for 2014! You may have noticed that we have experimented with some new venues for the Annual Scientific Meeting over the last few years. The urban venues were well-received but now we are returning to more recreation-oriented locales: Whistler from February 26-March 1, 2014 and Quebec City from February 3-6, 2015.

Capitalizing on successes from our previous meetings, we will continue to offer plenary sessions for the most highly ranked abstract submissions, keynote addresses from celebrated international rheumatologists, a state-of-the-art lecturer, and our distinguished investigator awardee, plus many workshops and our blockbuster "Great Debate". The topic for 2014 is, "Be it resolved that rheumatologists monitor their patients too closely while on disease-modifying antirheumatic drugs and biologics".

Our venue at the Fairmont Chateau Whistler should be a beautiful one. In order to ensure that attendees get a chance to appreciate the beauty, we will have three- to four-hour breaks in the afternoon, should anyone wish to ski or explore the beauty of Whistler Village. The entertainment also includes the ever-popular banquet and dance on the Friday night.

Hope to see you all in Whistler!



Joanne Homik, MD, MSc, FRCPC
Associate Professor of Medicine,
Director, Division of Rheumatology,
University of Alberta
Chair, Scientific Committee,
Canadian Rheumatology Association
Edmonton, Alberta

Annual General Meeting

The next Annual General Meeting of the CRA will take place the morning of Saturday, March 1st at the Chateau Whistler Hotel.

The meeting is open to CRA members in good standing only.

Please visit *www.rheum.ca* for meeting registration information.

Human Resources Committee

By John Thomson, MD, FRCPC

Medical workforce issues are very much in the news these days. The Royal College of Physicians and Surgeons of Canada released an employment report in October 2013, which documented disturbing statistics in medical manpower resources primarily to do with unemployment and underemployment in certain medical and surgical specialties and subspecialties in Canada. That this is a complex issue that will require much further study and action is abundantly clear. There are no easy or quick solutions to this unfortunate and serious problem.

Meanwhile in the sub-specialty of rheumatology, by and large, our medical workforce issue is primarily that of under-supply and maldistribution of resources. The fact is that, in most areas of Canada, there is an under-supply of rheumatologists. Most academic centres have positions to fill. Many large cities in Canada are in need of more rheumatologists working in the community. Perhaps the most acute shortages are in medium-sized urban centres. The reasons for the shortages and maldistribution are complex, but are certainly due in part to a relative under-exposure of the subspecialty to medical students and internal medical trainees.

The CRA has recognized this shortage for many years, responding with a number of initiatives and ongoing programs designed to ultimately increase the number of practicing rheumatologists in Canada. Medical student preceptorships, both clinical and research-based, have been in place for several years. Medical students from medical schools across Canada apply for summer positions with preceptors, usually after their first or second year of medical school. This has increased the exposure of rheumatology early in medical training and led to many of these students pursuing a career in rheumatology. Dr. Janet Pope has been the champion behind these preceptorships, which are supported by sponsorship from our industry colleagues at Roche and AbbVie.

For many years, CRA has funded a textbook program that provides rheumatology textbooks to all students and residents rotating through rheumatology programs across Canada. Again, this has led to increasing exposure of the specialty and better knowledge of rheumatology by all medical trainees.

Another recent initiative includes increasing the awareness and use of the employment portal on the CRA website, a facility that allows posting of job opportunities from across the country. To-date it is under-used, but we hope to increase its presence. Dr. Jane Purvis, current president of the Ontario Rheumatology Association (ORA), has made medical workforce issues a centrepiece of her presidency. She has initiated innovative measures to help align rheumatology availability (new trainees) with rheumatology opportunities in Ontario. The CRA is working with Dr. Purvis to hopefully expand the program nationally.

Rheumatology "awareness programs" in various forms have been in place across the country for several years. Internal medical residents in their first and second years of training have been invited to and attended programs in Vancouver, Calgary, London, Hamilton, and Montreal, at which they were made familiar with the specialty of rheumatology and all its attributes, including job availability. There has been a general feeling that internal medical residents have been underexposed to rheumatology or exposed too late in their internal medical training. The CRA is looking to increase the number of these rheumatology "awareness programs" by providing some funding and guidance to centres not yet offering such opportunities.

The good news is that the numbers of trainees in rheumatology seem to be increasing in a sustained fashion. Overall, the number of medical students entering medical school has increased very significantly over the past several years, and these numbers are now being seen in training programs. There is a feeling and hope that recent graduates will recognize the tremendous opportunities that exist in our fascinating sub-specialty and thus help correct the misdistribution of rheumatology personnel.

John Thomson, MD, FRCPC
Chair, Human Resources Committee,
Canadian Rheumatology Association
Assistant Professor, Department of Medicine,
Division of Rheumatology,
University of Ottawa
Staff, The Ottawa Hospital
Ottawa, Ontario

Pediatric Committee

By Rosie Scuccimarri, MD, FRCPC

The Pediatric Committee of the CRA (Ped-CRA) has grown tremendously over the years; we now have close to 50 members representing eight of the 10 provinces of Canada. The Committee is led by an Executive, comprised of: myself (Chair), Dr. Susanne Benseler (Chair-elect), Dr. Lori Tucker (Past-Chair) and Dr. Janet Ellsworth (Secretary/Treasurer). The Executive has regular teleconferences to assure that the objectives of the Committee are met. The objectives are:

- to promote awareness of childhood rheumatic diseases;
- to promote optimal models of care for children with these diseases;
- to promote education of health professionals to optimize the recognition and treatment of childhood rheumatic diseases; and
- to provide advocacy for these children.

We are very fortunate to have been invited by the CRA to prepare documents for pediatric rheumatology on the Wait Time Alliance and Choosing Wisely projects of the Canadian Medical Association (CMA). These projects are aligned with the objectives of our Committee and work towards promoting optimal models of care for children with rheumatic diseases. These projects will allow for better advocacy for our patient population.

We are currently establishing working groups for these projects. The Wait Time Alliance project will establish medically acceptable benchmarks for wait times for juvenile idiopathic arthritis (JIA). The Choosing Wisely project aims at educating physicians, patients, and other health care stakeholders on the medical tests and procedures that may be unnecessary for the pediatric rheumatology patient population.

Lastly, Dr. Lori Tucker will be submitting the triamcinolone hexacetonide statement to the Access to Care Committee (ATCC) this fall. This statement was prepared with the input of the members of the Ped-CRA. Pediatric rheumatologists have used this intra-articular corticosteroid for more than 30 years for joint injections in children with arthritis. For over two years, this drug has been under restricted access through Health Canada's Special Access Program; this causes unacceptable delays to treatment and necessitates an application to be made each time this product is used. The endorsement of this statement by the CRA will allow us to advocate further on this issue.

The Ped-CRA will be busy working on these projects. We hope to give each of these the time, dedication and leadership needed to enable fruitful discussions and ultimately yield finalized documents that can allow pediatric rheumatologists to advocate for improved care for their patients.

Rosie Scuccimarri, MD, FRCPC
Pediatric Rheumatologist, Department of Pediatrics
Assistant Professor, McGill University
Program Director, Division of Pediatric Rheumatology
Montreal, Quebec

Access to Care Committee

By Viktoria Pavlova, MD, FRCPC; Henry L. Averns, MBChB, FRCP(UK), FRCPC; and Nigil Haroon, MD, PhD, DM

We are pleased to update you on the key activities that the Access to Care Committee (ATCC) has been involved with over the past year. Our primary interests and focus were on improving care for the Aboriginal population, developing wait-time benchmarks for patients with rheumatic diseases, creating a new approach to comprehensive patient care, and collaborating with the Arthritis Alliance of Canada (AAC) and the Ontario Rheumatology Association (ORA).

Dr. Henry Averns took the lead in improving care for Aboriginal people, noting, "the ATCC has embraced the challenge of exploring the provision of rheumatologic services to the Aboriginal population. In late 2013 a survey was sent to members of the CRA, revealing some

important themes, repeated across all provinces, around the healthcare challenges unique to the Aboriginal population in both urban and remote communities.

We have focused on working with the Non-Insured Health Benefits (NIHB) program, first to review the Limited Use Criteria for provision of biologic therapy and, as a longer-term project, to discuss and improve the process of applying for required medications, which most physicians feel lends itself to improvement. Finally, many members of the CRA are continuing to explore models of care, including telehealth and liaison with trained nurses in remote communities. In 2014, we are hoping to build on these initiatives and generate future strategies to improve rheumatologic healthcare to the Native population."

Dr. Nigil Haroon has been involved with the Wait Time Alliance (WTA), working on developing wait-time benchmarks for rheumatic patients, reporting "the WTA was formed out of concern among Canada's doctors over delayed access to care for their patients. The WTA is comprised of several national medical specialty societies who work in collaboration with stakeholders. The initial focus was on five priority areas: cancer, cardiac care, diagnostic imaging, joint replacement, and sight restoration. Benchmarks were set for these in 2004. Over the years, more specialties and areas of medical care have been brought under the WTA umbrella. This year the CRA was invited to participate in the process and come up with medically acceptable wait times.

We were charged with identifying the threshold wait-time for rheumatic disease beyond which the best available evidence and clinical consensus indicate that the patient's health is likely to be adversely affected. These benchmarks will be considered as health-system performance goals that can be used to assess performance, wait times, and differences among services, hospitals, and provinces.

Over the past year, the CRA has been working to set up rheumatology benchmarks with the help of expert committees. The WTA benchmarks being set in the first round include rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and lupus. A pediatric sub-committee has been formed to assist in the process. The first CRA wait-time benchmarks will appear in the 2014 WTA report, after addressing comments from the CRA membership."

The ORA Models of Care (MoC) Committee has been exploring new models of care that would deliver greater value for patients living with inflammatory arthritis (IA), their health care providers, and those that fund their care. This project was initiated and has been guided by Dr. Vandana Ahluwalia. The MoC committee has been considering the gaps in current care and whether or not resources are readily available, along with examining successful care models across Canada in different disciplines. The MoC committee is working on a model that optimizes all existing resources and promotes their sharing, and coordinates quality care for patients with IA. It was strongly felt that one piece of such a model must include the provision of patient support throughout the disease management continuum.

The first interactive meeting that brought together arthritis stakeholders took place on October 4, 2013. The purpose of the meeting was to initiate an open dialogue among stakeholder groups currently offering patient support programs, identify unmet needs, explore strategies to improve coordination and effective delivery of services, and enhance the comprehensiveness of support programs, especially in the early phases of the disease diagnosis. Stay tuned for more updates on this!

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RHEUMINATIONS

As part of a community, we wish to share in your celebrations. Announcements of births, academic appointments, marriages, and significant life events are most welcome, and will be published in the next issue of the *CRAJ*.
Please submit details to *katiao@sta.ca*.

Ontario Rheumatology Association's 2013 Annual Meeting Report

By Jane Purvis, MD, FRCPC

Once again, the Ontario Rheumatology Association (ORA) met at the J.W. Marriott resort for our 12th annual meeting. This was our best-attended and most successful meeting yet, with over 200 participants, including rheumatologists, rheumatology trainees, allied health participants, industry sponsors, and invited guests. The scientific sessions, once again expertly organized by Dr. Janet Pope, were extremely well received and touched upon diverse topics, such as liver disease, myopathies, an update from the Ontario Medical Association (OMA), and clinical criteria for scleroderma.

Dr. Janet Pope accepting the 2013 ORA Rheumatologist of the Year award from ORA president Dr. Jane Purvis.

The keynote speaker was Ms. Suzanne LePage, who addressed the membership on the subject of insurance company coverage for medications in Canada, a very topical presentation. Friday evening featured an electronic medical record (EMR) vendor fair organized by the ORA EMR committee, led by Dr. Vandana Ahluwalia, as well as an excellent poster tour led by Drs. Jacob Karsh and Bill Bensen. The Walk for Arthritis was held on Saturday afternoon; there were over 100 participants who helped raise more than $16,000 for The Arthritis Society (TAS). Other Saturday activities included a birds of prey show, a culinary demonstration, and a bicycle tour. Saturday night was our gala dinner and awards ceremony. The 2013 Rheumatologist of the Year was Dr. Janet Pope, of London, Ontario, whose work has had international impact as well as tremendous resonance in the Ontario rheumatology community. We continued the gala evening with legendary dancing, courtesy of Dr. Pope.

The J.W. Marriott, site of annual ORA meeting.

With our ongoing successes and with the membership's agreement, the ORA's 13th annual meeting will be held at the J.W. Marriott, from May 23-25, 2014. Save the date in order to secure your spot!

Jane Purvis, MD, FRCPC
President, Ontario Rheumatology Association
Rheumatologist, The Medical Centre
Peterborough, Ontario

Need A Reason to Attend the CRA ASM? Here Are Five!

1. Expand Your Knowledge. Hear from more than 30 experts and attend keynote sessions presented by Dr. Walter Grassi, Dr. Luke Chen, and Dr. Brian Feldman.

2. Networking Opportunities. Interact with your colleagues from across Canada and participate in many small-group sessions focusing on diverse disease groups.

3. Stir Up Some Controversy! New this year, an exploration of Controversies in Rheumatology.

4. Workshops. Try to pick between 27 excellent workshops held during three workshop sessions.

5. Easy on Your Wallet. Attendance is cheap—book for only $250 before the early bird deadline!

The ASM will take place February 26 - March 1, 2014, at the Fairmont Chateau Whistler in British Columbia. For more details, please visit *www.rheum.ca*.

News from the Quebec Rheumatology Association

By Gaëlle Chédeville, MD

As of July 1st, 2013, 110 rheumatologists are members of the Quebec Rheumatology Association (QRA). This demonstrates a very nice growth curve over the years. Not so long ago, our association was one of the smallest of the specialist associations in Quebec. The growth in the QRA will certainly significantly improve our ability to offer services to the population in all areas of Quebec. Currently, there are still a few areas that are unfortunately underserved, but we are working hard to correct this.

To attract new members, our association is very dynamic regarding educational activities, targeting medical residents before they choose their specialty. Under the lead of Dr. Marie Hudson, this program was rejuvenated two years ago. For one weekend every year, first- and second-year internal medicine residents are welcomed and taught rheumatology through different workshops, depending on their level of training. For the first time this year, a pediatric resident also benefited from this program. Many residents attend both years, and some of them will go on to choose rheumatology as their specialty.

The educational outreach component of our association's work is also directed towards family physicians, through our yearly publication *Le Rhumatologue*. Each issue is focused on a specific topic; the next issue is an update on osteoporosis which will be published by the end of 2013. Every family physician in Quebec receives this publication. The feedback has always been very positive and encourages us to continue. One year, we also reached pediatricians with a publication on juvenile idiopathic arthritis (JIA).

Member education is conducted through our annual meeting and a separate meeting called "Update in Rheumatology". The plan for next year is to host both meetings concurrently, to facilitate attendance and to offer even better-quality teaching. These meetings have a slightly different focus, with a more practical aspect and case discussions during the annual meeting, and a review or discussion of hot topics during the Update. The spirit of each meeting will be preserved, to the great advantage of the rheumatologists.

In our community, the use of musculoskeletal (MSK) ultrasound has been developing very quickly. Under the leadership of Dr. Alessandra Bruns, interest has grown significantly. Almost every resident-in-training in Quebec takes courses through the Canadian Rheumatology Ultrasound Society (CRUS) to learn the basics of the techniques of ultrasound and to become comfortable in using with patients. Many young rheumatologists have passed through Dr. Bruns's hands to acquire more expertise in the domain. Very soon, every rheumatologist will incorporate MSK ultrasound in their practice as a standard of care. We are not far from implementing MSK ultrasound as mandatory in our training programs.

We are very proud that our association has a website (*www.rhumatologie.org/rhumatologie.html*), implemented a few years ago by Dr. Sai-Yan Yuen. Its aim is to facilitate communication between our members and provide updates on events in our specialty, but also to link to the latest guidelines, lectures, and other useful information for practice. A forum is also accessible to discuss challenging cases. The website also provides public access to *Le Rhumatologue*, which is quite popular. Links are in place to access further information on diseases and medications. There is also a directory to find a rheumatologist by area, which can be very useful for patients or physicians seeking to refer patients.

Lastly, regarding the economic aspect, negotiations with the Quebec government and the "Fédération des médecins spécialistes du Québec", which represents all specialist associations including ours, have taken place. Over the past two years, our members have seen a significant increase in their income due to an increase in the fees for medical acts. This was obtained by the endless work and discussions of Dr. Denis Choquette, our President, and Dr. Frédéric Morin, Vice-President. Different strategies have made this increase possible, including creating new codes that recognize the complexity of care of some of our patients, including the pediatric population, elderly patients, and those with inflammatory rheumatic diseases. Other projects are still under discussion to improve access to care.

Overall, the QRA is doing very well and we hope to continue on the same path for many years to come.

Gaëlle Chédeville, MD
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The Montreal Children's Hospital
Montreal, Quebec

News from the Society of Atlantic Rheumatologists: Atlantic Update 2013

By Sylvie Ouellette, MD, FRCPC

Thirty years: some would call this a generation, while others would argue that this is only a short time. But 30 years ago, in a windowless room at the Victoria General Hospital in Halifax, the first meeting of the Society of Atlantic Rheumatologists (SOAR) was held. Much has changed since that time in the practice of rheumatology and, sadly, several of those initial members have passed away. What has not changed, however, is the enthusiasm that brings our small group together on an annual basis.

It is with these memories in mind that we came together again on PEI's north shore from June 21-23, 2013 to celebrate 30 years of collegiality and cooperation amongst Atlantic rheumatologists. The weather was fine (for a change), the lobster sweet, and the golf? Best not to say (what happens on the course stays on the course). On Saturday night there was musical entertainment with Andrew Creeggan, for those intrepid few who chose the bar instead of the hockey game.

This year's invited speakers included Dr. Susan Manzi and Dr. John Stone. Dr. Manzi spoke about therapeutic options in systemic lupus erythematosus (SLE), along with the tribulations of trials in this field, followed by a thought-provoking presentation on outcomes in SLE and the concerns about management of comorbidities. Dr. Stone provided an update on the management of vasculitis and the broadening role of rituximab. He also provided updated information on IgG4-related disease and potential biomarkers. Spoiler alert: think plasmablasts and not IgG4. There were also case presentations by Dr. Bianca Lang, Dr. Alexa Smith, and myself.

The 2013 meeting gave us an opportunity to reflect on SOAR's past, and to consider its future. It therefore seemed only fitting that an original member attended with his first granddaughter (the first SOAR grandchild!). We took this opportunity to remember Dr. David Hawkins by establishing a named lectureship in his honour. Dr. Hawkins, along with Dr. Jack Woodbury, were instrumental in bringing the original SOAR group together. Rooted in their pioneering efforts, we look forward to the next 30 years of meetings!

Dr. John Hanly has agreed to take over the reigns as president of SOAR for the next two years. I wish him every success.

Atlantic rheumatologists, guests, and honorary members, a plate of fresh lobster!

Sylvie Ouellette, MD, FRCPC
Assistant Professor, Dalhousie University
Clinical Assistant Professor, Memorial University
Past-President, Society of Atlantic Rheumatologists
Rheumatologist, The Moncton Hospital
Moncton, New Brunswick

Western Alliance of Rheumatology: 2013 Meeting Report

By Paul Davis, MD, FRCPC

The sun shone and, as usual, some of western Canada's finest rheumatologists convened at the Manteo Resort in Kelowna for the 11th annual Western Alliance for Rheumatology (WAR) meeting. The meeting has taken on a familiar format since its inception. There are no lectures, invited speakers, or sponsored symposia: the attendees are the faculty. Each person is allotted 15 minutes to make a clinical presentation and presenters take pride in finding the most challenging clinical problems possible. This year's "winners" have to be a "case of insect fingers" and "can't see, pee, or climb a tree". Presenters are kept strictly to time by the formidable co-chairs, Dr. John Esdaile and myself, or run the risk of ending up in Lake Okanagan!

An important aspect of this meeting has always been to promote collegiality amongst western Canadian rheumatologists and an integral focus has been to encourage participation from local trainees. This year we again ran a pre-meeting rheumatology-focused objective structured clinical examination (OSCE) for residents; 11 trainees attended, pitting their skills against the likes of Dr. Anik Godin, Dr. Angela Juby, Dr. Stuart Seigel, Dr. Kam Shojania, and Dr. Tony Russell. Immediate anonymous feedback is provided. Although the "examiners" won the day, the "examinees" made a valiant effort. Any bruised egos were soon washed away by a glass of Okanagan wine! Trainees are also encouraged to present at the meeting, and all did so with class and professionalism, and with a sartorial elegance that put their mentors to shame. If anything is to be learnt from this year's meeting, the future of rheumatology looks bright.

Clinical science is the priority of the meeting, but our philosophy has always been that continuing professional development should be fun and that family pleasure should be a component of the event. In this regard, our social activities included a welcome wine and cheese reception, a children's party, and an adult BBQ dinner as components to promote our mission. For those with a more discerning palate our annual wine tasting is a popular event.

Once again we are indebted to our colleagues in industry who provide unrestricted grants to support the meeting. We look forward to their continuing support and another sunny weekend in 2014.

Paul Davis, MD, FRCPC
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Edmonton, Alberta

Update from the British Columbia Society of Rheumatologists

By Jason Kur, MD, FRCPC, ABIM

The British Columbia Society of Rheumatologists (BCSR) continues to be active in order to improve the delivery of rheumatology services in B.C. through leadership, advocacy, and member support. To that end, there have been some further successes on the West Coast.

B.C. Medical Association Recruitment and Retention Funding

After several months and two submissions, the BCSR was very successful in its case for recruitment and retention support through the B.C. Medical Association (BCMA) Recruitment and Retention initiative. Mr. Eric Harris, Q.C., arbitrated the allocation of $20 million available to specialist sections that


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- 3rd trimester of pregnancy
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- severe uncontrolled heart failure
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- history of asthma, urticaria, or allergic-type reactions after taking ASA or other NSAIDs
- active gastric/duodenal/peptic ulcer, active GI bleeding
- cerebrovascular bleedings
- inflammatory bowel disease
- severe liver impairment or active liver disease
- severe renal impairment or deteriorating renal disease
- known hyperkalemia
- patients <18 years of age

SERIOUS WARNINGS AND PRECAUTIONS:

- **Risk of CV adverse events:** ischemic heart disease, cerebrovascular disease, congestive heart failure (NYHA II-IV)
  - Some NSAIDs are associated with increased incidence of CV adverse events which can be fatal
  - NSAIDs can promote sodium retention which can increase blood pressure and/or exacerbate congestive heart failure
- **Risk of GI adverse events:** NSAIDs are associated with an increased incidence such as ulcers, perforation, obstruction and bleeding
- **Risk in pregnancy:** caution in 1st and 2nd trimesters

OTHER RELEVANT WARNINGS AND PRECAUTIONS:

- Not recommended for use with other NSAIDs (except low-dose ASA)
- Risk in patients who are renally compromised
- Blood pressure, renal and ophthalmologic monitoring
- Concomitant warfarin use
- Blood dyscrasias
- Abnormal liver tests
- Increased risk of hyperkalemia
- Hypersentivity reactions: anaphylactoid, ASA-intolerance, NSAID cross-sensitivity, serious skin reactions
- Neurologic adverse reactions
- Blurred and/or diminished vision
- May impair fertility
- CYP2C9 poor metabolizers
- Some NSAIDs associated with persistant urinary symptoms, hematuria or cystitis
- Rarely, with some NSAIDs, aseptic meningitis

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Reference: 1. IMS data, October 2012-March 2013. NSAID Market, monthly data, prescriptions.

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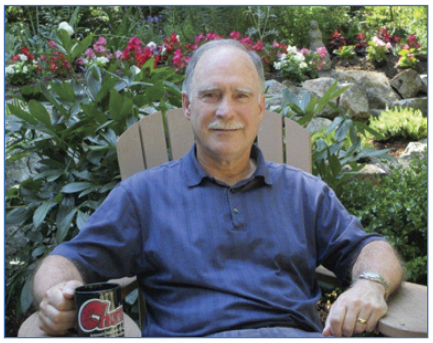
have had difficulty recruiting and retaining physicians. Submissions were received from 26 specialties. Mr. Harris then applied criteria to the proposals to help determine where recruitment and retention issues were most severe.

In his decision, he identified different categories of specialties with the highest recruitment needs. The Group A specialties determined to be experiencing the greatest need included: endocrinology, geriatric medicine, neurology, pediatrics, and rheumatology. These groups received the highest award per full-time equivalent physician. Only 13 groups received funding in this process. In total, this process represented $975,000 in new support for rheumatology practice initiatives across B.C. Our proposal to the arbitrator outlined strategies for improving the attractiveness of rheumatology as a specialty that will reward physicians for managing patients with complex rheumatic diseases.



A relaxed Dr. Paul de Champlain, enjoying his retirement.

Nursing in B.C.

More than 50% of rheumatology practices in B.C. are using the services of nurses. There has been dramatic uptake in the use of nursing services since the implementation of the multidisciplinary consultation code that allows rheumatologists to involve a nurse in a patient's management plan. The BCSR held its first primer for rheumatologists on the logistics of nursing care in private practice in Vancouver in the spring; plans are in the works to repeat this event for members on Vancouver Island and the B.C. interior.

Website

The BCSR is excited to announce the launch of its first website, *www.bcrheumatology.ca*. The site includes practice resources for members, and will serve as the public face for the profession in the province through advocacy and media relations.

The BCSR would like to congratulate Dr. Paul de Champlain on his recent retirement. Paul began practice in Victoria in 1979, after completing rheumatology training in Calgary and an undergraduate MD degree in Edmonton. Paul worked diligently as a community rheumatologist for those 34 years. He is commonly known as Mr. Dependable: always organized and meticulous in his obligations to his community and colleagues. An avid golfer, he is well liked by all in the medical community. We wish him well in his new more relaxing green pastures, or perhaps just "greens and fairways".

Jason Kur, MD, FRCPC, ABIM
Clinical Assistant Professor, University of British Columbia
President, British Columbia Society of Rheumatologists
Co-Director, Pacific Arthritis Centre
Vancouver, British Columbia

British Society for Rheumatology Annual Meeting

By John Thomson, MD, FRCPC

I attended the British Society for Rheumatology (BSR) annual meeting this past 23-25 April, 2013. The meeting took place in Birmingham, England. Birmingham is the second-largest city in the UK with a population of 2,300,000 in the greater metropolitan area. It is located about 140 km northwest of London, in the West Midlands region of England. Historically it is acknowledged to be the first industrial city in the world and the heart of the Industrial Revolution. Today it is an important city of commerce, and home to six different universities. Birmingham is known by the diminutive "Brum" and people from Birmingham are known "Brummies". It is a vibrant city known for its numerous pubs and excellent East Indian restaurants, which I can personally vouch for.

Dr. Thomson bumming around Birmingham at the 2013 BSR Meeting.

The BSR Annual Meeting took place over three days, at the impressive International Convention Centre in downtown Birmingham; accommodations were abundant, with numerous hotels within easy walking distance of the Centre. Presenters were mostly from the UK, and there were approximately 2,100 attendees, mostly from the UK, Ireland, and continental Europe. A sizable contingent from the Middle East and a smattering of Canadians made up most of the rest of the attendees. Allied Health Professionals were well represented in numbers and in content in the scientific program.

The scientific program included the usual mix of posters, oral abstracts, symposia, and keynote addresses. The calibre of presentations was very high. Highlights included the Heberden Oration by Dr. Paul Emery, in which he reviewed the paradigm shift in rheumatoid arthritis (RA) treatment, which has occurred over the past two decades. Canadian Dr. Kimmie Hyrich, now living and working in Manchester, UK, summarized the findings of the BSR Biologics Registry for RA as regards the risk of malignancy with anti-tumour necrosis factor (TNF) therapy. I attended a myositis oral abstract session that presented invaluable information from centres of excellence in the UK. A session on the emerging role of epigenetics in rheumatic diseases was likewise fascinating.

This meeting was high quality; logistically, it was easy to navigate given its size: somewhat larger than the CRA annual meeting but much smaller than meetings of the European League Against Rheumatism (EULAR) and the American College of Rheumatology (ACR). The overall cost of the meeting was quite reasonable, with higher airfare cost to the UK offset by cheaper accommodation in a relatively smaller city. I would recommend this meeting and plan to return myself.

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Ethics in Rheumatology

By Emily J. McKeown, MSc, MD, FRCPC

How often have you left your busy clinic at the end of the day and wondered, "If only that patient with seronegative rheumatoid arthritis (RA) had a positive rheumatoid factor (RF) then the Exceptional Access Program (EAP) would fund her biologic treatment." Perhaps, you reflected on how you should have responded when a pharmaceutical representative wanted to schedule another meeting with you regarding their new product, or saw the natural history of RA unfold before your eyes because the patient refused disease-modifying antirheumatic drug (DMARD) therapy and you respected their wish for patient autonomy? These are just some of the clinical examples where ethics displays itself in rheumatology.

As a community of rheumatologists, how often have we sat down to discuss these issues? It is about time we did. That is the impetus behind the recent endeavour of myself, Dr. Carter Thorne, Dr. Heather McDonald-Blumer, Dr. Ronald MacKenzie, and a selection of committee volunteers who, with the help of the CRA, aim to address the perceived ethical challenges in rheumatology. This project is building on a similar body of work that was completed in the United States by the American College of Rheumatology (ACR), under the leadership of Dr. MacKenzie, a co-investigator on the Canadian project. The administration of the current study will be conducted through the CRA in support of its mandate to enhance the practice of its members. The survey will address five core areas:

1. Awareness of daily ethical challenges;
2. Perception of ethical issues in clinical and basic research;
3. Perception of potential effects of industry relationships on daily work;
4. Understanding conflicts of interests; and
5. Personal education around medical ethics.

Our objective is to catalogue ethical issues recognized by Canadian rheumatologists, and compare and contrast those with the American data. We are interested in assessing if there any differences given the dissimilarities of our healthcare systems, with respect to funding, use of infusion/injectable medications, and delivery of health care.

We have recently organized an Ethics Committee through the CRA. We have nine committee members, including cross-country representation and a pediatric representative. The committee will be provided with the study findings and, subsequently, will be able to assist in providing direction and vision to the CRA in promoting dialogue amongst CRA members. The results of the survey will be submitted for presentation at the CRA Annual Scientific Meeting in 2014 and for possible publication thereafter.

This endeavour has implications for future educational initiatives from the ground up. We hope to be able to identify generic, often unperceived, ethical concerns that may result in development of specific training modules for subspecialty residents in their rheumatology training program. While some trainees have received some formal ethics training previously, many have no formal education in this domain. Furthermore, the literature reflecting key ethical issues in rheumatology literature is sparse. We hope to extend and develop educational activities for rheumatologists in their clinical practices. At the very minimum, we will be bringing the discussion of ethics in rheumatology to the forefront, a laudable first step.

We are very much looking forward to CRA members' participation in the upcoming survey. The link for the survey will be sent in the near future. We value your input and look forward to reading your responses. If you have questions about our group, please contact Dr. Emily McKeown, the study coordinator (*emily.mckeown@sunnybrook.ca*).

Emily J. McKeown, MSc, MD, FRCPC
Rheumatologist, Sunnybrook Health Sciences Centre
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RA Guidelines: Practice Patterns of Rheumatologists in Canada Compared to CRA Recommendations for RA (Part III)

By Sankalp Bhavsar, MD, FRCPC; on behalf of Carter Thorne, MD, FRCPC, FACP; Claire Bombardier, MD, FRCPC; Vivian P. Bykerk, MD, FRCPC; Glen S. Hazlewood, MD, FRCPC; Pooneh Akhavan, MD, FRCPC; Orit Schieir, MSc; and Sanjay Dixit, MD, FRCPC

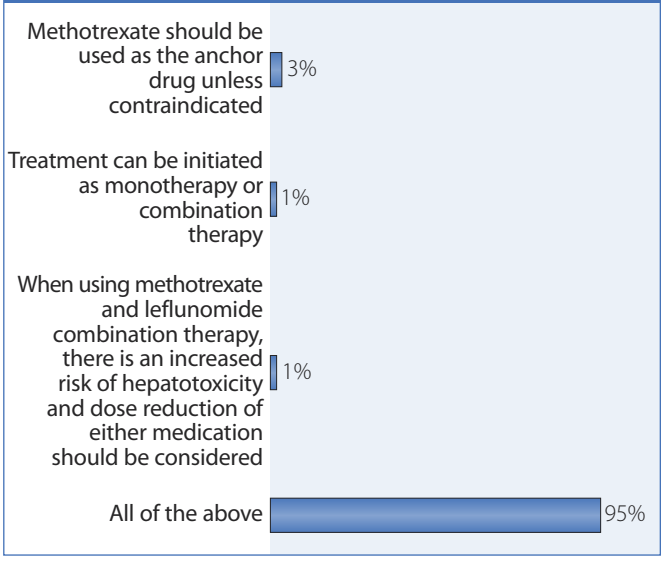
In this installment, we present the results of survey questions pertaining to treatment with traditional and biologic disease-modifying antirheumatic drugs (DMARDs).

1. Regarding combination DMARD therapy in rheumatoid arthritis (RA), which statement is true?

Answer: All of the above.

Recommendation/supporting evidence: American College of Rheumatology (ACR) 2012,[1] National Institute of Clinical Excellence (NICE) 2009,[2] European League Against Rheumatism (EULAR) 2013,[3] Visser 2009.[4]

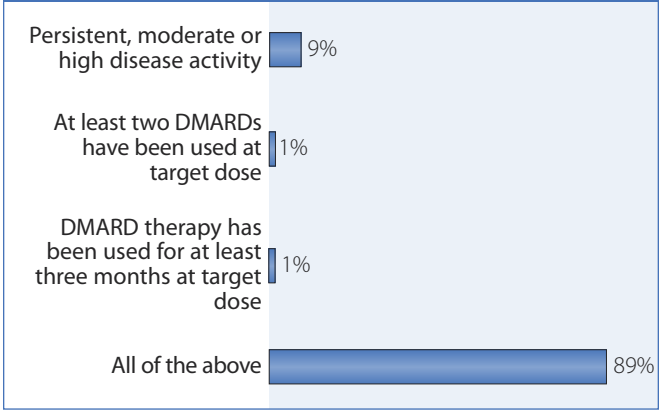
Table 1. **Regarding combination DMARD therapy in rheumatoid arthritis, which statement is true?**



Different highly rated guidelines came to different conclusions regarding the same literature. While the body of evidence supporting combination therapy has some limitations, there is sufficient evidence to consider the use of specific DMARD combinations as initial therapy and/or after inadequate response to monotherapy, particularly in patients with poor prognostic features, moderate-high disease activity, and recent-onset disease.

There is sufficient evidence to support the use of methotrexate (MTX) as the anchor drug when using combination therapy, although other DMARD combinations may also be considered. Several different combination therapies have been shown to be effective in the treatment of RA, but direct comparative data of the effectiveness of

Table 2. **When considering initiating biologic therapy, which of the following criteria indicate an inadequate response to DMARDs?**



different combinations is lacking. The choice of combination should be left to the discretion of the rheumatologist as a shared decision with the patient, based on individual patient circumstances.

There is evidence from randomized controlled trials supporting the efficacy of MTX and leflunomide (LEF) in patients with high disease activity with an inadequate response to MTX. Many patients have been successfully treated with this combination without serious adverse events; however in general, other combination therapies of proven efficacy would be preferred over MTX + LEF due to increased gastrointestinal side effects and hepatoxicity. LEF combination therapy is typically considered after an inadequate response to MTX, and in this situation it is not desirable to withdraw MTX to treat with LEF as this may result in worsening of disease control. If MTX + LEF is used, liver enzymes should be monitored monthly and dose reduction of LEF (to 10 mg) or MTX should be considered. Similarly, clinicians should exercise caution when combining LEF with other drugs that have the potential to cause liver injury.

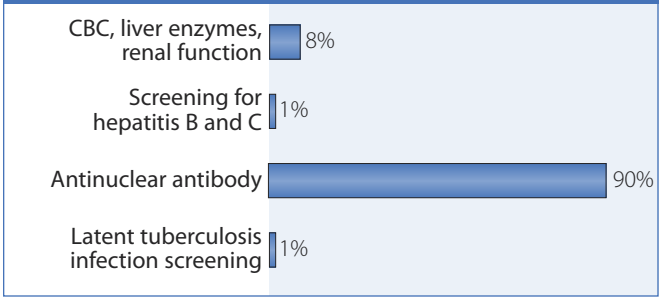
2. When considering initiating biologic therapy, which of the following criteria indicate an inadequate response to DMARDs?

Answer: All of the above.

Recommendation/supporting evidence: NICE 2009.[2]

Biologics, while proven effective in DMARD inadequate responders and DMARD-naïve patients, are associated with higher costs and potential risk for toxicity. Prior treatment with two DMARDs in monotherapy or combination therapy balances the potential opportunity for a response to DMARD therapy against the early initiation of a biologic which may be necessary to reach the treatment target. Three months at target dose is a sufficient period to observe a therapeutic effect for most DMARDs while minimizing delays in adjusting treatment.

Table 3. **Which of the following baseline tests do not routinely need to be done prior to initiating anti-TNF therapy in rheumatoid arthritis?**



3. Which of the following baseline tests do not routinely need to be done prior to initiating anti-tumour necrosis factor (TNF) therapy in RA?

Answer: Antinuclear antibody (ANA).

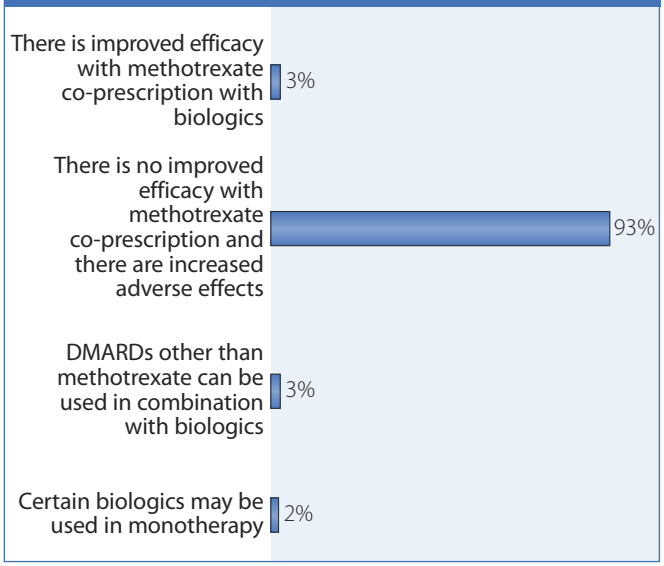
Recommendation/supporting evidence: Australian Rheumatology Association (ARA) 2010,[5] ACR 2012.[1]

Although there is only weak evidence supporting existing guidelines, the recommendations made by the ACR and ARA are reasonable. Having a baseline ANA assessment is not mandatory but could be considered, as it may be useful in patients who develop lupus-like symptoms. Based on expert opinion, there is insufficient evidence to recommend immunoglobulin screening or B-cell levels prior to rituximab. Investigations related to managing comorbidities or cardiovascular risk may also be necessary when treating with a biologic but are beyond the scope of the present guidelines.

4. Which of the following statements regarding DMARD combination therapy with biologics in RA is false?

Answer: There is no improved efficacy with MTX co-prescription and there are increased side effects.

Table 4. **Which of the following statements regarding DMARD combination therapy with biologics in rheumatoid arthritis is false?**



Recommendation/supporting evidence: EULAR 2013,[3] Furst 2010,[6] Fautrel 2010.[7]

There is strong evidence to recommend coprescription of MTX with biologic agents. In cases where MTX cannot be used, another DMARD is recommended. If coprescription with MTX or another DMARD is not possible, certain biologic agents may be used in monotherapy. Currently, etanercept, adalimumab, certolizumab, abatacept, and tocilizumab are licensed for use as monotherapy in Canada. Patients that have remained in a low disease-activity state taking biologic monotherapy may not require the reintroduction of a DMARD.

For further information on these recommendations and the supporting evidence of these results, please consult the CRA RA Guidelines document, available at *www.rheum.ca/en/publications/cra_ra_guidelines*.

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on behalf of Carter Thorne, MD, FRCPC, FACP;
Claire Bombardier, MD, FRCPC;
Vivian P. Bykerk, MD, FRCPC;
Glen S. Hazlewood, MD, FRCPC;
Pooneh Akhavan, MD, FRCPC;
Orit Schieir, MSc; and Sanjay Dixit, MD, FRCPC

Janet Markland

By Bindu Nair, MD, FRCPC

1948 - 2013

Our colleague Dr. Janet Markland passed away on August 30, 2013 from chronic lymphocytic leukemia. At the time of her passing, Janet was a Clinical Professor of Medicine and had practiced as a rheumatologist in Saskatoon, Saskatchewan for over 30 years. Janet received her Honours degree in biology at the University of Saskatchewan in 1970 with a special interest in molecular genetics. She then attended the College of Medicine and completed her medical degree in 1975. Her certification in Internal Medicine was received in 1979 and she completed a subspecialty residency in rheumatology in 1982. During her studies, Janet met and married her husband Don Drysdale, and subsequently took periods of leave to have her children, Heather and Mark.

Janet had one of the largest clinical rheumatology practices in Saskatoon. Her dedication to her patients was well known and served as a model to the trainees that she would supervise. Janet would not only hold a regular workweek of clinics in Saskatoon, but frequently travelled to hold satellite clinics on the weekend in the smaller communities of Saskatchewan. In recent years, she oversaw telehealth clinics to reach patients who lived far away from urban centers. As many of us know, Janet was the clinician whom when called upon, could always be relied upon to add that extra patient to her clinic or fill in for that empty space on the call schedule. Her work ethic was amazing and always accompanied by her boundless optimism. In a meeting last year, during a discussion of the local growing local shortfall in resources for patient care and teaching, Janet's response was to smile and say, "Tell me what I can do to help. We can do this."

Janet was an enthusiastic educator; over the years, she served as mentor to many medical residents and students. Janet was active in the CRA, especially on the Human Resources Committee and on the editorial board of the *CRAJ*. One of the CRA projects closest to her heart was the CRA's effort to ensure that residents across the

country were provided with rheumatology textbooks. In 2007, the University of Saskatchewan recognized her work in education with the College of Medicine's Excellence in Teaching Award. Janet was always interested in the pursuit of new knowledge which led to her being one of the first clinicians in Saskatoon to adopt an electronic medical record (EMR) system. Janet later worked as an EMR peer-to-peer advisor with the Saskatchewan Medical Association. Her enthusiasm also extended to research; she served as the Saskatchewan site director for the Canadian Scleroderma Registry and contributed to many research publications.

As many of us know, Janet's true passion was gardening. Her garden was an incredibly beautiful gathering place for her family and friends. Tours of her garden served as fundraising events for the local Scleroderma and Lupus Societies.

Janet made her best efforts to keep caring for her patients, even after her diagnosis and between sessions of chemotherapy. After the closure of her medical practice, she planned to continue participation with teaching. At the time of her passing, messages came from colleagues across the country, remarking on her dedication and advocacy for rheumatology care and education. We will greatly miss our dear colleague and friend, Dr. Janet Markland.

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Good Tidings from Halifax

By Trudy Taylor, MD, FRCPC

It is always a treat to be living in the Maritimes this time of year with so many activities available to choose from, whether one of the many outdoor music festivals, theater productions, or a simple hot day spent at the beach or on the golf course. And of course there is the food – fresh seafood, vegetables, and fruit abound this time of year!

We currently have nine rheumatologists (eight full-time, one part-time) serving the province of Nova Scotia as well as Prince Edward Island and western parts of Newfoundland and Labrador. All are based in Halifax with the exception of one based in Lunenburg and one in Sydney.

As the new academic year gets underway, we welcome some exciting changes in the Division of Rheumatology at Dalhousie University which have occurred in the past few months:

- After seven years of dedicated leadership, Dr. Volodko Bakowsky has passed the torch of program director for the Adult Rheumatology Training Program at Dalhousie to yours truly. I was very fortunate to do my adult rheumatology training here in Nova Scotia, where I have stayed to set up practice as an academic rheumatologist with my main extra-clinical interest being education. This new role will, no doubt, be both a rewarding and challenging chapter in my early career as a medical educator to which I am very much looking forward.
- The Division of Rheumatology has been lucky to welcome the two most recent graduates of our rheumatology-training program, Dr. Alexa Smith and Dr. Markus Klaus, to practice in the Halifax area. Both will have a combined academic/private practice. Welcome to the fold!
- We welcome our newest trainee to the program, Dr. Sam Aseer, who joins us from Memorial University of Newfoundland where he completed his first three years of internal medicine training. He joins Dr. Elana Murphy who is now in her second year of rheumatology training.

Glorious fall colours of Cape Breton.

In other news, the Society of Atlantic Rheumatologists (SOAR) held its impressive 30th Annual Meeting in June 2013 at Shaw's Cottages in Prince Edward Island and it was, by all accounts, a great success. Featured were presentations by Dr. John Stone and Dr. Susan Manzi as well as plenty of time for the beach, golf, lobster, and beautiful weather.

In the upcoming months we will be looking forward to one of the highlights of the year: the Celtic Colours International Festival, held in Cape Breton every fall with 46 concerts held all across the island over a nine-day period on the backdrop of breathtaking fall colours. If you ever have the chance to visit Nova Scotia in October, it is a must!

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Capillaroscopy in Rheumatology

By Geneviève Gyger, MD, FRCPC; and Marie Hudson, MD, MPH, FRCPC

A 40-year-old woman is referred to the rheumatology clinic for nailfold capillaroscopy. She has had Raynaud's phenomenon for 10 years, has no other relevant medical history, and is a non-smoker. She has three healthy children and no history of miscarriages. She does not take any medication. Family history is unremarkable, including the absence of Raynaud's phenomenon in any relatives. On history, she denies heartburn, shortness of breath, arthritis, or any other symptoms of connective tissue diseases. The physical exam is negative for sclerodactyly, neck sign, increased peribuccal folds, or skin thickening; however, she has two telangiectasias on her lower inner lip. Her anti-nuclear antibody was positive (1:160), with an anti-centromere pattern. Antibodies to extractable nuclear antigen, including anti-topoisomerase I antibodies, were negative. Nailfold videocapillarocopy was performed (DS Medica, 200x magnification) and showed an active scleroderma pattern (Figure 1).

Does This Patient Have Scleroderma?

According to epidemiologic studies, the prevalence of Raynaud's phenomenon ranges from 2% to 22%, of which roughly 15% is associated with systemic sclerosis (SSc).[1-2] Which patients with Raynaud's phenomenon are likely to progress to SSc? A twenty-year prospective study of 586 patients with Raynaud's phenomenon showed that abnormal nailfold capillaroscopy at baseline, in the presence of an SSc-specific antoantibody (anti-centromere protein B [CENP-B], anti-topoisomerase I, anti-Th/To, or anti-RNA polymerase III), were excellent predictors for the development of definite SSc, whereas their absence practically ruled out this outcome. Indeed, subjects with both abnormalities at baseline were 60 times more likely to develop SSc compared to patients without these predictors; 80% of the patients with both abnormalities developed SSc over 20 years of followup. In contrast, only 2% of patients with Raynaud's phenomenon with normal capillaroscopy and absent SSc-specific auto-antibodies at baseline developed definite SSc in follow up.[2]

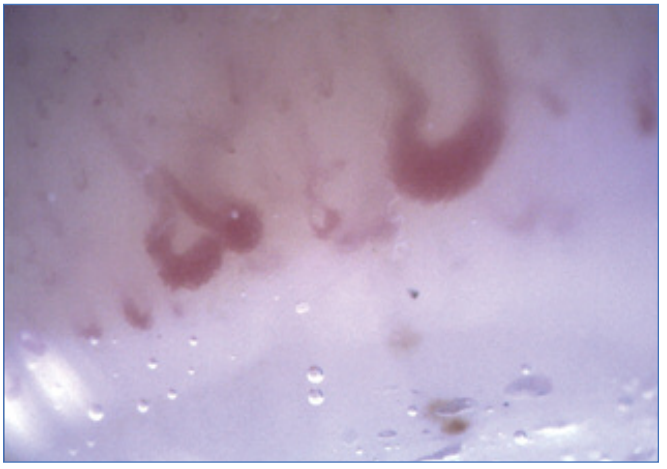

Figure 1. Giant capillaries are the hallmark of the scleroderma pattern. The presence of even one giant capillary is never normal and is characteristic of the scleroderma pattern. Other features of the scleroderma pattern include ectasias, capillary hemorrhages, capillary loss, neoangiogenesis, and disorganisation. More than 95% of SSc patients will have this pattern on videocapillaroscopy. Represented are two giant capillaries, one hemorrhage, and mildly diminished capillary density.

This landmark study[2] provided validation for the criteria proposed for early SSc in 2001 by Leroy and Medsger,[3] that included Raynaud's phenomenon, SSc-specific autoantibodies (anti-centromere, anti-topoisomerase I, anti-fibrillarin, anti-PM/Scl or anti-RNA polymerase I or III) and a scleroderma pattern on capillaroscopy. Those criteria increased the sensitivity of the 1980 American College of Rheumatology (ACR) preliminary criteria[4] for limited SSc from 33% to 92%.[5] Nevertheless, we should keep in mind that 20% of the patients who fulfill those criteria will not develop SSc, at least with 20 years of follow-up.

In 2012, an ACR-European League Against Rheumatism (EULAR) committee was established to develop new classification criteria for SSc (Table 1).[6] These criteria were expanded to include abnormal nailfold capillaries. A

Table 1
ACR-EULAR Criteria for the Classification of SSc

Criteria	Sub-criteria	Weight
Skin thickening of the fingers of both hands extending proximal to the meta-carpophalangeal (MCP) joints *(sufficient criterion)*		9
Skin thickening of the fingers *(only count the highest score)*	Puffy fingers; Whole finger, distal to MCP	2 4
Fingertip lesions *(count the highest of the two)*	Digital tip ulcers; Fingertip pitting scars	2 3
Telangiectasia		2
Abnormal nailfold capillaries		2
Pulmonary arterial hypertension and/or interstitial lung disease *(maximum score is 2)*		2
Raynaud's phenomenon		3
SSc-related antibodies (any of anti-centromere, anti-topoisomerase I, anti-Scl-70, anti-RNA polymerase III *(maximum score is 3)*		3

A patient with a score of 9 or more is classified as SSC.

subject with a score of 9 or more is classified as having SSc. The case-study patient described above fulfills the criteria for definite SSc according to the new ACR-EULAR criteria. She has Raynaud's phenomenon (2 points), anti-centromere antibodies (3 points), SSc-capillaroscopy pattern (2 points), and telangiectasias (2 points), for a total of 9 points. Capillaroscopy was therefore a very useful tool to make a diagnosis of SSc in the case of this patient.

Suggested Work-up

The next step in her investigation should be to determine whether internal organs are involved, including esophageal transit or barium swallow to rule out esophageal dysmotility, echocardiography to measure pulmonary arterial pressures, and chest x-ray and pulmonary function tests to rule out interstitial lung disease. Hand x-rays could also be considered to determine the presence of calcinosis or acro-osteolysis. This patient had a normal work-up, baring the fact that her esophageal transit was compatible with moderate esophageal dysmotility.

Treatment

The treatment for Raynaud's phenomenon remains symptomatic. Non-pharmacologic interventions include smoking cessation, warm clothes, and minimizing cold exposure. Calcium channel blockers are used as first-line treatment when pharmacotherapy is considered.[7] Proton-pump inhibitors (PPIs) should be considered, even in asymptomatic patients, to prevent complications resulting from gastric reflux. Such complications may include esophagitis, esophageal strictures and Barrett's esophagus. The importance of aggressive treatment of esophageal dysmotility has been highlighted by recent studies which showed a relationship between asymptomatic micro-aspiration secondary to acid reflux and interstitial lung disease in SSc.[8-9] Of note, 70% to 90% of SSc patients have esophageal involvement, and 50% of these patients are asymptomatic.[7]

Conclusion

Nailfold capillaroscopy is a rapid, non-invasive, and easy-to-perform test that should be considered as part of the evaluation of individuals with Raynaud's phenomenon, to facilitate the diagnosis of SSc, and to reassure those with negative autoantibodies and normal capillaries. The devices presently available for nailfold capillaroscopy include the dermatoscope (10X magnification), ophthalmoscope (20X magnification), widefield microscope (50X magnification), and videocapillaroscope (200X magnification). Although the dermatoscope and ophthalmoscope are available in the clinic, the better resolution of widefield microscopy and videocapillaroscopy is preferable

to identify all of the features of the SSc-pattern. The diagnostic and prognostic value of capillaroscopy in other rheumatologic diseases is still being investigated, in particular in the myositides where a scleroderma-like pattern has been described. No specific pattern for other connective tissue diseases has been described. The presence of the SSc-pattern in those diseases suggests an overlap with SSc.

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Highlights of Whistler, British Columbia

Schedule full of meetings, workshops, lectures, sessions, and abstracts? Be sure to enjoy some of the bounty of beautiful British Columbia, land of "splendour without diminishment". Here are a few suggestions to get you started.

5) Explore the wonders of Whistler Blackcomb.
Consistently ranked one of the top ski destinations in the world, Whistler Blackcomb features a dizzying array of alpine bowls, glaciers, half-pipes, and trails. Open daily from 8:30 A.M. to 4 P.M.
www.whistlerblackcomb.com

4) Take part in a dinner tour.
Table surfing more your speed? Why not try a dining adventure with Whistler Tasting Tours. Enjoy a delectable four-course meal, with each course hosted by a different local restaurant.
www.whistlertastingtours.com/whistler-dining-tours-hidden-gems-tour

3) Kokanee Valley Race Series - Super G.
On February 27th come out to watch skiers, telemarkers and snowboarders carve up the trails. You can even take part yourself! For more information on results, how to register and the entry fee, please call the Whistler Blackcomb Reservation Centre.
Reservations: 1-800-766-0449.

2) Visit the Whistler Olympic park and sliding centre.
The glory of the 2010 Olympics lives on at the Whistler Olympic Park. Visitors can tour the attractions, accommodations, and the central plaza, reveling in our golden glory as hosts of the international community. Daring individuals can even enjoy the thrill of a bobsled or skeleton ride down the Olympic track. Follow the map for a self-guided tour or book a guide for the full experience.
www.whistler.com/olympic_experience/

1) Après ski.
Skier or not, who would not want to unwind after a long day by a roaring fire with a glass of something to warm the soul? From local beers to inventive martinis, there is a terrace to suit all your needs. See a complete listing here.
www.whistler.com/apres/

Top Ten Things Rheumatologists Should (And Might Not) Know About Dermatologic Disorders

By Kim Alexander Papp, MD, PhD, FRCPC

Rheumatologists can positively impact patients beyond diagnosing and treating musculoskeletal disorders. All patients suffer dermatologic conditions at some time; the first organ we see during a physical examination is the skin. Cutaneous malignancies affect nearly one third of the population; a rheumatologist's examination may be the first opportunity to diagnose skin cancer. Common inflammatory disorders may be mistaken for infectious processes. With an increasing number of patients on immunosuppressive therapies, distinguishing dermatitis from cellulitis is important. Moreover, dermatologic assessments may assist in the diagnosis of rheumatologic diseases, for example, connective tissue diatheses and psoriatic arthritis (PsA). Rheumatologists have additional opportunities to reduce morbidity and mortality by recognizing certain dermatologic conditions.

1. Malignant Melanoma

With a lifetime risk of 1%, melanomas have a relatively high incidence and prevalence in the adult population. Worldwide, melanomas are responsible for 48,000 deaths annually. Primary malignant melanomas occur in tissues seeded with melanocytes, which include eyes, brain, gut, and skin. Cutaneous melanomas are by far the most common. The frequent diagnosis, and ready detection, of cutaneous melanomas undoubtedly reflects the relative abundance of melanocytes in the skin, which is exposed to the most common inducer of melanomas: ultraviolet radiation. Early diagnosis and treatment should reduce morbidity and mortality.

2. Non-melanoma Skin Cancer

Basal cell carcinoma is the most common cutaneous malignancy with a nearly 30% lifetime risk. Basal cell carcinomas are typically slow growing, pink papules or macules possessing a scant degree of translucency.

Squamous cell carcinomas present with a broad, clinical spectrum. The textbook presentation is that of a rapidly growing, indurated, keratotic papule or nodule. Like basal cell carcinomas, squamous cell carcinomas are far more common on sun-exposed skin than non-exposed skin.

3. Cutaneous Infections

Cutaneous infections are extremely common and range from near trivial folliculitis to life-threatening cellulitis caused by common, as well as exotic and opportunistic, organisms. Of the common and noteworthy infections, cellulitis and erysipelas are the most frequent; Strep. pyogenes and less frequently Staph. aureus are the responsible organisms. Generally, cellulitis and erysipelas are readily diagnosed with warm, inflamed, tender expanding patches of skin associated with constitutional symptoms. In some instances, cellulitis is confused with other inflammatory dermatoses, venous stasis dermatitis (SD) being the most common. An additional confounder is the mild suppression of the typical signs of cutaneous infections: redness, warmth, and tenderness by systemic anti-inflammatory agents with tumour necrosis factor (TNF)-antagonists possibly being the most prominent. The latter may result in delayed diagnosis.

Prudence, rather than evidence, suggests dosing of biologic agents should be held until resolution of the cellulitis.

4. Stasis Dermatitis

Because it is common and readily misdiagnosed as cellulitis, it is important for rheumatologists to recognize and confidently diagnose stasis dermatitis (SD). Superficial varices on the legs are principal in the development of the condition; back pressure resulting from incompetent deep venous structures causes dilation of superficial venous plexes.

Inflammation of skin is associated with rubor and calor. One helpful distinction between SD and cellulitis is that stasis may be pruritic whereas cellulitis is not. Unfortunately, tenderness or pain does not always distinguish cellulitis from SD.

5. Allergic Contact Dermatitis

Allergic contact dermatitis (ACD) presents as pruritic, well-demarcated, erythematous, and sometimes bullous plaques. Lines of demarcation reflect the area of contact with an allergen. Nickel remains the most common allergen; however, topical antibiotics and topical corticosteroids are frequently administered, and are common allergens as well. Untreated, allergic contact reactions will persist for several days to a few weeks. There are several reasons ACD is important to a rheumatologist. Like SD, ACD may be confused with cellulitis; however, ACD is often pruritic while cellulitis is not.

6. Pyoderma Gangrenosum

One of the more dramatic cutaneous disorders is pyoderma gangrenosum (PG). Sometime indolent in nature, PG more often than not develops from a small erythematous papule that rapidly expands into a plaque with central ulceration and undermined, elevated, erythematous, crenate edges.

7. Drug Eruptions

Cutaneous drug eruptions are common and not usually difficult to diagnose. The difficulty is in determining causality. Nonsteroidal anti-inflammatory drugs (NSAIDs) are common causes of cutaneous drug reactions; these are frequently prescribed by rheumatologists. Cutaneous drug reactions are an important aspect of rheumatologic practice, but, unfortunately, many of the rheumatologist's patients are on multiple drugs, many of which are over-the-counter products, making causal attribution difficult.

The diagnosis of a drug reaction is based upon two aspects of the presentation, namely, the distribution of the reaction and the contemporaneous development of a reaction associated with the introduction of a drug. Most reactions occur within the first seven to 10 days of therapy.

8. Psoriasis

Affecting 2% to 5% of the population, the accurate and rapid diagnosis of psoriasis can play an important role in establishing the diagnosis of PsA, with upwards of 30% of these psoriasis patients going on to develop PsA. Classically, psoriasis presents as erythematous patches or elevated plaques covered with varying degrees of scale from nearly scale-free to oyster shell keratosis. Those areas most commonly affected are the scalp, elbows, knees, and gluteal cleft. A great deal of scientific noise has been made regarding the association of disease location and development of arthritis, but given the high prevalence of disease in the classic regions, such associations are of no predictive value.

9. Nail Pitting

Though most dermatologists and rheumatologists associate nail pits with psoriasis, nail pits are associated with several cutaneous disorders. Certainly, nail pitting is common in patients with psoriasis, but it may be equally common in patients with alopecia areata.

10. Psoriasis is the Best Disease for Assessing Drug Safety

Evaluating safety signals is fraught with confounders: co-morbidities, concomitant medications, and the impact of the underlying condition. While co-morbidities are common in psoriatics, the underlying disease tends to be more indolent than RA. Additionally, psoriatics are usually treated using a monotherapy paradigm. For the most part, psoriasis patients resemble a normal population, making them an ideal population in which to ascertain potential risks associated with a given therapy.

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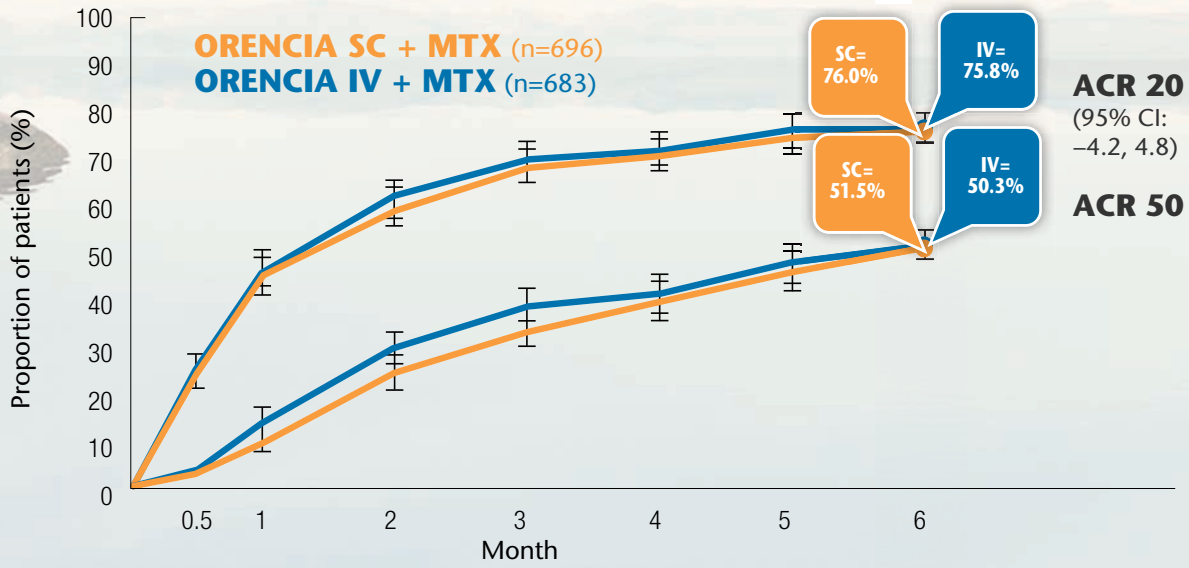
The complete version of this article is available online at *www.stacommunications.com/craj.html*

DEMONSTRATED EFFICACY

ORENCIA® SC + MTX demonstrated non-inferiority in ACR 20 response to the IV formulation + MTX in moderately-to-severely active RA patients who were MTX-inadequate responders[1]*



The non-inferiority margin of 7.5% was defined only for the primary endpoint.

Adapted from Genovese *et al.*[1]

PROVEN SAFETY PROFILE

Most serious adverse reactions (at least possibly related) for the IV perfusion[2]	% of patients	
	ORENCIA (n=1,955)	Placebo (n=989)
Serious infections	**3.0%**	**1.9%**
Malignancies	**1.3%**	**1.1%**

There were two reported cases of tuberculosis, one in each group. These cases were not confirmed by smear, stain or culture.

Adapted from Product Monograph[2]

Commonly reported side effects included (ORENCIA IV vs. placebo): headache (10% vs. 6.3%), nausea (6.0% vs. 5.1%), upper respiratory tract infection (4.8% vs. 3.9%), dizziness (4.6% vs. 3.5%), nasopharyngitis (3.2% vs. 1.9%). Commonly reported side effects in ORENCIA SC patients included (ORENCIA SC vs. ORENCIA IV): headache (2.2% vs. 4.0%), upper respiratory tract infection (2.0% vs. 1.8%), somnolence (1.8% vs. 0.4%), bronchitis (1.6% vs. 2.1%) and nausea (1.6% vs. 1.5%), nasopharyngitis (1.2% vs. 1.4%), sinusitis (1.2% vs. 0.3%) and diarrhea (1.1% vs. 2.2%).

Abatacept is recommended by

THE CANADIAN RHEUMATOLOGY ASSOCIATION GUIDELINES[3†]

- After inadequate response to DMARD or anti-TNF therapy
- As an option after failure with one anti-TNF due to lack of efficacy or toxicity

Clinical use:

May be administered by Intravenous (IV) or Subcutaneous (SC) route.

May be used as monotherapy or in combination with DMARD therapy.

When used as first-line treatment in recently diagnosed patients who have not been previously treated with methotrexate (MTX), should be given in combination with MTX.

The IV infusion has not been studied in children less than 6 years of age.

The SC injection has not been studied in children.

Contraindications:

- Patients with, or at risk of, sepsis syndrome, such as immunocompromised and HIV+ patients

Most serious warnings and precautions:

Hypersensitivity: a case of fatal anaphylaxis following the first infusion of ORENCIA reported in post-marketing experience

Infections:

- Do not initiate in patients with active, chronic or latent infections
- Discontinue if a patient develops a serious infection
- Caution in patients with a history of recurrent infection or underlying conditions which may predispose them to infections, or who have resided in regions where tuberculosis and histoplasmosis are endemic
- If active tuberculosis is diagnosed, therapy should not be initiated. If inactive tuberculosis diagnosed, treatment for latent tuberculosis should be started with anti-tuberculosis therapy before initiating ORENCIA
- Patients receiving ORENCIA should be monitored for signs and symptoms of active tuberculosis, including patients who tested negative for latent tuberculosis infection

Concurrent therapy with a biologic RA agent: not recommended

Other relevant warnings and precautions:

- Allergic reactions
- Serious infections
- Blood glucose monitoring in IV patients
- Live vaccines
- Malignancies or history of lymphoma
- Caution in patients with chronic obstructive pulmonary disease
- Caution in the elderly
- Not studied in patients with hepatic insufficiency or renal impairment
- Not recommended for use in pregnant women

For more information:

Please consult the product monograph at http://www.bmscanada.ca/static/products/en/pm_pdf/ORENCIA_EN_PM.pdf for important information relating to adverse reactions, drug interactions, and dosing information (particularly respective subcutaneous and intravenous dosing) which have not been discussed in this piece.

The product monograph is also available by calling 1-866-463-6267.

MTX = methotrexate

* Double-blind, double-dummy, non-inferiority study of 1457 adults with moderately-to-severely active RA who were inadequate responders to MTX (≥15 mg/week) for ≥3 months and had mean tender and swollen joint counts of 30 and 20, respectively. Patients were randomized to one of two treatment groups: 1) ORENCIA SC + MTX, which consisted single ORENCIA IV loading dose (~10 mg/kg, weight-tiered dose) on day 1 and ORENCIA SC injections (125 mg) on day 1 and weekly thereafter; patients also received a placebo IV dose on Days 15, 29, and every 28 days thereafter; 2) ORENCIA IV + MTX, which was a weight range-based dose (~10 mg/kg) on Days 1, 15, 29, and every 4 weeks thereafter; patients also received placebo SC on Day 1 and weekly thereafter. The primary endpoint (per-protocol analysis) was non-inferiority based on ACR 20 response rate at 6 months.

† Please refer to the guidelines for complete recommendations.

References: 1. Genovese MC *et al.* Subcutaneous abatacept versus intravenous abatacept: a phase IIIb noninferiority study in patients with an inadequate response to methotrexate. *Arthr Rheum.* 2011;63:2854-64. **2.** ORENCIA Product Monograph. Bristol-Myers Squibb Canada, February 21, 2013. **3.** Bykerk *et al.* Canadian Rheumatology Association recommendations for pharmacological management of rheumatoid arthritis with traditional and biologic disease-modifying antirheumatic drugs. *J Rheumatol* 2012;38:1559-82.

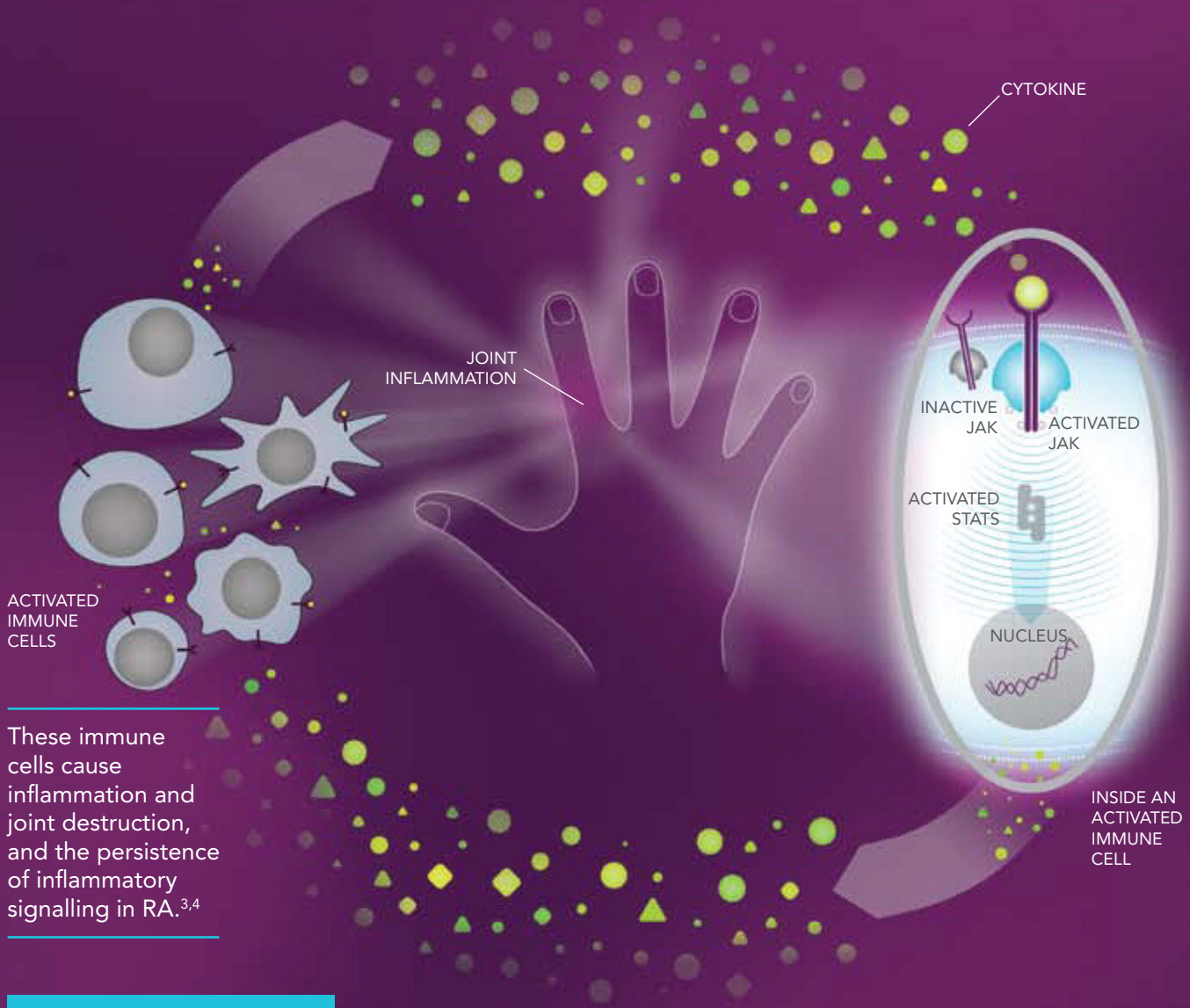
Pr ORENCIA® (abatacept) SC

Pr ORENCIA® (abatacept) IV

In rheumatoid arthritis,

JAK pathways play an important role in the cycle of inflammation that leads to joint destruction.[1,2]

Activated immune cells infiltrate the joint in rheumatoid arthritis (RA) and produce cytokines and chemokines.[2-4] These proteins bind to cell surface receptors, initiating a signal transduction cascade through intracellular signalling pathways such as the **Janus kinase (JAK) pathways**.[1,2] This signalling stimulates the production of additional pro-inflammatory proteins, triggering the recruitment and activation of additional immune cells in the synovium of joints.[3,4]



These immune cells cause inflammation and joint destruction, and the persistence of inflammatory signalling in RA.[3,4]

JAK PATHWAYS IN ACTION

References: 1. O'Shea JJ, Murray PJ. Cytokine signaling modules in inflammatory responses. *Immunity* 2008;28:477-487. **2.** Walker JG, Smith MD. The Jak-STAT pathway in rheumatoid arthritis. *The Journal of Rheumatology* 2005;32:1650-1653. **3.** Yokota A *et al.* Preferential and persistent activation of the STAT1 pathway in rheumatoid synovial fluid cells. *J Rheum* 2001;28:1952-1959. **4.** Firestein S. Evolving concepts of rheumatoid arthritis. *Nature* 2003;423:356-361.

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