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# CRA SCR

The Journal of the Canadian Rheumatology Association

## *Focus on:*
## Art & Rheumatology

> *"I am not sick. I am broken.*
> *But I am happy to be alive as*
> *long as I can paint."*
>
> *- Frida Kahlo, interview with*
> *Time Magazine, 1953*


Courtesy of www.frida-khalo-foundation.org

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EDITORIAL

# The More Things Change...

By Philip A. Baer, MDCM, FRCPC, FACR

Recently, I have been working on systematically scanning the old paper files of my active patients into my relatively new electronic medical record system (EMR). It turns out to be a lot of work, but also very interesting. I have some rheumatoid arthritis (RA) patients who have been with me for close to 30 years, including some who followed me from my rheumatology fellowship to my private practice. Their charts are incredibly thick, and wading through them reveals just how much I have forgotten about what used to pass for effective treatment, both on my part and those of my teachers and peers. Did we really treat RA in 1985 by adding indomethacin at night to high dose acetylsalicylic acid (ASA) given three times a day? Sadly, yes. Next would come chloroquine (the dogma at one time was that hydroxychloroquine was safer, but also less effective), perhaps gold, and then very tentative use of methotrexate (MTX). The results were what you might expect: active disease with joint damage that could be seen with the naked eye.

Well, that's all history in the age of biologics and combination disease modifying anti-rheumatic drug (DMARD) therapy given in aggressive modern fashion; in fact, RA is now an "invisible disability". I learned that from an article in the Toronto Star in March 2014. The story relates to a patient with severe RA, Sandra Kendall, who has filed an Ontario human rights complaint asking for $100,000 in damages. She claims that the local transit authority has failed to maintain access to disabled parking spots. "Kendall doesn't use a mobility device... She says people who, like her, have invisible disabilities are frequently met with cold stares when they request priority seating or other assistance on transit."[1] She also had no luck getting the transit police to ticket people blocking accessible parking spots used by drivers with a disability permit, which she holds.

So, in some quarters, RA has been converted from an obvious and visible disability to an invisible one. In other arenas, however, nothing has changed from the 1985 mindset. Every three months, I receive a paper survey from IMS Brogan known as the Canadian Disease and Therapeutic Index (CDTI). The incentive is small, and I keep trying to resign, but this usually leads to a pleading phone call explaining how valuable the data is in understanding prescribing trends. Judging by the anguish on the other side, I must be the only rheumatologist contributing data to this project.

What I am asked to do? For two days each quarter, I am asked to record anonymized data about the patients I see and their prescribed medications. To help me get the idea, the company supplies an example at the front of each booklet. Who is this prototypical patient? A 67-year-old male with RA who was not referred to me by another physician, and whom I have seen four times in the last year, the last time 10 days ago. What is being prescribed for this patient? Naproxen 250 mg BID as an anti-inflammatory, and ECASA 5 grains prn for pain relief! No DMARD, no biologic, and how much is 5 grains of aspirin anyway? I do not think this was my 1985 standard of care, let alone what I do now, but the speed of knowledge translation from the world of the rheumatologist to the broader consciousness of society is clearly glacial.

Reference

1. Kalinowski T. "GO rider files human rights complaint after other drivers block disabled parking." Toronto Star [Toronto] 27 March 2014. Available at: *http://www.thestar.com/news/gta/2014/03/27/go_rider_files_human_rights_complaint_after_other_drivers_block_disabled_parking.html*

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# AWARDS, APPOINTMENTS, ACCOLADES

Effective July 1, 2014, Dr. Gillian Hawker was appointed Chair of the Department of Medicine, University of Toronto. The Department of Medicine at the University of Toronto is one of the longest-standing and largest in North America with over 1,200 faculty distributed throughout the Toronto region—including six fully-affiliated hospitals—and 740 postgraduate trainees in 21 residency programs. As Chair, she will hold the title of Sir John and Lady Eaton Professor; this post was established in 1919 as the first full-time endowed chair in medicine in what was then the British Empire.

A rheumatologist at the University of Toronto, Dr. Hawker has an established record of academic excellence, with national and international recognition as a leading clinical epidemiologist/health services researcher in the field of osteoarthritis (OA) outcomes. Dr. Hawker has continuously received peer-reviewed research funding from the Canadian Institutes of Health Research (CIHR) since 1994 and has published over 200 peer-reviewed articles in high-impact journals. She is a founding member of the Arthritis Alliance of Canada (AAC) and a member of the Board of the International Society for Osteoarthritis Research (OARSI). In 2013, she received a Queen's Jubilee Medal from The Arthritis Society (TAS) for her contributions to OA research.

Dr. Rayfel Schneider is a paediatric rheumatologist at The Hospital for Sick Children. He has held a number of leadership positions in the Department of Paediatrics, including Director of Undergraduate Medical Education, Division Chief, and Subspecialty Program Director of Paediatric Rheumatology. Since 2007, he has been the Associate Chair for Medical Education, overseeing all educational activities in the Department of Paediatrics, with a particular focus on subspecialty training programs for Canadian and international learners. He was instrumental in establishing the Canadian Resident Matching Service (CaRMS) for paediatric subspecialties. He has won numerous departmental, university, and national teaching awards, and was recently the recipient of the 2013 Paediatric Chair of Canada Educational Leadership Award and the 2014 University of Toronto Mickle Fellowship Award for long-term contributions to postgraduate education.

His major clinical focus is juvenile idiopathic arthritis (JIA) with a specific interest in systemic JIA, and one of its most serious complications, macrophage activation syndrome. His research has focused on prognosis, outcome, and clinical treatment trials for these patients, as well as the development of diagnostic and treatment guidelines.

Dr. Cy Frank is one of 64 new appointees to the rank of Member of the Order of Canada for 2014. The Order of Canada is one of our country's highest civilian honours and recognizes outstanding achievement, dedication to the community, and service to the nation. Dr. Frank received his appointment for his contributions to advancing orthopedic healthcare services in Alberta and for his scientific contributions to bone and joint repair research.

Dr. Frank is currently the President and Chief Executive of Alberta Innovates – Health Solutions, a Professor of Orthopedic Surgery at the University of Calgary, and the McCaig Professor in Joint Injury and Arthritis Research. He helped develop the Sport Medicine Centre and the McCaig Centre for Joint Injury and Arthritis Research at the University of Calgary. He is a Fellow of the Canadian Academy of Health Sciences (CAHS) and chaired a Blue Ribbon International Panel for CAHS on "Defining the Best Framework and Metrics to Capture Returns on Investment in Health Research". Between 2000 and 2006, Dr. Frank was the inaugural Scientific Director of the Canadian Institutes for Health Research (CIHR) Institute of Musculoskeletal Health and Arthritis, as well as serving as the Executive Director of the Alberta Bone and Joint Health Institute. He has previously held the positions of President of the Canadian Orthopedic Association (COA), Canadian Orthopedic Research Society (CORS), and the Canadian Orthopedic Foundation (COF), as well as Vice-President Research Strategy for Alberta Health Services. Recent awards include: International Bone and Joint Decade Builder (2005), CIHR/Canadian Medical Association Journal Top Achievements in Health Research (2010), Alberta's 50 Most Influential People (2011), Queen Elizabeth II Diamond Jubilee Medal (2013), and "Member of the Order of the University of Calgary" (2013).

NORTHERN (HIGH)LIGHTS

# Bone Deep: Where Art and Illness Intersect

By Otto Kamensek

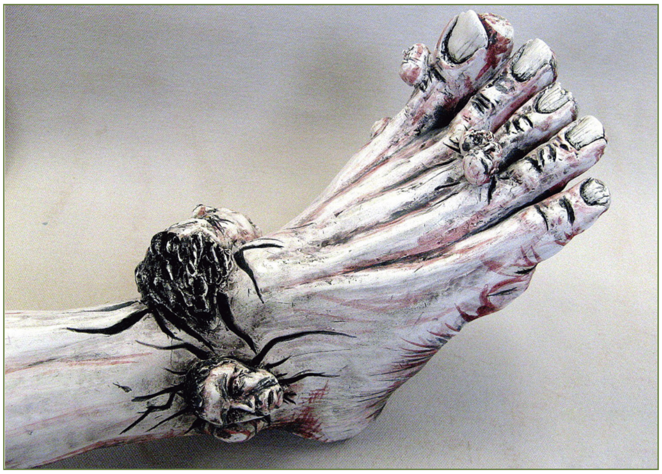
My images are an expression of my relationship with my chronic illness; for 40 years I have been living with a type of inflammatory arthritis known as juvenile idiopathic arthritis (JIA). It has given me unexpected gifts and much aggravation over those years.

My systemic JIA has taken a toll on my body over the years, including total hip and knee replacements and the lifestyle modifications that eventually came as well. This toll on my physical body forced me to look at my working life and contemplate a disability pension. Though this meant defeat and that the disease was winning, it was the correct choice and a new path of arthritis advocacy began.

Volunteering for 10 years has given me unexpected gifts, a sense of control over my illness that I had not experience prior. Though I know it is only a sense, that sense makes my life a bit more colourful. I believe that this sense stem from a few sources; certainly, it comes from a greater understanding of my situation and trying to be part of the solution. Using my arthritic findings as a resource, sharing my tribulations allows for new healthcare professionals to experience first-hand what arthritis can do to a body and explain what living with it is like. These experiences are shared through Patient Partners in Arthritis. The Arthritis Research

*Burning Man.* Clay, stain, glaze.

Close up of ***An Angry Joint.*** Clay, stain, glaze.



***An Angry Joint.*** Clay, stain, glaze.

Centre (ARC) of Canada has given me the opportunity to be part of their research process as a consumer (patient) collaborator, where I have contributed to the creation of an abstract, dissemination of research materials, and worked as an advocate speaker.

Retirement from the working world permitted time to explore an old hobby I enjoyed as a child and young adult, namely visual art. Over the same 10-year period of arthritis volunteerism, I was honing my skills as a ceramic sculptor. I decided that I would let these two worlds collide and created a 16 piece solo show called "Shards, Bone Deep". This body of work (pun intended) explores the many different relationships with my arthritis.

A final wish of mine is to have my installation displayed at the many medical training universities across Canada. The hope is to catch people off guard with the rawness of my work and create a lasting impression on those who study chronic rheumatic illness.

***Postshock of Diagnosis.*** Clay, stain, glaze.

***Fog of Fatigue.*** Clay, stain, glaze.

***Healed.*** Clay, stain, glaze.

***A Glimmer of Hope.*** Clay, stain, glaze.

Suggested Readings

1. Anita C. Otto Kamensek's "Arthritis Still Life" shines a glimpse of hope. Available at: *www.arthritisbroadcastnetwork.org/2014/05/otto-kamensek-arthritis-still-life-shines-a-glimpse-of-hope/*.
2. Maloney C. Art and Arthritis: Shards, Bone Deep. Available at: *www.arthritisresearch.ca/newsletter-art-and-arthritis*.
3. Warren J. Four decades of chronic pain. Available at: *www.tricitynews.com/entertainment/257024131.html*.

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## CRA: CALL FOR ABSTRACTS

You are invited to submit abstracts for presentation during the 2015 CRA Annual Scientific Meeting and AHPA Annual Meeting!

Deadline for submissions is Monday, October 20th. Details are available at *www.rheum.ca or www.owpm.net/abstracts/CRA/*.

# Arthritis, Art, and Motherhood: Hand in Hand

By Linda Del Fabro Smith, MSc, BSc(OT)

As an occupational therapist, I was curious to know the impact on motherhood activities was when arthritis was in the picture. As part of my MSc research and thesis requirements, I undertook a narrative study involving artwork, along with other data collection, from eight women with arthritis. Through interviews, observations, and looking at family photos I constructed narratives of each woman's experience using as much as their language and tone as possible. Each woman interviewed had a number of stories; these were compared and used to build a meta-story. Another methodology in this narrative study was to ask the study participants, none of whom have artistic training, to paint a simple picture in response to the question, "What are the most important things about being a mother?" Not surprisingly, the artwork supported the meta-story: **"Just because I can't do doesn't mean I'm not a mom"**. The paintings also echoed each woman's smaller narratives. I was surprised that firmly claiming "mother" as an identity enabled these women to remain not only strong and positive, despite chronic disability, but also provided a way for them to prosper in their daily lives during motherhood activities. The occupational identity, in some ways, rose above the effects of arthritis. Here are but a few of their paintings and the accompanying descriptions.

"Well, in the four corners there are four circles of color. The light pink represents B, my eight-month-old daughter; the light blue represents M, my ten-year-old daughter, the darker blue represents me, and the green represents my husband. So there is kind of a swirl that's meant to be my day: the beginning of my day starts with a long period of peace. There is a red piece—red represents pain and my color is mixed in with the red. There are some yellows, and it gets brighter as the day gets busier. And then the red represents pain again. It circles, though I don't know why I chose circles; I think maybe because we are a well rounded family, we kind of all meld in together."

"The painting is supposed to be about being a mother and so I thought I would draw a painting of the family. I am not good at faces. At first when [I painted this] the hands were not touching, but we always hold hands so I wanted to show that: us all holding hands, because one thing I enjoy every day about being a mom is being able to hold hands with my kids. We like hiking and walking so I thought I would make an outside scene. As far as how it reflects on my arthritis, I am really not too sure, except that my family and my husband have always been supportive of me and helpful. This sort of shows us all together and shows how my family has helped me with that."

All photos taken by Brooke McAllister, 2014.

“I guess the tree was a good image because I feel like I am the tree of the family—I support the family, and things just wouldn’t be the same without me. The leaves on the motherhood side are a little brighter and fresher, and the ones on the arthritis side are kind of tired and dormant, because they need to go to sleep down at the bottom. I put a silver lining on the clouds on the arthritis side, because there are positive things—it’s not all bad—I am at home with my kids, and that’s a definite plus. I am less stressed. In the picture, it shows the branches being sort of tired and broken, which is what my limbs feel like. The roots are a bit stronger on the motherhood side; on the arthritis side I do not feel as stable.”

“I put in the sunshine because I always feel so good when the sun is out. The rainbow kind of looks like a slide, and I guess that is to say that sometimes things are up and sometimes things are down. I like to think that I keep myself on the curve of the rainbow, so that I am not too—you know, feeling super good or super bad but try to keep myself in the middle, I guess. And the hand is for so many things. The hand is for being a mother—I know there are people that cannot use their hands and they are mothers, and I do not know how they do it. For me, the hand is so much a key part of me and being a mother; it gives everything: it gives discipline, it gives love, it gives encouragement but also, now, the hand symbolizes the arthritis too.”

“Well, it is just the hands of my three kids and myself, basically that we are all connected, all joined I guess, with me, the mom, being the focal point and the kids are all together. My hand fits on top as sort of the basis, the grounding, the keeping them together, the anchor. Because of the arthritis, it will not let my hand go flat anymore, and that would be it, a great big hole in the middle (laughing). It would have been nicer had it had gone flat; it would have shown more connection, more anchoring and drawing in.”

*Thanks to Dr. Catherine Backman, who gently and persistently encouraged me to publish the mother’s art from my thesis work, and to Dr. Diane Lacaille for remembering the beauty in these paintings.*

Reference

1. Del Fabro Smith L, Suto M, Chalmers A, Backman CL. Belief in doing and knowledge in being mothers with arthritis. OTJR: Occupation, Participation and Health 2011; 3(1)1:40-8.

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# Tips For Getting Your Best Photographs

By Fred Doris, MD

**Backyard Photography:**

The advantages of backyard photography are plentiful and include ready accessibility, little gear, and never having to say "cheese". Aperture priority and selective focus to blur out background clutter is important here; this is likewise applicable to other photographic subjects.

- Compact cameras are almost the equal of fancy SLRs and macro lenses in closeup photography! Although getting in closer for details is advisable, occasionally a bigger picture captures the right feeling.
- Avoid the harsh midday sun. Try pictures just before sunset or within an hour or two of sunrise.
- Try a different viewpoint. Keep compositions simple to emphasize flower colour and texture.
- A little garden tidying up and a spritz from a spray bottle go a long way to help the final results.
- Although it breaks my gardening heart to say so, there are subjects in your backyard other than flowers.

**Firework Photography:**

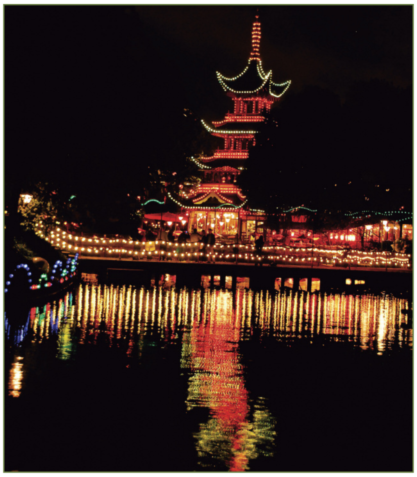
Photographing fireworks is surprisingly easy and enjoyable. You do not even have to stare through the viewfinder as you are shooting, as long as you have a cable release. A sturdy tripod is the only absolutely necessary piece of equipment. A single-lens reflex (SLR) camera works best, but most compact cameras with a few manual controls would be up for the task. To get going:

1) Location, location. Foreground interest is helpful; try to get away from or above people in front of the camera, though. Setup camera in vertical orientation on tripod.
2) Use a wide-angle lens to capture a big area of sky. You cannot move the camera during the exposure.
3) Set to shutter mode and set speed to five to eight seconds to capture rocket trails and multiple bursts. The camera will likely automatically adjust to mid-range aperture (f8-11). Use a cable release to activate shutter, or alternatively, make use of the camera's two-second self-timer. Repeatedly fire these same long duration exposures.
4) Set manual focus to infinity. Turn off auto-focus, if possible. Ensure there is no flash, of course!
5) Set ISO as low as it will go: 100-200.
6) Bring survival stuff: chair, warmer clothes, LED light (to adjust camera settings), bug spray, and company are all recommended.
7) That is it. Enjoy!

## Action Photography:

Knowing how to photograph movement lifts your pictures from the staid posed portraits, landscapes, and architectural photographs that fill our hard drives. This does not mean limiting your shooting to sporting or dancing endeavours, but it does mean becoming very familiar with your camera settings. While compact cameras can do a decent job, especially in bright sunlight, this is where SLRs and pro-photographers excel. You will not find a hummingbird frozen in flight among this amateur's photos, but here are some thoughts.

- Get to know how to set shutter speed, continuous drive mode and or sports mode, and know about autofocus.
- Give the subject space to move.
- Anticipate action and shoot in short bursts.
- Most human movement can be captured at 1/250 s or so. That hummingbird, maybe 1/2000 s.
- Aim to capture the face by shooting from a low position.



## Travel Photography:

Instructions go out the window for our travel pictures and personal taste rules. Fortunately, there are numerous subjects so that we do not arrive home with hundreds of building or beach shots. Think about a trip theme: Transportation? People? Animals? Colourful doors?

**Preparation:** Have a camera with you all the time. Digital means: keep shooting! Be ready for the moment.

**Timing:** Get out early, or stay out late.

**Location:** Finally, do you go close for detail or wide for a sweeping panorama?

# Life Around 60

By Sharon A. LeClercq, MD, FRCPC

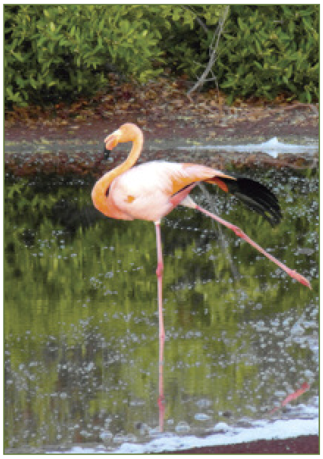
On September 14, 2013, I celebrated my 62nd birthday; only a few years left until I am eligible to collect from the Canada Pension Plan (CPP) and consider myself a senior citizen. Well, that is just not going to happen! Who could have known that from age 58 onward, I would be been having the time of my life, travelling the world, taxing my physical and mental limits, and learning to do things I have carefully avoided for many years (such as buying a bathing suit and actually getting in the ocean—in fact, in the last three years I have put my foot into four oceans).

I have travelled each year since 2009 with an old friend; Helen Ward came to Edmonton from Australia in 1978 when I was a medical resident and she lived with me while I completed my rheumatology fellowship. She was a research fellow in pulmonary medicine during this time. The fact that she went winter camping her very first year in Canada and measured the temperature in various places in her immediate environment (it was -39˚C just outside the door of her tent) tells you much about the spirit of adventure of my mate. Once we both became empty nesters, we made a bucket list and we have applied ourselves rigorously to it. The category of up to and including age 65 contained the most physically taxing places, just in case we later ran out of steam. The fact of the matter is however that the more you do, the easier it gets. We have already started to revise our "after 65 years of age" list.

Last year was very special. Helen and I spent five weeks in South America: two weeks sailing in the Galapagos Islands, one week in rubber boots in the Amazonian rain forest, and a little over two weeks hiking in Peru. I would be hard pressed to rank these places in order, as they were all unique and amazing. What follows is a photo essay along with snippets of information from each of these areas.

Graceful in the air and beautiful on land, the courtship ritual of the blue-footed booby is hilarious: male boobies dance around with their heads and tails pointing to the sky, all the while calling out to the females cruising overhead.

The solitary, beautiful, golden land iguanas (right) are found inland on several of the Galapagos islands, and their counterparts, the slothful marine iguanas (top), are found lying all over each other on the hot black lava rock of the more western islands. On islands with land iguanas, the prickly pears cactus has sharp hard prickles, but on islands without these lovely creatures, the pears have soft short hairs rather than prickles. These islands actively illustrate evolution and adaptation in action.



Up as usual by 5:30 AM, we left in our panga (speed boat), and landed by 6:00 AM on a beautiful island called Rabida Island, where we walked quietly to a brackish water lagoon. Here I captured my one and only dancing flamingo.

"Where next?", you might ask. In the summer of 2014, we plan to explore more of beautiful Western Canada, hopefully after we have both sold our houses, moved into condos free of responsibilities, and still have a few dollars left in the bank. Although we are empty nesters, we still have children on the payroll. We plan to hike in and around Lake O'Hara, into the Burgess Shale just up the mountain from Emerald Lake, and into Crypt Lake in Waterton Lakes National Park where the prairie meets the mountains. Life is short. Make sure you enjoy it.

*Sharon A. LeClercq, MD, FRCPC*
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After hiking in and around Cusco, Peru for several days and then hiking along the Urubamba river, we took the train to KM 104 and rejoined the Inca trail for the ascent to the Sacred Gate and Machu Picchu. Here I am with our guide, Joana (above right) before starting the 10 km leg of the trail, which continues up and up to a beautiful Inca site called Winay Wayna, an Inca site close to Machu Picchu that was thought to be an agricultural research station. There is a temperature gradient of five degrees between the different terraces which allowed for cultivation of plants at different temperatures to encourage adaptation (left). Winay Wayna is the Quechua word meaning forever young and is also the name of an orchid that grows in this area (above left).

Typical beautiful day in the Galapagos, with rock lava, sandy beaches, and gorgeous blue water.

(Above) On the Inca Trail, on the way to the Sacred Gate that looks down on Machu Picchu. Much of the countryside in Peru features trails and ruins all oriented with the sun and the major Inca sites. This relatively flat section is the exception. For the most part, the journey is upward, as evidenced by the second picture (right). Slow and steady will eventually get you to your goal.

Machu Picchu is an amazing place. We spent several hours roaming around the site and revisiting some of the very special places, such as the Temple of the Sun, designed and physically oriented to worship Inti, the Sun God. This spectacular round building was built over a very large rock that has a cave in its base. It is believed that this was the royal tomb of Pachacuti, the ninth Inca ruler who began the expansion of the Inca Empire far and wide.

# I Have Arthritis, but Arthritis Does Not Have Me: A Journey of Musical Achievement

By Ariel Kwan, ARCT, BSc

I grew up with the sounds of my older sister practicing the piano and violin and, to this day, our grand piano still bears the scars of the many objects I threw at it, both during tantrums and when conducting the orchestral accompaniment to the next concerto. At age 4, I began music lessons and flourished under the tutelage of wonderful teachers. I was cast in Toronto Canstage's production of Amadeus at the age of 10, opening the play with a Mozart piano sonata. In 2003 and 2004, I was invited as a presenter for Zoomer Media's ideacity Conferences. By the age of 12, I had completed The Royal Conservatory of Music's Grade 10 exams in both piano and violin, and was actively competing in competitions across Canada.

An article on my experiences and achievements as a musician, and how coping with JIA has influenced my trajectory and career aspirations.

The summer prior to entering high school found me preparing for my Associate of The Royal Conservatory (ARCT) Performer diplomas. I spent grueling three-hour practice sessions on each instrument daily, which culminated in marks of 92 and 94 in piano and violin, respectively. During this time, the joints in my hands had become swollen and painful but I dismissed the symptoms as secondary to overuse. I was also landing double-jumps in figure skating, so when my knees and hips became affected, I again attributed the symptoms to repetitive joint stress.

However, when my symptoms persisted in high school despite a reduction in practicing, I knew there was something else going on. At age 14, I was diagnosed with juvenile idiopathic arthritis (JIA). Progression in my hands not only affected my ability to play instruments, but also began interfering with my capacity to write.

My competitive music days were over; however, under the care of Dr. Carter Thorne and with the use of multi-modal therapeutics, I was able to face adversity and continue exploring my passion for music as a violinist with the Toronto Symphony Youth Orchestra. I also toured with the prestigious National Youth Orchestra of Canada for three summers until age 18, spending my final year as concertmaster. Due to unpredictable flare-ups, however, a professional music career was impractical.

I chose to pursue Health Sciences in university, a decision influenced by my diagnosis of JIA. However, I was also determined to keep music in my life. In 2013, I graduated with a BSc (Major in Medical Sciences) from Western University where I also studied violin performance. I am presently a 2017 candidate for a PharmD degree at the University of Toronto. I continue my passion for violin performance as a member of the Hart House Orchestra, as well as an occasional substitute for the Cathedral Bluffs Symphony Orchestra.

As I reflect back on that teenager who was devastated with the diagnosis of JIA, I realize that arthritis does not have me. I have arthritis. With passion, dedication, determination, and a hint of stubbornness, I have triumphed despite its barriers. I thank my family for their support and the multidisciplinary team which has provided exceptional care. My dream of music performance is still a reality.

*Ariel Kwan, ARCT, BSc*
*Toronto, Ontario*

# Rheumatology Perspectives: On Working With a Nurse

## By Jacqueline C. Stewart, BSc (Hons), B Ed, MD, FRCPC; and Michelle M. Teo, MD, FRCPC

We are fortunate to have the new billing code in British Columbia for "Multidisciplinary Care" which requires the services of a nurse at the visit. For a busy rheumatologist this has created a very positive impact enabling us to provide better service to our complex patients with inflammatory disease. I hired a nurse, Anne Scott, to work part-time with me in my inflammatory arthritis (IA) clinic initially one and then one-and-a-half days a week, which has already increased to two days a week. There is an initial training period required, but now my nurse is able to assess the patient and determine their major concerns at the visit and she is continually improving in doing joint counts. She also collects information such as morning stiffness, patient global assessment (PtGA), and does a DAS28 calculation. One of the major improvements in managing complex patients, especially those on biologics, is the medication counselling provided by the nurse. For patients starting disease modifying antirheumatic drugs (DMARDs) or biologics, she discusses the side effects of the drugs and other issues such as birth control (if applicable), immunizations, and instructions for planned surgery with the patients. This gives me more time to evaluate the patients and prescribe treatment, therefore making visits more efficient. In addition, all injection training for methotrexate (MTX) and biologics is done in the clinic with the patient administering their first injection with nursing supervision. For follow-up patients, she will assess any possible side effects they may be having, as well as remind them about special issues and precautions with respect to their medication. Finally, the nurse oversees the completion of forms to be submitted to BC Pharmacare to obtain medication coverage, particularly for biologics, which relieves me of a large burden of paperwork. Integration of a nurse into my practice has been very successful.

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I am new graduate who took over a mature rheumatology practise in a community setting; what a steep learning curve the past year has been! As a result, my rheumatology knowledge and experience has increased immensely, but so has my awareness of the current issues related to providing care for our patients. It is no surprise to anyone, especially the wait-list patients, that there is a general shortage of rheumatologists. The ability to see new consults is also limited by the sheer number of patients with inflammatory diseases requiring life-long follow up. With an aging population who are increasingly presenting with both inflammatory and non-inflammatory disease, it is no longer efficient for the rheumatologist to be a one-person show.

I initially hired Joel, my nurse, for one day a week; he now works full time. I quickly realized that while Joel saves me time by doing patient teaching and counselling regarding DMARD medications, patients feel comfortable discussing lifestyle issues related to their arthritis with him. He covers a large range of topics—including diet, exercise, rehabilitation, complementary therapies, sleep, smoking cessation—issues that come up during the majority of follow-up visits. With the increased risk of morbidity and mortality amongst our patients, having a nurse is an added opportunity to make a positive change to modifiable risk factors.

I often hear from our patients that they appreciate our team-oriented approach to their care. Traditionally, rheumatology allied health care has been limited to physiotherapists (PTs) and occupational therapists (OTs). Involving nurses is the next logical step. I feel fortunate that I am able to incorporate a nurse into my practice, especially with my interest in rheumatology models-of-care. We look forward to exploring ways to further this role in order to continue enhancing rheumatologic care.

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# Analysis of Rheumatology Nursing Interventions in Out-patient Practice Settings

By Muxin Sun, MD; Shahin Jamal, MD, FRCPC, MSc; and Jason Kur, MD, FRCPC

**Objectives: To describe the characteristics of patients referred for nursing assessments in rheumatologist offices and types of interventions performed.**
**Methods: The electronic charts of patients seen by a rheumatology nurse between January and March 2012 in three Vancouver-based rheumatologists' offices were reviewed.**
**Results: Data was extracted on 300 patients. The most common disease referral was rheumatoid arthritis (RA), followed by connective tissue disease, ankylosing spondylitis (AS), psoriatic arthritis (PsA), and other diagnoses. In total, 895 interventions were performed. Rheumatic disease counselling, disease-modifying anti-rheumatic drug (DMARD) counselling, and general education were implemented in 277 patients. Methotrexate (MTX) and biologic subcutaneous administration and/or education were given to 81 patients. Tuberculosis (TB) skin test and immunizations were also performed on 11 and 127 patients, respectively.**
**Conclusion: Education was the most common service offered to patients referred for nursing assessment, along with immunizations and TB skin tests. Addition of rheumatology nurses provides services that are key elements of management for patients with rheumatic diseases.**

## Introduction

Rheumatic diseases hinder many aspects of a patient's life, making them highly reliant on the medical system.[1] Management of chronic rheumatic diseases now requires a multidisciplinary effort with a spectrum of health care providers and complex treatment strategies.[2-7] Most require lifelong management plans, aiming to induce remission, suppress disease activity, maintain function, and develop coping strategies.[1,8] With the advent of intravenous (IV) and subcutaneous (SC) biologics, rheumatic patients have seen enormous advancements in their disease control.[9,10] Healthcare models must be adapted to teach proper and safe administration of these newer therapies to a wide population, including the elderly or those with impaired joint mobility.

In the United States and Europe, nurses are comprehensively integrated into rheumatology clinics.[11] This model can increase the efficiency of rheumatology clinics, curtailing long wait times due to rheumatologist shortages and improving patient care.[2,12] This is especially relevant as the current management of inflammatory diseases emphasizes rapid access to specialized care to receive early targeted treatment before joint damage develops.[13]

Nursing care has been shown to have a long-term positive impact in multiple disease-related psychosocial issues, such as depression, pain, and fatigue, major features in many RA patients.[2,8,11,14-17] Satisfaction with care translates to improved patient compliance with treatment, functional ability, and well-being in chronic diseases.[18,19] Additionally, having a nurse present to provide active education and support may help avoid unnecessary consultations with the general practitioner.[11] Many of the services offered by nurses with training in rheumatology are recommended interventions by the American College of Rheumatology (ACR), British Society for Rheumatology (BSR), and European League Against Rheumatism (EULAR) in the management of rheumatic diseases.[13,20,21] These include vaccinations, monitoring for drug side effects, and TB screening. Similarly, the BSR and EULAR guidelines for RA emphasize the importance and benefit of rheumatology nursing support.[4,21] Overall, the most successful outcome for patients is achieved when the skills of physicians and nurses are combined, utilizing their expertise appropriately and in a time-efficient manner.[14]

Currently, nursing support is well established in a number of fields including diabetes, heart failure, and psychiatric care. This study will examine the scope of interventions and education performed by nurses in outpatient rheumatology practice settings following funding for access to this added service.

## Materials and Methods

Patients were identified by use of a new billing code indicating that they were seen in conjunction with a rheumatology nurse. The electronic charts of all patients who had a visit labelled as "31060" between January 1, 2012 and March 31, 2012 in three different Vancouver-based, outpatient rheumatology offices were reviewed. Patients underwent medical review with the rheumatologist first and, if deemed appropriate, were then referred to the clinic nurse for multi-disciplinary care needs. Interventions performed by the nurse were recorded in the electronic medical record (EMR). Each of the three clinics had one nurse per rheumatologist. These registered nurses have received supplemental training in rheumatology though local and national courses, as well as observerships in rheumatology practices. The goals of their training were based on professional nursing competencies set out by the ACR.

The inclusion criteria for the 31060 code are: patient must be seen by a rheumatologist; only to be used for the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires continuing management by a rheumatologist, and not to be used for uncomplicated rheumatologic disorders; patient must be seen by a registered nurse; and use once per patient every six months.

Patient variables included: date of visit, sex, age, and rheumatologic diagnosis. Disease duration and activity parameters, co-morbidities, and medications were not included. Rheumatologic diagnosis was identified using the International Classification of Diseases (ICD-9) code.

Data was extracted by the individual nurse from each office through retrospective chart review. Each intervention was recorded based on available documentation within the EMR. Data collection was not corroborated by a second extractor.

The nursing interventions for each patient visit were categorized and recorded as dichotomous variables (done/not done). There was no limit to the number of interventions per visit. Interventions performed up to two weeks before or after the nursing visit were permitted for inclusion (*e.g.*, reading a TB skin test). Nursing interventions included:

1. Education about IV biologic therapy for a first start;
2. Administration of an IV biologic;
3. Education about SC biologic therapy for first start;
4. Administration of a SC biologic;
5. Teaching patient to self-administer SC MTX for a first start;
6. Administration of SC MTX;
7. Rheumatic disease education;
8. General education regarding lifestyle modification, nutrition, weight loss strategies, pain control, dental hygiene, family planning, joint protection;
9. DMARD counselling including hydroxychloroquine, oral MTX, sulfasalazine, leflunomide, azathioprine, and mycophe-nolate mofetil;
10. Performing and reading the TB skin test;
11. General advice on immunizations and/or administration of influenza/pneumococcal vaccine;
12. Other interventions: an open field for additional nursing services performed that were not listed above.

Table 1

### Demographics & Disease Characteristics of Patients Referred for Nurse Assessment

| **Gender (n = 300)** | **No. (%)** |
|---|---|
| Female | 226 (75) |
| Male | 74 (25) |
| **Age, years, (n = 300)** | **No. (%)** |
| ≤ 30 | 33 (11) |
| 31 - 50 | 96 (32) |
| 51 - 70 | 131 (44) |
| > 70 | 40 (13) |
| **Rheumatologic diagnosis at time of referral for nurse intervention, (n=300)** | **No. (%)** |
| RA | 160 (53) |
| CTD / Lupus | 53 (17) |
| PsA | 33 (11) |
| AS | 33 (11) |
| Others diagnosis* | 21 (7) |

* Other diagnosis: Non-specific soft tissue disorders; monoclonal paraproteinemia; quadriplegia; other disorders of the synovium/joint; polymyalgia rheumatica; osteoarthritis; non-specific arthritis; arthritis associated with other disorders; mental disorder following traumatic brain injury; non-specific joint disease.

Descriptive statistics were used to calculate the frequency of each individual intervention as well as the different combinations of interventions performed.

Table 2
**Number and Type of Interventions Performed**

| | **No. (%)** |
|---|---|
| General Education | 169 (19) |
| Rheumatic disease counselling | 167 (19) |
| Other interventions | 167 (19) |
| DMARD counselling | 135 (15) |
| Immunization | 127 (14) |
| MTX SC education for first start | 48 (5) |
| MTX SC administration | 25 (3) |
| Biologic SC education for first start | 19 (2) |
| Biologic IV education for first start | 13 (1) |
| TB skin testing | 11 (1) |
| Biologic SC administration | 10 (1) |
| Biologic IV administration | 4 (0) |
| **Total interventions** | **895** |
| **Median number of interventions per patient** | **3** |

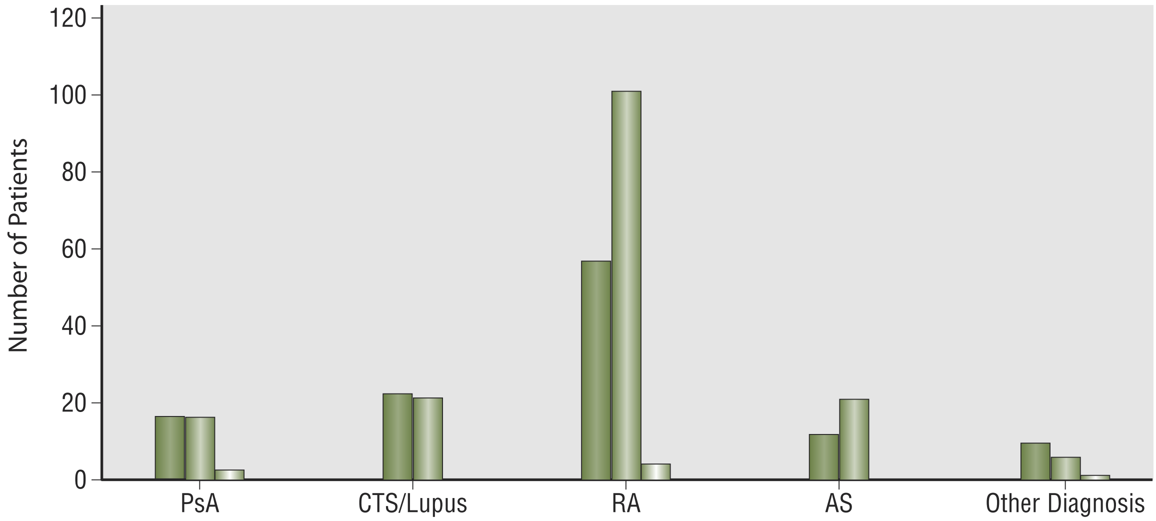
## Results

Data from 300 patients were collected from the three consultant rheumatologist offices. Demographic information is summarized in Table 1. The female to male ratio was approximately 3:1. The majority of patients were between the ages of 50 to 70, but the youngest and oldest patient to receive nursing assessment were 21 and 88 years old, respectively.

This patient sample had a total of 18 different diagnoses based on their identified ICD-9 code on referral to the nurse. The most commonly referred rheumatologic diagnosis was RA, followed by connective tissue disease (CTD)/lupus, AS, and PsA. Other diagnoses were less likely to be referred for nursing assessment (Table 1).

In total, registered nurses performed 895 interventions on the 300 patients reviewed. Table 2 lists the type as well as the number of times an intervention was recorded as being performed. The most frequent nursing interventions were general education, rheumatic disease counselling, and other interventions. In the "other interventions" category, various other duties were performed, with the most common being physician supervised drug monitoring performed on 97 patients. This was followed by a

Figure 1.
**Number of Interventions Performed Per Patient**



| | PsA | CTS/Lupus | RA | AS | Other Diagnosis |
|---|---|---|---|---|---|
| ▨ ≤ 2 | 16 | 27 | 55 | 9 | 12 |
| ▨ 3 to 6 | 16 | 26 | 103 | 24 | 8 |
| ▨ ≥ 7 | 1 | 0 | 2 | 0 | 1 |

teaching review of DMARDs or biologics for patients already on therapy.

The majority of patients had more than one intervention per visit; the highest incidence was three interventions (91 patients), followed by two interventions (78 patients), and four interventions (47 patients). The greatest number of interventions on a single visit was 10. The median number of interventions per patient was three, and was consistent across all diagnoses. Figure 1 shows the breakdown of the number of interventions per patient in accordance to their diagnosis.

Comparing the type of intervention to rheumatologic diagnosis (Table 3), there was a similar pattern of distribution across all diseases. Rheumatic disease counselling, DMARD counselling, and general education were the most often performed. The number of patients who received at least one of the above services included 29 PsA patients, 51 CTD/Lupus patients, 145 RA patients, 31 AS patients, and 21 patients with other diagnoses, for a total of 277 of 300 patients. MTX and biologic administration and/or education were given to 81 patients in this review. TB skin testing and immunization were also performed on 11 and 127 out of the 300 patients, respectively.

## Discussion

Our data indicates that patient education is a large component of services offered by nurses to rheumatology patients. This not only includes disease specific counselling and medication teaching, but also a substantial amount of non-pharmacologic education (*e.g.*, joint protection techniques, family planning), which are widely reported as being of therapeutic value.[4,5] BSR and EULAR also recommend education be offered to every patient with inflammatory arthritis.[4,21] Dedicated patient teaching and nursing consultation has been demonstrated to improve patient behaviours,[6] increase understanding about adverse drug reactions,[7,22] and results in better patient compliance.[23] Given improved adherence, patients may have better control of their disease, potentially decreasing the economic burden of illness; patient education is thus an integral part of the successful management of rheumatologic diseases.[23] More importantly, those who require SC MTX or biologics have more severe disease, and early education with optimal adherence has been shown to reduce long-term disability and hospitalizations.[1,24]

Other interventions, including drug monitoring, were performed 167 times, suggesting that there are many other nursing activities that may have added benefits beyond the pre-set options in this review. Physician-supervised medication monitoring was widely performed by nurses, potentially decreasing emergency department visits due to medication complications or disease flares.

Table 3

**Type of Intervention, By Disease Indication**

| Type Of Intervention | PsA (%) | CTD/Lupus (%) | RA (%) | AS (%) | Other Diagnosis (%) |
|---|---|---|---|---|---|
| Biologic IV education for first start | 1 (1) | 0 (0) | 9 (2) | 2 (2) | 1 (2) |
| Biologic IV administration | 1 (1) | 0 (0) | 1 (0) | 1 (1) | 1 (2) |
| Biologic SC education for first start | 3 (3) | 0 (0) | 9 (2) | 6 (6) | 1 (2) |
| Biologic SC administration | 1 (1) | 0 (0) | 7 (1) | 2 (2) | 0 (0) |
| MTX education for first start | 8 (8) | 3 (2) | 28 (6) | 3 (3) | 6 (10) |
| MTX SC administration | 4 (4) | 2 (1) | 13 (3) | 0 (0) | 6 (10) |
| Rheumatic disease counselling | 13 (14) | 34 (25) | 88 (18) | 22 (21) | 10 (17) |
| General education | 21 (22) | 22 (16) | 81 (16) | 24 (23) | 21 (35) |
| DMARD counselling | 9 (9) | 28 (21) | 85 (17) | 10 (10) | 3 (5) |
| TB skin testing | 2 (2) | 0 (0) | 5 (1) | 2 (2) | 2 (3) |
| Immunization | 16 (17) | 16 (12) | 71 (14) | 16 (15) | 8 (13) |
| Other interventions | 16 (17) | 31 (23) | 102 (20) | 17 (16) | 1 (2) |

The ACR recommends regular drug monitoring for side effects, as well as TB skin tests and scheduled vaccinations for patients with RA[13] in addition to SC and IV therapies. In our current medical system, patients require multiple visits to receive multifaceted medical care (*e.g.*, counselling, diagnostic testing, and complex medication injections). In this review, over 92% of patients (277/300) received education (regarding rheumatic diseases, DMARD counselling, non-pharmacologic therapies, or a combination of all three), 11 received TB skin tests, 127 were given immunizations, and 81 underwent non-oral immunosuppressant education and administration (related to MTX and/or biologics). Thus, without direct access to multidisciplinary nursing care, these patients would have required a combined total of 496 visits to other health care providers compared to the 300 nursing visits provided. This is an almost 40% decrease. With a single point-of-care at the office, these services can be offered in one setting, thereby helping reduce demand on the health care resources of British Columbia. A previous study also reflected these findings, with the number of doctor visits decreasing by 35% over 20 months of follow up after patient educational sessions.[25] Streamlining visits in this manner can lead to a significant reduction in health care costs.

Incorporating nursing management for rheumatologic diseases can provide rheumatologists with more time to concentrate on problematic cases or new consults, while nurses supply much needed support in teaching SC injections, TB skin tests, and vaccinations.[14] Studies demonstrate that lack of access to rheumatology services has been associated with the underuse of DMARDs and an increase in acute flares and hospitalizations.[26]

Our study has several limitations. First, we do not know the amount of time spent by the nurse with each patient. We estimate that, given such extensive education requirements in rheumatic diseases, a minimum of 30 minutes would be spent per patient; this may, however, be an underestimation in that some patients received multiple interventions. Moreover, the field of rheumatologic nursing is relatively new, with nursing roles still evolving. There are no set educational guidelines dictating outpatient rheumatology nursing practice and different nurses may vary in their delivery of patient education.

Our patient data were identified through billing codes; however, we were unable to capture data on patients who saw a nurse without a corresponding code due to billing restrictions. It is likely there were other patients seen by the rheumatology nurse where the intervention data was not captured.

Lastly, in this analysis, no disease outcome data was collected, nor did we assess patient and physician satisfaction or patient outcomes with nursing interventions. We cannot specifically quantify whether there was a change in healthcare utilization or a decrease in other healthcare visits after implementation of nursing care, as this was not measured. Comparing rates of non-adherence and complications between a nurse-involved group and a control group would be useful. As these nursing visits are a single encounter, longer-term studies with review of periodic nursing involvement and the effect on clinical outcomes would be constructive.

This study has demonstrated that a wide variety of nursing interventions were provided after the implementation of a multidisciplinary rheumatology nursing code. These assessments can provide many recommended essential therapies for rheumatic patients. We believe these services have the potential to improve comprehensive patient care, increase rheumatologist clinic efficiency, and reduce visits to other health care professionals.

*We are grateful to Dr. Kam Shojania who, in addition to the clinical authors, entered patients into the review. We are also grateful to Bonnie Leung, Patricia Patrick, and Sheryl Rosenhek, the rheumatology registered nurses involved in the data collection. Finally we are grateful for the statistical advice of Dr. Kerry Wilbur, of Qatar University.*

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# *Every Member* Campaign Draws New Recruits to Rheumatology

In 1991, The Arthritis Society (TAS) funded a research fellowship for Dr. Joanne Homik, helping kick-start the career of the current CRA Vice-President. Over the years Dr. Homik stayed involved, becoming chair of the Society's medical advisory committee and a national board member, after which she continued to help raise funds through the Walk to Fight Arthritis. Dr. Homik's support now continues through the *Every Member* campaign.

"This campaign aligns perfectly with what I desired to do all along," says Dr. Homik, a professor of medicine at the University of Alberta.

A joint project between the CRA and TAS, *Every Member* is a five-year, $2 million campaign to inspire a future generation of rheumatology clinicians and researchers. Funds donated by CRA members will join those raised by other donors to help attract top medical students to the field, boosting the capacity for care and research, and hopefully raising the number of practising rheumatologists in Canada far above the 350 where it now stands.

Dr. Gilles Boire, professor of medicine at Université de Sherbrooke, says when he first entered the field there were few effective tools to ease a patient's pain. He notes that, "now we can treat most inflammatory conditions effectively and, for diseases that once appeared hopeless, we can do much to prevent complications and improve disease manifestations." Still, Dr. Boire recognizes a major need among Canadian arthritis patients must be filled: "Three hundred and fifty rheumatologists is about half of what we need."

Dr. Boire has also pledged to the *Every Member* campaign, recalling that TAS was the first to support him as a fellow amidst a difficult period for rheumatology research. He considers the field of rheumatology very rewarding for, unlike decades ago, patients with severe inflammation and chronic pain can return to work and to a better quality of life.

"We are in a position to change people's lives profoundly," he says, adding that this message is reaching more and more medical students on the clinical side, though he cautions that the growth among researchers remains slow, itself a concern for the future of arthritis care.

Dr. Homik chose to study rheumatology after practising alongside a Winnipeg rheumatologist and witnessing the care required to address patients' problems as well as the stoicism these patients projected in the face of their disease. "It's a hands-on specialty: examining the patient, listening to their story, getting the full picture," she says. "We are still a specialty that doesn't rely on a lot of tests to find the answers."

Dr. Homik notes it is always a challenge to attract more recruits to rheumatology. At the University of Alberta, she shares her enthusiasm for the field with medical students and residents who spend time on the service. Many, she observes, are surprised to discover the full breadth of patients in the care of rheumatologists.

"I'm pleased that TAS and the CRA are interested in developing opportunities that expose students to rheumatology," Dr. Homik says. "Even if they don't become rheumatologists, the hope is they become more competent physicians in terms of assessing people with arthritis. If I can create a more informed family doctor or surgeon or cardiologist, then that benefits all people with arthritis."

For more information about the *Every Member* campaign, or to make your pledge, please contact The Arthritis Society's Kathryn De Carlo at 416-979-7228 ext. 3395, or *kdecarlo@arthritis.ca*.

The Arthritis Society

# EULAR 2014

By Philip A. Baer, MDCM, FRCPC, FACR

The weather in Paris for the European League Against Rheumatism (EULAR) 2014 meeting was no mystery as I had been watching the French Open tennis daily for two weeks before leaving. It was wonderful to see two Canadians, Eugenie Bouchard and Milos Raonic, reach the semifinals and quarterfinals respectively. I thought I was arriving early for the Wednesday start to the conference by flying out on Sunday; with a bit more foresight, I could have left earlier and perhaps seen the French Open finals live.

Six years had elapsed since the last EULAR conference in Paris in 2008, which I attended with my wife. The conference was excellent, but our lasting memory was of the entire plumbing system of the conference centre failing in the middle of the meeting. Fortunately, we had booked a small hotel within walking distance, so we were not as inconvenienced as some other attendees.

While plumbing troubles were not anticipated, the conference organizers did send an email just before I left indicating that Paris was expecting train and taxi strikes during the conference. Always nice to be forewarned, I suppose. Once again, I had reserved a hotel within a reasonable walk of the conference. For the first time that I recall, the EULAR organizers also provided complimentary bus transportation tickets between the airport and the city centre. I ended up having only a 100 metre walk from bus to hotel on arrival, and the same in reverse on departure. The taxi and train strikes occurred but posed little inconvenience.

This year's meeting was the 15th annual EULAR Congress and also marked the 40th anniversary of my first visit to Paris, the world's most visited city. Almost 14,000 scientists, physicians, allied health professionals, and patients were expected to be in attendance from 130 countries. Over the course of the congress, there were 302 oral and 1,806 poster abstract presentations, 155 sessions, 725 lectures, 33 poster tours, and 421 invited speakers. Exhausting!

Canada was well represented in both attendees and presenters. Dr. Carter Thorne presented a symposium session on the benefits of subcutaneous (SC) methotrexate (MTX) and interprofessional health care teams for patients with rheumatoid arthritis (RA). Dr. Mary-Ann Fitzcharles gave an excellent review of cannabinoids in rheumatic diseases; the 2014 Summer issue of the *CRAJ* featured a similar article. Dr. Paul Emery's closing clinical highlights session featured Canadian research on the links between systemic lupus erythematosus (SLE) and chronic obstructive pulmonary disorder (COPD),[1] and between Sjögren's and myocardial infarction (MI),[2] both from the Arthritis Research Centre of Canada (ARC). In fact, Dr. Emery's first selected paper was also Canadian, a study of factors predicting successful withdrawal of immunosuppression in SLE, from the Lupus Clinic at the University of Toronto.[3]

Smoking and its negative impact on rheumatic diseases was a topic of several EULAR presentations. Increase in RA incidence in smokers related to interaction with the shared epitope is well-known, but more evidence is accumulating on the lowered response to both disease-modifying antirheumatic drug (DMARD) and biologic therapies in smokers, and the negative cardiovascular consequences in patients who already are at high risk related to both inflammation and traditional risk factors. Data from the cleverly-named NINJA registry was typical.[4] Similar findings were reported in studies from Japan, Ontario, Denmark, and Sweden, and in disease states including RA, psoriatic arthritis (PsA), and ankylosing spondylitis (AS).[5-8] Interesting data was also presented at the "How to Treat" session on comorbidities by Dr. Will Dixon from the UK. He quoted the QUEST-RA study in which 35% of RA patients who are smokers were not told to stop smoking by their rheumatologist. Further analysis showed that rheumatologists who smoke rarely provided smoking cessation advice to their patients. Watch for an upcoming Top Ten feature in the *CRAJ* from a Canadian expert on smoking cessation.

None of this seems to have entered the wider Parisian consciousness, judging from the number of smokers I saw while out walking. Statistics from the 2012 DataBlog of *The Guardian* newspaper indicate that 35.6% of men and 27.4% of women in France were smoking any tobacco product in 2009, with 34.6% of health professionals smoking. In Canada, 23.8% of men and 16.8% of women were smoking any tobacco product in 2009. Only 6% of health professionals smoke.[9]

Speaking of vices, the other one highlighted was alcohol consumption, but not in the way one might think. At the session on "Analgesics for rheumatic diseases: re-thinking old drugs", the topic was "Association Between Alcohol Consumption And Chronic Widespread Pain (CWP)" from the MUSICIAN Study Team at the University of Aberdeen.[10] Moderate alcohol consumption, up to 35 units/week in men and 20 units/week in women, was associated with lower CWP prevalence, and strongly associated with lower levels of disability in those with CWP. A potential biological mechanism is alcohol's agonist effects on the neurotransmitter gamma-aminobutyric acid (GABA). A lot of pain-preventing behaviour was going on in Paris, by residents and EULAR attendees alike.

EULAR 2014: An electrifying experience.

I really enjoyed participating in a human Likert scale demonstration, also at Dr. Dixon's session. He asked the audience whether the cardiovascular benefit of statins outweighed the cardiovascular risks of non-steroidal anti-inflammatory drugs (NSAIDs) in patients with RA. His slide showed a semicircle with neutral at the top, greater benefit for statins to the left, and greater risk for NSAIDs to the right. To vote, we all stood up and extended our arms either straight up, to the left, or to the right to indicate our choice; think of the motions associated with the song "YMCA" by Village People. The correct answer was that NSAIDs had five times the risk compared to the benefit of statins.

Other Paris highlights: a free walking tour I took from Notre Dame to the Eiffel Tower with wegowalking.com, visiting the Pont des Arts just after a section had collapsed from the weight of padlocks left by lovers, the terrific Paris Metro system, seeing Paris so clean (attributed to the visit of Queen Elizabeth just before EULAR for the 70th anniversary of D-day), and escaping my one meeting with potential pickpockets. Trilingual pickpocket warnings were a staple of Metro travel, and the subject of electronic ads at the Palais de Congres. I encountered the petition-wielding teenagers, but not the "lost" gold ring or baby-dropping diversions which are also to be avoided.

Other EULAR highlights: Dr. Martin Boers' session on improving graphs and tables in presentations and publications. In addition, I noted a new series entitled "The Young Rheumatologist". Clearly this wasn't intended for me, but more youthful CRA members may be drawn to explore it further. Topics included basic epidemiology and immunology explained, career development, e-health, learning from exchange visits and educational research projects, funding of research, and marketing rheumatology.

EULAR 2014 was the typical blend of great science, food and wine, and tourism. Think now of joining your Canadian rheumatology colleagues at EULAR 2015 in Rome, the Eternal City, next June.

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*Editor-in-chief, CRAJ*
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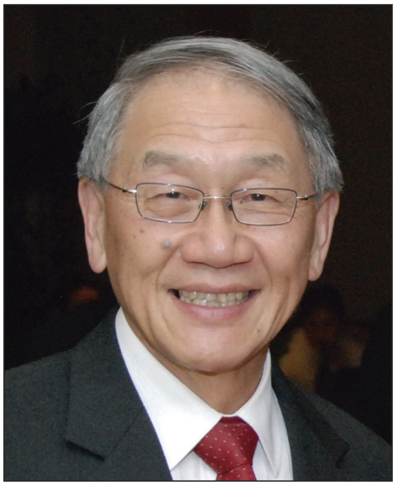
# Peter Lee

By Edward C. Keystone, MD, FRCPC



1943 - 2014

Peter Lee passed away peacefully on June 21st, 2014 at the age of 71. Peter was born in New Zealand on February 18th, 1943. He was a graduate of the University of Otago, in New Zealand, where he received his internal medicine training. He completed his rheumatology training as a research fellow at the Centre for Rheumatic Diseases and Glasgow Royal Infirmary with Dr. Watson Buchanan, and subsequently as a clinical fellow in the Rheumatic Disease Unit (RDU) at the Wellesley Hospital in Toronto. Peter joined the staff of the RDU in 1979 and moved to Mount Sinai Hospital in 1998 with the impending closure of the Wellesley Hospital.

Peter truly exemplified the excellence of an academic as a clinician, educator, and researcher. As a clinician, he was an excellent diagnostician with caring, kindness, and a generosity of spirit toward his patients that generated their enormous love and respect. The many gifts from his patients that adorned his office were a true testament to his care. Few people can point to a certificate of greetings from the Pope on their office wall, a personal gift from a grateful patient. Peter loved to interact with his patients very much on a personal level, getting to know their family, interests, hobbies, goals and aspirations.

Peter was known for his excellence in teaching, as well as his mentorship. He was clearly responsible for attracting many students into the field of rheumatology.

As a researcher, Peter had a long and distinguished academic career exemplified by his promotion to Professor of Medicine within the University of Toronto in 1995. He established the first Scleroderma Research Program in Canada at the Wellesley Hospital with a longitudinal research database of over 1,000 patients–easily the largest in Canada and one of the major centres in the world. The Scleroderma Clinic became a local, provincial, and national resource. He published some 115 peer-reviewed papers, many of which described novel features of scleroderma, including articular, neurologic, and coagulation abnormalities, as well as its association with breast cancer.

An internationally recognized expert in the field of scleroderma, Peter served as a member of the Medical Advisory Board of the Scleroderma Research Foundation (USA), as well as being a medical advisor to the Scleroderma Society of Ontario. Peter's legacy in scleroderma will live on with the appointment of the best and the brightest to direct the Scleroderma Clinic and the Scleroderma Research Program.

His many professional accomplishments include Chairman of the Rheumatology Examination Board for the Royal College, Chair of the Therapeutic Committee of the CRA, and member of the Editorial Board of the Journal of Rheumatology. He was also an active member of the Research Grants Council of Hong Kong.He made significant contributions to the Chinese medical community, serving as President of the Chinese Canadian Medical Society of Ontario and President of the Federation of Chinese Canadian Professionals.

His colleagues recognized Peter's distinguished career in 2008 with The Rheumatologist of the Year Award from the Ontario Rheumatology Association (ORA). The CRA recognized his national and international leadership in the field of scleroderma in 2013 with the Distinguished Rheumatologist Award. He also received the Ontario Volunteer Service Award from the Ministry of Citizenship and Immigration in 2012.

On a personal note, Peter has been an outstanding colleague to work with. His easy-going manner, delightful sense of humour and masterful storytelling coupled with his warmth and extremely supportive nature made him a key player in our unit. Despite his illness he never wavered in his commitment to his colleagues and patients alike. Peter was stoic and courageous without complaints throughout his cancer journey; his philosophy was to "just get on with it". Unlike many of us, Peter was able to maintain a great work-family balance, spending quality time with his family and still managing to have a reasonable golf score and a well-manicured garden.

While many of us like to be remembered for their academic accomplishments, I prefer to remember Peter as a really great guy and wonderful human being whom we were all privileged to know.

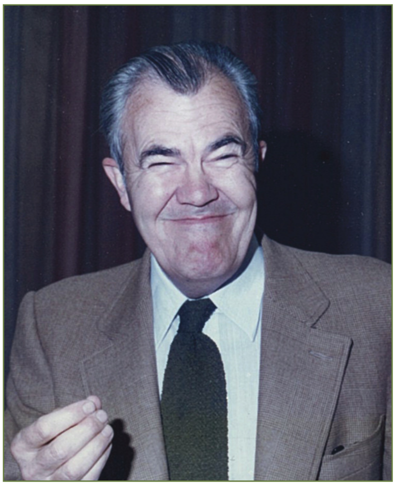
*Edward C. Keystone, MD, FRCPC*
*Professor of Medicine, University of Toronto*
*Director, The Rebecca MacDonald Centre for Arthritis and Autoimmune Disease*
*Consultant Rheumatologist, Mount Sinai Hospital*
*Toronto, Ontario*

Dr. Lee received the CRA Distinguished Rheumatologist award in 2013.

# Harold Robinson

By Andrew Chalmers, MD, FRCPC

When Harold Robinson passed away on April 13th, 2014, the Canadian rheumatology community lost an icon.



1919 - 2014

Harold graduated in Medicine from McGill and then joined the Canadian Army Medical Corps. After the war he spent time doing medical training in rheumatology in London, England. He then returned to Banff to work with his father and brother as a family physician and, with his father, treated patients with rheumatoid arthritis (RA) with gold. He moved to Vancouver in 1951 to complete his studies in internal medicine. He became Medical Director of the Canadian Arthritis and Rheumatism Society (CARS), now The Arthritis Society (TAS), in Vancouver in 1956.

There was already an experimental program for arthritis rehabilitation: three traveling physiotherapists (PT) who visited patients in their homes. Harold championed the team approach to patient care through medications, PT, occupational therapy (OT), and social work. He initiated a gold treatment program. Harold worked at a time when there were few medication options, but lived through a time when many became available.

Over 35 years he oversaw the growth of the BC Division, developing a network of physicians and OT outreach across British Columbia. This program served 24 BC communities and aboriginal reserves. The size of the program grew with centres in Vancouver, Victoria, Penticton, and Cranbook as well as in-patient beds at the GF Strong Hospital in Vancouver.

His interest and expertise became internationally known; Harold was invited to speak and write about the team approach across the world. The Vancouver program resulted in a visit from members of the U.S. congress which drew forth this comment from Harold, "My view is the performance of the rehabilitation unit operated by CARS in Vancouver is not surpassed anywhere in the world". He advocated for the development of a school of rehabilitation science at the University of British Columbia (UBC) because of a shortage of OTs and PTs.

Harold's interests were broad and he authored 42 peer-reviewed papers, many on arthritis and spondylitis in Aboriginal patients, as well as other non-rehabilitation topics. He wrote chapters, published handbooks on RA rehabilitation, and spoke at many international meetings.

When I first met him as a Fellow in 1976 I was overawed by his presence but soon got to know him as a kind, considerate, thoughtful man. He was always posing questions; one I will never forget was, "Why when RA affects the right first metacarpophalangeal joint does it affect the left? Explain the symmetry and there is a Nobel Prize".

At Christmas every year the staff of the Arthritis Centre put on a concert and every department presented their own piece. The doctors were invited to the Robinsons (Harold was a talented pianist and organist and his wife, Jean, a singer) to practice their program and all its shenanigans with piano accompaniment.

Harold was highly committed as a physician, educator, program director, collaborator, and scholar, quiet and unassuming.

He was recognized by his country with The Order of Canada and the Queen's Silver, Gold, and Diamond Jubilee Medals, and by his colleagues as a Master of the American College of Rheumatology (ACR). At UBC, Harold was made Professor Emeritus at and had a Chair developed, The Harold Robinson Chair in Rehabilitation Science.

*Andrew Chalmers, MD, FRCPC*
*Professor of Medicine and Rheumatology,*
*University of British Columbia (UBC)*
*Vancouver, British Columbia*

# RA Guidelines: Practice Patterns of Rheumatologists in Canada Compared to the CRA Recommendations for RA (Part VI)

By Sankalp V. 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 sixth and final instalment, we present the results of survey questions pertaining to malignancy.

1. A patient with rheumatoid arthritis (RA) maintained on etanercept and methotrexate (MTX) now has newly diagnosed lung cancer and will be starting radiation and chemotherapy. Regarding etanercept, you would suggest:

Answer: Stop etanercept.

Recommendation/supporting evidence: Not applicable. Consensus recommendation.

No identified evidence addressed the use of traditional or biologic disease-modifying antirheumatic drugs (DMARDs) in RA patients with active malignancy. The CRA recommendation is that, in general, RA patients with active malignancy should have their treatment with traditional and biologic DMARD delayed or withheld while they are receiving chemotherapy or radiotherapy. Treatment decisions should be made on a case-by-case basis in conjunction with a cancer specialist and the patient.

2. A patient with RA has a history of lymphoma. You would consider all of the following therapies in this patient except:

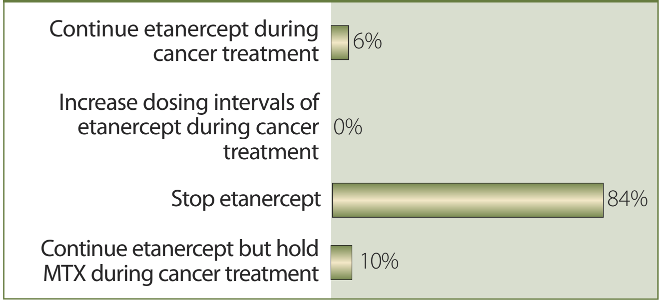
Answer: Infliximab.

Recommendation/supporting evidence: Not applicable. Consensus recommendation.

***MTX/DMARD:*** One nested case-control study examined the risk of incident lymphoma (not recurrence) in RA patients treated with MTX compared to RA patients treated with other DMARDs and reported a small but not statistically significant increased risk associated with MTX (RR 1.23, 95% CI 0.97–1.57). In that study, no increased risk of lymphoma was associated with use of leflunomide, sulfasalazine, antimalarials, or gold. Four studies examined risks of lymphoproliferative disease in patients with RA treated with MTX and/or other DMARDs relative to the general population; all showed an increased risk (non-Hodgkin's lymphoma: standardized incidence ratio [SIR] = 5.1, 95% CI 2.2–10, SIR = 5.4, 95% CI 1.1–15.7; any lymphoproliferative disease: SIR = 3.8, 95% CI 2.2–6.2; lymphoma: SIR = 1.7, 95% CI 0.9–3.2).

***Biologics:*** A Cochrane network meta-analysis of randomized trials examining the safety of biologic therapy (excluding tocilizumab) did not observe an increased risk of lymphoma associated with any biologic therapy (OR 0.53, 95% CI 0.17–1.66), although data were limited to very few events. Similarly, four observational studies compared the risk of lymphoma in RA patients treated with anti-tumor necrosis factor (TNF) therapy relative to RA patients who were biologic-naïve; none showed an increased risk associated with anti-TNF therapy, although small numbers

Table 1. **A patient with RA maintained on etanercept and MTX now has newly diagnosed lung cancer and will be starting radiation and chemotherapy. Regarding etanercept, you would suggest:**



of malignancies and lack of precision around this study estimates precluded definitive conclusions (RR 1.4, 95% CI 0.8–2.1; HR 1.1, 95% CI 0.5–2.4; OR 1.0, 95% CI 0.6–1.8; and HR 5.0, 95% CI 0.9–27.9). Eight studies reported an increased risk of lymphoma in RA patients treated with anti-TNF compared to the general population, among which one study reported a higher risk associated with adalimumab or infliximab relative to etanercept (adalimumab: OR 4.7, 95% CI 1.3–17.7; infliximab: OR 4.1, 95% CI 1.4–12.5). In an open-label extension of a randomized, controlled trial, no increased risk of lymphoma was observed in RA patients treated with abatacept relative to RA patients treated with traditional DMARDs.

The CRA recommendation is that hydroxychloroquine, sulfasalazine, and rituximab may be used in RA patients with a history of lymphoma. Treatment with anti-TNF therapy is not recommended, and treatment with other traditional and biologic DMARD should be used with caution.

3. A patient with RA was previously treated for colorectal cancer and has been cancer-free for 11 years. Which of the following are possible treatment options in this patient?

Answer: All of the above.

Recommendation/supporting evidence: Not applicable. Consensus recommendation.

***MTX/DMARD:*** Treatment with specific traditional DMARDs was not associated with statistically significant increased risk of lung cancer in a nested case-control study within an administrative claims database. Two studies reported an increased risk of lung cancer in RA patients treated with MTX relative to the general population (SIR 2.9, 95% CI 1.6–4.8; and SIR 3.5, 95% CI 1.4–7.1), one of which also reported an increased risk of melanoma (SIR 3.0, 95% CI 1.2–6.2).

***Biologics:*** RA patients treated with anti-TNF agents were not at increased risk for solid tumors relative to RA patients treated with traditional DMARD in four studies, although one study found an increased risk of melanoma associated with infliximab (OR 2.6, 95% CI 1.0–6.7) and etanercept (OR 2.4, 95% CI 1.0–5.8). Treatment with anti-TNF therapy was not associated with an increased risk for solid tumors relative to the general population in three studies; however, in an analysis of specific types of solid malignancies, one study reported an increased risk of lung cancer and a separate study reported a non-significant trend toward an increased risk for smoking-related cancers (SIR 2.2, 95% CI 0.7–5.1). An increased risk of smoking-related cancers and a decreased risk of breast cancer have also been reported in RA patients not receiving anti-TNF therapy relative to the general population. Abatacept was not associated with an increased risk of solid tumors relative to RA patients receiving traditional DMARDs or the general population in an open-label extension study.

The CRA recommendation is that, in RA patients with a history of solid malignancy, traditional DMARDs may be used. Treatment with biologic DMARDs should be used with caution.

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*. The previous installations of these Guidelines can be viewed at *craj.ca*.

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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*

Table 2. **A patient with rheumatoid arthritis has a history of lymphoma. You would consider all of the following therapies in this patient except:**

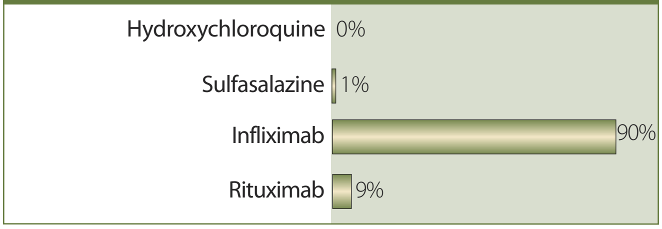
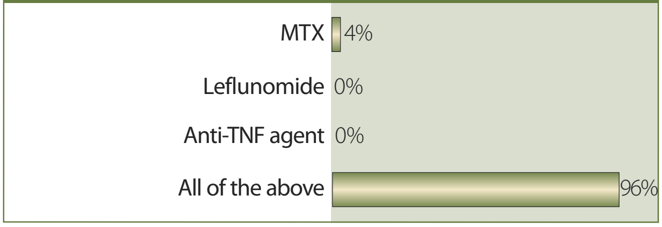


Table 3. **A patient with rheumatoid arthritis was previously treated for colorectal cancer and has been cancer-free for 11 years. Which of the following are possible treatment options in this patient?**



# News of the North

### By Dale Sholter, MD, FRCPC

When asked to take over Dr. Sharon LeClercq's Yellowknife clinics in 1997 I knew I would have big shoes to fill. Sharon had been serving the Northwest Territories and western Nunavut for nine years, and I was finishing my rheumatology fellowship at the University of Alberta with plans to join Dr. LeClercq, Dr. Avril Fitzgerald and Dr. Alexander Yan in community practice in Edmonton. With some trepidation, I said yes!

I finished my fellowship at the end of June that year and flew up to Yellowknife a week later. Dr. John Morse, a general internist/gastroenterologist, and Dot Bergman, the clinic manager, offered a warm welcome. The first evening I wore a tie to dinner, but quickly realized I was vastly overdressed. We went to Bullocks' Bistro, a charming place that serves fresh, locally caught fish. Dinner was fantastic. We were seated on the patio – but oh, the mosquitoes! One of the servers took care of that, liberally spraying us with bug spray as she zipped from table to table.

Bullocks' Bistro, home of the man-eating mosquitoes.

Walking over the Canadian Shield to the hospital.

It seemed I saw more patients during those four days of clinic than I had in my entire fellowship! And how come nothing followed the textbooks? The pathology was unbelievable. I continue to be amazed at what I see considering the entire population is fewer than 50,000 people. My patients are warm and genuinely appreciate being seen; over 50% of the population is Aboriginal, representing a wide variety of groups from Dogrib to Inuvialuit.

Currently I do a busy four-day clinic in Yellowknife four times per year. Usually once or twice per year one of our rheumatology trainees from the University of Alberta joins me. Patients are flown in from various communities including Inuvik, Cambridge Bay, Fort Smith, and Hay River. The nurses, occupational therapists (OTs), and physiotherapists (PTs) are a great bunch to work with and I'm fortunate to often have an OT or PT in clinic with me. I am currently exploring alternative models of care delivery in order to improve quality and accessibility.

I feel privileged to have been given the opportunity to be a part of providing care to Northern peoples now for 17 years.

Atop Pilots Monument overlooking the houseboats on Great Slave Lake.

*Dale Sholter, MD, FRCPC*
*Associate Clinical Professor, Division of Rheumatology*
*University of Alberta*
*Edmonton, Alberta*

WHEN IT COMES TO
HOW I RECEIVE MY RA TREATMENT
I WANT WHAT SUITS
ME