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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on:
CRA Committee & Regional Association Reports

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I have rheumatoid arthritis. But I didn't want that to stop me from having a busy life.

When it comes to choosing an RA treatment, it's true that everyone's different. Some prefer a subcutaneous treatment, while others may find an I.V. medication a suitable choice.

As a shift worker, I looked at my schedule and discussed it with my doctor before choosing a treatment option. It was good to know that I had options – and to talk about them – before choosing a therapy.

– **Jim, Fork Lift Operator***
Has had RA for 5 years; currently on I.V. medication.

* Based on a real patient. May not be representative of all patients.

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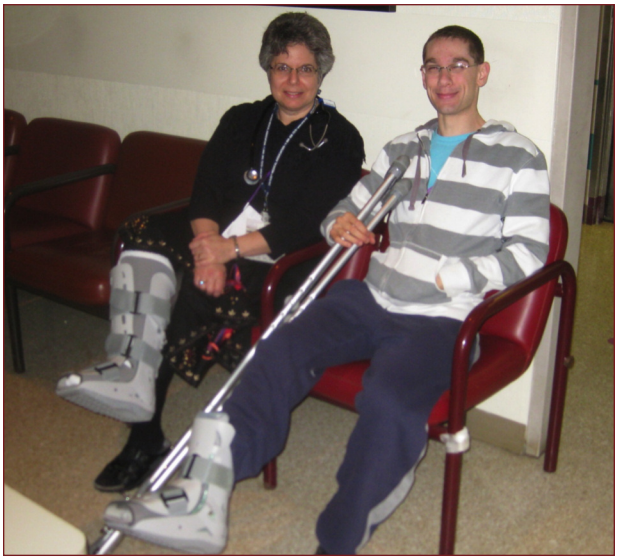
Holiday Ups and Downs

By Philip A. Baer, MDCM, FRCPC, FACR

A lovely thing about Christmas is that it's compulsory, like a thunderstorm, and we all go through it together.
- Garrison Keillor

The time has come to close the books on another year of highs and lows, work and play, remissions and exacerbations, and any other pairing of extremes you care to mention.

The holiday season is meant to be a time of celebration and reunions with family and friends. However, the real world frequently intrudes. In the prototypical Christmas film, "It's a Wonderful Life", the protagonist George Bailey is not in the mood for partying. Rather, he has to be persuaded not to kill himself and not to view his life as a failure, due to the impact of the Great Depression on his life and his town.



Comrades in feet: Dr. Erica Weinberg and Aaron Baer, JD.

I am hoping for a calm peaceful holiday season this year, but that has not always been in the cards in recent years. I remember December 2009 vividly. My wife Erica had just undergone orthopedic surgery, and was in a walking boot. Our son Aaron called us just before Christmas to tell us he had a broken 5th metatarsal (Jones fracture). Apparently these occur with minimal or no trauma in younger people. He was living in London, Ontario at the time, studying at Western University. With the holidays, his roommates away, and a painful foot, he found it hard to manage. I recall driving in the middle of the night from Toronto to London, picking him up from the local emergency room, packing up some supplies, and bringing him home to stay with us. Finding orthopedic follow-up care between Christmas and New Year's is not easy, but we squeezed him in at the Fracture Clinic where Erica already had an appointment.

Christmas 2013 put the shoe on the other foot, though this time no casts or crutches were involved. The ice storm that struck Ontario left us in the dark December 22nd. Living in a 12th floor condominium, we eventually ended up without light, heat, water, and power when our building's backup diesel generator ran out of fuel. Seeing buildings right across the street from us have their power restored days before us did not help the mood, nor did walking up and down 12 flights of stairs with a flashlight as the only illumination. I was almost happy to be working right up until Christmas Eve, as my office had power and provided a place to recharge all our electronics, shave, and brew something warm to drink.

On Christmas Eve, faced with the prospect of ongoing power and water disruptions, we decided to move in with Aaron, by now living in a downtown Toronto condo that had been bypassed by the ice storm. We started a new holiday tradition by enjoying Christmas dinner at a Vietnamese restaurant in Toronto's Chinatown. Hot food tasted even better after three days of eating whatever food we had salvaged from our fridge and freezer and stored outside on our balcony. Aaron was a great host. Within a few hours, we found out our power was restored at home—the best present in recent memory!

My hope for this holiday season: Good food, good company, and no power failures. Enjoy!

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Editor-in-chief, CRAJ
Scarborough, Ontario

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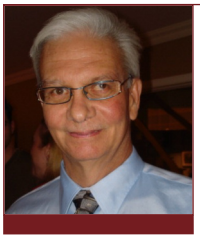
AWARDS, APPOINTMENTS, ACCOLADES

Dr. Claire Barber was the recent recipient of a Vanier Canada Graduate Scholarship. This prestigious graduate scholarship supports her PhD thesis work, which focuses on the development and testing of cardiovascular quality indicators for rheumatoid arthritis (RA). She has developed a set of 11 cardiovascular quality indicators through a rigorous process that involved an international panel of clinicians, researchers, and patients who participated in an online panel discussion and modified-Delphi procedure using a platform called ExpertLens (conducted in collaboration with the RAND Corporation). The indicators are presently being tested and will inform the development of an intervention to improve the quality of cardiovascular screening for patients with RA.

Dr. Barber is a Clinical Assistant Professor in the Department of Medicine, Division of Rheumatology, at the University of Calgary. Her research is also supported by Alberta Innovates Health Solutions.



Dr. Mark Hazeltine is a rheumatologist, clinical instructor at the Université de Montréal, and Director of the Centre de Rhumatologie de Laval. He was Chief of Rheumatology at Saint-Luc and Cité de la Santé de Laval hospitals, as well as Chief of Specialized Medicine at the latter. Continuing medical education is his greatest passion. He is the author of the *Guide pratique de rhumatologie*.

On May 9th, 2014, Dr. Hazeltine was honoured with the Marie-Thérèse Fortin Prize, an award presented annually at the Laurentian Conference of Rheumatology to a rheumatologist in recognition of his or her professional and human qualities. Dr. Hazeltine is the founder of the Programme d'Accès Rapide Lavallois en Rhumatologie (PARLER), which provides multidisciplinary priority care to patients with various inflammatory conditions. Thanks to this initiative, many of these patients have experienced major improvements in their quality of life and are now able to lead active lives. In awarding Dr. Hazeltine the Marie-Thérèse Fortin Prize, the Laurentian Conference recognized the value of this program.

AWARDS, APPOINTMENTS, AND ACCOLADES

The Journal of the Canadian Rheumatology Association (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.

WELCOME TO THE RHEUM

The CRA would like to welcome the following new members:

Ali Akram, Ajax, ON
Hafsah Al-Azem, Ottawa, ON
Hugues Allard-Chamard, Sherbrooke, QC
Neda Amiri, Vancouver, BC
Deepti Chopra, Kingston, ON
Julie Couture, Montréal, QC
Anita Dhanrajani, Vancouver, BC
Sehriban Diab, Ancaster, ON
Angela George, Hamilton, ON
Kerstin Gerhold, Winnipeg, MB
Jess Heyland, Edmonton, AB
Mehul Jariwala, Toronto, ON
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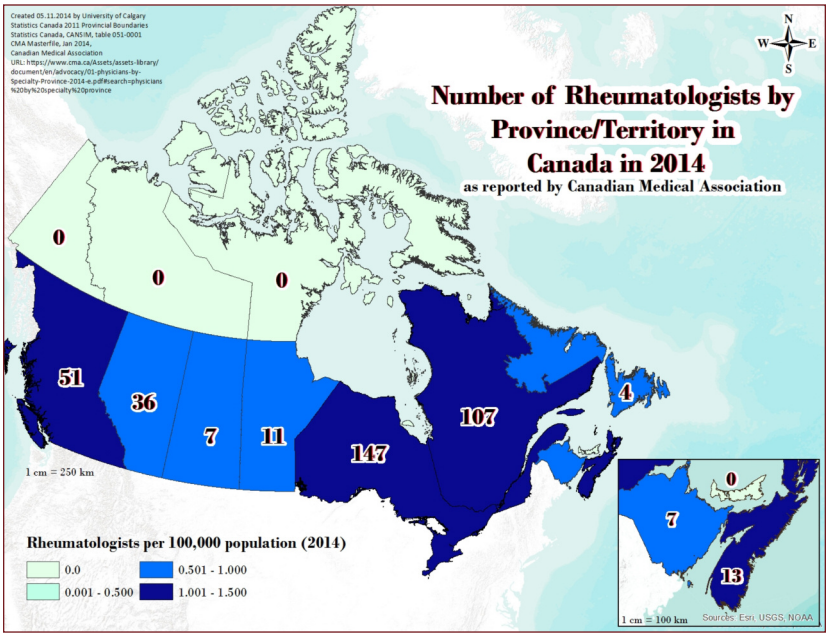
Jacqueline Malette, London, ON
Patrick Nguyen, Quebec City, QC
Krista Rostom, Ottawa, ON
Ahlam Sherbeeni, Kingston, ON
Neha Srivastava, Brossard, QC
Reza Taghavi, Kingston, ON
Ola Wierzbicki, Hamilton, ON
Kristy Yap, Toronto, ON

Stand Up and Be Counted

By Claire Barber, MD, FRCPC; on behalf of Lauren Jewett, BSc; Dianne P. Mosher, MD, FRCPC; Cory Baillie, MD, FRCPC; Vandana Ahluwalia, MD, FRCPC; Carter Thorne, MD, FRCPC, FACP; Michel Zummer, MD, FRCPC; Alfred Cividino, MD, FRCPC, FACR; Henry L. Averns, MBChB, FRCP(UK), FRCPC; and Deborah Marshall, PhD

How many rheumatologists does it take…? No, this is not the beginning of a joke waiting for a punch line, but a critical capacity and workforce issue that threatens the quality of care delivered to our patients. In most regions across Canada, there remains a critical shortage of rheumatologists.[1,2] Furthermore, the distribution of rheumatologists may not align with populations in greatest need. Models of care delivery have been championed by provincial[3] and national organizations including the Arthritis Alliance of Canada (AAC);[4] and include multidisciplinary care teams, and Telehealth and travelling clinics to improve access to care delivery in rural and remote areas. But how do we measure how many rheumatologists are required per capita to plan for current and future needs of our population?



The Canadian Institutes of Health Information (CIHI) reports on the ratio of physicians per capita, however it does not report on the number of rheumatologists, only the total number of specialists.[5] In 2014 the Canadian Medical Association (CMA) counted 383 rheumatologists in Canada.[6] While this estimate provides a general idea of the supply of rheumatologists in Canada, it does not consider the time rheumatologists spend seeing patients in clinic, and says little about where they are seeing patients (as Telehealth and travelling clinics are not accounted for). Currently, the map displayed is the limit of our understanding of the distribution of rheumatologists at a national level.

The Canadian Council of Academic Rheumatologists (CCAR) is a reliable data source that counts academic rheumatologists and estimates full time equivalents (FTEs) at academic sites;[7,8] however, data on community rheumatologists are limited to those with an academic affiliation. The 2014 CCAR survey reports that there are 207 adult rheumatologists and 34 pediatric rheumatologists.[9]

Another source that can be used to estimate the number of practicing rheumatologists is administrative billing claims. Estimating the availability of care from rheumatologists is more challenging than it might appear, though, as some rheumatologists bill as internists or pediatricians instead of as adult and pediatric rheumatologists. These claims data may not accurately reflect service capacity provided.

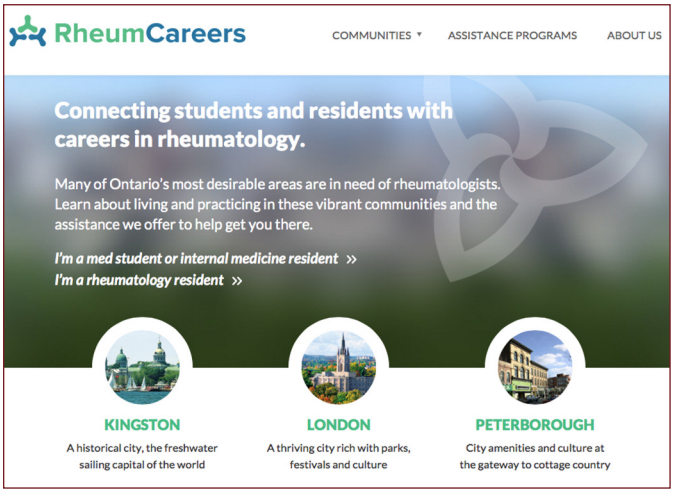
Based on the long waiting times across Canada for patients to see a rheumatologist, we need to accurately assess the capacity of rheumatology specialists and the anticipated need for care, in order to plan for the future and ensure timely and equitable access for all Canadians with arthritis. Estimating workforce capacity is a crucial element

Continued on page 11.

RheumCareers.com: An ORA Manpower Project

By Jane Purvis, MD, FRCPC

Ontario rheumatology, like many other jurisdictions in Canada, is currently underserviced. Predictions suggest that there will be insufficient rheumatologists to see all the patients with inflammatory arthritis (IA) in the coming years. In several communities, rheumatologists have ceased practice without a replacement to fill the void; other communities have seen significant growth in demand for rheumatologists without a change in the number of available physicians. The Ontario Rheumatology Association (*www.ontariorheum.ca*) is committed to finding solutions to this problem as part of a model of care that would make arthritis care available in a timely fashion for all Ontarians. The ORA Manpower Committee, made up of rheumatologists, Arthritis Society (TAS) members, and patients, is working towards solutions both for now and for the longer term. An initial priority of the committee was the creation of a new website, called RheumCareers (*www.rheumcareers.ca*), in support of this mandate.



The purpose of the website is twofold. The first is to create increased awareness of rheumatology as a career choice for those in medical school and early years of residency. Promotional materials, including information postcards available at medical student functions, as well as other tangible reminders, facilitate the awareness mandate. The website allows medical students and early-year residents to contact program directors across the province and access further information on electives and summer student programs in which they might participate.

The website's second purpose is to allow current rheumatology residents in Ontario to view communities across the province that are looking for rheumatologists. They can obtain information about the community itself, as well as arrange opportunities to visit the region, meet the local rheumatologists, and tour with a physician recruiter. The ORA will be helping to support these residents by providing physician mentors, as well as links to practice information from the Ontario Medical Association (OMA) and the Canadian Medical Association (CMA). It is anticipated that this process will facilitate new rheumatologists setting up their practices, hopefully in communities of greatest need.

Information about our project has been made available to medical schools in Ontario, the internal medicine program directors across Ontario, the Professional Association of Residents of Ontario (PARO), HealthForceOntario, OMA, CMA, the Royal College of Physicians and Surgeons of Canada, the Ontario Medical Students Association, TAS, and the CRA.

The Manpower Committee is confident that these and other measures will be effective in attracting new trainees into rheumatology and, ultimately, allow for equitable, timely, and effective arthritis care throughout Ontario.

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

The Arthritis Patient Charter

By Dawn P. Richards, PhD

The effort to create a new Arthritis Patient Charter has been sincerely grassroots, with all Canadian arthritis stakeholders collaborating under the Canadian Arthritis Patient Alliance's (CAPA's) leadership. The landscape of arthritis and healthcare continue to change and evolve; to reflect those changes, CAPA wishes to provide patients and the community with a tool that states the rights and responsibilities of today's arthritis patients. CAPA also hopes that this updated Charter and the original Canadian Arthritis Patient Bill of Rights demonstrate just how far the Canadian arthritis community has come.[1] CAPA will continue to work together with the arthritis community to enable people with arthritis to reach their full potential.

In early 2014, CAPA began conversations with the Ontario Rheumatology Association's (ORA) Models of Care Committee about potentially updating the 2001 Bill.[1] There was consensus between these two groups that, in the 13 years since the Bill's creation, there have been significant positive changes in the arthritis community. The original Bill was really an advocacy document (thus still relevant in that capacity) but required an update. This update was envisioned to: revise the rights and responsibilities to better reflect the current landscape of arthritis in Canada, create an easily-accessible format (*e.g.*, available as post-cards in healthcare providers' offices and online at CAPA's website[2]), and better reflect the condensed nature in which our world now operates.

A new draft of the Canadian Arthritis Bill of Rights, renamed the Arthritis Patient Charter, was created with initial support from the ORA, engagement of patient groups (including Arthritis Consumer Experts [ACE], the Canadian Spondylitis Association, Patient Partners in Arthritis) and individual patients, along with input and support from The Arthritis Society (TAS), the CRA, and the Arthritis Alliance of Canada (AAC). Furthermore, all of these groups sought input from their own stakeholders through an online survey that collected feedback on the draft Charter's contents. Over 730 stakeholders from across Canada responded, and their comments are incorporated in the final Charter. In just eight short months, CAPA mobilized the Canadian arthritis community to create this new Charter.

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Dawn P. Richards, PhD
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Canadian Arthritis Patient Alliance
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Arthritis Patient Charter

People with arthritis have the right to:

- **Be treated with dignity, respect and consideration.** This includes being heard by healthcare providers who respect privacy and confidentiality.
- **A timely and accurate diagnosis.** Arthritis leads to significant joint damage when left undiagnosed and untreated.
- **Timely access to all types of high-quality care.** This includes access to all qualified healthcare providers and professionals.
- **Readily available current information, education and support programs about arthritis and evidence-based arthritis care.** People living with arthritis have the **responsibility** to learn about arthritis and arthritis care.
- **Be informed and participate with their healthcare providers in all treatment decisions.** This includes discussing treatment risks and benefits and timely access to medical records. People with arthritis have a **responsibility** to live a healthy lifestyle, speak openly with their healthcare providers, ask questions about treatment and follow the agreed upon course of treatment.
- **Equal public reimbursement and timely access in all provinces and territories to available medication and non-medication treatments.** Surgery and rehabilitation therapy that improve activities of daily living and quality of life should not be considered elective.
- **Live their lives fully without discrimination.** Enjoying life to its fullest potential includes taking part in family, social activities, school and employment. This may require removal of barriers and access to disability programs.
- **See that research is underway to find a cure and improve quality of life.** Arthritis research must: be funded to an amount equal to other chronic illnesses and include people with arthritis to help set priorities, participate as research partners or in clinical trials and benefit from its discoveries.
- **Be included in the development of health policies and programs that affect them.** The voices of people living with arthritis must be considered to develop the most relevant and meaningful policies and programs.

This charter can be found online at:
http://arthritispatient.ca/projects/arthritis-patient-charter/

Make the First Break the Last! Fracture Liaison Services (FLS)

By Diane Theriault, MD, FRCPC, CCD

The Problem

After they break a bone, fewer than 20% of fragility fracture patients ever receive the bone mineral density (BMD) evaluation and/or treatment they require for their underlying osteoporosis. Countless Canadians go on to suffer debilitating repeat fractures because of this huge care gap.

Fractures Are Common

One in three women and one in five men will suffer a fracture during their lifetime. The overwhelming majority of these fractures are due to osteoporosis (Figure 1).

Fractures Beget Fractures

- 14% of wrist fracture patients will suffer another fracture within three years.
- 20% of vertebral fracture patients will suffer another vertebral fracture within one year.
- 9% of hip fracture patients will break the other hip within one year.
- Of patients with hip fractures, half have "warned" physicians in advance that they were at high risk when they suffered a prior "signal" fracture.
- Many secondary fractures can be avoided with effective drug treatment.

The Cost-effective Solution: FLS

FLS is a systematic approach that ensures that all patients who present with a "signal" fracture receive the osteoporosis care they need to prevent future fragility fractures. Support for FLS is growing around the world, and while Canada is seen as an innovative leader, there is a long way to go. Most Canadian hospitals do not have an FLS—indeed, most provinces do not have any FLS!

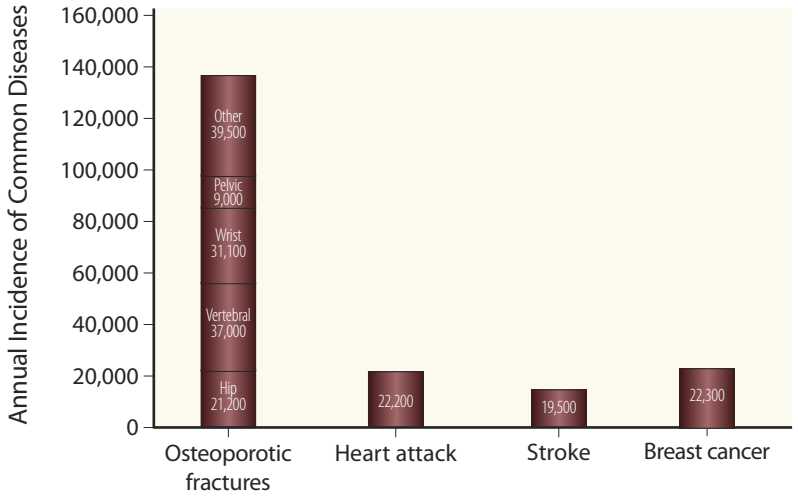
How Does It Work?

A dedicated FLS coordinator (usually a nurse or nurse practitioner) intervenes immediately after a first fragility fracture to ensure that all fracture patients have a comprehensive fracture risk-assessment, and then receive treatment as warranted to prevent the next fracture. The steps in the process are:

- Identification: all men and women over 50 years of age who present with fragility fractures will be assessed for risk factors for osteoporosis and future fractures.
- Investigation: as per the 2010 Osteoporosis Canada Guidelines, those at risk will undergo BMD testing.
- Initiation: where appropriate, osteoporosis treatment will be initiated.

Under this "3-i" model, the dedicated FLS staff coordinate the patient's care, working within the protocols of the institution and under the direction of a physician with expertise in osteoporosis.

Figure 1. **Incidence of Osteoporotic Fracture, Heart Attack, Stroke, and Breast Cancer in Canadian Women**



What Does Success Look Like?

The FLS model of care has been shown within Canada and many other countries to eliminate the post-fracture osteoporosis care gap, reducing the incidence of repeat fractures, reducing mortality, and resulting in significant cost savings. When formal cost–effectiveness analyses are done, even when considering all costs (including additional BMD tests performed and additional osteoporosis medications prescribed), the 3-i FLS model is consistently proven to be the most cost effective.

What You Can Do To Help

Rheumatologists can become engaged and respected as local champions for FLS. Implementing an FLS from scratch is not an easy task. For this reason, Osteoporosis Canada has developed an FLS Toolkit to facilitate matters. This Toolkit contains comprehensive background information on FLS including province-specific information and templates for various documents (algorithms, job descriptions, form letters to primary care providers, etc.) which can be downloaded and adapted to fit the needs of individual institutions.

Make the First Break the Last! by joining the campaign to improve osteoporosis care for fragility fracture patients in your community. More information, resources, and practical guidance on the implementation of FLS can be found at *www.osteoporosis.ca/fracture-liaison-service*. Join Osteoporosis Canada's FLS Network (for free!) and you will receive regular updates and invitations to webinars on topics related to FLS and post-fracture care. You can also contact me at *dtheriault@osteoporosis.ca*.

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Continued from page 6.

to inform models-of-care and address long wait times. Consequently, a measure of the number of rheumatologists per capita has been included in a set of six performance measures for model-of-care evaluation by the AAC.[10] This measure is of critical importance to the CRA and provincial organizations when addressing workforce capacity issues based on accurate evidence; it is also of interest to trainees looking for jobs.

We are asking for your support in mapping current service demands and capacity in rheumatology to inform resource planning for the future. To do this we need accurate information about the services rheumatologists provide and where we provide them. Over the next year we will evaluate methodologies to examine workforce capacity in rheumatology and start measuring and mapping rheumatologists in Canada.

Will you join us by standing up to be counted?

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on behalf of Lauren Jewett, BSc; Dianne P. Mosher, MD, FRCPC; Cory Baillie, MD, FRCPC; Vandana Ahluwalia, MD, FRCPC; Carter Thorne, MD, FRCPC, FACP; Michel Zummer, MD, FRCPC; Alfred Cividino, MD, FRCPC; Henry L. Averns, MBChB, FRCP(UK), FRCPC; and Deborah Marshall, PhD

Current Gout Management Practices By Primary-care Physicians in Canada

By Gregory Choy, MD, FRCP; Niloofer Baria, MD, CCFP; Alan Bell, MD, CCFP; Lydia Hatcher, MD, CCFP, FCFP, CHE, CAPM; Denise Sequeira, MD; and Daniel Gagnon, MD

Background

Gout affects nearly 3% of adults in Canada.[1,2] Several studies have revealed that patients with serum uric acid (SUA) levels lower than 360 µmol/L showed improved outcomes, including reductions in the frequency of attacks,[3,4] reductions in tophus area,[5,6] and depletion of urate crystal stores in synovial fluid.[5,7,8] Prophylactic anti-inflammatory agents should be prescribed with the initiation of chronic urate-lowering therapy (ULT) to avoid or to reduce the risk of mobilization flares.[6] Inadequate control of hyperuricemia in gout may have a significant economic impact in society due to both direct medical costs and indirect costs.[9-11]

Gout is managed mostly by primary care physicians.[12,13] The European League Against Rheumatism (EULAR) had developed evidence-based recommendations for the management of gout prior to our study being undertaken.[6,14-17] As the new American College of Rheumatology (ACR) 2012 guidelines were published after this study was completed, they were not taken into consideration in this study.

This chart audit program was designed to monitor how gout has recently been managed within Canadian primary-care settings and to identify any care gaps.

Method

This program consisted of a Canada-wide retrospective multicentre observational clinical chart review on gout. Between September 2011 and January 2012, 500 outpatients with gout attending primary care clinics were profiled. General practitioners/family physicians (n = 72) were each asked to complete 10 case report forms based on the first 10 consecutive patients who visited their office, had documented gout, and satisfied the selection criteria requirements. Inclusion criteria included patients above 18 years of age (both male and female) with a history of gout for at least one year. Patients undergoing cancer therapy were excluded. Each physician completed a structured case-report form questionnaire online. The report form questionnaire included patient demographics, burden of illness (SUA levels, number of flares, and symptoms), comorbidities, and treatment. Participating physicians were initially asked to recall the target SUA level prior to initiating ULT treatment. All patients profiled were asked to provide their informed patient consent. This study has been reviewed and approved by Institutional Review Board Services (IRB Services). Current gout treatment practices were benchmarked with EULAR guidelines for the management of gout. Data was collected using a standardized data abstraction form, and was analysed and compared using confidence intervals (CI) and Student's unpaired 2-tailed *t*-test.

Participant Demographics and Patient Baseline Characteristics

Overall, 72 family physicians were recruited across Canada and 500 patient profiles were completed. The main sociodemographic and medical characteristics of the study cohort are presented in Tables 1 and 2, and Figure 1. Approximately 85% of patients were male and the average age was 64 years old, with a male-to-female ratio of 6:1. The proportion of patients diagnosed with chronic gout was nearly the same across Canada (58%). On average, patients

Table 1
General Demographics

	West	Ontario	Quebec	East	Total
Physicians (n)	24	26	15	7	72
Patient profiles (n)	173	160	115	52	500

Table 2
General Demographics

	Male	Female
Gender of patients (%)	85	15
Average age (years)	63	69

had their SUA levels measured twice a year since initiation of their current therapy and experienced one flare in the previous 12 months. Approximately 75% of chronic gout patients in this cohort received ULT. The vast majority of patients (61%) were receiving allopurinol, with 11% receiving febuxostat. Nearly 60% of gout patients were taking anti-inflammatory medications over an average period of eight weeks.

Standard Target SUA Levels

Approximately two-thirds of the physicians surveyed across Canada claimed to have a standard therapeutic SUA target. However, only 38% of the respondents were treating gout patients to an optimal SUA target (SUA level < 360 µmol/L). Nearly 45% of the physicians were treating gout patients suboptimally or were not aware of a therapeutic target.

Physicians treating to an optimal target tend to have an increased number of patients with fewer than three flares in the last year (43%), compared to those (56%) who are not treating to target. The average SUA measurement was significantly lower in patients who had experienced fewer than three flares in the previous 12 months (378 µmol/L compared to 467 µmol/L, $p \leq 0.004$). Overall, these results showed that patients with non-target SUA levels were 56% more likely to flare than those at target.

Triggers for Initiating ULT

In the current study, several factors motivated family physicians to initiate ULT therapy for gout patients (Figure 2), with increasing number of flares over past year being the most common.

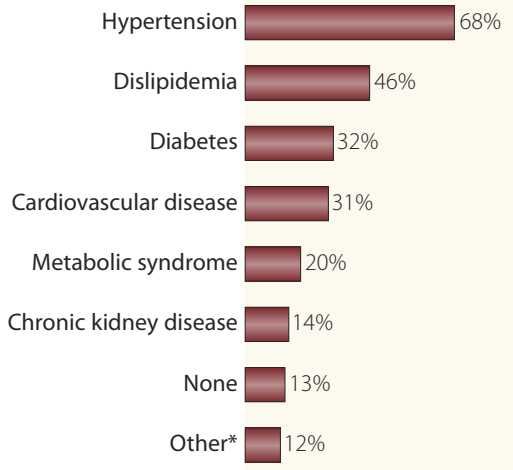
Duration of Anti-inflammatory Prophylaxis in Conjunction With ULT

Patients treated to an optimal target were more likely to be prescribed anti-inflammatory prophylaxis (64%) relative to patients suboptimally treated (54%). Physicians prescribed anti-inflammatory prophylaxis to patients on ULT for an average period of eight weeks, which is below the guideline duration (six months) recommended by the EULAR task force.

Discussion

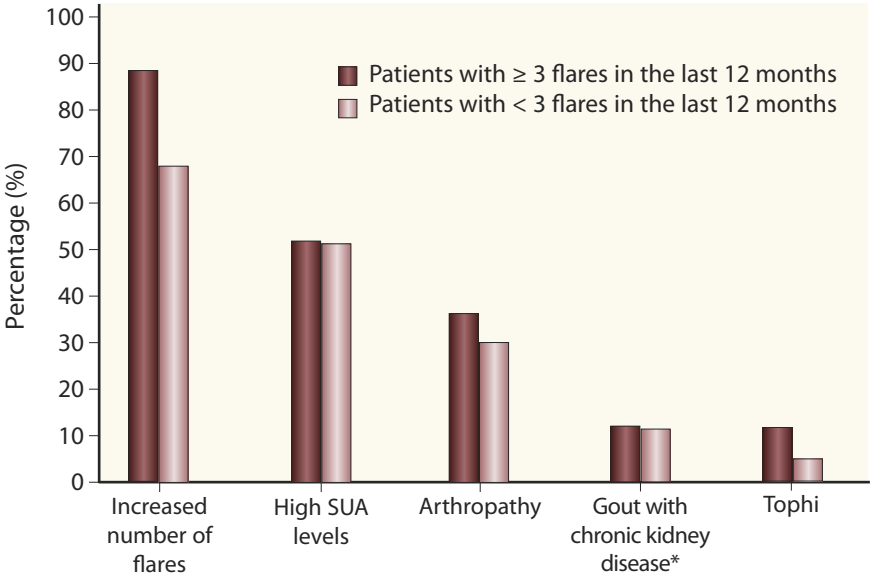
To our knowledge, this chart audit program is the first study conducted in Canada undertaken to examine practice patterns in the management of gout, as well as

Figure 1. **Incidence of Comorbidity in Patients With Gout**



*Includes alcoholism, chronic obstructive pulmonary disease, hypothyroidism, osteoarthritis, asthma, gastroesophageal reflux disease, obesity, arthritis, benign prostatic hyperplasia, and sleep apnea.

Figure 2. **Triggers for Initiating ULT**



*Creatinine clearance < 60 mL/min.

The most common triggers for initiating ULT therapy are an increase of flares in the past year, high SUA levels, and presence of arthropathy. Less important triggers are radiographic changes, recurring renal stones, and daily urinary urate excretion > 1,000 mg.

the quality of care received by gout patients from family doctors.

This Canadian study population showed demographics similar to those in the US and UK, with men in their 60s being the most common group. Over 70% were on ULT; allopurinol remained the most common agent and febuxostat accounted for approximately 10% of usage.

A significant proportion of primary-care physicians were not treating gout to target therapeutic SUA levels. The patients who were not treated to target experienced more flares overall. In addition, patients were often not prescribed anti-inflammatory prophylaxis, or the duration of time on prophylaxis was too short. This would also lead to more post-initiation flares.

This study had several limitations. Physicians were invited randomly to participate in the program. Those who participated might have a higher level of interest in gout management, which could have influenced our results as they may not be representative of the common primary care physician population. A small sample size (n = 500) and the retrospective nature of chart audits also limited statistical analysis.

Overall, this study highlights the need to educate physicians on the importance of treating gout more aggressively. With no recently updated Canadian guidelines in gout management, it was unclear which set of evidence-based guidelines had been followed by primary care physicians in Canada. The etiology of gout is well characterized, and effective therapies are available for both acute and long term management. Better dissemination of best practice guidelines would be important in improving quality of treatment for patients with gout.

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Update on Rheumatologist Demographics in British Columbia

By Jon Chan, MD, FRCPC; and Jason Kur, MD, FRCPC, ABIM

Physician human resource planning requires accurate, up-to-date information to prepare for future physician needs. The British Columbia Society of Rheumatologists (BCSR) conducted a study in 2010[1] that highlighted a looming crisis of rheumatology manpower in the province, as losses from retirements were likely to outpace gains in new specialists, thus exacerbating a significant shortage. We aimed to update these demographics and compare them with those collected in 2010 as well as with other subspecialists throughout Canada.

We conducted an online survey in August 2013 that was sent to all Royal College-certified rheumatologists and general internists who practice rheumatology in the province. Information gathered included when practitioners were first licensed, whether they practiced alone, in a group, or in an academic/research setting, what population they served, how many half days per week they worked, and in how many years they expected to retire.

Our survey response rate was 94% with 58 replies. As of August 2013, there were 41 full-time equivalent rheumatologists practicing in BC. Full-time equivalence (FTE) was defined as working 9-10 half days per week. These 41 practitioners represented an increase of nine rheumatologists from 2010; these new positions were predominantly in centers with a population < 300,000 patients. Male/female percentages changed from 69% / 31% in 2010 to 60% / 40% in 2013. Compared to data from the Canadian 2013 National Physicians survey,[2] rheumatologists in BC have been practicing for a significantly longer period of time, with over 60% having been licensed for over 20 years compared to the national average of 49%. Of working rheumatologists, 21% plan on retiring in the next five years and over 48% plan on retiring within the next 10 years.

Our study in 2010 highlighted the looming crisis in the rheumatology workforce. In the last three years our province has retained nine new rheumatologists. This influx of physicians merely replaces the number of rheumatologists expected to retire. To juxtapose, a workforce study in 2005 in the US noted one rheumatologist per 60,000 people,[3] though there is no clear guideline detailing how many rheumatologists are needed to serve a given population. The 2013 population of BC was 4,581,978,[4] meaning there was one rheumatologist for every 80,000 people or one FTE rheumatologist for every 112,000 people. New advances in the field of rheumatology have enabled rheumatologists to improve the quality of life of their patients and prevent long-term disability; however, this often requires treatment be initiated within a window of opportunity. To address this gap in care, a continued emphasis on physician recruitment, innovative models for the delivery of care, collaboration with allied health practitioners, and remedying the inequalities in physician remuneration will be required.

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

Introducing PrXELJANZ™: Simplicity of twice-daily oral dosing, power to reduce symptoms of RA.[1]

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

NEW ORAL

PrXELJANZ™

(tofacitinib citrate)

Demonstrated efficacy where response to methotrexate was inadequate

XELJANZ + MTX demonstrated:

- Significant symptom reduction at 6 months in MTX-IR patients vs. placebo + MTX.[1*]

  ACR20 response rates at 6 months: 52% XELJANZ 5 mg BID or 47% adalimumab 40 mg QOW vs. 28% placebo ($p<0.0001$ and $p<0.001$, respectively).
  This study was not designed to compare XELJANZ to adalimumab.

- Significant improvement in physical functioning at 3 months in MTX-IR patients vs. placebo + MTX.[1*]

  Mean HAQ-DI decrease from baseline at 3 months: -0.56 XELJANZ 5 mg BID or -0.51 adalimumab 40 mg QOW vs. -0.25 placebo ($p<0.0001$).
  This study was not designed to compare XELJANZ to adalimumab.

Proven tolerability profile

- The most commonly reported adverse events during the first 3 months in Phase 3 studies (≥2% of patients treated with XELJANZ) in patients treated with XELJANZ (n=1216) vs. placebo (n=681) were upper respiratory tract infection (4.4%, 3.4%), headache (4.4%, 2.2%), nasopharyngitis (3.9%, 2.8%), diarrhea (3.7%, 2.3%), nausea (2.6%, 2.6%), and urinary tract infection (2.1%, 1.8%).[1]

Most serious warnings and precautions:

Risk of Serious Infections: Patients treated with XELJANZ are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt XELJANZ until the infection is controlled. Reported infections include: active tuberculosis, invasive fungal infections, bacterial, viral, and other infections due to opportunistic pathogens.

Treatment with XELJANZ should not be initiated in patients with active infections including chronic or localized infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with XELJANZ, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

Malignancies: Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications.

Other relevant warnings and precautions:

- Risk of gastrointestinal perforation. Use with caution in patients who may be at increased risk for gastrointestinal perforation.
- Risk of viral reactivation, including herpes zoster.
- Risk of malignancies, lymphoproliferative disorder, and nonmelanoma skin cancer.
- Risk of lymphopenia, neutropenia, anemia, and lipid elevations.
- XELJANZ should not be used in patients with severe hepatic impairment, or in patients with positive hepatitis B or C virus serology.
- Use with caution in patients with a risk or history of interstitial lung disease (ILD).
- XELJANZ can increase the risk of immunosuppression. Concurrent use with potent immunosuppressive drugs is not recommended.
- Concurrent use with live vaccines is not recommended.
- Use with caution in patients with impaired renal function (i.e., CrCl <40 mL/min).
- XELJANZ should not be used during pregnancy.
- Women should not breastfeed while being treated with XELJANZ.
- The safety and effectiveness of XELJANZ in pediatric patients have not been established.
- Caution should be used when treating the elderly because of an increased risk of serious infection.
- Use with caution in Asian patients because of an increased risk of events including: herpes zoster, opportunistic infections and ILD.
- Treatment with XELJANZ was associated with increases in creatine kinase.
- XELJANZ causes a decrease in heart rate and a prolongation of the PR interval. Caution should be observed in patients with a low heart rate at baseline (<60 beats per minute), a history of syncope or arrhythmia, sick sinus syndrome, sinoatrial block, atrioventricular (AV) block, ischemic heart disease, or congestive heart failure.
- Treatment with XELJANZ was associated with increased incidence of liver enzyme elevations.

For more information:

Please consult the product monograph at http://www.pfizer.ca/en/our_products/products/monograph/342 for important information relating to adverse reactions, interactions, and dosing information which have not been discussed in this piece. The product monograph is also available by calling us at 1-800-463-6001.

Reference: 1. Pfizer Canada Inc. XELJANZ Product Monograph. April 16, 2014.

BID = Twice daily; QOW = Every other week; MTX-IR = Methotrexate Inadequate Responders
*Multicentre, randomized, double-blind, placebo-controlled study in patients ≥18 years with active RA according to ACR criteria. Patients received MTX and were randomized to receive XELJANZ 5 mg BID (n=196), adalimumab 40 mg sc QOW (n=199), or placebo (n=106). The primary endpoints were the proportion of patients who achieved an ACR20 response at month 6, mean change from baseline in HAQ-DI at month 3, and the proportion of patients who achieved DAS28-4 (ESR) <2.6 at month 6.

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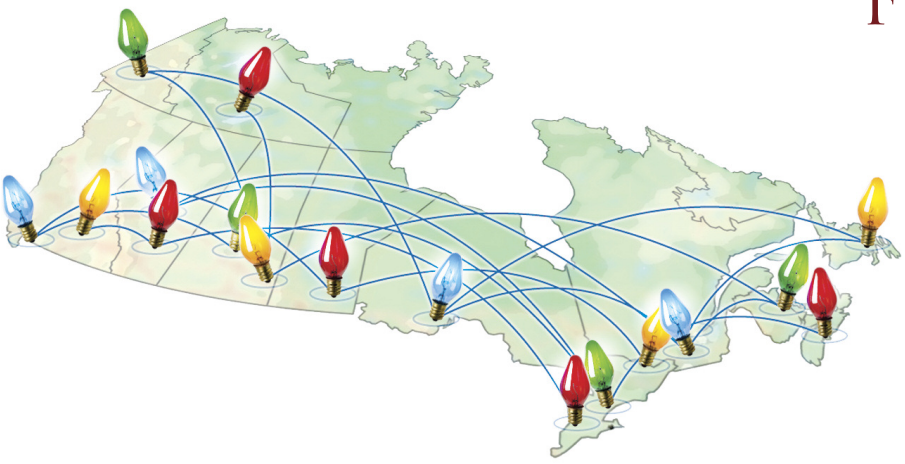

FROM COAST TO COAST:

Reports from the CRA Committees & Provincial Rheumatology Associations

Update from the Therapeutics Committee

By Shahin Jamal, BScPT, MD, FRCPC, MSc

The CRA's Therapeutics Committee has had another busy and productive year. We continue to work on guideline development and dissemination, with groups actively working on dissemination and translation of rheumatoid arthritis (RA) and fibromyalgia guidelines, development of consensus statements for vasculitis and lupus, and submitted guidelines for management of spondyloarthropathies (SpA). There is a new group working on guidelines to inform management of rheumatic diseases in pregnancy. To try to streamline the guideline development process and ensure our methodology is up-to-date, we have liaised with expert guideline methodologists at McMaster University. We are hoping to utilize guidelines to support development of quality indicators, and to guide strategies like Choosing Wisely Canada.

In addition to guidelines, the Therapeutics Committee has been actively working with the government and pharmaceutical industry on issues surrounding drug shortages, particularly naproxen suspension for the pediatric population (see article on page 20). We have been actively following the changing Canadian landscape on use of medicinal marihuana and have published an editorial on medical marihuana access in Canada, with a needs assessment of the CRA membership to be published soon. We have also been keeping up-to-date with the progress of subsequent entry biologics (SEBs) and their arrival in Canada. A survey of CRA membership was conducted and a manuscript has been submitted for publication.

Based on activities of the past year, I have no doubt that Therapeutics Committee will continue to be an exciting and interesting committee to chair. Our mandate has expanded so much over the years, particularly in the area of guidelines, that it may become its own freestanding committee. I feel fortunate to have such enthusiastic colleagues that continue working hard to improve rheumatology in Canada. I would like to thank all of our passionate members for their time and dedication. I would also like to give particular thanks to Christine Charnock, and the CRA Board and 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.

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Reporting on Access to Care

By Henry L. Averns, MBChB, FRCP(UK), FRCPC; and Michel Zummer, MD, FRCPC

We are pleased to update you on the key activities that the Access to Care Committee (ATCC) over the past year. Our focus continues to be on improving care for the Aboriginal population, working with the Wait Time Alliance (WTA), and collaborating with the Arthritis Alliance of Canada (AAC) and the Ontario Rheumatology Association (ORA).

We have successfully improved the Limited Use Criteria for provision of biologic therapy to patients covered by the Non-Insured Health Benefits (NIHB) program. CRA members have been very kind in passing on further advice to us that was shared with the NIHB program over the summer. Some of the discomfort about the forms and processes has been shared, but there are many systematic barriers impeding the pace we wish to set. We are embarking on a new project to focus on access to medication for pediatric patients. These discussions progress slowly but steadily, and whilst we feel our relationship with the team at the NIHB program is a good one, we have to develop modest ambitions for the timeframe of change.

At the CRA Annual General Meeting (AGM) we held a session for CRA members interested in the specific challenges faced by the indigenous population. Dr. David Robinson described his research interests, involving the development of a program to train nurses in remote communities to share the care and help deliver services to patients. We will repeat this event at the next CRA meeting.

Dr. Nigil Haroon has now completed his term as Chair of the WTA; his leadership until this point has been invaluable. Whilst the CRA defines its commitment to the process, Dr. Averns will assume the role of Chair, but this is a responsibility that will ultimately be taken on by another CRA member once we have a better definition of the scope of the tasks that lie ahead. If you are interested in this area please contact Dr. Averns via his website, *www.rheumors.com*. The WTA is comprised of several national medical specialty societies who work in collaboration with stakeholders. The rheumatology benchmarks have been submitted under the section "Arthritis Care". Current clinical conditions and their respective benchmark wait times are on the WTA website; these include rheumatoid arthritis (RA), spondyloarthritis (SpA), psoriatic arthritis (PsA), systemic lupus erythematosus (SLE), juvenile idiopathic arthritis (JIA), and JIA uveitis screening.

The WTA met in September to continue exploring ways of collecting and communicating reliable and meaningful data to inform our strategies. Its role has shifted from a data collecting watchdog to one of seeking solutions for Canadian patients. We also met with some MPs to share our concerns and to raise the profile of wait times with the federal government.

The AAC, in collaboration with the provinces and key stakeholders in the health system, recently published *A Pan-Canadian Approach to Inflammatory Arthritis Models of Care*. The report establishes a framework for the development of high-quality models of inflammatory arthritis (IA) care that are evidence-based and reinforced by best practices. To complement the report, the AAC developed an "IA Care Path and Tool Kit", a comprehensive map of each step of the patient's journey through the health care system.

Together with the provinces and key stakeholders, the AAC is defining system-level performance measures for IA care in Canada. These measures will serve as a toolkit for healthcare decision-makers to evaluate health systems and inform system changes with the goal of developing safe, cost-effective, efficient, high-quality care for patients.

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An Advocacy Success Story

By Rosie Scuccimarri, MD, FRCPC; and Carter Thorne, MD, FRCPC

Naproxen (Naprosyn®) is the preferred non-steroidal anti-inflammatory drug (NSAID) for treating juvenile idiopathic arthritis (JIA) and is widely used in pediatric rheumatology. In November 2013, pharmacists received a memo notifying them that Roche Canada was discontinuing production of naproxen suspension. Unfortunately, Roche did not notify the prescribers. It is only as stock disappeared, and when patients could no longer renew their prescriptions, that this was brought to the attention of the pediatric rheumatology community. This was of concern given that there is no generic for naproxen suspension, it is difficult to compound, and incurs an additional expense to the consumer.

Given this information, the CRA established an ad hoc committee and requested the aid of Mr. Denis Morrice from the Ontario Rheumatology Association (ORA), to deal with the implications of Roche's decision. The CRA committee quickly established communication with executives of Roche to see if this decision could be reversed. They learned that since 1997, Roche had been outsourcing production of naproxen suspension to a third-party supplier and that this company had stopped production of all oral suspension products.

In February 2014, as a result of the pressure from the CRA, Roche reached out to the pediatric rheumatology community to inform them that they were looking for a solution. It is at this point that Roche executives established weekly teleconferences with the CRA *ad hoc* committee. Roche began investigating a number of potential alternate companies that could produce a generic oral suspension formulation; they also began looking for alternate supply for interim use. By the end of February, Roche had tracked down a large supply of naproxen suspension from a Finnish manufacturer; the issue now was importation of the product.

In parallel, the CRA committee began communicating with Health Canada, initially through a face-to-face meeting in Ottawa, then through teleconferences. Various alternatives to facilitate importation of the Finnish product were discussed, including a Phase 4 study; this option was deemed too demanding, both on the part of Health Canada and the prescribers. Finally, availability through the Special Access Program (SAP) of Health Canada was considered and contact was made with the appropriate Health Canada administrators. After a number of teleconferences with Health Canada, and satisfying regulatory compliance with the pharmaceutical companies involved, special access to the Finnish naproxen suspension was granted. In a further display of responsibility, Roche accepted the recommendation of the CRA representatives that patients and families would not bear the financial burden associated with this process, and thus the product was to be provided at no cost to the patient during the time of the SAP.

On July 2nd, 2014, after months of discussion, Roche announced that they had sold the Canadian rights to naproxen suspension to Pediapharm of Montreal. Pediapharm took over responsibility for the importation and distribution of the imported product for the SAP, while establishing local, Canadian manufacturing capacity. By mid-July, Pediapharm received the first shipment of the Finnish product in Canada, and on July 22nd, the Health Canada SAP for naproxen suspension was opened.

The CRA committee continues to have regular teleconferences with Pediapharm to ensure that patients are acquiring naproxen suspension via the SAP. Pediapharm is currently working on getting naproxen suspension back on the Canadian market. They believe that this could be possible by March 2015, which is incredible given that at the beginning of this venture, the CRA committee had been informed that it could take from two to five years! Pediapharm is also reviewing the situation with provincial payers since, in some jurisdictions, naproxen suspension has been taken off the provincial formularies.

The *ad hoc* committee's quick action and commitment to getting naproxen suspension back on the market is truly an advocacy success story. The *ad hoc* committee was able to identify key stakeholders including Roche Canada and Health Canada, and establish a collaborative relationship based on a shared vision of "best outcomes for patients".

The CRA committee could not have done this without the tireless input and dedication of Mr. Morrice , and the

involvement of the Association des médecins rhumatologues du Québec (AMRQ), The Arthritis Society (TAS), Best Medicines Coalition (BMC), and the Canadian Arthritis Patient Alliance (CAPA). For more information on how to access naproxen suspension for your patients, go to: *www.rheum.ca/en/the_cra/drug_updates*.

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on behalf of the CRA Naproxen ad hoc Committee: Dr. Rosie Scuccimarri, Dr. Carter Thorne, Dr. Deborah Levy, Dr. Susa Benseler

News from the Scientific Committee

By Evelyn Sutton, MD, FRCPC

Quebec City was so much fun last time, members told us we had to go there again! Pack your bags, review your French language tapes, and join us from February 4-7, 2015 for state-of-the-art lectures, workshops, and interactive sessions. Translation is the theme in its broadest sense—knowledge translation in research, adult and pediatric clinical care, education, and policy development to name but a few. World-class experts will share their knowledge during the State of the Art address and the Dunlop-Dotteridge lecture, as well as various workshops. This year, we have facilitated a special "Meet the Experts" bazaar where you can discuss clinical questions with these experts.

The format this year will remain similar to past years with a generous mid-day break to allow you to explore beautiful Quebec City; skiers are perfectly located to head to the hills. We will review your evaluations—if participants prefer more content during the day, we will adjust future meetings accordingly. We will of course have the ever-popular Great Debate ("Be it resolved that pre-arthritis is real and must be treated"), workshops, as well as abstract and poster sessions. New this year is Clinical Pearls and Challenging Cases; see your email inbox for an invitation to submit your clinical pearl or instructive case and have a chance to win an allegedly fabulous prize!

I look forward to seeing you all in beautiful Quebec City!

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ANNUAL GENERAL MEETING

The next Annual General Meeting of the CRA will take place Friday, February 6th at the Fairmont Chateau Frontenac Hotel.

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

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

Educational Update

By Christopher Penney, MD, FRCPC

The CRA re-applied for Royal College Accreditor status in April 2014 and our application was generally well received by the College reviewers. The College as well as the CRA are wrestling with how to deliver palatable outcome-based Continuing Profess-ional Development (CPD) in a cost effective and unbiased manner. Using that number of qualifiers in a single sentence indicates that achieving this ideal will not be easy nor will it happen overnight.

The Education Committee in Whister, BC.

Beginning with new (or next) Royal College Maintenance of Competence (MOC) cycles starting on or after January 1st, 2014, all MOC Program participants will be required to complete a minimum of 25 credits in each section of the MOC Program during their new five-year MOC cycle. Thus a minimum of eight hours (three credits per hour) of Section 3 (self-assessment) activities will be compulsory in your next five-year CPD cycle. The CRA Education Committee is working to provide you with such programs.

The Education and the Scientific Committees are striving to go beyond traditional lecture and workshop formats at the upcoming Annual Scientific Meeting (ASM). We will be trialing new educational methods such as the flipped classroom workshop, discussion tables, and pre- and post-multiple-choice exams at the Quebec City ASM. An Image of the Month contest will run in the CRA newsletter starting in the fall of 2014. Images from this contest will be used to develop an annual self-assessment photo quiz for the membership. A column on rheumatology apps will also run in the newsletter. If you have thoughts on innovative teaching techniques or suggestions of any sort, email me at *penney@ucalgary.ca* or apply for the CRA Innovation in Education Award.

Patient Partners in Arthritis remains active, albeit with great difficulty, in many educational centers across Canada. The Education Committee is negotiating with The Arthritis Society (TAS) on ways to support this program. Hopefully I will have good news for you soon.

We had no winners of the Innovation in Education Award in 2013. I encourage the membership, especially residents and those presenting at the ASM, to consider applying for this award in 2014.

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Highlights of Québec City, Québec

Schedule full of meetings, workshops, lectures, sessions, and abstracts? Ensure you enjoy a *petit pause* and take in the charms of Quebec City. Here are a few suggestions to get you started.

Feast on *cuisine de terroir*.
Les Québecois are formidably proud of their cuisine, emphasizing local ingredients like lamb, lake-caught fish, wild mushrooms, duck, and ripe cheese. Maple syrup no longer reigns supreme in this city! Consider Laurie Raphaël for an upscale gastronomic tasting exeprience. La Gueule de Bois is perfect for hearty *chasseur* fare. Hip bistro more your style? Then check out if "everything is cool" at the funky L'affaire est ketchup.
Laurie Raphaël: www.laurieraphael.com/en/
La gueule de bois: www.lagueuledebois.ca/
L'affaire est ketchup: 1 418 529 9020

ORA: Ongoing Activities

By Arthur Karasik, MD, FRCPC

The Ontario Rheumatology Association (ORA) will continue to advocate for its membership and for arthritis care in the province. We continue to aggressively pursue our organizational priorities, which focus on access to treatment, inter-professional patient-centric models of care, advocacy, and communications. Our endeavours are aligned with many of the goals and efforts of the CRA.

Dr. Arthur Karasik and his bony colleague.

The lead of our private payer committee, Dr. Jane Purvis, has worked diligently with all provinces and insurance companies to develop transparent standardized criteria for access to biologics in rheumatoid arthritis (RA), based on published guidelines. The ORA has been appointed as a representative for the CRA on this issue, meaning these efforts represent a national mandate on behalf of Canadian rheumatologists. The ORA's work with the Ontario government has resulted in modernization of criteria using an ongoing evidence-based process. Leveraging this expertise, combined with experience developed over the past eight years collaborating with the Ontario Ministry of Health, we hope to ensure a consistent approach to development and acceptance of criteria among private payers using a standardized application and renewal form. The aim is to offer a more efficient streamlined process for both the prescriber and the payer (*i.e.*, clarity).

Dr. Vandana Ahluwalia, our director of Models of Care, continues to work with the CRA and the Arthritis Alliance of Canada (AAC). A new arthritis patient charter developed by the Canadian Arthritis Patient Alliance (CAPA) and supported by the ORA's Model of Care committee, the CRA and the AAC has been developed (see article on pages 8-9). This charter highlights an arthritis patient's rights and responsibilities associated with their arthritis and their care. This is a grassroots project led by the CAPA with input, support, and participation provided by all Canadian arthritis stakeholders. The charter is a reflection of the continued partnership of patients and their healthcare providers as well as all Canadian organizations involved in arthritis care.

The Models of Care Committee has reinvigorated the MedsCheck Program while partnering with the Ontario Pharmacy Association. MedsCheck supports the provision of high-quality patient care through pharmacist review of complex treatment regimens, facilitating message consistency, and fostering greater rates of medication adherence. More information is available at *www.health.gov.on.ca/en/pro/programs/drugs/medscheck/resources.aspx*.

The ORA will continue its work liaising with the government through the Exceptional Access Program (EAP), promoting new electronic medication record (EMR) adoption programs, and supporting our manpower committees.

The ORA is excited to fulfill its organizational priorities and to liaise with the CRA.

Arthur Karasik, MD, FRCPC
President,
Ontario Rheumatology Association
Rheumatologist
Toronto, Ontario

Celebrate during Carnaval!

The Carnaval de Québec will take place from January 30th to February 15th, 2015. Snow sculpture competitions are ongoing, as are parades, ice canoe races, and the creation of an elaborate ice palace. See the sights and sounds of the old city as you wander the streets with a strong cup of *caribou*. Be sure to say hello to Bonhomme! Ticket information and complete schedule is available online.
www.carnaval.qc.ca/en/edition-2015/preliminary-program-schedule-calendar-winter-activities/

Hit the slopes.

Québec City is perfectly located for skiers and snowboarders alike, in close proximity to le Relais, le Massif de Charlevoix, and Mont-Sainte-Anne. Spend your breaks racing downhill or enjoying a more leisurely pace on cross-country skis or snowshoes. Lift ticket prices and park admission details available online.
Le Relais: www.skirelais.com/le-relais-ski-snow.php
Le Massif de Charlevoix: www.lemassif.com
Mont-Sainte-Anne: www.mont-sainte-anne.com

The AMRQ: Turbulent Times in Quebec…

By Frederic Morin, MD

As I write these lines, the climate between medical specialists and the Quebec government is unsettled at best. Imposed negotiations are under way to reopen the 2010-2015 agreement. Having taken a firm stand on returning to a balanced budget, the government, it seems, expects medical specialists to cooperate. Will we succeed in finding common ground or will the heavy hand of a special law be brought to bear on us? By the time you read these lines, you will know the answer…

For the Association des médecins rhumatologues du Québec (AMRQ), this turn of events threatens years of hard work to build a solid and relevant economic foundation for Quebec's rheumatologists. We are determined to fight to keep these gains in the hope that they can serve as leverage for other provincial associations in the upcoming rounds of negotiations.

Happily the charm and appeal of rheumatology far outweigh economic concerns. In the past eight years, our workforce has grown more than 40%, and our training programs for rheumatologists are moving ahead at full speed. In October 2013, I enthusiastically assumed the role of association president, a role that my distinguished colleague Dr. Denis Choquette filled with such panache for five years. We are all grateful for his dedication and achievements. Thank you, Denis!

At the AMRQ, the suggestion box is always open and we are currently working on a promising project for all Canadian rheumatologists aimed at organizing and optimizing rheumatology practice. This is a long-term project, but results need to be achieved quickly. An efficient and organized practice will ensure a modern and rewarding environment for rheumatologists.

I invite you to visit our website for a look at what we are up to: *www.rhumatologie.org*, and practice your French a little!

Frédéric Morin, MD
President,
Association des médecins rhumatologues du Québec
Montreal, Quebec

WAR Secrets

By John M. Esdaile, MD, MPH, FRCPC

This year's Western Alliance of Rheumatology (WAR) meeting was held to extraordinary acclaim, with Dr. Manny Ferreira in attendance. Given the nature of a WAR meeting no photographs can be provided.

John M. Esdaile, MD, MPH, FRCPC
Professor of Medicine, University of British Columbia
Adjunct Professor, University of Calgary
Scientific Director, Arthritis Research Centre of Canada
Richmond, British Columbia

Top 5 Reasons to Attend the CRA ASM

1. Expand Your Knowledge.
This year promises an agenda full of didactic talks and interactive workshops, excellent keynote speakers, and a plethora of other sessions to broaden your understanding.

2. Solve Mysteries.
Think you can stump your colleagues? Submit your videos, pictures, or descriptions to *www.fluidsurveys.com/s/pearls_cases/* and see if your puzzling case baffles the audience.

3. Acquire Pearls.
New this year, a session on Clinical Pearls allows participants to submit short, practical medical tips to solve everyday clinical problems. These patient-centered observations will be shared amongst your colleagues. Submit yours now at *www.fluidsurveys.com/s/pearls_cases/*.

News from SOAR: Atlantic Update 2014

By John Hanly, MD, FRCPC

An enthusiastic group of rheumatologists with representation from all three Maritime provinces gathered for the 31st annual meeting of the Society of Atlantic Rheumatologists (SOAR) on June 20-22, 2014 at Shaw's Inn and cottages in Brackley Beach, Prince Edward Island. This annual get-together was characterized by the usual intoxicating mix of renewing personal and professional friendships, updating scientific knowledge and, for some, that never-ending pursuit of trying to improve their golf game. Success was achieved on the first two fronts and two out of three is certainly not bad.

Dr. Marie Hudson presenting an update on scleroderma.

Dr. Hanly presenting a plaque to Dr. John Esdaile upon delivering the inaugural David Hawkins Lecture in Rheumatology.

This year's guest speakers were an all-Canadian team. Dr. John Esdaile from the University of British Columbia gave the inaugural David Hawkins lecture in rheumatology with the provocative title, "There is No Such Thing As Co-morbidity from Arthritis – Only Complications." On the following day he updated the group on the pathogenesis and outcome of osteoarthritis (OA) with the question, "Is OA as boring as we think?" Dr. Marie Hudson from McGill University provided two excellent presentations; her first was an update on "Scleroderma in 2014: Recent Advances and Future Challenges," followed by an introduction to a new national database "The Canadian Inflammatory Myopathy Study – The Role of Registries for Rare Diseases." To complete the scientific program, SOAR members presented data on PET/CT scanning in giant-cell arteritis (Dr. Elana Murphy), Outcome of Lupus Nephritis in an Inception Cohort (Dr. John Hanly), Choosing Wisely Recommendations (Dr. Sylvie Ouellette), and Models of Care: Arthritis Alliance Update (Dr. Jamie Henderson).

At the end of this two-day meeting, SOAR members left with a renewed enthusiasm for applying their newly acquired information in the care of their patients, confident in the knowledge that SOAR is in good shape as it begins its fourth decade.

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

4. Stretch Your Networks.
Take this opportunity to meet new CRA members and colleagues from across the country. The daily yoga sessions provide the perfect chance to stretch your acquaintences.

5. Easy on Your Wallet.
Attendance is cheap—book for only $250 before the early bird deadline January 3rd! Visit *ww.rheum.ca/en/events/upcoming_events/travel_and_transport2* for promotional codes for various participating airlines.

The ASM will take place February 4-7, 2015, at the Fairmont Chateau Frontenac in Québec City.

For more details, please visit *www.rheum.ca*.

The Laurentian Conference of Rheumatology Turned 45 in 2014!

By Carol Yeadon, MD, FRCPC

It started off as a group of guys getting together in Montreal to discuss what was new, interesting, or challenging about rheumatic diseases. From the outset, it was a forum for the shared interests of these French- and English-speaking physicians, surgeons, and basic scientists. In addition to getting away from the hospital, office, or lab, they chose a venue that allowed breathing mountain air between sessions of serious talk. Finally, with pharmaceutical industry support, they invited some star guest speakers.

Thus, the Laurentian Conference of Rheumatology was born! Dr. Roger Demers of Montreal's Hôtel-Dieu hospital was the tenacious captain of the enterprise through the '70s and '80s, ensuring an appealing, top quality meeting.

The 45th edition maintained these goals, emphasizing immunological topics and recent controversies in osteoporosis prevention and management. All investigators (trainees and staff) gave excellent oral and poster presentations, covering a wide range of topics pertinent to rheumatology. Our invited guest speakers were outstanding! Dr. John Stone of Boston brought his unique knowledge and expertise on IgG4-related disease to his talk on "Vasculitis: Pearls and Myths". Dr. Jack Karsh and Dr. William Rigby from Dartmouth (his third Conference, almost an honorary Canadian!) reminded us of their encyclopaedic knowledge with their coverage of acquired immune deficiencies. Dr. Emil Nashi, a colleague from our own Montreal General Hospital and Dr. Michael Walsh, a nephrologist from McMaster, helped us understand and use immunoglobulin manipulation, focusing on how "we giveth and we taketh away" as we use therapeutic IV Ig and plasmapheresis in many clinical situations. We are now more sophisticated in their uses. Finally, Dr. Suzanne Morin and Dr. Sophie Roux, from Montreal and Sherbrooke respectively, brought enlightening answers to the topical questions "calcium, good for the bones, bad for the heart?" and "is too much anti-resorptive therapy dangerous?".

The gang attending the 1999 Conference at La Sapinière.

Dr. Jean-Pierre Pelletier presenting the first Marie-Thérèse Fortin award in 1994 to Dr Edith Verrier-Jones in recognition of her professional and humanistic qualities in the care of patients with rheumatic diseases.

Dr. and Mrs. Donato Alarcon-Segovia flanked by Thérèse Haraoui and Dr. Carol Yeadon at Montebello, 2001.

Dr. Pelletier presenting the first Roger Demers award to Dr. Duncan Gordon in 1998 in recognition for his contribution to the international rheumatology community.

As the accompanying photos to this article remind us of great Conferences past, it is time to plan next year's Conference and to look ahead to our golden anniversary landmark in 2019!

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CRUS: Focused on the Future

By Maggie Larché, MBChB, MRCP(UK), PhD; Abraham Chaiton, MD, MSc, FRCPC; Johannes Roth, MD; and Christopher Lyddell, MBChB(UCT), DA(SA), FCP(SA)

The Canadian Rheumatology Ultrasound Society (CRUS) was established as a not-for-profit organisation in 2010. Since inauguration, there have been three major foci: training, research, and practice implementation and billing.

Training

Endorsed by the CRA, the annual national basic and intermediate courses have been established. Both include Canadian and internationally renowned tutors.

To date, 91 rheumatologists from across Canada have been trained with the basic course. The fifth year of the basic course begins in November 2014. This course consists of three weekends with didactic sessions, anatomy room demonstrations, and hands-on practice, interspersed by weeks of self-directed training and uploading of scanned images to a website for expert review and commentary.

The inaugural two-day intermediate/refresher course was held prior to the CRA Annual Scientific Meeting (ASM) in February of 2014; it counted 21 participants with four world-class international tutors.

The first of two three-day sessions of basic US training was held in May 2014 in Riyadh, Saudi Arabia, for approximately 20 Saudi rheumatologists and allied health professionals.

Between 2012 and 2013 training was initiated in Toronto during the rheumatology fellowship, with 10 fellows taking part in six half-day sessions. This format is currently being reproduced at Ottawa and McMaster Universities. A joint US training for the rheumatology fellowship programmes in Ottawa and Kingston will take place in 2015. The University of Sherbrooke has been training rheumatology fellows in ultrasonography since 2008.

There has also been a WebEx curriculum with two-hour sessions discussing setting up a practice in US, using US as a treat-to-target tool, assessing vasculitis, and countering pitfalls and challenges.

Research

The Prospective Observational Study to Evaluate the Use of MSK US to Improve Rheumatoid Arthritis Management: Canadian Experience (ECHO) includes 350 patients to evaluate musculoskeletal (MSK) US in improving rheumatoid arthritis (RA) outcomes. Other ongoing studies include an atlas of normal US findings in children, a foot imaging study to compare clinical and imaging findings in early RA, ultrasonographic measures of joint inflammation and serum biomarkers in patients with RA in clinical remission, and the international BIODAM study looking at biomarkers, including US, in RA.

The website is currently under construction. Members will be provided more content including an image library, important literature in the field of MSK US, access to professionally filmed lectures, and ask the expert/case review sessions. This will be on a restricted site accessible by password to the members of CRUS.

Practice Implementation

In collaboration with the Emergency Medicine specialty, a joint application to create a new Area of Focused Competence (AFC), Diploma in Point of Care Ultrasound (POCUS), has been submitted to the Committee on Specialties of the Royal College. The Royal College currently recognizes 13 AFC disciplines. If approved, university-based POCUS programs will confer the degree of DRCPSC to successful candidates who satisfy predefined training requirements, for each stream. This will be a postgraduate, national, competency-based degree program for rheumatologists unique to North America and Europe.

CRUS has a strong international presence, being part of the Outcome Measures in Rheumatology (OMERACT) groups and the Targeted Ultrasound Initiative (TUI). There are teachers and representatives in the Ultrasound School of North American Rheumatalogists (USSONAR), the American College of Rheumatology (ACR), the European League Against Rheumatism (EULAR), and the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM).

In future, we intend to: Continue the basic and intermediate CRUS courses; continue fellowship training and expand sites across the fellowship programs; develop the Royal College Diploma program; continue filming the lectures during the courses; launch the updated website; and continue lobbying for billing codes across the country to make POCUS a viable tool for every rheumatologist.

Maggie Larché, MBChB, MRCP(UK), PhD;
Abraham Chaiton, MD, MSc, FRCPC;
Johannes Roth, MD; and
Christopher Lyddell, MBChB(UCT), DA(SA), FCP(SA)

Top Ten Things Rheumatologists Should (And Might Not) Know About Smoking Cessation

By Adam Ramzy, BHSc; and Milan Khara, MBChB, CCFP, ABAM

Since researchers first identified smoking as a risk factor for lung cancer and heart disease in 1950,[1] there has been a consistently growing body of research outlining the incredible risks associated with smoking cigarettes. In more recent years, a convincing body of research and many large trials and registries (including BARFOT, DANBIO, DESIR, HUNT, NINJA, and SWEFOT), have found relationships between smoking and rheumatologic diseases. We present a basic introduction into the specific rheumatologic risks of smoking and the evidence-based treatment options to help patients become smoke free.

1. Risk Factor

Smoking is the most conclusively proven environmental risk factor for rheumatoid arthritis (RA) and increases risk twofold.[2,3] Smoking may also double risk for ankylosing spondylitis (AS)[4-6] and evidence is growing to suggest that smoking is linked to the development of systemic lupus erythematous (SLE)7,8 and psoriasis.[9,10]

2. Patient Outcomes

Smoking has been linked to increased severity and worsened trajectory of RA, SLE, psoriatic arthritis (PsA), and AS.[4-6,11-15]

3. Treatment Failure

Smoking has been shown to decrease the efficacy of tumor necrosis factor (TNF)-α inhibitors and patients who smoke are up to 80% less likely to respond well to therapy.[11,13] Furthermore, smoking cessation has been shown to reduce failure of biologics for the treatment of RA.[16]

4. Addiction

Tobacco dependence is a bona fide addictive disorder, best viewed as a chronic disease; treatment frequently entails repeated interventions, multiple relapses, and multiple quit attempts. Each year 40% of smokers make at least a single quit attempt and many long-term smokers have made more than 20 failed quit attempts.[17]

5. Obligation

A Canadian clinical practical guideline by the Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT) states that it is a Grade 1A recommendation for physicians to identify, document, and treat the tobacco usage status of every patient in the healthcare setting.[18]

6. Counselling

Any intervention is worthwhile—even brief physician counselling sessions have been shown to be effective at helping patients achieve abstinence. Counselling in any form—individual, group, or telephone—has been shown to be effective at increasing rates of smoking cessation.We should focus on practical counselling and social support. Offering more than 30 minutes of counselling can triple rates of abstinence.[19]

7. Medications

Medication-based treatments for smoking cessation have been validated in a wide array of populations and can be used in isolation or in combination. The use of any nicotine replacement therapy (NRT; gum, patch, spray, inhaler, or lozenge) will approximately double rates of abstinence. Chances of success further increase when multiple types of NRT are used in combination (*e.g.*, patch with gum or oral spray) or are used in combination with buproprion. The use of varenicline alone (2 mg/day) triples abstinence rates.[19]

8. NRT and Smoking

Continuing to smoke while using NRT is not dangerous and does not increase risk of adverse cardiovascular events. Patients can begin NRT at any stage of readiness for change and consistently are twice as likely to achieve abstinence.[20] The FDA has allowed label changes on NRT products to remove the statement that smoking while using NRT is contraindicated.[21,22]

9. Cost Effectiveness

Tobacco treatment programs are among the most cost effective interventions available. Combining counselling and pharmacotherapy is the most effective intervention and may increase chances of a successful quit attempt five-fold.[19]

10. Moving Forward

You can help patients at any stage along the quit process, from those currently unwilling to quit, to those who have recently quit. There are many resources available to learn more about pharmacological options and the general principles of cessation counselling.[19,23]

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Fracture Liaison Service: Update

Plans for implementation of Fracture Liaison Services (FLS) are ongoing in several jurisdictions across Canada. To support ongoing implementation of FLS, Osteoporosis Canada has developed Quality Standards for FLS in Canada. The CRA has endorsed these Quality Standards, along with the Canadian Orthopedic Association, the Canadian Orthopedic Nurses Association, and Bone and Joint Canada. The list of endorsing organizations will be updated as additional endorsements are received.

The Quality Standards provide a concise set of statements which describe the most important functions of an FLS and which provide very clear guidance for healthcare professionals and administrators on what a world-class FLS will actually deliver. The Quality Standards will help ensure that any FLS can be set up for success at the time of implementation. These Standards are in compliance with the 2010 Osteoporosis Canada Clinical Guidelines and the International Osteoporosis Foundation Capture the Fracture Best Practice Framework for FLS.

Download the Quality Standards for FLS in Canada from *www.osteoporosis.ca/fls*.

Indications and clinical use

- SIMPONI® I.V., in combination with methotrexate, is indicated for the treatment of adults with moderately to severely active rheumatoid arthritis
- No studies with SIMPONI® I.V. have been performed in pediatric patients
- Caution should be used when treating the elderly as there is a higher incidence of infections in this population

Contraindications

- Severe infections such as sepsis, tuberculosis and opportunistic infections
- Moderate or severe (NYHA class III/IV) congestive heart failure
- Hypersensitive to golimumab or any other ingredient in the formulation or component of the container

Most serious warnings and precautions

- **Serious infections leading to hospitalization or death:** sepsis, tuberculosis, invasive fungal infections and other opportunistic infections have been observed with SIMPONI® I.V.
  - Treatment should not be initiated in patients with active infections, including chronic or localized infections
  - Treatment should be discontinued if a patient develops a serious infection or sepsis
- **Recurring/latent infections:** including tuberculosis, or with underlying conditions which may predispose patients to infections, or who have resided in regions where tuberculosis and invasive fungal infections are endemic
- **Tuberculosis (from reactivation or latent tuberculosis infection or new infection):** has been observed in patients receiving TNF-blocking agents
  - Before starting treatment, all patients should be evaluated for both active and latent tuberculosis
  - If latent tuberculosis is diagnosed, start with anti-tuberculosis therapy before initiation
  - Monitor for signs and symptoms of active tuberculosis
- **Lymphoma and other malignancies:** some fatal, have been reported in children and adolescent patients treated with TNF-blockers

Other relevant warnings and precautions

- Risk of bacterial, mycobacterial, invasive fungal and opportunistic infections, including fatalities
- Risk of hepatitis B virus reactivation
- Risk of malignancies, including lymphoma, leukemia, non-lymphoma malignancy, colon dysplasia/carcinoma and skin cancers
- Risk of worsening or new onset of congestive heart failure
- Concurrent use of Anakinra or Abatacept is not recommended
- Concurrent use with other biologics is not recommended
- Risk of pancytopenia, leukopenia, neutropenia, aplastic anemia and thrombocytopenia
- May affect host defenses against infections and malignancies
- Risk of allergic reactions
- Concurrent use with live vaccines/therapeutic infectious agents is not recommended
- May result in the formation of autoantibodies
- Risk of new onset or exacerbation of central nervous system (CNS) demyelinating disorders
- Closely monitor patients who have undergone surgical procedures for infections
- Contraception recommended in women of childbearing potential; and for 6 months after last treatment
- Use with caution in subjects with impaired hepatic function
- May influence the ability to drive and use machinery

For more information

Please consult the product monograph at http://www.janssen.ca/product/579 for important information relating to adverse reactions, drug interactions and dosing information which have not been discussed in this piece.

The product monograph is also available by calling 1-800-387-8781.

Reference: SIMPONI® I.V. Product Monograph, Janssen Inc., May 15, 2014.

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RA=rheumatoid arthritis; I.V.=intravenous.

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

Introducing PrXELJANZ™: Simplicity of twice-daily oral dosing, power to reduce symptoms of RA.[1]

Demonstrated efficacy where response to methotrexate was inadequate

XELJANZ + MTX demonstrated:

- Significant symptom reduction at 6 months in MTX-IR patients vs. placebo + MTX.[1*]

  ACR20 response rates at 6 months: 52% XELJANZ 5 mg BID or 47% adalimumab 40 mg QOW vs. 28% placebo ($p<0.0001$ and $p<0.001$, respectively).
  This study was not designed to compare XELJANZ to adalimumab.

- Significant improvement in physical functioning at 3 months in MTX-IR patients vs. placebo + MTX.[1*]

  Mean HAQ-DI decrease from baseline at 3 months: -0.56 XELJANZ 5 mg BID or -0.51 adalimumab 40 mg QOW vs. -0.25 placebo ($p<0.0001$). This study was not designed to compare XELJANZ to adalimumab.

Proven tolerability profile

- The most commonly reported adverse events during the first 3 months in Phase 3 studies (≥2% of patients treated with XELJANZ) in patients treated with XELJANZ (n=1216) vs. placebo (n=681) were upper respiratory tract infection (4.4%, 3.4%), headache (4.4%, 2.2%), nasopharyngitis (3.9%, 2.8%), diarrhea (3.7%, 2.3%), nausea (2.6%, 2.6%), and urinary tract infection (2.1%, 1.8%).[1]

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

BID = Twice daily; QOW = Every other week; MTX-IR = Methotrexate Inadequate Responders
*Multicentre, randomized, double-blind, placebo-controlled study in patients ≥18 years with active RA according to ACR criteria. Patients received MTX and were randomized to receive XELJANZ 5 mg BID (n=196), adalimumab 40 mg sc QOW (n=199), or placebo (n=106). The primary endpoints were the proportion of patients who achieved an ACR20 response at month 6, mean change from baseline in HAQ-DI at month 3, and the proportion of patients who achieved DAS28-4 (ESR) <2.6 at month 6.

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CA0114TOF015E

Most serious warnings and precautions:

Risk of Serious Infections: Patients treated with XELJANZ are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt XELJANZ until the infection is controlled. Reported infections include: active tuberculosis, invasive fungal infections, bacterial, viral, and other infections due to opportunistic pathogens.

Treatment with XELJANZ should not be initiated in patients with active infections including chronic or localized infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with XELJANZ, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

Malignancies: Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications.

Other relevant warnings and precautions:

- Risk of gastrointestinal perforation. Use with caution in patients who may be at increased risk for gastrointestinal perforation.
- Risk of viral reactivation, including herpes zoster.
- Risk of malignancies, lymphoproliferative disorder, and nonmelanoma skin cancer.
- Risk of lymphopenia, neutropenia, anemia, and lipid elevations.
- XELJANZ should not be used in patients with severe hepatic impairment, or in patients with positive hepatitis B or C virus serology.
- Use with caution in patients with a risk or history of interstitial lung disease (ILD).
- XELJANZ can increase the risk of immunosuppression. Concurrent use with potent immunosuppressive drugs is not recommended.
- Concurrent use with live vaccines is not recommended.
- Use with caution in patients with impaired renal function (i.e., CrCl <40 mL/min).
- XELJANZ should not be used during pregnancy.
- Women should not breastfeed while being treated with XELJANZ.
- The safety and effectiveness of XELJANZ in pediatric patients have not been established.
- Caution should be used when treating the elderly because of an increased risk of serious infection.
- Use with caution in Asian patients because of an increased risk of events including: herpes zoster, opportunistic infections and ILD.
- Treatment with XELJANZ was associated with increases in creatine kinase.
- XELJANZ causes a decrease in heart rate and a prolongation of the PR interval. Caution should be observed in patients with a low heart rate at baseline (<60 beats per minute), a history of syncope or arrhythmia, sick sinus syndrome, sinoatrial block, atrioventricular (AV) block, ischemic heart disease, or congestive heart failure.
- Treatment with XELJANZ was associated with increased incidence of liver enzyme elevations.

For more information:

Please consult the product monograph at http://www.pfizer.ca/en/our_products/products/monograph/342 for important information relating to adverse reactions, interactions, and dosing information which have not been discussed in this piece. The product monograph is also available by calling us at 1-800-463-6001.

Reference: 1. Pfizer Canada Inc. XELJANZ Product Monograph. April 16, 2014.

NEW ORAL
PrXELJANZ™
(tofacitinib citrate)