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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on: The Shoulders of Rheumatology Giants

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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]

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.

Pfizer Working together for a healthier world®

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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)

Cyberbullying: Online Anxieties

By Philip A. Baer, MDCM, FRCPC, FACR

"If you can't say something nice...don't say nothing at all."– Thumper Rabbit, *Bambi*, 1942.

Recently I had to present a paper at our local rheumatology journal club. The choice is always difficult, with the ideal paper being interesting but a bit offbeat. While searching, an article came across my desk on treatment trends in psoriasis and psoriatic arthritis (PsA). The lead author was an American dermatology researcher, Dr. April Armstrong.[1]

The article was a typical scientific paper, with the requisite tables and graphs, research methods, discussion, and conclusions. However, in the instructions regarding the corresponding author, I found a comment that I have never before seen in a scientific paper. The author provided her email address, followed by instructions indicating that her address was provided "for intellectual questions regarding the article only".

I wondered why she had found it necessary to make that comment. The answer is not too difficult to discern. Social media exposure, including disclosure of a personal email address, leaves one open and vulnerable to anyone on the Internet. A recent article in the *Canadian Medical Association Journal* (*CMAJ*) in September 2014[2] discussed issues with post- publication peer review on social media. Traditionally, one would write a letter to the editor to dispute points raised in a scientific paper. The editor would function as a neutral mediator. However, the availability of multiple social media platforms allows researchers to critique one another, sometimes in a very negative way, without any filtering. The *CMAJ* article discusses back and forth interactions between researchers characterized as cyber-bullying and mocking.

Another April was targeted in Toronto around the same time, in a social media attack on Twitter. This had nothing to do with science, but rather with the passion of Toronto Maple Leafs fans for a winning season, after 47 years without a Stanley Cup. In March 2014, one of the Maple Leafs goaltenders, James Reimer, had a particularly poor game. On social media, notably Twitter, his wife April Reimer received a number of offensive comments.[3,4] One went so far as to suggest she stab her husband while he slept.

Women certainly feel more vulnerable than men in this setting. I checked out a scientific paper by a leading male psoriatic arthritis researcher, Dr. Iain McInnes, reporting on the PSUMMIT-1 study. He listed his email address without any qualification or apparent worry.

The broader social context also plays a role. I am writing this article in the midst of the never-ending explorations of the sordid Jian Ghomeshi affair, while Canadian MPs continue to accuse each other of sexual harassment on Parliament Hill. As well, one of our journal club members pointed out the "Gamergate" controversy when I presented the Armstrong article, in which female video game developers and their supporters were the subjects of online harassment and threats of violence, leading some to flee their homes.[5]

I hope that Dr. Armstrong does not experience any problems regarding the publication of her article. I actually did use her email address myself, writing to compliment her on the article itself, and to ask for a PDF for my files. She responded quickly and graciously. I would like to think I reduced her anxiety about publication of her email address a little bit.

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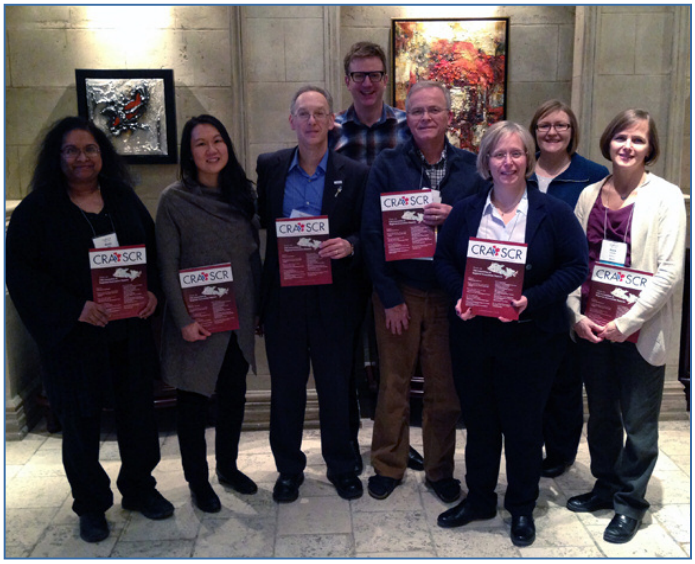
Mission Statement. The mission of the *CRAJ* is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.



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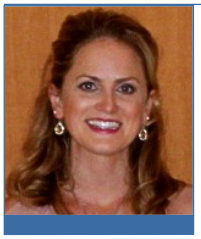
AWARDS, APPOINTMENTS, ACCOLADES

Recognition as a Master is one of the highest honours that the American College of Rheumatology (ACR) bestows on its distinguished members. In November 2014, at the ACR Meeting in Boston, Professor Jean-Pierre Pelletier, MD, was bestowed this honour in recognition of his outstanding contributions to the field of rheumatology.

Dr. Pelletier completed his medical degree at the Université de Montréal (UdeM) with rheumatology training at both UdeM and McGill University. In 1981, he co-founded, with Professor Johanne Martel-Pelletier, the Osteoarthritis Research Unit at the UdeM Hospital Research Centre (CRCHUM), which has since grown to become one of the most highly renowned and respected facilities of its kind. He has led UdeM's Arthritis Centre since 1985. In 1997, he was appointed Head of the Division of Rheumatology of the UdeM Hospital Centre (CHUM) and in 2000, co-titular Head of the Chair in Osteoarthritis at UdeM.

Dr. Pelletier is a well-known expert in the field of osteoarthritis for his work in both basic and clinical research. His principal research interest lies in understanding the mechanisms involved in the pathophysiology of osteoarthritis. His work in the field of arthritis research has led to a large number of landmark studies and in turn to major breakthroughs and discoveries with regard to the pathophysiology and new avenues of treatment of musculoskeletal diseases.



Dr. Jessica Widdifield, of the McGill University Department of Epidemiology, Biostatistics and Occupation Health, has recently been awarded a Banting Fellowship, Canada's most notable post-doctoral award.

Her postdoctoral research focuses on enhancing the validity of using Canadian and international electronic health databases for research and surveillance in rheumatology; the research conducts comparative analyses across settings to characterize patient populations, the burden of morbidity, and premature mortality.

This prestigious Fellowship is named in memory of Sir Frederick Banting, the Canadian physician, researcher, Nobel laureate and war hero who, with his assistant Dr. Charles Best, is credited with the discovery of insulin. Only 23 fellowships across all health disciplines are awarded each year through the Canadian Institutes of Health Research (CIHR).

This award recognizes leaders in their field and helps attract and retain top talent in Canada.

Dr. Marie Westby was awarded the Association of Rheumatology Health Professionals (ARHP) Distinguished Clinician Award at the 2014 American College of Rheumatology (ACR)/ARHP Scientific Meeting in Boston, MA on November 15th. This award recognizes an ARHP member who demonstrates outstanding clinical expertise in arthritis and contributes to advancing the art and science of rheumatology. Dr. Westby has served on several ARHP committees and task forces over the past 20 years. Currently, she is the only Canadian representative on the ARHP Practice Committee as well as a joint initiative through the Centers for Disease Control and Prevention (CDCP)/Arthritis Foundation to develop online resources identifying appropriate physical activity opportunities for people with arthritis. In addition to her role as the Physical Therapy Teaching Supervisor in the Mary Pack Arthritis Program in BC, she is a postdoctoral fellow in the School of Public Health, University of Alberta/Arthritis Research Canada (ARC) and a Clinical Associate Professor in the Department of Physical Therapy at the University of British Columbia.

AWARDS, APPOINTMENTS, AND ACCOLADES

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

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

Update on the CRA *Choosing Wisely* Campaign

By Michelle Jung, MD, FRCPC; and Shirley Chow, MD, FRCPC; on behalf of the CRA Choosing Wisely Dissemination Committee

Medicine, and in particular rheumatology, is a rapidly growing field with new tests and therapies being developed to improve patient care. As self-regulated professionals, we acknowledge our foremost obligation is to provide safe, efficient and effective care, while also respecting the fiscal constraints of our medical system.[1] Although a difficult task, it can be achieved by reflecting on our own practices, keeping up-to-date on evidence, and ensuring that our approach is devoid of unnecessary investigations, procedures, and treatments. This reflection and improvement are the principles of the Choosing Wisely Canada (CWC) campaign.

The CWC campaign began last spring to help physicians and patients make decisions about medical care that is effective, safe, evidence-based, and mindful of resource stewardship.[2] The CRA has joined the campaign alongside the Canadian Medical Association (CMA) and nineteen other Canadian medical societies. The CRA released a list of five rheumatology practices, therapies, or procedures which, based on current literature,[3] may be unnecessary and/or expose patients to harm.

The CRA has recently conducted two surveys to evaluate the dissemination of the CWC campaign. The first was sent during the month the list was released and the second six months after.

Figure 1 reflects member awareness of this initiative (80% from the first survey, 96% from the second) and the CRA lists (73% from the first survey, 80% from the second). The number of people who thought it would change their practice was 25%. One explanation for why practice was not changed is that 91% of rheumatologists stated they are already compliant with these recommendations; 6% felt that family physicians should be changing their practice accordingly. Others stated that these recommendations did not apply to their practice (5%), while others needed more evidence (5%).

The two most common investigations the CRA members would order differently (Figure 2) were the ANA test (68%) and bone mineral density (BMD) testing (64%).

This important act of optimizing patient safety and value in medical care is reflected in the incorporation of quality improvement and patient safety in the CanMEDS 2015 competencies.[4] Our multifaceted roles as medical experts, health advocates, professionals, and managers is centred in our commitment to continuously improve health care quality, patient safety, and resource stewardship. As self-regulated professionals, we are accountable to the patient and committed to provide a safe and sustainable health care system. The motto is, "everyone in healthcare has two jobs when they come to work every day: to do their work and to improve it."[5]

Figure 1. **Member Awareness of the Choosing Wisely Initiative and CRA 5 Items, As Reflected in the Online Surveys (2014)**

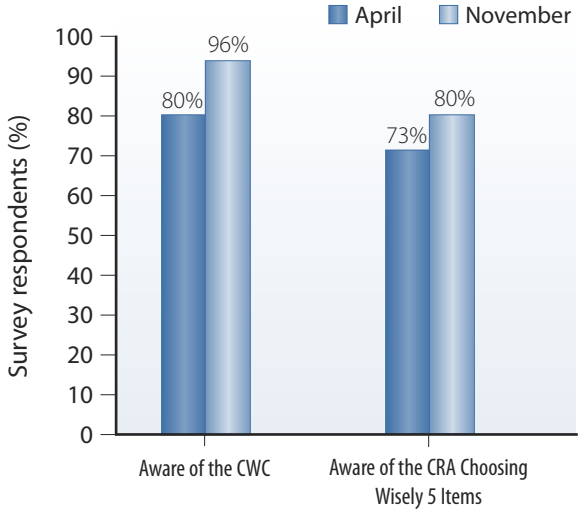


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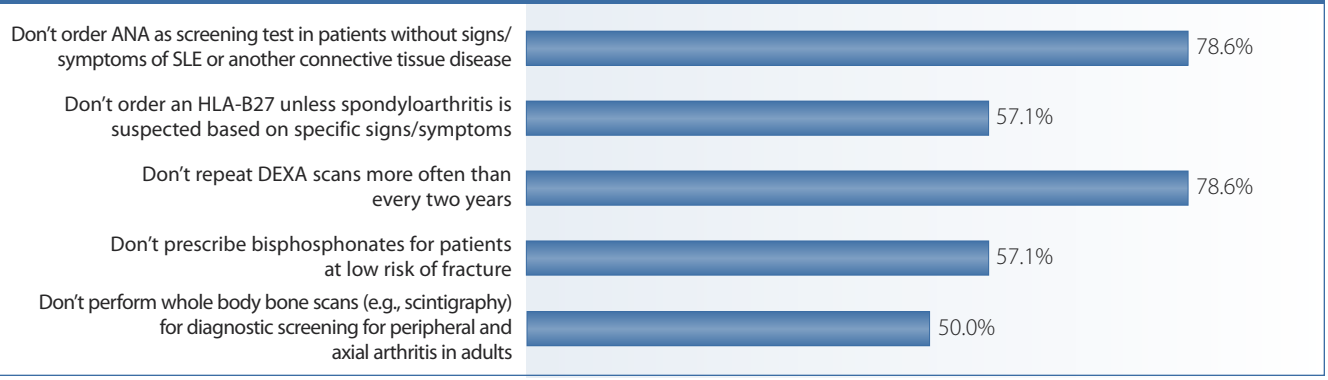
Figure 2. **CRA Choosing Wisely Items Rheumatologists Have Re-evaluated Ordering, Of Those Who Responded It Would Change Their Practice**



CRA Committees: Where Might You Fit In?

- Annual Scientific Meeting (Content) Committee: Develop the scientific content for the ASM.
- Annual Scientific Meeting (Planning) Committee: Develop all aspects of the ASM apart from the scientific content innovations, speakers, etc.).
- CIORA Review Committee: Review and evaluate project submissions.
- Communications Committee: Review and develop communications content, including newsletters and website copy.
- Education Committee: Help to develop, review, or disseminate Continuing Rheumatology Education, review applications for accreditation of CME activities, and facilitate the sharing of resources amongst rheumatology educators.
- Guidelines Committee: Supervise the creation and dissemination of evidence-based guidelines and provide feedback to other related organizations on pertinent issues.
- Human Resources Sub-Committee: Document current HR situation nationally, provincially, and regionally, particularly to determine areas of shortage). Explore and implement measures to alleviate identified HR problems.
- Optimal Care Committee: Provide advice to the CRA on emerging issues in the field of access to care including Wait Time Alliance (WTA), Non-Insured Health Benefits (NIHB), and Choosing Wisely.
- Research Committee: CIORA is the main focus of this committee, which requires volunteers to assist in the strategic implementation of the program.
- Therapeutics Committee: Provide advice to the CRA on emerging issues in the field of rheumatology therapeutics and address the issue of drug shortages.

Please contact Claire McGowan-Shaw at *claire@rheum.ca* if you are interested in volunteering for any of these committees or even for a specific project.

Training the Rheumatologists of Tomorrow: A Qualitative Case Study

By Alfred Cividino, MD, FRCPC, FACR; on behalf of the participants

In 2012, the Canadian Initiative for Outcomes in Rheumatology Care (CIORA) funded a one-year grant for a pan-Canadian study to explore participants' views on a career in rheumatology, how programs can inform and attract learners, and what to do to attract more trainees in order to meet the growing need for rheumatologists in Canada.

After receiving ethics approval, each of the nine postgraduate rheumatology programs invited their faculty and trainees to join the study. Participants completed a self-administered online survey in English or French, or an individual telephone interview in English. Data from the 103 participants were subjected to Thematic Framework Analysis to identify key concepts and issues separately for learners (junior = undergraduate medical students and PGY1-3s, senior = PGY4-6s) and faculty/administrators.

Faculty were very enthusiastic about the profession, saying "rheumatology is the specialty of the future" but noted the need to update perceptions about it, noting that "rheumatology is often thought of as dealing only with arthritis and diseases of the elderly. We need to promote rheumatology as a specialty with fascinating immuno-pathogenesis and cutting-edge research at the frontier of discovery". They advocated targeting both undergraduates, as "people who influenced me were [role models] I had as a medical student" and junior internal medicine residents through face-to-face interactions and formal courses in medical school. Specific messages to grow interest in the field ranged from "tell them it exists: I didn't know about rheumatology until the start of internal medicine [training]" to "emphasize [we're] happy doctors."

Junior learners suggested personal contact with practitioners at career talks, observerships, and other mentoring opportunities, hosting small-group information sessions with undergraduates, as well as formal training through MSK blocks and clinical skills sessions, such as providing "more teaching by rheumatologists in the medical curriculum so students are aware of what the specialty is." Senior learners also mentioned increased rotation placements, to "make sure that we're not turning away interested internal medicine residents."

Messages to positively brand rheumatology include those focusing on the intellectual challenge ("novel immunotherapies make it very exciting," "nice mix of procedural and cerebral work"), alleviating suffering, good quality-of-life ("according to a recent survey we are the happiest specialists," "excellent work-life balance"), and excellent job prospects ("the health care system needs you").

This is the first pan-Canadian qualitative study providing an insider perspective on how to attract more trainees to rheumatology. Due to the growing shortage of rheumatologists in Canada, it is important to increase awareness about the field by selectively using limited resources, such as collaboratively developing tools to increase interest in rheumatology for use across Canada.

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Three Updates to the MOC Program Support Your Learning Needs

The following information has been provided by the Royal College of Physicians and Surgeons of Canada to help you understand recent updates to the Maintenance of Certification (MOC) Program. Responding to your feedback, the Royal College is continually evolving the MOC Program to help you achieve better performance and patient care.

1. You may be eligible for the MOC Program's new cycle minimums

New cycle minimums introduced in 2013 aim to encourage Fellows and MOC Program participants to intentionally integrate each section of the MOC Program as they develop and implement a learning plan relevant to their professional practice.

Did you start a new or next Maintenance of Certification Program cycle on or after January 1, 2014?

- If **yes**, then you must document at least 25 credits in each section—1, 2, and 3—of the MOC Program before your five-year cycle ends. Remember, this is a cycle requirement, not an annual one, so you have five years to achieve these minimums.
- If **no**, then the new cycle minimums will not affect you until after you finish your current cycle.
- If you **do not know**, simply log in to your MAINPORT ePortfolio (*www.mainport.royalcollege.ca*) to check your current cycle dates on the dashboard under your name.

2. The 75% policy has been eliminated

The 75% rule used to restrict the number of credits in any one section that could contribute to MOC cycle requirements. There is no longer a cap on the percent of credits that can be earned in each section during an MOC cycle.

3. The Royal College offers a special MOC benefit for Resident Affiliates

Resident Affiliates of the Royal College participating in the MOC Program can earn and transfer up to 75 credits—25 from each section of Group Learning, Self-Learning, and Assessment—into their first MOC cycle as a Fellow. This is a key opportunity for residents to get a head start on the continuous improvement of competence that will become crucial for annual re-licensure once they become Fellows and enter professional practice.

Resources and Support

For more information, visit *www.royalcollege.ca/moc*

Log in to MAINPORT at *www.mainport.royalcollege.ca*

Download the app for iPhones at *www.royalcollege.ca/apps*

Contact the Royal College Services Centre at *cpd@royalcollege.ca*, 1-800-461-9598 or 613-730-6243 for year-round support.

MOC Program Fast Facts

You must earn and report at least:

- 400 credits over the course of your five-year cycle by participating in educational activities that meet the identified needs of your professional practice.
- 40 credits of continuing professional development (CPD) activities per year, even in the years after you have reached the 400-credit minimum requirement.
- 25 credits per section of the MOC Program over the course of your five-year cycle. *Note: only applies to Fellows who started a new/next MOC cycle on/after January 1, 2014.*

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

MOC PROGRAM
enhancing learning, advancing care

Interview with Christine Charnock, CEO of the CRA

1. What circumstances propelled you towards a career with the CRA?

Wanting to stay home with my kids.

2. Did you anticipate your career trajectory leading in this direction?

Not at all! I was working for a relief and development agency managing all of their projects in developing countries and relief situations. After I had my second daughter, I wanted to be around my family more and I did not want to travel for weeks at a time. I had a friend who was a physician and she suggested I put in my name just to do typing for specialists until I found something else; she knows I hate to be bored. Carter Thorne called me a few months later and asked if I was interested in helping him out—he was the Secretary-Treasurer of the CRA—and it just grew from there.

3. How does your professional background influence your approach to leading an organization and managing issues that arise under your leadership?

I have always worked in the not-for-profit sector, and recently completed all of the courses to get the Certified Association Executive designation. I love the challenge of change to improve things, to provide what the members need and to look beyond their perceived needs to the future.

4. How do you measure the success of the organization?

Getting positive feedback from the members, especially in terms of being able to let them know that we are listening to them and addressing their needs.

5. Are there any untapped resources you plan to help the CRA leverage?

There must be so many—we just need to identify them and find the time to develop them! I am always searching for new ideas or thinking during talks and sessions about how something can be adapted to the needs or wants, or even unidentified needs or wants, of the CRA and our members.

6. What benefits do you think electronic and social media can bring to Canadian healthcare that will aid patients, physicians, and healthcare providers? Will these help the CRA stay relevant? How?

I think that the future is all about people and technology and how they interact to communicate. The CRA will need to embrace this reality and figure out how it can best leverage this relationship to provide a unique benefit to our members.

7. Your tenure within the CRA is long and storied. What do you feel is your lasting legacy within the organization?

Innovation—mostly quietly, to the point where people do not really know where the ideas came from. For example, controversies: "Who shall we get to chair the meeting? How about the person who suggested it?…Who was that?… Oh, Christine."

I love making changes to make things better, more efficient, more interesting.

8. What has been the most poignant observation you have realized over the course of your career?

To always listen to feedback; no one knows it all and it is a shame when you think you do, that you are an expert and thus cannot learn anything more.

9. What do you foresee as challenges to Canadian rheumatologists in the future? What can individual rheumatologists and the CRA do to meet these challenges?

Being averse to change, and not thinking that things will change in the future. I remember when I went back to work after I had my first daughter and they had this stupid new thing called AOL and the World Wide Web (internet) and I thought, "I am not going to learn this as I will **never** use it! Now my life is consumed by it!"

Christine did eventually come around to the idea of the World Wide Web...

10. You are provided with a blank billboard. What do you put on it?

Zip your mouth and open your ears—you will learn so much even if you are an expert!

11. You are handed a plane ticket to anywhere in the world. Where are you going?

Tahiti—I think the glass-bottomed cabins are so beautiful!

12. What was your first paid job? How long did it last?

Delivering the *Toronto Star* newspaper at the age of seven…I did it for seven years! I have never been without a job since then.

Pillars of the CRA indeed: Dr. John Thomson, Dr. Michel Zummer, and Christine Charnock.

13. What is your biggest pet peeve?

People not being considerate to or thinking of others!

14. What would you like to do when you retire?

Sell our house and have a cottage somewhere to come back to in the summertime, but spend the winters in Africa or Haiti, learning, helping, and living a simple life. I would like to do house exchanges all over the world and experience new communities and people.

Christine Charnock
CEO,
Canadian Rheumatology Association
Newmarket, Ontario

WELCOME TO THE RHEUM

The CRA would like to welcome the following new members:

Zainab Alabdurubalnabi, Edmonton, AB
Samar Alharbi, Toronto, ON
Sam Aseer, Halifax, NS
Janique Dyba, Kingston, ON
Isabelle Fortin, Rimouski, QC
Maya Gerstein, Toronto, ON
Waleed Hafiz, Toronto, ON
Karlene Hagley, Toronto, ON
Mark Harrison, Vancouver, BC
Linda Hiraki, Toronto, ON
Alena Ikic, Quebec, QC
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Mohammad Refaei, Edmonton, AB
Alexander Tsoukas, Montreal, QC

CRA: Your Organization, Our Governance Structure

By Cory Baillie, MD, FRCPC

In January 2015, the CRA Board completed its governance restructuring and the goal of this article is to update the membership on these changes.

Over the last two years, the CRA Board considered governance options that would allow for the continued and increased success of the organization. To this end, the Board engaged an expert in non-profit governance, Catherine Raso, to help provide input and recommendations for the future. With our expert's guidance, it became clear that the CRA Board had become too focused on the operational aspects of the organization; this had limited the capacity of the Board to focus on where the CRA should be going in the future, rather than what we had done in the past.

The accompanying organizational chart outlines the new structure of the CRA. The most crucial change is the establishment of the new position of CRA Chief Executive Officer (CEO); the Board has hired Christine Charnock for this new position. As CEO, Christine will report to and be accountable to the Board for the operations of the CRA. Instead of reporting to the Board itself, the operational committee chairs now report to the CEO. The CEO is responsible for ensuring that the wishes of the Board, as expressed by the Board's strategic plan, are carried out by the committee chairs. Similarly, Christine is responsible for the supervision of all staff and consultants (accounting, legal, governance, etc.) hired by the CRA to help in the pursuit of its mission.

The responsibilities of the CRA Board change with the new structure. Freeing the Board from direct oversight of operations allows the Board to focus on governance. The key governance responsibilities of the Board will be:

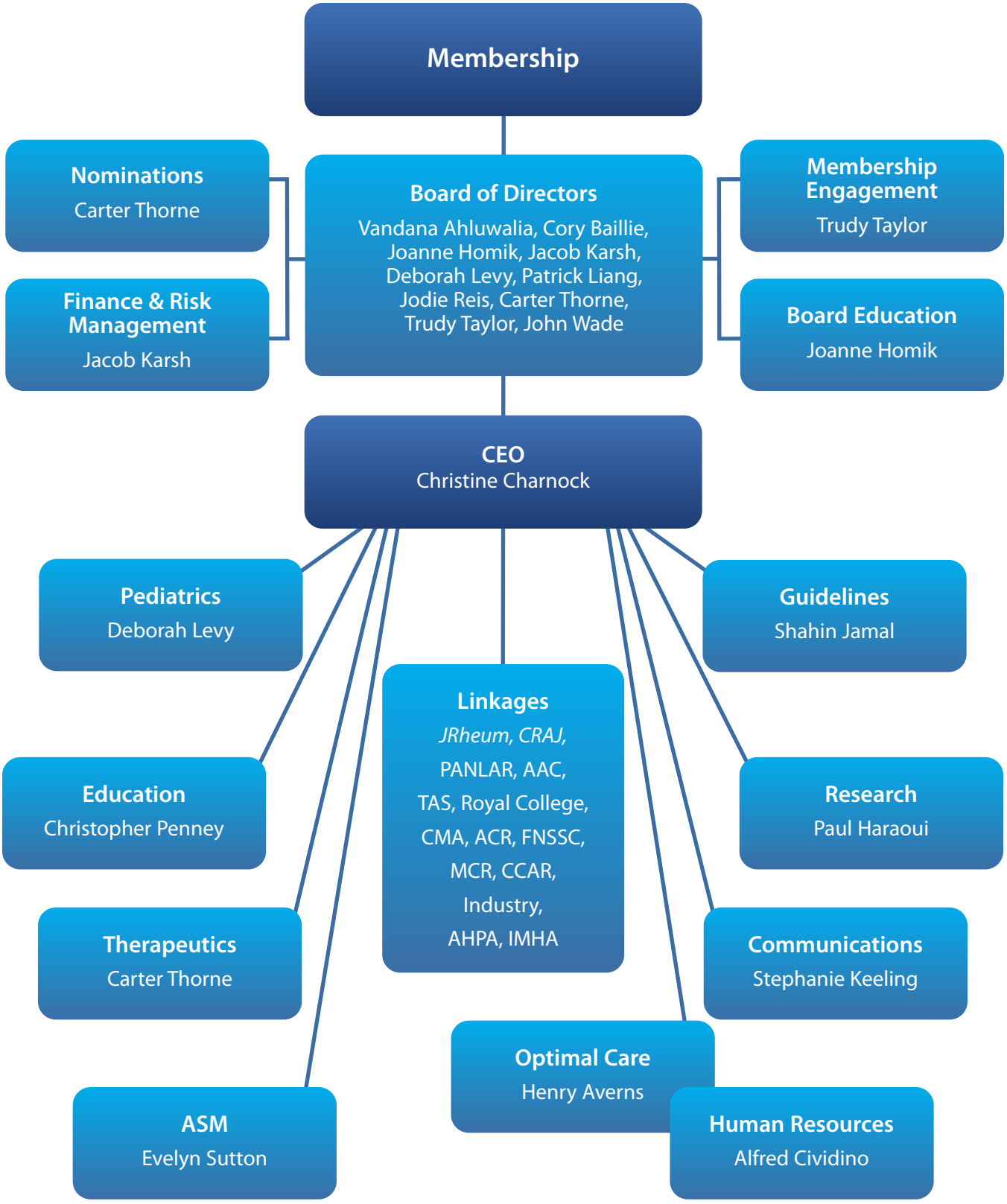
- Member engagement,
- Development and monitoring of strategic priorities,
- Monitoring and evaluation of the CEO,
- Self-evaluation of the governance process,
- Education on the CRA organization, and
- Monitoring the external environment in which the CRA functions.

The CRA President continues to act as the Board Chair and as the spokesperson for the organization. The President will develop the agenda for the bimonthly Board meetings. The CRA President, or his/her designate, is the CRA representative to all of the various organizations with which the CRA interacts, such as The Arthritis Society (TAS), the American College of Rheumatology (ACR), the Pan-American League of Associations for Rheumatology (PANLAR), and the like.

The operational committee structure of the CRA has been updated. Most of the committees remain similar in structure; a few new committees have been created and a few others have been merged. The greatest change is that the committee chairs now report to the CEO. The CRA committee chairs will be appointed jointly by the CRA President and CEO. Moving forward, committee chairs and members will serve for a minimum two-year term. We welcome any CRA member to volunteer to serve on any one of our committees; interested parties can contact *info@rheum.ca* for more details.

While certainly there will be some growing pains as the CRA adapts to the new structure, the Board has complete confidence that this is a necessary and correct step for our organization to ensure the successful pursuit of our mission to represent Canadian rheumatologists and to promote the pursuit of excellence in arthritis care, education, and research.

Cory Baillie, MD, FRCPC
President,
Canadian Rheumatology Association
Assistant Professor,
University of Manitoba
Winnipeg, Manitoba


Membership
Nominations
Carter Thorne
Board of Directors
Vandana Ahluwalia, Cory Baillie, Joanne Homik, Jacob Karsh, Deborah Levy, Patrick Liang, Jodie Reis, Carter Thorne, Trudy Taylor, John Wade
Membership Engagement
Trudy Taylor
Finance & Risk Management
Jacob Karsh
Board Education
Joanne Homik
CEO
Christine Charnock
Pediatrics
Deborah Levy
Guidelines
Shahin Jamal
Linkages
JRheum, CRAJ, PANLAR, AAC, TAS, Royal College, CMA, ACR, FNSSC, MCR, CCAR, Industry, AHPA, IMHA
Education
Christopher Penney
Research
Paul Haraoui
Therapeutics
Carter Thorne
Communications
Stephanie Keeling
Optimal Care
Henry Averns
ASM
Evelyn Sutton
Human Resources
Alfred Cividino

Accreditation History of the CRA

By Christopher Penney, MD, FRCPC

During 2010, the CRA Board noted that fewer and fewer University Continuing Professional Development (CPD) departments were willing to provide Royal College accreditation for our educational events, such as the CRA Annual Scientific Meeting (ASM). The majority of Canadian subspecialty societies were Royal College Accredited CPD Providers, performing accreditations of their own educational events. Why could the CRA not do the same?

There was some sentiment on the Board that the CRA "brand" on Canadian rheumatology continuing education programs made great sense, since CRA members are the major producers and consumers of those programs. The CRA also needed to represent the CPD concerns of rheumatologists to the framers of the accreditation rules at the Royal College.

I refer you to the following link for a listing of Royal College Accredited CPD Providers and what that involves: *www.royalcollege.ca/portal/page/portal/rc/members/cpd/cpd_accreditation/group_learning/cpd_accredited_providers.*

The CRA Board executive authorized the expenditure of $10,000 in November of 2010, and contracted with Jack Corman and Ron Fehst at Institutional Review Board Services to submit an application for Accredited CPD Provider status to the Royal College on behalf of the CRA. Dr. Carter Thorne and Christine Charnock, with my assistance, spearheaded this initative.

The application process was much more complex, frustrating, and time consuming than anyone anticipated. Institutional Review Board Services consulted with the executives of several other subspecialty societies, and was given much valuable advice and assistance with the documentation. To comply with Royal College accreditation standards, changes were and will be made to the structure and operation of the CRA.

Our application for Accredited CPD Provider status was submitted in the spring of 2011. The application was thousands of pages long and took hundreds of hours to prepare. We were granted Provider status for three years effective January 1, 2012. The Royal College required us to undertake to correct multiple partially compliant and non-compliant accreditation standards over those three years. As a CPD Provider, the Royal College holds the CRA to a higher standard than the typical physician association submitting programs for accreditation.

Like other small subspecialty societies, the CRA has contracted with an experienced CPD manager to deal with the accreditation of CPD events, and to handle the considerable paperwork required to maintain our Provider status. Thank you to Domenica Utano, our current manager, for her expert help. On behalf of the CRA, I also thank the many members of the Education Committee who have assisted with accreditation reviews over the past three years.

The 2015 CRA application for Accredited CPD Provider status was submitted in late 2014. We volunteered to test the new 2015 rules for accreditation and give our opinion on ways to improve those standards. We are now certified accreditors for five years, effective January 1, 2015. Of course, no application is perfect and, over the next few years, we will continue to work with the Royal College to resolve our partial compliance with some of their standards.

Is all the effort expended on maintaining the CRA as a Royal College Accredited CPD Provider worthwhile? I think so. What do you think? Your feedback and/or comments are welcome at *penney@ucalgary.ca*.

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

History of the Arthritis Health Professions Association

By Jennifer Burt, BScPT

Attempts to start a professional body of allied health professionals working in rheumatology in Ontario began in the 1970s. Planning began in earnest in the early 1980s and was supported by The Arthritis Society (TAS), Ontario Division. In her capacity as Director of Allied Health Education, Carolyn Thomas worked with a core group of dedicated allied health professionals from the Toronto area to establish the association known then as the Arthritis Health Professions Association of Ontario (AHPA, Ontario). Carolyn was instrumental in translating the vision into a reality; when she retired from TAS, AHPA granted her an honorary lifetime membership and established the Carolyn Thomas Award to acknowledge her support of scientific research.

The AHPA Board in Quebec City in 2015: (left to right) Nancy Ellis, Jennifer Boyle (IT), Jennifer Burt, Rashmi Mandhane, Karine Toupin-April (outgoing); Andrea Weagle, Angelo Papachristos, Sameer Chunara, Karen Gordon (outgoing), Leslie Soever (President) Missing: Raquel Sweezie, Julia Farquharson, Mandy McGlynn.

In 2000, due to growing interest from across Canada, our name dropped the reference to Ontario; with that, the Association's mandate expanded to take a national perspective that welcomed members from across Canada.

The mission of the AHPA is to:

- Stimulate interest in rheumatology among health professionals.
- Promote research and education in the field of rheumatology.
- Encourage interprofessional communication.
- Act as a resource body for those with an interest in rheumatology.
- Promote public awareness of the needs of people with arthritis.

AHPA members started attending the CRA Annual Scientific Meeting (ASM) in 2005. In 2008, Marlene Thompson, then President of the AHPA, collaborated with the CRA with the aim of allowing the AHPA to sponsor workshops providing educational opportunities specific to allied health professionals during the CRA ASM. The successful one-day AHPA pre-course started in 2009 and continues to grow annually.

In September 2013, the AHPA officially incorporated. Membership is still expanding, and we now boast over 140 members from coast to coast. AHPA continues to collaborate with the CRA by participating on their Scientific Committee to plan the annual conference and scientific meeting, which AHPA members attend yearly.

The AHPA is a society of health professionals who work in the field of rheumatology. Our members come from a variety of clinical and administrative settings such as hospitals, clinics, community programs, and universities. We are dedicated to improving healthcare standards for people with rheumatic disease through the promotion of education and support of research among our members.

Jennifer Burt, BScPT
AHPA Past President
St. John's, Newfoundland and Labrador

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Contraindications

- Severe infections such as sepsis, tuberculosis (TB) and opportunistic infections
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  - 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
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- **TB (from reactivation or latent TB 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 TB
  - If latent TB is diagnosed, start with anti-TB therapy before initiation
  - Monitor for signs and symptoms of active TB
- **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
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The product monograph is also available by calling 1-800-387-8781.

Reference: SIMPONI® I.V. Product Monograph, Janssen Inc., November 25, 2014.

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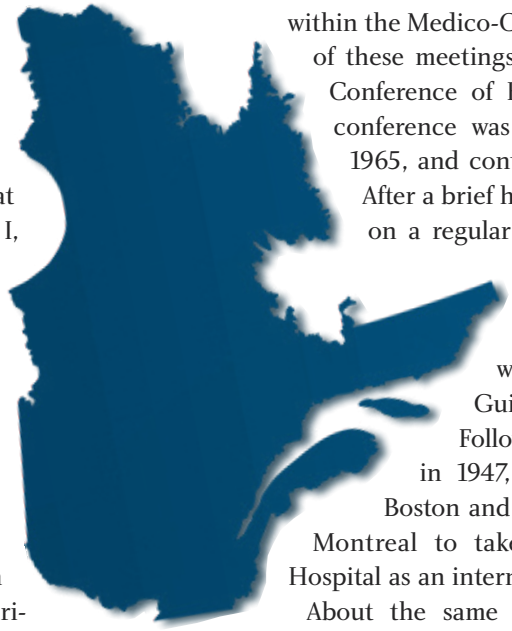
RA=rheumatoid arthritis; I.V.=intravenous.

History of Rheumatology in Quebec

By Jean-Yves Lang, MD, CSPQ



It is almost impossible to trace the origins of rheumatology in Quebec with any certainty. The most likely scenario is that a close link existed with what was happening elsewhere in Canada, especially at the Toronto General Hospital (TGH). It was at the TGH that, in the aftermath of World War I, first Dr. Almon Fletcher (1890-1965) and then Dr. Wallace Graham (1906-1962) focused their efforts on sufferers of rheumatic disorders.

According to my research, around 1936 Dr. Douglas Taylor, an internist affiliated with McGill University, joined with Dr. Fletcher to establish the Canadian Rheumatism Disease Association (CRDA); Dr. Taylor was later elected its president in 1938. We know that he was interested in arthritis thanks to one of his articles published in the Annals of Internal Medicine, detailing his radiological observations of various forms of chronic arthritis.[1]

Following World War II, the Canadian Arthritis and Rheumatism Society (CARS) was incorporated, likely in 1947-1948. Among the names in its founding manifesto are those of two Montreal physicians who served as directors.[2] One of the main objectives of CARS was to encourage fellowships to increase the number of rheumatology specialists and promote advances in arthritis treatment. Dr. Graham died prematurely in 1962, at the age of 56; the greatest wish of his successor, Dr. Metro Ogryzlo, was to establish, through CARS, rheumatic disease units (RDU) in all medical faculties in Canada.[3]

Armed with two years of training in arthritis in Paris and an internship in the same field in the United States, Dr. Réné Dandurand (1906-1949), of Montreal's Hôtel-Dieu Hospital, possessed all the attributes to become one of the fathers of rheumatology in Quebec. Regretfully, this pioneer died tragically in a plane crash on October 9, 1949.

Around 1947, Francophone and Anglophone physicians came together in Montreal to create a rheumatology section within the Medico-Chirurgical Society. During one of these meetings, the idea for the Laurentian Conference of Rheumatology was born. The conference was held annually beginning in 1965, and continued for the next five years. After a brief hiatus, the conference resumed on a regular basis in 1974, thanks to the combined efforts of Dr. André Lussier and Dr. Roger Demers. Another contributor worthy of mention was Dr. de Guise Vaillancourt (1921-2000). Following graduation in medicine in 1947, he studied rheumatology in Boston and New York before returning to Montreal to take a position at Hôtel-Dieu Hospital as an internist and rheumatologist.

About the same time, Dr. Maurice Campbell (1919-2014), a general practitioner in Cap-de-la-Madeleine, opted to specialize in internal medicine and rheumatology in 1947. He began a series of internships at Hôtel-Dieu Hospital in Montreal and in 1955 returned to Trois-Rivières to practice rheumatology, a vocation he pursued to the end of his long and exemplary career.

In 1969, Dr. Lussier founded the first RDU in Quebec at the Centre Hospitalier Universitaire de Sherbrooke (CHUS), drawing on his earlier years of training in rheumatology at one of the most prestigious centres in the United States, under the guidance of Dr. J. L. Hollander.

The following year, Dr. Lussier presented a brief to the Collège des Médecins du Québec (CMQ), advocating for official recognition of rheumatology as a sub-specialty of internal medicine.[4] For these and many other reasons, Dr. Lussier merits the title of Father of Quebec Rheumatology.

In 1970, all Quebec physicians with an interest and competency in rheumatology prior to the creation of the training program were granted rheumatology certification under a grandfather clause. At the CHUS, Dr. Daniel Myhal, who had been trained in Scotland, became an associate of Dr. Lussier and helped usher in the first generation of rheumatologists.

The first two rheumatology graduates in Quebec were Dr. Monique Camerlain and Dr. Henri Ménard, in 1973.

In 1975, the Université de Montréal's RDU was inaugurated; Dr. Guy Germain of Notre-Dame Hospital was its director, assisted by Dr. Jacques Gascon and Dr. Alain Prat. The RDU held a special association with Montreal's Hôtel-Dieu Hospital through Dr. Jacques Durivage, Dr. J.A. Blais, Dr. Vaillancourt and Dr. Demers, all of whom trained in rheumatology in the United States or in Europe. St-Luc Hospital participated courtesy of the involvement of Dr. Murat Kaludi and Dr. Claude Blondin.

Around 1975, McGill University's RDU was formally established, with Dr. Kirk Osterland of the Royal Victoria Hospital as its director, assisted by Dr. Louis Johnson, Dr. Cooper Stacey, and Dr. Douglas Kinsella. The RDU was also able to draw on the expertise of many other specialists, including rheumatologists Dr. John Martin, Dr. David Hawkins, and later, Dr. Hyman Tannenbaum and Dr. John Esdaile from the Montreal General Hospital, and Dr. Lyon Lapin, Dr. Morton Kapusta, and Dr. Murray Baron from the Jewish General Hospital.

In 1976, the last RDU was established in Canada at Université Laval in Quebec City. Dr. Lucien Latulippe was named its director, assisted by Dr. Jean Rousseau and myself.

In the early 20th century, rheumatology was generally misunderstood, ignored, and not viewed as a priority by most universities in the Western world. Due to sheer ignorance, the prevalent belief was that rheumatology had nothing to offer arthritis sufferers. The result was a teaching void. Thanks in large part to the RDUs' threefold vocation of care, research, and teaching, a new generation of highly skilled practitioners was trained.

In 1970, there were approximately 25 rheumatologists in Quebec. The majority of these were internists and physiatrists who had taken advantage of the grandfather clause prior to certification. In 2014, there are more than 100. Since the advent of biotherapies in the early 2000s, a major step forward has been taken in the fight against arthritis. Let us hope that this continues.

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4. Ménard H. In Memorium: André Lussier. CRAJ 2009; 19(3):17.

My sincere thanks to Dr. Guy Germain, Dr. Claude Blondin, Dr. Carol-Anne Yeadon, and Dr. Henri Ménard, who probed their memories and came up with names or facts that were indispensable to the writing of this article, which I hope faithfully mirrors the reality of rheumatology in Quebec.

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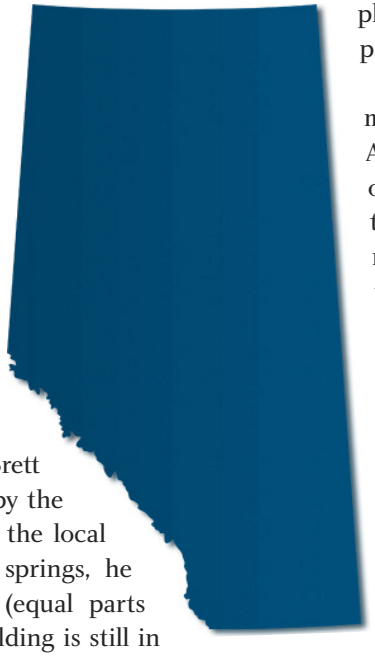
Centre hospitalier de l'Université Laval (CHUL)
Quebec, Quebec

History of Rheumatology in Southern Alberta

By J. Paul Ryan, MD, FRCPC

In the fall of 1883, Canada was a young nation and the Canadian Pacific Railway (CPR) arrived in the Bow Valley, west of Calgary. That winter, three men employed by CPR stayed and "discovered" the thermal springs. For many years the local First Nations' peoples knew of the thermal springs and had used them to treat their aches and pains. Because of the potential of these springs and the surrounding mountains, the Canadian government established the first national park in 1887, later to be known as Banff National Park.



The first physician in Banff was Dr. R.G. Brett (1851-1921). He was sent to Banff in 1886 by the CPR to look after the medical problems of the local population. To capitalize on the thermal springs, he quickly established the Brett Sanitarium (equal parts bar, poolroom, hotel, and hospital). The building is still in use as the current headquarters for the Banff Parks Administration. In 1904, Dr. Brett built the Brett Hospital, which was later named the Banff Mineral Spring Hospital. The water from the mineral springs was piped down the mountain to the hospital as well as the newly built Banff Springs Hotel. Patients came to Banff from all over North America to try this thermal (spa) therapy for their arthritis.

In 1925, Dr. Dean Robinson joined Dr. Harry Brett (son of Dr. R.G. Brett) in Banff to look after patients with arthritis. Dr. Robinson went to Europe in 1930 seeking new knowledge and treatment for these patients. Upon his return, he initiated the first hospital program treating patients with arthritis using exercises, rest, casting, and gold injections, in addition to thermal therapy. He was the first to publish a paper in Canada describing the treatment of more than 100 patients using two forms of gold injections. In 1950, he was one of the first to use and report on the side effects of adrenocorticotropic hormone (ACTH) and cortisol in the treatment of arthritis. In most of his publications Dr. Robinson ended the paper by a political plea for increased funding for treatment of patients with arthritis (sound familiar?).

Dr. Robinson was one of the founding members of the Canadian Rheumatic Disease Association (CRDA), along with a number of other physicians in eastern Canada. During the Second World War, this organization was not very active. After the war, however, it was renamed the Canadian Rheumatism Association (CRA) at a meeting at the newly renovated Banff Springs Hotel.

Dr. Robinson encouraged a number of Banff patients to form an arthritis club. This group, along with others in Vancouver, petitioned the government to support the treatment of patients with arthritis. Because of this lobby, a conference was called in 1947 and the Canadian Arthritis and Rheumatism Society (CARS) was formed. Dr. Dean Robinson was the father of Dr. Harold Robinson, who later became one of the Rheumatic Disease Unit (RDU) heads in Vancouver.

Calgary now became the centre of rheumatic disease treatment. At the encouragement of Edward Dunlop, Dr. D. G. (Red) Howard trained as a rheumatologist. After

Photo courtesy of the Whyte Museum of the Canadian Rockies. V263/NA 5968. Byron Harmon Fonds.

Bathing at the Mineral Hot Springs, circa 1930.

his training he returned to Calgary to set up a rheumatology practise in 1954. In the early 1960s, the convalescent and rehabilitation wing was built at the Calgary General Hospital and 30 beds were designated for rheumatology patients.

In 1966, the Faculty of Medicine was created at the University of Calgary, with the first medical students being admitted in 1970. The RDU of the University of Calgary was formally established at the General Hospital in 1973 with Dr. Howard as the first Head. To complement Dr. Howard, Dr. Martin Atkinson was recruited to join him at the Calgary General Hospital.

The next head of the Calgary RDU, from 1975 to 1985, was Dr. Doug Kinsella, whose research interest was sero-negative arthritis. His successor, Dr. Marvin Fritzler, was keenly involved in researching autoimmune diseases and serology. With Dr. Fritzler as Head, the RDU moved from the General Hospital to the University of Calgary and the Foothills Hospital. Dr. Atkinson remained as the clinical director at the Calgary General Hospital.

Under the leadership of Dr. Fritzler, the Arthritis Chair was established. The first individual to occupy this chair was Dr. Mark Adams, whose research focused on osteoarthritis. By now the Calgary RDU was well established, boasting research, resident training, and patient care.

From its humble beginnings in Banff, we now have 25 rheumatologists (both adult and pediatric) practicing in Calgary.

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Calgary, Alberta

Photo courtesy of the Whyte Museum of the Canadian Rockies. V469. 1780. George Noble Fonds.

Banff Mineral Springs Hospital, circa 1930.

The Battle of Alberta

The Arthritis Society

"The Battle of Alberta" used to refer to a Flames/Oilers hockey game. Now it means a lighthearted – but very serious – challenge between rheumatology clinics in Calgary and Edmonton to see which can generate the most support for The Arthritis Society's **Walk to Fight Arthritis**.

Dr. Stephanie Keeling, rheumatologist at The Edmonton Clinic, and team captain of the *Arthritis Annihilators* says, "We were narrowly edged out by Calgary last year; heading into the 2015 Walk, we are pulling out all the stops to ensure we come out on top."

For three years now, The Edmonton Clinic and the Calgary Rheumatology Clinic have squared off in a fundraising challenge with the help of rheumatologists, support staff and patients' families. In 2014, Calgary's *Rolling Bones* brought in $16,523 to lead not only the challenge but the country; the *Annihilators* clocked in at $13,542, good for third-place nationally. Together the teams eclipsed their ambitious $30,000 target for the challenge.

Says Dr. Keeling, "When you consider how important TAS has been in supporting not only our patients, but also the development and practice of the rheumatology profession in Canada, finding a meaningful way to give back is a no-brainer."

Over the three years that the teams have been participating, they have combined for nearly $100,000 in funds raised.

Rolling Bones captain Terri Lupton, a nurse clinician at the Calgary Rheumatology Clinic, stresses the importance of making the challenge fun. "Whether it is our physicians taking part in a foot race or posting regular updates on each team's fundraising totals, finding entertaining ways to get people involved in the spirit of the competition helps make it a success."

It is exactly that spirit of giving back that lies at the heart of the **Every Member Campaign**: the CRA and TAS are partnering to raise $2 million between them to support rheumatology recruitment and professional development programming in Canada, towards a goal of providing enough rheumatologists to support another 300,000 Canadian patients over the next five years.

Many CRA members have chosen to pledge to the campaign directly; others, like Dr. Keeling, are using the **Walk to Fight Arthritis** as their way to contribute. Either way, the funds are urgently needed to help address rheumatologist capacity concerns in many parts of the country.

"The way I see it," says Dr. Keeling, "most of us would not be where we are in our careers if not for the support of TAS at one point or another. We owe it to them, and to our patients, to help support the next generation of researchers and clinicians."

The 6th Annual **Walk to Fight Arthritis** takes place on Sunday June 7th. For more information, check out *www.walktofightarthritis.ca*.

To pledge your contribution to the **Every Member Campaign**, please contact Sandra Dow at *sdow@arthritis.ca*, or by phone at 416-979-7228 ext. 3343.

Jack Stein

By Michael Stein, MDCM, FRCPC

1938 - 2014

It is with great sadness that family and friends must announce the passing of Dr. Jack Stein in Toronto on December 27, 2014. Jack was the deputy Chief of Staff at Scarborough General Hospital for many years (1995 to 2007) and prior to that he was Chief of Medicine. His positions of leadership reflected his remarkable talent for connecting and communicating with colleagues and patients. He was known by many trainees at the University of Toronto where he was an Assistant Professor of Medicine. He was a clinical teacher affiliated with the Division of Rheumatology at Sunnybrook Health Sciences Centre. Perhaps the greatest testament to his example of achievement and professionalism is the fact that two of his sons, Michael and Jonathan have become rheumatologists.

We wish his family our condolences and sympathy. Jack was held in high esteem and regarded with great affection by all who knew him, and his passing is a loss to us all.

Michael Stein, MDCM, FRCPC
Professor,
Department of Rheumatology,
McGill University
Montreal, Quebec

BC

Jason Kur @drjasonkur
Artus Health Centre, Western Canada's largest group of rheumatologists has moved into new world class facilities near Vancouver General Hospital.

Jason Kur @drjasonkur
#ARTUS #Vancouver

Michelle Teo @drmichelleteo
The Kelowna group has been busy not only with patient care but with training medical students, internal medicine and rheumatology residents. Rheumatology nurses continue to be vital to the care of our inflammatory arthritis patients.

Robert Offer
The future looks bright for Fraser South. A recent environmental scan commissioned by TAS pointed out the need to restructure the delivery of arthritis care in BC; Surrey was top of the Missing in Action list. Any solution would be impossible without the critical element, rheumatology manpower, being addressed. As it appears that over the next year we will acquire three more rheumatologists, locating in Surrey, White Rock, and Abbotsford and with two of these speaking Punjabi, even the astrologers will agree that the stars are aligned.

Kim Northcott @drkimnorthcott
#Victoria #WestIsBest

Kim Northcott @drkimnorthcott
There are currently six rheumatologists (five adult, one pediatric) serving the Capital Region of Victoria. With the accumulation of three rheumatologists in Nanaimo, our patient population base north of the central island has been gratefully offset.

Robert Offer
In BC there are large geographic areas void of rheumatology services, hence the importance of the Travelling Consultation Service (TCS), which supports rheumatologists doing outreach several times per year in many remote areas.

Michelle Teo @drmichelleteo
#OkanaganRheums Dr. Godin, Michelle Jung (R5), Dr. Seigel, Dr. McLeod, Dr. Stewart, Dr. Shojania

Jason Kur @drjasonkur
Doctors of BC negotiate a new five-year contract with the Province. Work will begin in 2015 on new specialist initiatives in rheumatology.

Michelle Teo @drmichelleteo
Dr. Jacquie Stewart has started an outreach rheumatology clinic in Princeton. In conjunction with UBC Okanagan, Penticton is about to begin a multidisciplinary research study for the treatment of fibromyalgia. Dr. Anick Godin and Dr. Teo have come back from maternity leave; not sure which is busier, rheumatology clinics or taking care of little ones!

Jason Kur @drjasonkur
The doctors at Artus Health Centre once again organize the well-attended and much appreciated BRIESE conference featuring Dr. Cem Gabay, Dr. Christian Pagnoux, Dr. Rick Adachi, and Dr. Marvin Fritzler.

ACR 2014

By Philip A. Baer, MDCM, FRCPC, FACR

"You wanna be where you can see, our troubles are all the same / You wanna be where everybody knows your name."
– Gary Portnoy, "Where Everybody Knows Your Name"(lyrics, Portnoy and Angelo), Soundtrack from *Cheers*, 1982.

Boston 2014 was my third go-round with the American College of Rheumatology (ACR) in Beantown. The first time, I recall staying right downtown, with the conference held at the Hynes Convention Centre. Getting around was a bit of a nightmare due to Boston's Big Dig project to reroute and bury expressways; it finished years behind schedule and over budget, but was worthwhile in the end. I compensated by taking several walking tours through Back Bay, Boston Common, and along the Freedom Trail. The ACR used to offer them at nominal cost through the conference "Spouses Program"—a relic of a different era.

The second time in Boston, we were at the Boston Convention and Exhibition Center (BCEC) in the revitalized Seaport District, the largest building in New England. The year was 2007, and the talk among Canadian attendees was of our mighty loonie flying high at $1.10 US in value. Everything was cheap for us, including attending a Montreal Canadiens vs. Boston Bruins hockey game at the TD Centre.

For Boston this year, I was looking forward to a leisurely conference, attending with my wife, balancing the three-ring circus of meeting sessions, networking, and CRA-related events with touring some of Boston's tourist highlights, including Harvard Yard, the Institute of Contemporary Art, and the Boston Tea Party museum. I am not a regular at the Harvard Rheumatology Review Course, so my visits to Boston are quite sporadic.

The whole relaxing conference idea went out the window when I found out an abstract we had submitted had been accepted for a podium presentation at ACR. Great, except I was the first author, so it was up to me to actually present the study, something brand new to me after 30 years in rheumatology! I had presented posters over the years, of course, the first at ACR 1986. I remember typing the different parts in a huge font on standard pieces of paper, attaching them to contrasting pieces of cardboard, putting them in a brown envelope, and needing 24 pushpins to put the various parts on the posterboard. The topic: "Impact of intra-articular steroid injections on salicylate levels in RA." Probably a paper with one of the lowest impact factors in rheumatology research history, but we did manage to publish an article based on it after the meeting. Going through my rheumatology papers recently, I even found the abstract acceptance letter from Dr. Ronald Messner, indicating ours was one of 300 accepted posters. Obviously, that meeting was a far cry from the thousands of posters on offer at ACR 2014.

Thereafter, I had presented various posters at pain and rheumatology conferences, usually co-authored with my wife. Production ramped up when I joined the Biologic Rheumatology Registry Across Canada (BioTRAC) registry as an investigator, and we obtained a critical mass of patients, allowing for analysis of multiple research questions in a Canadian real-world observational setting. This led to standing in front of posters at various CRA, ACR, and European League Against Rheumatism (EULAR) meetings, culminating in presenting a poster on one of the ACR Poster Tours in San Diego in 2013. I thought I had achieved my maximum in terms of research participation.

This podium presentation presented additional opportunities for embarrassment. I did not want to be recalled for fainting during a presentation; I already have witnessed that at a prior rheumatology meeting. Likewise, I did not relish facing the memory challenge Dr. Ed Keystone (author #2 on our study) withstood at a past EULAR when the power failed during his presentation. He did not miss a beat, as he had memorized every number on his slides down to two decimal points.

Fortunately, our paper had 14 co-authors, including an excellent biostatistics team and the support of a committed sponsor. From an initial skeleton, we quickly progressed through five drafts. Dr. Keystone scrambled our slide order, and rearranged everything to increase the simplicity and coherence. My son coached me on basic statistics, including the Chi square test, Pearson's correlation coefficient, and ROC curves, and the biostatistics group taught me how to explain the rationale for our modelling choices. I

practiced at our Journal Club and at other CMEs on the topic of composite indices in rheumatoid arthritis (RA). As I found out a few years ago at the CRA Great Debate, 10-12 minutes is not a long time to convey a logical and understandable presentation. I want to thank everyone who listened and provided feedback. Dr. Jacques Brown, Dr. Claire Bombardier, Dr. Dafna Gladman, Dr. Bob Josse, and Dr. Keystone all provided helpful advice on dealing with questions, and on presenting in large dark rooms where you can barely see the audience. My plan included filling the room with Canadian colleagues and friends, and leaving as little time as possible for challenging queries.

The next attack of nerves came when the ACR published the final conference program. Our paper was scheduled as part of an afternoon with nine concurrent sessions. It turned out I would be presenting in the largest of the nine session halls, indicating our paper was part of a session expected to be quite popular. I figured perhaps the second-biggest hall would attract some of our audience, given the co-chairs were the ever-popular Dr. Iain McInnes and Dr. Vivian Bykerk. At least I no longer had to worry about having a shaky hand on the laser pointer, as I would not be using one in a large hall with multiple projection screens.

In the end, everything went well. Our paper was paired with one from the DANBIO registry on the same topic of patient-related outcomes in composite disease activity measures, which I was able to reference in introducing our study. Our slides projected well in the large room, and no one asked any questions regarding statistics. The Canada-USA divide on physical examination was exposed by the questions, dealing with our confidence in our joint examinations without the use of bedside ultrasound.

With that out of the way, I could enjoy the meeting, including our lively CRA Council and CRAJ Board meetings, and many breakfast, lunch, and dinner meetings with colleagues. Canada night at the downtown Harvard Club, on the 38th floor of a skyscraper, was terrific: familiar and friendly colleagues and their families, tasty food and great views, despite the rainy weather. Dr. Andy Thompson and his *www.rheuminfo.com* team provided insightful suggestions regarding which sessions to attend with their new *www.rheumreports.com* website. My thanks to Dr. Janet Pope, one of Dr. Thompson's reporters, for the following statistics on prolific Canadian authors at ACR 2014: DD Gladman (39), E Keystone (28), WP Maksymowych (26), B Haraoui (22), P Rahman (20), JS Sampalis (20), V Chandran (18), B Bensen (17), D Choquette (17), E Rampakakis (16), J Pope (16), VP Bykerk (16), C Thorne (15). The list is a *Who's Who* of Canadian rheumatology, of whom we can all be extremely proud. I thought I was doing well with nine abstracts, one jointly with my wife, but we are playing in a different league.

The weather was typical for the Northeast in November, and the WiFi was spotty at the conference centre, but overall it was another excellent meeting. I enjoyed presentations on new ACR-EULAR PMR guidelines, though the 2015 update on the ACR RA Guidelines was disappointing. Reassuring data was presented on antimalarials for reduction in cardiovascular morbidity in rheumatic diseases, and the ability to give zoster vaccine to patients on biologics. Our own Dr. Ron Laxer was the expert presenter at a CPC on chronic recurrent multifocal osteomyelitis (CRMO), an autoinflammatory disorder that mostly affects children. Dr. Earl Silverman received an ACR Award for excellence in investigative mentoring. New therapies targeting IL17 in seronegative arthritis and URAT-1 transporters in gout were highlighted, as well as therapies targeting interferon in lupus.

In the end, we made it to Harvard for a tour led by a sophomore student, and walked the Freedom Trail. The aquarium, Institute of Contemporary Art, and the Boston Tea Party museum will have to wait for another visit. Alcohol was in plentiful supply, but we did not make it to the bar featured on *Cheers* either.

Finally, no trip would be complete without some travel-related pain. We stayed until the meeting ended Wednesday at noon, and landed in Toronto at 4PM in the midst of a fall snowstorm. That resulted in a two-hour wait for a taxi, with an unruly crowd requiring the police to be called to maintain order. We ended up in line with Dr. Rayfel Schneider, a pediatric rheumatologist whom I had never met. Chatting with him made the time pass quickly, and also generated some ideas for future *CRAJ* articles. We wound up sharing a cab, which only took another two hours through bumper-to-bumper traffic to get us all home. Shades of CRA 2008 in Mont Tremblant, when we slept overnight at Trudeau airport in Montreal, but this was not quite as bad.

I look forward to ACR 2015 in San Francisco, but I cannot even think that far yet—CRA 2015 looms, followed by EULAR. The cycle never ends.

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Does This Patient Have IgG4-related Disease?

By Luke Chen, MD, FRCPC, MMEd

Case: A 72-year-old woman of East Indian descent presents with nephrotic range proteinuria of 7.2 g/day and an albumin/creatinine (ACR) ratio 1,360 mg/mmol creatinine. A renal biopsy is consistent with membranous glomerulonephritis (MGN). She has a long history of unusual clinical problems starting with a pancreatic mass at age 48. Histology of the Whipple's resection revealed an atypical lymphocytic infiltrate with no evidence of malignancy; 15 years later, small bowel biopsies for workup of anemia showed a similar atypical T-lymphocyte infiltrate. At age 67, she had autoimmune pancreatitis responsive to steroids as well as bilateral parotid and salivary gland swelling. Excisional salivary gland biopsies revealed "an intense lymphoplasmacytic infiltrate with fairly numerous germinal centres…a moderate degree of background fibrosis and sclerosis." The patient was diagnosed with Mikulicz' disease.

Her recent bloodwork shows eosinophilia 1.9 giga/L, C-reactive protein (CRP) 5.2 mg/L, negative anti-nuclear antibodies (ANA), low albumin 25 g/L, elevated total protein 91 g/L with increased gamma globulins 27 g/L (normal 7-14 g/L) in a polyclonal pattern with increased immunoglobulin G (IgG) 41 g/L (normal 6.3-18 g/L). She has been referred to address the question of whether there is a systemic disorder unifying the present renal disease with her prior medical history, and whether a unifying diagnosis might inform the optimal systemic therapy for her MGN.

IgG4-related disease (IgG4-RD) is a fibroinflammatory disorder typically associated with tumefactive (puffy) swelling of glandular tissues, with fibrosis and infiltration of affected organs by polyclonal lymphocytes, IgG4+ plasma cells, and eosinophils. About 70% of patients also have elevated serum IgG4 levels. Nearly any organ system can be involved, but like the non-caseating granulomas of sarcoidosis, the histological findings are very similar throughout diverse tissues: storiform (matted and irregularly whorled) fibrosis, obliterative phlebitis, lymphoplasmacytic infiltrate, and eosinophilia. IgG4-RD has been shown to be the underlying cause of numerous diseases which were previously thought unrelated, such as autoimmune pancreatitis,[1] Mikulicz' disease, and multifocal fibrosclerosis. Table 1 lists other manifestations.

This concise review focuses on three questions:

- When should I suspect IgG4-RD?
- How do I approach diagnosis of IgG4-RD?
- How do I treat IgG4-RD?

A number of detailed reviews are recommended for further reading.[2-4]

When should I suspect IgG4-RD?

Patients typically present with a subacute course, many with chronic unrecognized disease manifestations. The most common disease features are autoimmune pancreatitis, sialoadenitis, lacrimal gland involvement, and retroperitoneal fibrosis. One third of patients have associated atopy, asthma, and eosinophilia.[5] This case illustrates classic manifestations and the likelihood of IgG4-RD is extremely high. Her features of eosinophilia, polyclonal hypergammaglobulinemia, increased IgG, modestly elevated CRP, and negative or weakly positive autoantibodies are also consistent with IgG4-RD.

How do I approach the diagnosis of IgG4-RD?

When a case is suspected, the diagnostic tests in Table 2 should be considered. Most important is pathologic review of the tissue specimens. In many cases, archived tissue samples are available; if not, then the most affected organ with lowest risk of morbidity from biopsy should be sampled. Excisional biopsy is preferred over a core biopsy. Minor salivary gland biopsy can be considered in those

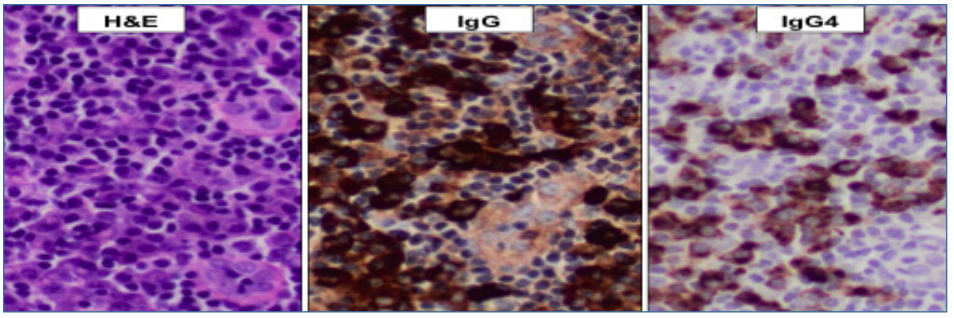

Figure 1
Lymph Node Biopsy, 200 x magnification.
Left: a dense infiltrate of lymphocytes and plasma cells ("lymphoplasmacytic").
Middle: many IgG positive plasma cells.
Right: many IgG4 positive plasma cells, > 100/high powered field and IgG4/IgG ratio > 40%.
(Photo courtesy of Dr. Graham Slack, BC Cancer Agency).

patients where a biopsy of other affected organs (such as retroperitoneal fibrosis) requires laparotomy or is otherwise too high-risk. If histologic findings are suggestive of IgG4-RD, immunostaining for IgG and IgG4 should be done (Figure 1). The *International Consensus Criteria*[6] are applied, wherein for most tissues, an IgG4 count > 50 hpf-100/hpf, and IgG4/IgG ratio > 40% with appropriate histologic findings, is considered diagnostic. Increased IgG4 positive plasma cells are not in themselves specific, and can be found in many "mimickers" of IgG4-RD such as Sjögren's syndrome, lymphoma, other malignancies, vasculitis, and Castleman's disease. Classic autoimmune pancreatitis with typical radiologic findings is the one situation where histologic confirmation of diagnosis may not be required.[7]

The patient's excisional salivary gland biopsy from 1996 was reviewed and confirmed "a prominent lymphoplasmacytic infiltrate associated with prominent fibrosis. The number of IgG4-positive plasma cells is increased, and there are multiple high power fields that contain more than 100 positive cells. The IgG4:IgG ratio is greater than 40%." Bloodwork revealed markedly elevated serum IgG4 of 25.7 g/L with other subclasses normal or slightly elevated (normal < 1.25 g/L). The pathology and lab tests confirm the diagnosis of IgG4-RD.

How do I treat IgG4-related disease?

Treatment is aimed at reducing symptoms, preventing further organ damage, and stabilizing fibrosis (which is typically not reversible). Initial treatment is usually with prednisone 1 mg/kg, with an 80% response rate reported.[8] The main toxicity is new or worsening diabetes, since many of these patients have pancreatic impairment to begin with. B-cell depletion with rituximab (1 gram IV Q2 weeks x 2 doses) is very effective, through ablation of the short-lived plasma cells producing

Table 1
Common Manifestations of IgG4-RD by Organ System

Gastrointestinal	• Autoimmune pancreatitis • Sclerosing cholangitis • Sclerosing mesenteritis
Head and Neck	• Eosinophilic angiocentric fibrosis (puffy, fibroinflammatory lesions of orbits and upper respiratory tract) • Orbital pseudotumour • Riedel's thyroiditis • Mikulicz' disease (enlargement of lacrimal, salivary, and parotid glands) • Kuttner's tumour (salivary gland enlargement)
Allergy/Respiratory	• Asthma, atopy, allergy • Tracheal stenosis • Chronic sinusitis • Pleural and pulmonary nodules, interstitial lung disease • Fibrosing mediastinitis
Systemic Disease and Large Vessels	• Multifocal fibrosclerosis (orbits, thyroid, retroperitoneum, mediastinum) • Inflammatory aortic aneurysm • Periaoritis and periartertitis
Renal/ Retroperitoneum	• Hypocomplementemic tubulointerstitial nephritis • Membranous glomerulonephritis • Retroperitoneal fibrosis
Nervous System	• Hypertrophic pachymeningitis • Hypophysitis • Peri-neural masses
Blood and Bone Marrow	• Polyclonal hypergammaglobulinemia (elevation in IgG4, other IgG subclasses, and other Ig's, sometimes to the point of hyperviscosity syndrome).[9] • Eosinophilia • Lymphoplasmacytic and eosinophilic infiltrate in marrow and lymph nodes but *not* fibrosis or obliterative phlebitis.[10]

Table 2
Common Diagnostic Tests in IgG4-RD

	Tests	Typical Findings
Bloodwork	CBC/differential/blood film	Eosinophilia
	CRP (also IL-6, other markers of systemic inflammation)	Mild-moderate elevation
	IgG subclasses	Mild elevation in IgG4 nonspecific, and 30% of IgG4-RD patients have normal serum IgG4 levels. Markedly elevated serum IgG4 is helpful both for diagnosis and as a disease marker.
	Immunoglobulins (IgG, IgA, IgM, IgE), serum and urine protein, electrophoresis (SPEP, UPEP)	Other immunoglobulins may also be elevated. SPEP and UPEP are important to rule out monoclonal proteins.
	Autoantibodies	May be weakly positive
	Other markers of end organ damage: creatinine, liver enzymes, lipase, urinalysis, urine albumin/creatinine ratio	Variable; many patients may have subclinical involvement of organs other than the presenting problem
Imaging	CT or MRI of affected area. Some patients may benefit from a "staging CT" from head (sinuses) to pelvis.	Pancreas and kidneys become diffusely enlarged. Ductal organs such as bile duct, bronchus, show diffuse "pipe-stem" wall thickening.
Pathology	Archived specimens	As long as tissue blocks are still available, the pathologist should be able to examine the histology and then order immunostaining for IgG and IgG4 if typical features are present.
	New biopsy	Excisional is preferable to core biopsy when possible.
	Bone marrow/lymph node	These tissues are unusual in that fibrosis and obliterative phlebitis are typically *not* seen, and thus biopsy of other tissues may be required for definitive diagnosis.

IgG4.[11] Duration of remission is variable, however, and many patients require re-treatment. The standardized *IgG4-RD Responder Index* can be used to monitor patients.[12] Patients with markedly elevated serum IgG4 at baseline have a convenient and non-invasive means of monitoring, although relapses have been known to occur even with normal serum IgG4. Plasmablast flow cytometry is under investigation as a more sensitive marker of disease activity.[13]

This patient had an excellent response to prednisone 1 mg/kg x 4 weeks followed by a slow taper. Because of the extent of her disease burden and risk of progression to end stage renal disease, she was also given rituximab 1 gram IV x 3 doses. She remains in remission, with normal eosinophils, serum IgG and IgG4, and ACR on maintenance prednisone 5 mg/day.

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For further information, please contact *lchen2@bccancer.bc.ca.*
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Switched On

By Christine Charnock

Member engagement is one of the key governance responsibilities of the CRA Board (see article on pages 12-13); as part of our mission to promote excellence in arthritis care, education, and research, this Joint Count survey asked members about their involvement with the CRA, and what reasons impact or influence their involvement. Of the 400-plus rheumatologists in the CRA, nearly half (189) took the time to comment on this key issue.

A recent surge in the attractiveness of rheumatology practice finds 27% of respondents in their first five years of practice. On the other end of the scale, 22% of respondents have been in practice for more than 30 years. There is a prime opportunity for long-standing rheumatologists to serve as mentors to the new cohort of practitioners in our field.

Of our respondents, 40% report being currently involved with the CRA, either through Committee involvement, Board participation, or other CRA endeavours. The main reasons for member involvement were commitment to improving the quality of rheumatology care in Canada, interest in advocacy, networking and staying in touch with colleagues across the country, and a genuine interest in affecting decisions made about Canadian rheumatology. The CRA is truly pleased to see our mission reflected in your reasons for getting involved.

The 60% of respondents not currently involved with the CRA cite a variety of factors limiting their involvement: not enough time (51%) was the main reason reported, followed by lack of awareness of opportunities that exist (11%) or of how to get involved (7%), or disinterest in participation (5%). The CRA cannot do much to alleviate the time pressures experienced by our members, but we certainly have short-term or small tasks that would contribute greatly to the CRA's value to you. We definitely wish to improve awareness of participation opportunities! Interested members should visit *www.rheum.ca* or contact *info@rheum.ca* for details on how to get involved.

Of the 26% of respondents who noted "other" reasons for not being involved with the CRA, retirement or trying to slow down were the most common reasons, along with prior involvement with the CRA. Again, the CRA encourages all members to get involved in any capacity they can; your commitment and leadership is what makes the CRA a powerful force in this country!

Christine Charnock
CEO, CRA
Newmarket, Ontario

Table 1. **How many years have you been in practice?**

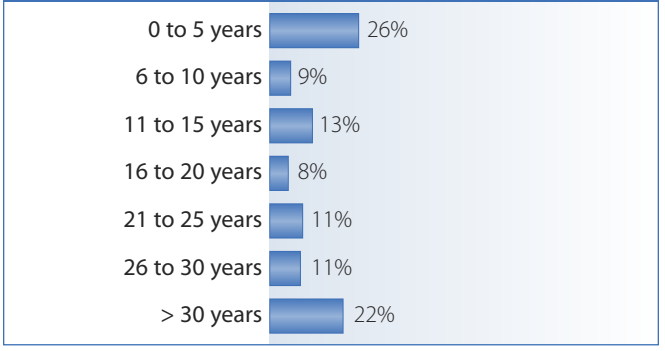


Table 2. **What type of practice do you have?**

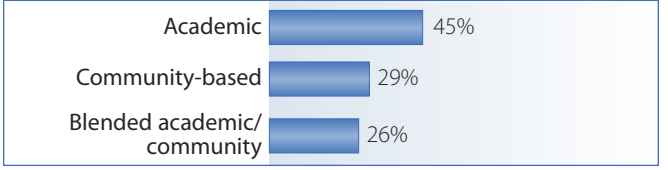


Table 3. **Are you involved in the CRA (committees, board, other endeavours)?**

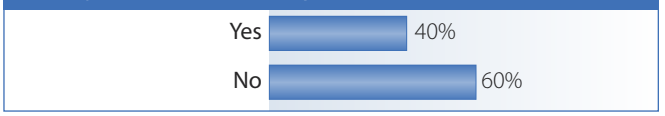
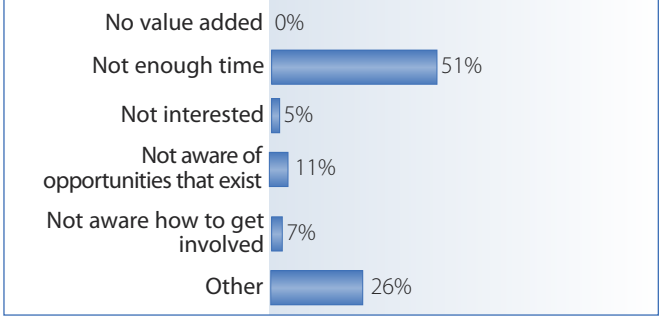


Table 4. **What is the main reason you are not involved? (Please select all that apply)**



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.

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- 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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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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