

Rheum Round Up

By Janet Pope, MD, MPH, FRCPC

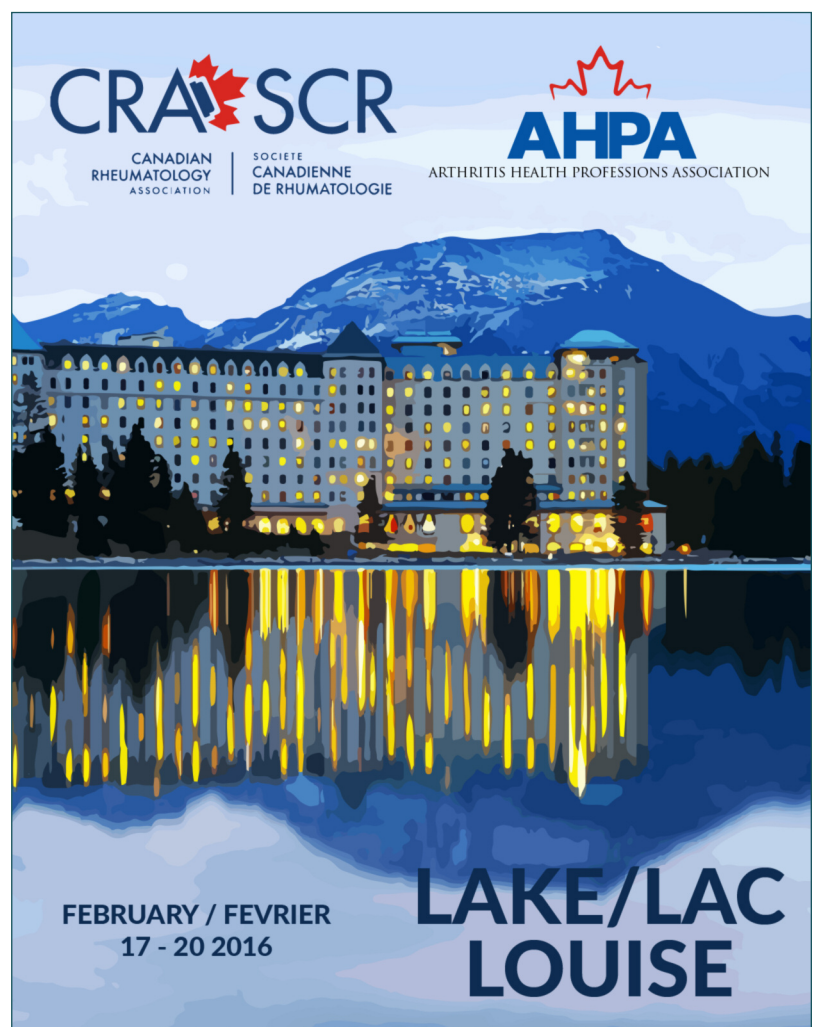
The CRA meeting in Lake Louise in February 2016 was a huge success. There were 255 posters, 14 oral presentations, and more than 20 workshops. These workshops ranged in focus from diseases (antiphospholipid syndrome, IgG4, spondyloarthritis, Lyme, central nervous system inflammatory disease, vasculitis, Sjögren's, systemic sclerosis) to special scenarios (imaging, pregnancy and rheumatic diseases, medical legal issues, sleep, depression, cardiovascular comorbidities, nonsteroidal anti-inflammatory drugs [NSAID] safety, research capacity, Cochrane reviews, nutrition, and practice management). The opinions I express about the meeting are my own. I could not attend every workshop as times conflicted, so important learnings may not be mentioned here.

There was a great review of sleep quality and quantity, including common sense points like avoiding eating or drinking too much (alcohol or caffeine) before bed, and striving to get enough sleep or risk missing out on crucial cycles of restorative sleep. We also learned that if we do not sleep well, we live shorter lives.¹ My thoughts are that, unfortunately, sleep is something we cannot outsource, unlike cleaning, child care, etc.!

Highlights are too many to mention but some excellent studies by trainees include work on the British Columbia claims database for RA patients showing that (obviously) steroid use increases the onset of Type II diabetes mellitus, but hydroxychloroquine, methotrexate, and tumour necrosis factor (TNF)-inhibitors decrease new onset of diabetes.²

IgG4 disease was the focus of a workshop. This disease can be considered a mimicker

with varied presentations; a common presentation is a patient with lymphadenopathy, submandibular gland enlargement, and autoimmune pancreatitis. Pearls were given. Half the patients with IgG4 disease do not have serum elevations of IgG4. The gold standard of diagnosis is biopsy. The pathologist needs to know what is suspected on biopsy so proper staining can be done to make a diagnosis.



There were abstracts about disparities in response or outcomes. There are different rates of lupus nephritis in the Canadian *1,000 Faces of Lupus* cohort. For instance, there is more nephritis in Canadians of Asian descent than in Caucasians, Blacks, or Aboriginals, but Asians demonstrate relatively lower rates of renal damage. There are also differences in clinical and antibody characteristics between South Asians and those from the Pacific Rim.³ Research into minimal important difference (MID) for the SLE responder index (SLEDAI-2K RI-50) was presented.⁴ Aboriginal Canadians with RA may experience delays in access to care along with receiving biologic prescriptions only at higher rates of disease activity; however, we also learned that Aboriginal populations have higher serious adverse events on biologics such as infections. The reasons for this are likely multiple (e.g., higher disease state is related to more infections; more comorbidities; low socioeconomic status; living in remote areas could mean problems monitoring for complications). An important take-home message is to warn high risk populations of signs/symptoms of serious infections and to seek medical attention before getting too sick.⁵

There were studies on improving early access to care. Dr. Paul Fortin has a referral tool that has identified early inflammatory arthritis so patients can be seen earlier while Dr. Walter Maksymowych has tried to identify younger onset chronic back pain patients from key clinics (dermatology, ophthalmology, and gastroenterology) where seronegative spondyloarthritis has an increased prevalence.

There could be hope for fibromyalgia patients, where, at the McGill Pain Clinic, there have been better outcomes when the baseline characteristics of the patients are taken into consideration and the main difference may be more exercise in patients over time.⁶

There was scientific debate in areas such as use of medicinal marijuana for chronic pain and use of social media in our practices.^{7,8}

The meeting was a success due to the great breadth and depth of topics and from the hard work of the Scientific Committee, led by Dr. Evelyn Sutton.

References

1. Maas J. State of the Art Lecture: Everything You Must Know About Sleep but Are Too Tired to Ask! Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta.
2. Schmidt T. Risk of Diabetes Mellitus in Rheumatoid Arthritis Associated with Medications Used in RA: A Population Based Cohort Study. Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta. Abstract #6.
3. Nguyen M. Comparison of Systemic Lupus Erythematosus in 3 Different Asian Ethnic Groups: Results from the 1,000 Canadian Faces of Lupus Cohort. Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta. Abstract #4.
4. Touma Z. Determining the Minimal Clinically Important Difference for Systemic Lupus Erythematosus Disease Activity Index-2000 Responder Index-50 (S2K RI-50). Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta. Abstract #14.
5. Barnabe C. Biologic Therapy Treatment Complications in the Alberta Aboriginal Population with Rheumatoid Arthritis. Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta. Abstract #8.
6. Karellis A. Assessment of the Temporal Variation of the Fibromyalgia Patient Profile between 2005 and 2013: Do Guidelines Inform Clinical Care? Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta. Abstract #35.
7. Controversies in Rheumatology - A Smokin' Panel. Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta.
8. Great Debate: Be it Resolved that Rheumatologists Get with the Times and Use Social Media for Communication with Patients and Research. Presented at the 2016 CRA/AHPA conference; February 16-20, 2016; Lake Louise, Alberta.

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