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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Spotlight on: All in the Rheumatology Family

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Get Out and Mingle

By Philip A. Baer, MDCM, FRCPC, FACR

"Everyone you will ever meet knows something you don't."
-Bill Nye, "the Science Guy"

Rheumatology is the happiest specialty, according to the American College of Rheumatology (ACR). Rheumatologists are pleasant, collegial and easy to work with, according to my contacts in industry (of course, they may express similar platitudes to other specialists they meet!). At our rheumatology journal clubs and rounds, we are often portrayed as the ultimate diagnosticians, figuring out difficult cases featuring obscure constellations of symptoms, which have stumped both general practitioners and other specialists.

Yet there is much to learn from other physicians and healthcare professionals. Many of the most memorable educational activities I have participated in recently have been cross-disciplinary. Our core diseases naturally lead to interactions with ophthalmologists, dermatologists and gastroenterologists. The latter used to thank us facetiously for enriching them through the epidemic of nonsteroidal anti-inflammatory drug (NSAID) gastropathy, but more recently the interface is all about inflammatory bowel disease and the gut microbiome. With cardiovascular disease now the leading cause of death for our patients, we might want to try to meet with cardiologists more than we have historically. In all these dealings, we can share, teach and learn to the benefit of our current and future patients.

Keeping abreast of developments in rheumatology and the comorbidities of rheumatic diseases is challenging, but sharing with medical colleagues in other disciplines around other issues is also of great importance. As physicians and allied health professionals, we are all struggling with fiscal constraints, increasing patient and regulatory demands, and issues of professional satisfaction and work-life balance. I was reminded of this when I was recently fortunate to be selected as an Ontario delegate to the 150th anniversary meeting of the Canadian Medical Association (CMA), held in August 2017 in Quebec City. Only four out of about 500 attendees were rheumatologists, and I crossed paths with two of the other three.

I was struck by the energy and dynamism of Canadian physicians, and the strength of our younger colleagues. The focus was on innovation, with keynote speakers from the worlds of art and technology inspiring us with their stories and achievements. From 3D printing of finger splints (Julielynn Wong, MD) to functioning as a professional dancer with a prosthetic foot (Jacques Poulin-Denis), there were lessons applicable to rheumatology. We debated national pharmacare, bullying and burnout within the profession, the opioid epidemic, as well as medical assistance in dying (MAiD). The latter made news recently when an Ontario patient with painful osteoarthritis was granted permission to proceed with MAiD, so rheumatologists could be faced with becoming involved.[1]

Dr. Gillian Hawker and Dr. Philip Baer at the 150th CMA anniversary meeting.

The highlight for me was the CMA Awards Gala. The Ontario Rheumatology Association (ORA) and CRA dance floors may be busier, but the accomplishments of the CMA award winners, from medical students to senior physicians, were unparalleled. The winners ranged from a medical student who started Zombies Hungry for Organ Donation to pioneers in MAiD, HIV therapy, military critical care medicine, prenatal screening and wide-awake hand surgery. I am proud to have been present when one of our own, Dr. Gillian Hawker, was honoured with the CMA *May Cohen Award for Women Mentors* (see photo from CMA).

Rheumatology is a wonderful specialty and career, but there are many positive developments to be explored in the rest of medicine as well. Get out there and mingle!

References:
1. "Woman at centre of Ontario-assisted death case dies. Available at: www.thestar.com/news/crime/2017/08/10/woman-at-centre-of-ontario-assisted-death-case-dies.html. Accessed on September 22, 2017.

Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
Scarborough, Ontario

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AWARDS, APPOINTMENTS, AND ACCOLADES

Dr. Abraham Chaiton was awarded the 2017 *Community Rheumatologist Award of Excellence*, from the University of Toronto's (U of T) Division of Rheumatology. The honour was presented to Dr. Chaiton at the annual Ogryzlo Research Day. This year, Dr. Chaiton was chosen as the community rheumatologist in the greater Toronto region, who has made an outstanding contribution to the field of rheumatology, at the community and regional levels, as well as to the U of T academic community.

Dr. Chaiton acknowledges his colleagues at Sunnybrook Hospital and the members of the Canadian Rheumatology Ultrasound Society (CRUS), who have supported his passion for the application of point-of-care ultrasound (US) in patient care, teaching and research. Currently, he is engaged with the Royal College Committee on Specialties in developing a university-based diploma level program in Neuromusculoskeletal US at point of care, while also developing an ultrasound-guided procedures workshop following the annual CRA meeting Vancouver. The impact of US teaching to over 250 rheumatologists has stimulated the introduction of US training in many fellowship training programs. Dr. Chaiton envisions the scope of rheumatology practice will soon incorporate point-of-care US into daily practice. He is confident that such a transformation should improve the quality and efficiency for the delivery of rheumatology health care.

On June 30, 2017, Dr. Peter Dent was among 99 new appointees to the Order of Canada. The citation reads: "For his contributions to improving the health of children through his roles in medical education, hospital administration and community service." Dr. Dent is Professor Emeritus of Pediatrics at McMaster University.

He trained in rheumatology and immunology at the University of Minnesota, and then joined the McMaster Department of Pediatrics as a career investigator in 1968. He served as Chair of Pediatrics, subsequently was Director of Research at Chedoke-McMaster Hospitals, and then Associate Vice-President (Clinical Services) for the Faculty of Health Sciences at McMaster University. Concurrently, he continued to practice pediatric rheumatology and immunology until his retirement in 2017. He was instrumental in the founding of the Children's Hospital at McMaster and the Hamilton Ronald McDonald House, and in the creation of the subspecialty of pediatric rheumatology by the American Board of Pediatrics. In 1985, he established the pediatric rheumatology listserver. In 2004, he became a Master of the American College of Rheumatology. In 2012, he received the *Alan Ross Award*, which is the most prestigious honour given by the Canadian Pediatric Society, recognizing lifelong excellence in the fields of pediatric research, education, healthcare and advocacy.

Dr. Gillian Hawker received the *May Cohen Award for Women Mentors* from the Canadian Medical Association (CMA) at the 2017 annual meeting in August. The award is presented to a woman physician who has demonstrated outstanding mentoring by: encouraging, facilitating and supporting career and leadership development; contributing to mentees' success through the sharing of insight, perspective and knowledge, and relationships; and acting as an effective role model in medicine. Throughout her career as a rheumatologist, clinician scientist and academic leader in medicine at the University of Toronto, she has had the pleasure of mentoring, formally and informally, many spectacular individuals in musculoskeletal medicine. She considers witnessing the academic and personal successes of her mentees an honour and a thrill.

I was thrilled to receive the 2017 *Dafna Gladman Award*. Dafna has been and continues to be a giant in the world of rheumatology and to be associated with her name is a great honour indeed. One of Dafna's major contributions to the University of Toronto Division of Rheumatology was to the Rheumatology Training Program which she directed for many years. I would like to think that this award is at least partially in recognition of my own participation in the training of Pediatric Rheumatology Fellows, which has been the most satisfying part of my career.

The *Dafna Gladman Award* was established by the University of Toronto in 2004 to recognize Dr. Gladman's dedication and committment to mentoring, counselling, and academic medicine.

- Dr. Ronald Laxer

News From the Therapeutics Committee

By Mary-Ann Fitzcharles, MD, FRCPC

Pharmacologic treatments are the cornerstone in the management of rheumatic diseases. Never before have rheumatologists had such a remarkable choice of drug treatment options, but day-to-day challenges regarding our drug toolbox exist. This is where the Therapeutics Committee (TC) of the CRA steps in to provide updated information on a variety of drug issues as they arise, such as availability of drugs, access to drugs, warnings about drugs, and even new information that may have slipped by the busy physician. In line with the goal of the CRA, "to provide the best services and support for membership so they can provide the best quality care for patients possible," the TC provides an extra set of eyes or a safety net for our membership. We are fortunate to have world experts in every field of rheumatology in our midst, and are grateful that we can call upon individuals within our community when the need arises. The following is a short overview of some of the activities and accomplishments of the TC in the past year.

Availability of injectable methotrexate was an issue this year that is now fortunately resolved, but we were able to keep our membership abreast of the status via the CRA website. We have now developed a standardized approach to address drug shortages to ensure that all are *au courant* with the status, and there is a process for engaging the implicated parties and exploring alternatives if appropriate. Following pressure from the Canadian Medical Association (CMA), new regulations require that drug shortages are reported on a new website, *www.drugshortagescanada.ca*. Fortunately, we do not anticipate any other imminent drug shortages.

An important and challenging project that is currently in the works is harmonizing access to biologic treatments for rheumatoid arthritis (RA) across Canada. This initiative has been spearheaded by Dr. Jane Purvis and Dr. Carter Thorne. Under the umbrella of the Canadian Life and Health Insurance Association (CLHIA), universal criteria for access to biologic treatments for RA have been developed and accepted by all private insurers across Canada associated with CLHIA, a feat that has never previously been achieved for any other drug or condition in Canada. Even with this huge first step, access to biologics across the country is still uneven, with different provinces requiring different criteria. There is much work still to be done.

Another area of activity has been the development of position statements when contentious issues that impact patient care arise. Since 2015, the CRA has made statements regarding medical marijuana use, biosimilars (with particular attention to respecting the decision of the treating rheumatologist), and opioid use. The latter reflects agreement in principle with the 2017 Canadian opioid guidelines, but emphasizes the importance of caring for all aspects of a patient's health in collaboration with other treating physicians. We anticipate that with the swell of attention given to the legalization of marijuana, the medical marijuana statement will need to be updated.

We appreciate the collaboration with our patient partner organizations and were present at The Arthritis Society (TAS) Pain Symposium in May, where TAS explored the ambitious project of developing a National Canadian Pain Strategy with the involvement of government, patient and healthcare providers as stakeholders. We were prominently at the table and will be active partners in this endeavour.

Finally as a new venture for the upcoming year, we plan to highlight new or interesting drug information to our membership. We will ask our national experts to comment on publications that are pertinent, possibly not mainstream, but which will impact day-to-day patient care, such as new information regarding hydroxychloroquine eye toxicity, alcohol use and methotrexate, and evidence for glucosamine and chondroitin in osteoarthritis (OA). There is, thus, a good bit of hard work ahead which will be effectively accomplished, as we have a truly wonderful TC team.

Mary-Ann Fitzcharles, MD, FRCPC
Associate Professor of Medicine,
McGill University Health Centre
Montreal, Quebec

2017 CIORA Awards

By Janet Pope, MD, MPH, FRCPC

The Canadian Initiative for Outcomes in Rheumatology Care (CIORA) held its 10th grant competition in March and received 34 grant applications this year, which is a record number.

CIORA's mission, as a unique granting organization, is to improve the care of Canadians living with rheumatic diseases. To that end, CIORA awards grants to scientists whose research helps advance our knowledge and understanding of rheumatic diseases and might not otherwise be eligible for other peer-reviewed funding.

More specifically, CIORA's grant program supports projects that are sustainable and help promote one of its three core pillars: Awareness/Advocacy/Education, Early Access for Rheumatic Disease Patients, and Multidisciplinary Care Teams.

Congratulations to all of the 2017 grant recipients! CIORA funded three one-year grants and five two-year grants for a total of just over $749,000. This was a very competitive cycle. The topics for CIORA grants are very broad with many unique ideas. Special thanks to our sponsors.

A special thank you to Dr. Paul Fortin for his contribution to CIORA as the Review Panel Chair. Dr. Fortin has served as Chair since 2015 and has provided valuable guidance and direction to the review process. We would like to welcome Dr. Marie Hudson as the new Review Panel Chair.

2017 CIORA Grant Awards

Aspirin Patterns of Use and Adherence for Prevention of Pre-eclampsia in Systemic Lupus Erythematosus (SLE) Pregnancies[1]
Principal Investigator: Dr. Evelyne Vinet
Award: $83,000

Raising Awareness of the Under-recognized Burden of Psoriatic Disease[1]
Principal Investigators: Drs. Lihi Eder and Karen Tu
Award: $119,024

The Scleroderma Support group Leader Education (SSLED) Program Feasibility Trial: A Scleroderma Patient-centered Intervention Network (SPIN) Project[1]
Principal Investigators: Drs. Brett D. Thombs and Marie Hudson
Award: $75,000

Bringing Patients and Therapies Together Sooner: Building Clinical Trial Capacity in Myositis to Facilitate Early Access to Treatments and Improved Outcomes[2]
Principal Investigators: Dr. Marie Hudson
Award: $119,300

Referral to Rheumatologists by Physiotherapists to Enhance Access to Care: Ability and Acceptability[2]
Principal Investigators: Drs. Debbie Feldman, Sasha Bernatsky, and Linda Woodhouse
Award: $117,160

Self-assessment Triage in Inflammatory Arthritis: A Pilot Study[2]
Principal Investigators: Drs. Mary Bell and Barry Koehler
Award: $70,000

A Multi-disciplinary, Community-based Group Intervention for Fibromyalgia: A Pilot Randomized Controlled Trial[3]
Principal Investigators: Drs. Michelle Teo and Nelly Oelke
Award: $91,231

Pilot Study of Mindfulness-based Stress Reduction (MBSR) in Patients with Rheumatoid Arthritis (RA) That Still Screen Depressed using the Centre for Epidemiologic Studies-Depression (CES-D) Questionnaire, Despite Adequate Control of Systemic and Joint Inflammation[3]
Principal Investigators: Drs. Gilles Boire, Patricia Dobkin, and Isabelle Gaboury
Award: $75,000

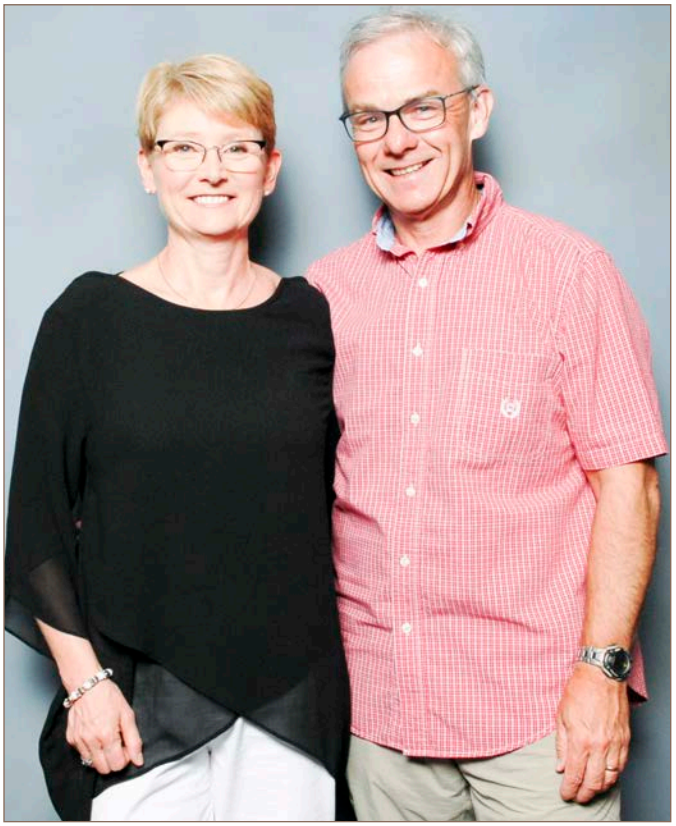
Pillars: 1. Awareness/Advocacy/Education; 2. Early Access for Rheumatic Disease Patients; 3. Multi-disciplinary Care Teams

Janet Pope, MD, MPH, FRCPC
Professor of Medicine,
Division Head,
Division of Rheumatology,
Department of Medicine,
St. Joseph's Health Care,
Western University
London, Ontario

Top Ten Surprising Things About Rheumatology Marriages According to Dr. Jane Purvis and Dr. Fred Doris

By Fred Doris, MD, FRCPC; and Jane Purvis, MD, FRCPC

We jumped at the opportunity to write this column for *The Journal of the Canadian Rheumatology Association (CRAJ)*. Another opportunity to recruit. An offer of marriage and a maternity job share with another rheumatologist were the incentives that Jane needed to come to Peterborough in the early 1990s as our fifth community rheumatologist. Sadly, the number of rheumatologists has dwindled to just the two of us. There were challenges when we first started out, including having to share 2/8 call on the Internal Medicine (IM) schedule for years and doing hospital rounds accompanied by our small children. Now the IM call is behind us, and the little ones are university-attending adults.



Because of that initial job-share, we ended up practicing in different medical buildings and still do. Although our patients are likely rather similar, our practice styles are rather different. While we both focus on inflammatory rheumatic diseases, other rheumatologists would be surprised at the under/over-representation of certain diagnoses between our two practices. We both enjoy our autonomy in creating an office that is aesthetically pleasing and convenient geographically. Not that anything in Peterborough is more than five minutes away though. Just call us or visit us to join us in Peterborough! The medical community has all you need to support the rheumatology practice style that suits you with a gentler cost of living, easy access to nature and no commutes longer than 10 minutes.

Top Ten Surprising Things About Rheumatology Marriages

1. The after work question, "How was your day?" is usually brief. A few words say it all, though you can get a really fast second opinion.

2. Centres of excellence. One of us handles the in-patient consultations. The other schedules more satellite clinics in the surrounding smaller towns, and is in the thick of medical politics.

3. Whose "critical value" is it that LifeLabs is calling after hours about?

Drs. Jane Purvis and Fred Doris.

4. Travelling usually means travelling together. Who covers for rheumatology then?

5. Journal club: anywhere, anytime!

6. Inside jokes such as personalized licence plates that read "SED RATE". Just don't tell Choosing Wisely Canada.

7. News! Gossip! Fred doesn't lunch in the hospital cafeteria or work in the operating room (OR). As a solo rheumatologist, with just one medical office administrator, he would never hear what is really going on in the medical community or the Ontario Medical Association. (Fred: Thanks Jane.)

8. You get absolutely no sympathy when you complain of your (usually self-inflicted) pains.

9. Shall we toss a coin to decide who does the next community arthritis forum for The Arthritis Society? (Fred: Thanks Jane – just like you accepted the pager to be on call when we first met on our first day of rheumatology fellowship.)

10, And finally…we get TWO copies of the *CRAJ*!

Jane Purvis, MD, FRCPC
Lead, Manpower Committee,
Past-president, Ontario Rheumatology Association
Rheumatologist,
Peterborough, Ontario

Fred Doris, MD, FRCPC
Rheumatologist,
Peterborough, Ontario

The Rohekar Family: Twin Rheumatologists

By Gina Rohekar, MD, FRCPC; and Sherry Rohekar, MD, FRCPC

My sister Sherry and I are both rheumatologists and happen to also be identical twins. Unsurprisingly, this often leads to confusion amongst patients, residents and other physicians. It doesn't help that we both work at the same academic centre, St. Joseph's Health Care in London (University of Western Ontario). I will jokingly (not jokingly) refer to myself as the "good twin" when people inevitably ask how to tell us apart. Both Sherry and I have traversed our medical careers together: same class in med school (where Dr. Janet Pope converted us both, separately, into future rheumatologists), same residency program, same rheumatology program, and finally both practicing in the same centre. Not all of this was planned, but it worked out that way and, fortunately, we get along quite well. I guess I've gotten used to Sherry being around! After all, we started life as womb-mates.

Can you guess who is who?

From the perspective of someone in a rheumatology family, I think there are probably more pros than cons. I have someone readily available who I can bounce ideas off, who I can vent to, and who won't judge me if I am accidently an idiot. It's not always great though – as we both are thinking about rheumatology for most of the day, and it can be very easy to get lost in rheum thoughts and conversations and not talk too much about the other things in life. Turning off the "work brain" can be hard.

I guess I've not known anything other than a career with my fellow monozygote, so I don't know if things would be better if we did not follow the same paths. But I think both of us are happy as both sisters and colleagues. Indeed, I need to make sure that Sherry is happy working with me – I might need her for a kidney or something one day!

One benefit that most other rheumatology families likely don't have: since Sherry and I look quite the same, if a patient approaches me "in the wild" (at the grocery store, for example) with questions, I can always pretend that I'm not actually their doctor and make an escape!

Gina Rohekar, MD, FRCPC
Associate Professor,
Western University,
London, Ontario

Sherry Rohekar, MD, FRCPC
Associate Professor,
Western University,
London, Ontario

The Shojania Family: Rheumatology Brothers

By Kam Shojania, MD, FRCPC; and Nima Shojania, MD, FRCPC

All the Shojanias in the world are related. We all have a similar, curly-haired and slightly rumpled appearance with unique spastic dance moves. There are a number of Shojania physicians in North America. Our father, Nasser, for example, is a retired dermatopathologist in Victoria, British Columbia. So, it is not unusual that out of three Shojania brothers, two of them became physicians. The third, Keyvan, became a lawyer, and when asked why he became a lawyer when the family tradition is medicine, Keyvan says it's because he "wants to help people." Our mother, Mitra, has mentioned that having two boys become rheumatologists was a slight disappointment, because she wanted at least one cardiologist or plastic surgeon son. However, she is now quite pleased that both her boys enjoy rheumatology practice.

The two Shojania rheumatologists are seven years apart. We both went to the University of Victoria for our undergraduate degrees and to the University of British Columbia (UBC) for med school and residency training. The elder brother (Kam) has stayed close to home in Vancouver in an academic practice and the younger brother (Nima) has moved to Kelowna in a community practice. While we often discuss the merits and occasional frustration of each choice. we agree that the community rheumatology practice in Kelowna is conducive to a wonderful quality of life. One of our favorite family times is when the entire clan (yes, even the lawyer) goes to Kelowna in August for water sports, great food, wine and rowdy conversation.

One interesting commonality is that each of us worked with Barry Koehler at different times. One can either feel sorry for us or feel sorry for Dr. Koehler. However, we admit that we learned a great deal from Barry and his wife, Mary, in terms of professional practice and work-life balance.

We enjoy sharing patients who move between Kelowna and Vancouver, but one unexpected dilemma is how we address each other in correspondence. "Dear Dr. Shojania" sounds awkward, so "Dear Kam/Nima", while perhaps too familiar, is what we have settled upon. While it is sometimes annoying that our laboratory and imaging reports are misdirected, our experience as brother rheumatologists has been good. It is great to have someone close to chat about diagnostic dilemmas and share a room at conferences. It is also confusing to plaintiff lawyers to have two Shojania rheumatologists. We are fortunate that we have a similar approach to clinical rheumatology.

Photo credit: Alexander Shojania

Drs. Kam and Nima Shojania at the 2017 family reunion.

Kam Shojania, MD, FRCPC
Clinical Professor and Head,
UBC Divison of Rheumatology
Medical Director,
Mary Pack Arthritis Program
Vancouver, British Columbia

Nima Shojania, MD, FRCPC
Clinical Instructor,
UBC Department of Family Practice
Kelowna, British Columbia

The Rai/Sekhon 2017 Guidelines for Keeping Marital Problems in Remission

By Raman Rai, MD, FRCPC; and Suneet Sekhon, MD, FRCPC

Drs. Suneet Sekhon and Raman Rai with their daughter, Aria.

My wife is a rheumatologist and so am I. We work the same days, in the same clinic, and share the same office. In short, we spend A LOT of time together. People always ask if we ever get sick of each other and if we ever talk about anything else other than rheumatology. In fact, I have had more than one colleague tell me finding an alternate career should be my top priority. Conventional wisdom states that distance makes the heart grow fonder, so what's the secret to keeping marital harmony when you are spending > 95% of your life with your significant other? Presented here are the five key recommendations of our latest guidelines (All are level FF recommendations - Follow or Fail)

1. Define your niche

This is easy if you genuinely have different interests but what if you both like the same area? Well, in that case you will need to work harder to differentiate yourselves professionally. In our practice, Dr. Sekhon will screen all consults and see patients with new onset inflammatory arthritis; Dr. Rai will see third opinions and referrals to "rule in fibromyalgia."

2. Dress for success

Nothing is more annoying for Dr. Sekhon than spending an hour with a patient, listening reflectively and coming up with a patient-centered care plan only to hear the dreaded "when is the real doctor coming?" Sadly, this means wearing a white coat over those fancy designer clothes.

3. Unlike the pizza, this is not a two-for-one deal

In the words of one patient: "I am a patient of this clinic, I see whoever can see me right away." That's great, but patients need to understand that Dr. Sekhon doesn't like Dr. Rai "messing" with her patients.

4. Play it cool

Pretending to ignore each other in the office has its benefits. One is that coworkers won't feel like they are intruding on your married life and the second is learning juicy gossip about the other person (*e.g.*, "I saw that you were ignoring Dr. Rai today, he must have done something to make you upset...I heard that he also made a poor old lady cry." (In my defense... she started it.)

5. Take ANY opportunity to escape

This could mean something professional, like a journal club or conference, but let's face it, you will likely be going to these together. Instead, try to make unpleasant tasks like cleaning the house, mowing the lawn or picking up your child early from daycare into a relaxing break away from each other!

In all seriousness, while having a partner in the same field has its challenges, it is a positive experience overall (Dr. Sekhon: Dr. Rai's words, not mine). The most important recommendation is not to take things too seriously and try to enjoy your time together, regardless of whether you are at work or at home!

Raman Rai, MD, FRCPC
Rheumatologist,
Hamilton, Ontario

Suneet Sekhon, MD, FRCPC
Rheumatologist,
Hamilton, Ontario

Rheumatology Couple: Dr. Marguerite Stolar and Dr. Michael Ramsden

By Marguerite Stolar, MD, FRCPC; and Michael Ramsden, MD, FRCPC

Marguerite: I met my husband at the Wellesley Hospital when I was an intern and he was working on his rheumatology fellowship. I was inspired by the dynamic group of rheumatologists and trainees at the Wellesley Hospital and decided to pursue rheumatology myself after my internal medicine training. Getting married at that point, we both had a good idea what the other individual faced in the future.

There are many practical aspects to being married to another rheumatologist, with definite benefits, which include sharing the cost of a practice, being available to cover for patients if needed, carpooling, sharing rheumatologic textbooks and journals, a second opinion regarding patient management always at hand and attending meetings together. On a personal level, the benefits include sharing the day-to-day challenges of looking after your personal health and that of your family while dealing with the stress of looking after patients with rheumatologic diseases. I think this degree of insight into your spouse's work and challenges is more positive than negative.

When we first started practice together I recall other physicians wondering how we would possibly be able to share an office with a spouse. Most days, we barely see each other until the end of the day and then we can share our day and try not to bring it home.

Mike: As Marguerite mentions, although we share an office, which has grown from the two of us to four rheumatologists since we started in British Columbia in 1990, we don't really bump into each other in the office, except when I bring her a daily cappuccino at lunch. We run a busy practice and do ask for help from each other with difficult or unusual cases, or when one of us just has difficulty remembering something (*What was the name of that drug again? Who's the best orthopod at …?*)

Carpooling helps: we get to use the high-occupancy vehicle (HOV) lane since there are two of us, but Marguerite usually falls asleep after a minute in the car, so it's a quiet ride.

We don't usually discuss the office at home, except when I have to troubleshoot the hardware to connect to the electronic medical record (EMR) – guess who the tech person in the family is?

Drs. Marguerite Stolar and Michael Ramsden.

The vaunted rheum lifestyle has allowed us to be present and available for our now adult children, one in engineering at the University of British Columbia (UBC), one starting medicine at McMaster University, and one working crazy hours in the production side of the TV industry, putting up with worse hours than most residents face.

Our work can be stressful but doesn't compare with the stress and balancing joy that comes with raising a family.

Marguerite Stolar, MD, FRCPC
Rheumatologist,
New Westminster, British Columbia

Michael Ramsden, MD, FRCPC
Rheumatologist,
New Westminster, British Columbia

Three(!) Generations of Rheumatologists: Only in Argentina

By Cecilia Catoggio, MD; and Luis J. Catoggio MD, PhD

Luis: It is an unforeseen privilege to be asked to discuss our family's three generations of rheumatologists for our Canadian colleagues. My father, a grandchild of poor Italian immigrants to Argentina, trained in rheumatology right after the Second World War with Dr. Walter Bauer at the Massachusetts General Hospital (MGH) in Boston. He was a fellow there when the lupus erythematosus (LE) cell was first described and cortisone first used in rheumatoid arthritis (RA) by Philip Hench at the Mayo. He participated in the famous International Congress held at the Waldorf Astoria in New York in 1949 when cortisone was first introduced, both as a fellow and as an English-Spanish translator.

Upon return to Argentina at age 30, and with this training, he went back to the University Hospital and became one of the founders of "modern" rheumatology in Argentina. He eventually became Chief of Rheumatology at an important suburban hospital and then Director of the local rheumatology national institute of health (NIH) when these were created in 1958. (Ten years later, these were dissolved by one of our military governments!)

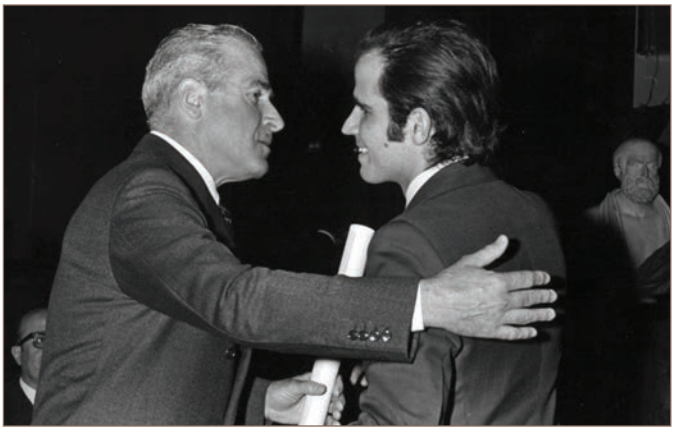
He returned to the University Hospital and worked there and in private practice until his untimely death at the age of 68 from prostatic carcinoma.

I wanted to be a doctor since around the age of five, probably impressed by my dad. I did not want to specialize in rheumatology but was more or less "forced" to do so, if I wanted to stay at the *Hospital Italiano,* where I had been Resident and Chief Resident in Medicine – so much for "multiple choices"!

I trained for almost three years in Bath, UK, at the Royal National Hospital for Rheumatic Diseases, mentored by people such as Drs. Peter Maddison, Allan St. J Dixon, Paul Bacon and Paul Dieppe. I have never regretted it! Our first daughter was born there, later to become a rheumatologist herself!

Upon return to the Hospital Italiano, over the years, I managed to grow the rheumatology section from a one-person team to a group of six consultants and six fellows-in-training at the time I stepped down as Chief a few years ago. I remain active in the section, am an Associate Professor of Medicine at our hospital´s medical school and am one of the chairs of the PhD program at the institution.

Drs. Walter Bauer and Pedro Catoggio in Argentina in 1954.



Dr. Luis Catoggio receiving his MD diploma from Pedro Catoggio in 1976.

Dr. Cecilia Catoggio receiving her MD diploma from her parents, Dr. Luis Catoggio and Dr. Patricia Gonzalez Salas de Catoggio, in 2007.

Our eldest daughter, Cecilia, the "Bathonian", decided to study medicine when she was about to end high school. But I will let her tell her own story!

Cecilia: I had always wanted to be a veterinarian, but after visiting and helping out at an underprivileged rural school with a doctor back in high school, I decided to study medicine. I did my residency in Internal Medicine at the *Hospital Italiano* because I liked the integral approach to the patient, but I knew I wanted to specialize in something. I grew up hearing about rheumatology, and finally understood why it is such an attractive specialty. I believe it has the perfect balance between in- and out-patients, and encompasses everything from clinical medicine to molecular biology. I did my rheumatology fellowship at another hospital, *Centro de Educación Médica e Investigaciones Clínicas (CEMIC)* to follow my own path. I completed my fellowship two years ago and have remained as a staff member. In the middle of the fellowship, I had my first child, and a year ago my second, so I am learning how to be both a doctor and a mom, enjoying every day as much as I can!

Cecilia Catoggio, MD
Assistant Professor of Medicine
Instituto Universitario CEMIC
Staff physician,
Centro de Educación Medica e Investigaciones Clínicas (CEMIC)
Buenos Aires, Argentina

Luis J. Catoggio, MD, PhD
Associate Professor of Medicine
Instituto Universitario Hospital Italiano de Buenos Aires
Honorary Associate Physician and Former Chief,
Rheumatology Section,
Medical Services
Hospital Italiano de Buenos Aires
Buenos Aires, Argentina

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- Reduction of signs and symptoms and induction and maintenance of clinical remission in pediatric patients with moderately to severely active CD who have had an inadequate response to conventional therapy (i.e., corticosteroid and/or aminosalicylate and/or an immunosuppressant)
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- Reduction of signs and symptoms, induction and maintenance of clinical remission and induction of mucosal healing in pediatric patients with moderately to severely active UC who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant)
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References: 1. Data on file, Janssen Inc.
2. REMICADE® Product Monograph, Janssen Inc., April 26, 2016.

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From Horse's Hoofbeats...to Zebras: Dad, the Rheumatologist

By Catharine Dewar, PhD, MD, FRCPC

David Lloyd George Howard died in 2015.[1] Dad involved me in his career from an early age. On house calls, I'd usually wait in the car unless the visit was a long one. On my wall is a gift to Dad from a patient with severe rheumatoid arthritis (RA). It is a fine watercolour of Bow Falls, which I treasure. Waiting for Dad to finish hospital rounds, I'd play with the leather medicine balls in "the gym." Sitting on Dad's exam table, I'd peer down at the Calgary Stampede Parade. My siblings and I were the envy of our school chums. Having a "Dr. Dad" was one thing, but one with a high-office view of the annual parade? Unimaginable.

Dr. Red Howard in 1948.

Dad asked questions as we walked: "What do you notice about that man, Catharine? Do you see how he walks?" Thus, he introduced the Trendelenburg gait. "See that man turning his whole body?" That was my first lecture on ankylosing spondylitis. "Do you see the woman with blue lips, who seems to be whistling?" That was a lesson on pursed-lip breathing and chronic lung disease. Like many pioneer rheumatologists in Canada, Dad practiced internal medicine and rheumatology for most of his career. Dad completed his rheumatology training at the Mayo Clinic in the early 1950s. He recalled one mentor berating him for missing clonus... at one patella! Dad recalled a boy baffling many MDs with his "spells." A visiting specialist came and, on cue, the boy had a spell. The doctor promptly slapped the boy and said, "Enough of that behaviour. This nonsense ends NOW!" The spells ended and all the MDs were in awe. Not of the slap (!) but the perspicacity of this esteemed specialist. So many stories come to mind when I'm with my patients using Dad's reflex hammer or stethoscope.

Dr. Catharine Dewar

Dad was born in Harris to Saskatchewan homesteaders. His father had asked him, "Why do you want to make money off sick people?" His father decided his two older brothers would work the farm. As a result, Dad found his mentor in the village general practitioner (GP). From the University of Saskatchewan, Dad went to Toronto to obtain his MD, and to McGill University for research training with Dr. Hans Selye.[2] With sage advice from Edward Dunlop[3] and a Canadian Arthritis and Rheumatism Society (CARS) scholarship, he left Canada to study with Dr. Philip Hench[4] at the Mayo Clinic. Canada wouldn't offer this training for decades.

Remarkable events for a boy who had to leave the farm, which he loved. I am blessed Dad lived to 93. It meant I had

Dr Red Howard at age 82.

years of tutelage. It meant he was there to see me awarded *Clinician Teacher of the Year* in 2000, as an academic rheumatologist at his alma mater, U of T. A final bond came when my mother developed severe RA at age 66.[5] She died just before the "biologic era" therapies which astounded Dad. Throughout my career I've been indebted to my first mentor, my Dad, the rheumatologist.

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5. Reflections on Rheumatoid Hands. Available at http://www.craj.ca/ archives/2016/English/Spring/Dewar.html. Accessed on September 12, 2017.

Catharine Dewar, PhD, MD, FRCPC
Head,
Division of Rheumatology
Lions Gate Hospital
North Vancouver, British Columbia

Why I Chose to *#MakeRheum* for Rheumatology

By Caroline Rita Barry, MD, FRCPC

As a small town girl from Rothesay, New Brunswick, I was born into a big family with parents in the health profession. I attended grade school in my hometown earning my bilingual certificate by the end of the twelfth grade. I balanced school with a career in competitive tennis that soon ended as I headed to Halifax, Nova Scotia, where I completed my science degree. Following my sister and father's footsteps with careers in medicine, I jumped ship to St. John's, Newfoundland, to obtain my medical degree at the Memorial University of Newfoundland.

Our best attempt at an Ellen DeGeneres selfie, featuring (from left to right) Dr. Trudy Taylor, Dr. Caroline Barry, Dr. Alexa Smith, Dr. Evelyn Sutton and Dr. Alexandra Legge.

My interest in rheumatology began in the early stages of my medical education. I was introduced to the specialty during a medical student summer observership supported by the New Brunswick Medical Society. I was then linked with a local rheumatologist, Dr. Eric Grant, who soon became a mentor to me. This early exposure triggered my immediate passion for rheumatology. I furthered my interest during my clerkship years, where I found musculoskeletal medicine and immunology appealing. Making the move back to Halifax in 2013, I chose to pursue a residency in internal medicine at Dalhousie University with the goal of specializing in rheumatology.

By my third year of residency, I had gained more experience in the field by completing electives both at the University of Toronto and the University of Western Ontario. I was fortunate to stay close to home and train with the rheumatology program at Dalhousie University where I am now in my fifth year with the most supportive Program Director, Dr. Trudy Taylor.

The specialty of rheumatology is a hidden gem. The ever-changing diseases, therapies and patient population make it appealing as a never-ending academic journey. Rheumatology allows for continuity of care and long term relationships with your patients. With the increasing need for rheumatologists across the country, there is ample opportunity for young physicians. I cannot imagine a more rich and rewarding specialty both in learning and in friendships.

As my time as a resident is nearing completion, I thank all the rheumatologists I have met along my journey, with an honourable mention to my staff in Halifax who are more than just staff, they are family. My husband and I look forward to our move back to our home province in the summer of 2018 to start practice in Saint John, New Brunswick.

Caroline Rita Barry, MD, FRCPC
PGY 5 Rheumatology Resident,
Dalhousie University
The Nova Scotia Rehabilitation Centre
Halifax, Nova Scotia

Survey Results on CRA Communications

"The single biggest problem in communication is the illusion that it has taken place."
-George Bernard Shaw

The mission of the Canadian Rheumatology Association (CRA) is to represent Canadian rheumatologists and promote the pursuit of excellence in arthritis and rheumatic disease care, education and research. As a nationally and internationally respected organization, we serve as a national voice for practicing rheumatologists and researchers with an interest in rheumatic diseases. Like any successful organization, success in fulfilling this mandate depends on how effectively we are able to communicate with our members. To that end, for this quarter's Joint Count section, we conducted a survey on communications as it relates to the organization and our members. The emphasis was on feedback about the website, *rheum.ca*; e-newsletter, *Rheum to Go*; and *The Journal of the Canadian Rheumatology Association (CRAJ)*. A total of 133 responses were received out of the 541 surveys that were sent to members, representing a 33% response rate.

The first question asked members whether they used the CRA website to obtain information (see Figure 1). Half of respondents replied that they referred to the website occasionally, as needed. Only 5% indicated that they never referred to the website, and 14% indicated that they rarely used it. Asked to specify their reasons, some indicated that they did not know what was available on the website and did not find it user-friendly. A few commented that they were not sure what information was available that would be beneficial to their practice.

Figure 1. **Do you use the CRA website to obtain information?**

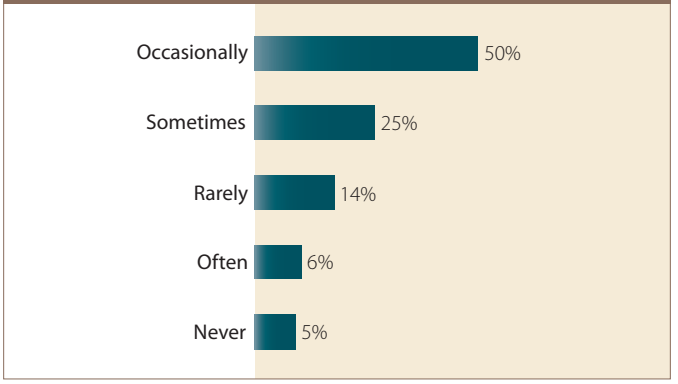
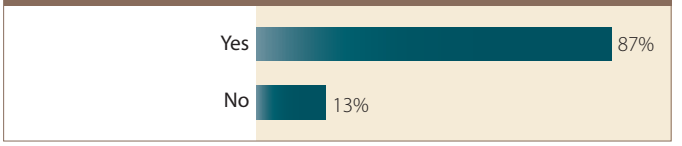


Figure 2. **Do you find the CRA website easy to navigate?**



The next question asked members to evaluate the navigation of the website: 87% of users found the CRA website easy to navigate (Figure 2). We're also trying to make this even better as we launch a new website this fall.

According to the survey, the most popular sections of the CRA website include the Membership Renewal section (79%); the Events section (*i.e.,* information related to the Annual Scientific Meeting [ASM] and Canada Night) (76%); the Membership Directory (52%); and Guidelines and Position Papers (see Figure 3 for more details). One commenter, ostensibly surprised, remarked that they "did not know that careers and jobs were posted on the website!"

When probed as to what additional information they would like to see on the CRA website, many survey respondents explained that they would like to see more clinical and educational resources, such as guidelines, clinical case discussions, and disease and drug information handouts

Figure 3. **What sections of the CRA website do you refer to?**

for patients. Other suggestions included more resources for Royal College Section 3 credits, information on funding opportunities for publications, European rheumatology news, and a link to the *Journal of Rheumatology (JRheum)* along with a *JRheum* community forum. Given that many of these resources are already available on the website, we must find a way to let our members know and make these more accessible.

CRA members were also asked to provide feedback on the CRA e-newsletter, *Rheum to Go*. Thirty-two percent of respondents indicated that they read *Rheum to Go* regularly and another 35% responded that they sometimes read the e-newsletter (Figure 4). Those who responded that they rarely or never read it were asked to specify why. Many of these members cited a lack of time and too many other things to read as reasons for not reading this specific e-newsletter.

The survey then asked how often members would like to receive *Rheum to Go*, which is disseminated on a bi-monthly schedule. More than half of the survey takers indicated that they would like to receive *Rheum to Go* bi-monthly (as they do now) and another 37% replied that they would prefer a monthly update.

Finally, the survey also asked questions regarding this journal, *The Journal of the Canadian Rheumatology Association (CRAJ)*. When members were asked if they read the *CRAJ*, more than half of those surveyed indicated that they read it regularly. A further 22% replied that they read it sometimes and 18% indicated that they read it occasionally (see Figure 5). Those who never or rarely read it specified a lack of time as their main reason for not reading it.

Regarding whether *CRAJ* readers prefers the electronic or print medium, the split was fairly balanced with 31% showing a preference for the electronic version, 33% reading the print copy, and 36% opting for both the electronic and print versions (see Figure 6).

The last question asked for overall comments on any aspects of the CRA's communications. While these were varied, one suggested not sending frequent e-blasts about minor issues, explaining that it "then becomes an annoyance rather than helpful communication." Other respondents were ostensibly content with the status quo. Other communication tools that members indicated they would find useful are listed in Figure 7.

In summary, while members appreciate the website and e-newsletter, there is always room for improvement. The CRA will carefully evaluate the results of this survey, particularly the comments, and strive to update and improve their communications for the benefit of all members.

If you have any other feedback or comments, you are encouraged to contact Claire McGowan at *claire@rheum.ca*. For feedback on the *CRAJ*, you are welcome to contact Jyoti Patel at *jyotip@sta.ca*.

Figure 4. **Do you read the CRA e-newsletter *Rheum to Go*?**

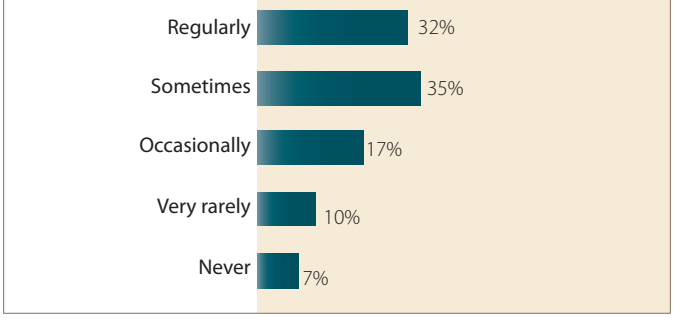


Figure 5. **Do you read the *CRAJ*?**

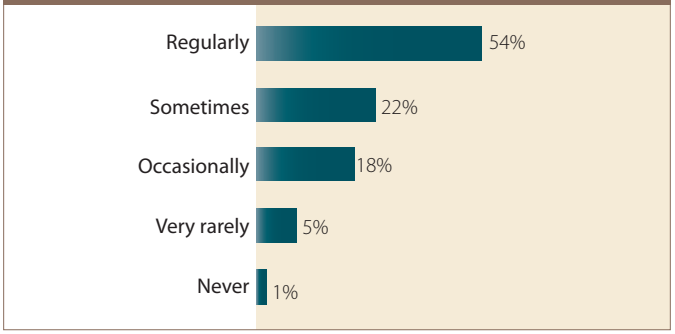


Figure 6. **Do you read the electronic or print version of the *CRAJ*?**

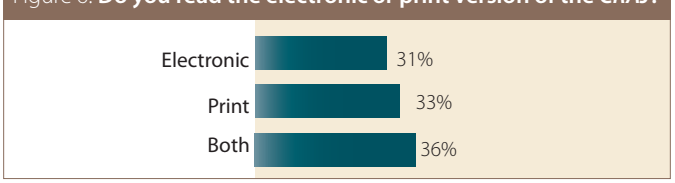
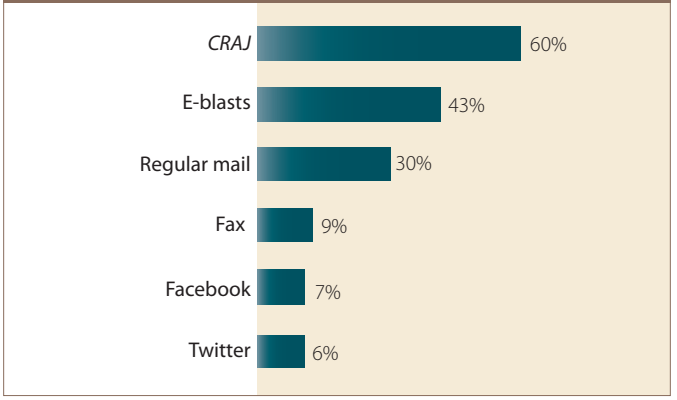


Figure 7. **Please indicate what other communication tool you would find useful.**



CPD for the Busy Rheumatologist

Effective and Efficient Clinical Learning: Is Real-time Learning Possible to Build Your MOC Credits?

By Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE; Jerry M. Maniate, MD, M.Ed, FRCPC; and Craig C. Campbell, MD, FRCPC

"After having read the article, *Continuing Professional Development (CPD) for the Busy Rheumatologist* in the summer 2017 issue of *The Journal of the Canadian Rheumatology Association (CRAJ)*, I reviewed the Royal College of Physicians and Surgeons of Canada (RCPSC) website (*http://www.royalcollege.ca/rcsite/cpd/moc-program/moc-framework-e*) and am aware that all the rounds I go to are potential opportunities for Maintenance of Certification (MOC) section 1 credits. Is there something more I can do?" asked Dr. AKI Joint, a rheumatologist member of the CRA.

"It's nice to record learnings for Section 1 through rounds, but what about recording questions I look up stimulated by my review of activities with patients?" reflected Dr. Joint. "Section 2 credits are an easier way to accumulate credits and self-learning, through a reflection of actual needs in my rheumatological practice."

"Last week in clinic, I was referred a 37- year-old female with a polyarthritis, fever and fatigue with a very elevated ferritin level. The presentation, although consistent with adult-onset Still's Disease caused me to reflect on the following question: What may be additional *evidenced-based* treatment options, in addition to prednisone? Is the learning I intended to complete to answer this question from my day-to-day practice something that I am able to report for credit?"

"On the Royal College website, I read about several strategies for Planned Learning that are part of Section 2. If I completed a personal learning project this would definitely qualify for credit in Section 2. In my case of adult-onset Still's Disease, I already had a defined question and then created a plan to look at the latest evidence. Based on my reading I concluded that further treatment options that should be considered include […] And, after arriving at this conclusion, I noted the time spent on this personal learning project was two hours. But, how would I record this in MAINPORT? "

Personal Learning Project

In MAINPORT, I found a template that allowed me to record each of the following:

- **Type of project:** Addressing clinical or academic questions across the CanMEDS framework
- **Hours spent:** 2 hours (= 4 credits)
- **Description of the question:** What are evidence-based treatment options beyond steroids for adult-onset Still's Disease?
- **Date:** October 19th, 2017
- **Resources used:** (1) UpToDate (website); (2) Klippel JH, Dieppe PA. Rheumatology 1998; and (3) Pouchot J, Arlet JB. Biological treatment in adult-onset Still's disease Best Pract Res Clin Rheumatol. 2012 Aug;26(4):477-87.
- **Reflection questions:** To solidify items learned and assist with practice implementation. This is where I recorded the key outcome or learning for me!
- **Relevant CanMEDS roles:** Collaborator, Communicator, Health Advocate, Manager, Medical Expert, Professional and Scholar

"In the past, I kept folders on my CPD activities and sat down at the end of the year for my annual ritual of recording all CPD activities into the MAINPORT system. I

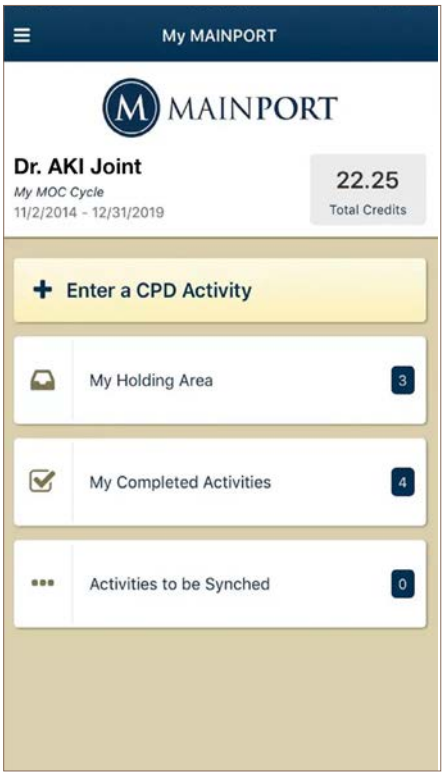


Figure 1. MAINPORT app interface.

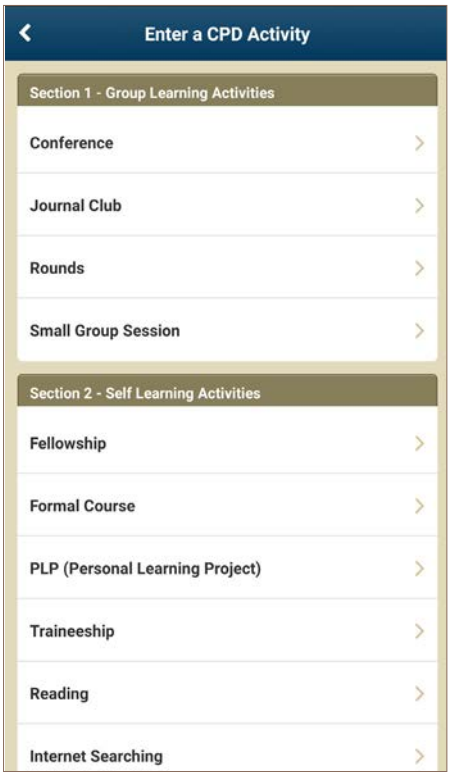


Figure 2. Section categories.

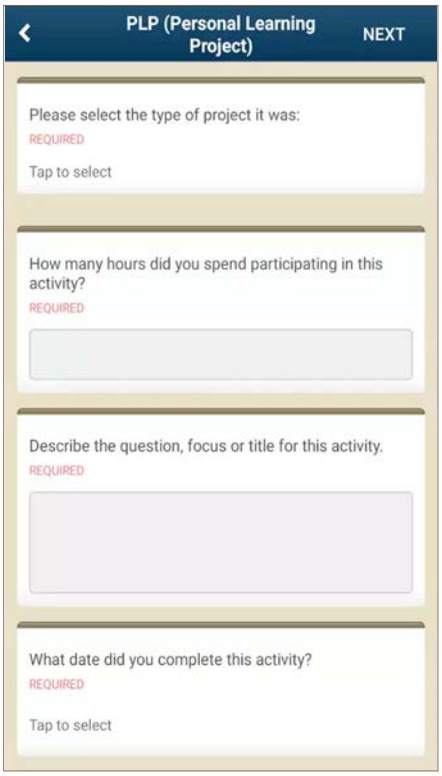


Figure 3. Personal learning project questions.

also read on the Royal College website (*http://www.royalcollege.ca/rcsite/resources/access-royal-college-apps-e*) that the system now includes a MAINPORT app for iPhone and Android users (see Figures 1, 2 and 3). This encourages real-time logging and capturing of learning opportunities and tracking of queries. Now, I can use the app to incorporate real-time tracking of learning I am doing to further the care of patients."

The MAINPORT app encourages and enables recording of these natural clinical learning activities centred around patient care.

Stay tuned for more adventures of Dr. AKI Joint, and her journey of learning through exploration of MOC Section 3 credits.

Acknowledgement to Dr. Barry Koehler (a CRA Past-President), for the initial discussion that lead to this article series, immediately following the 2017 CRA Annual Scientific Meeting (ASM).

Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE
CRA Education Committee Chair
Clinical Associate Professor, University of British Columbia
Medical Lead, Arthritis Program, GF Strong Rehabilitation Centre
Vancouver, British Columbia
Rheumatologist, West Coast Rheumatology Associates
Richmond, British Columbia

Jerry M. Maniate, MD, M. Ed, FRCPC
Chief, Medical Education,
Research and Scholarship, St. Joseph's Health Centre
Assistant Director of Researchers, Wilson Centre,
University of Toronto
Toronto, Ontario

Craig M. Campbell, MD, FRCPC
Director, Continuing Professional Development,
The Royal College of Physicians and Surgeons of Canada
Ottawa, Ontario

Juvenile Idiopathic Arthritis Management in Developing Countries

By Mercedes Chan, MBBS, MHPE, FRCPC

An hour and a half outside Johannesburg, South Africa, lies Muldersdrift, a United Nations Educational, Scientific and Cultural Organization (UNESCO) world heritage site best known as the Cradle of Humankind for its high yield of human ancestor fossils. Surrounded by all things musculoskeletal and evolutionary, it was perhaps fitting that for four days this past July 15 pediatric rheumatologists from around the world gathered here to discuss and reach consensus on recommendations for the management of juvenile idiopathic arthritis (JIA) in developing countries. This working group consisted of individuals with a vested interest in growing the field of pediatric rheumatology in the developing world and whose own work focused on education, the epidemiology of pediatric rheumatic disease, immunology, and clinical guideline development. As a pediatric rheumatologist with an interest in medical education and global health, I had the great privilege to be a part of these proceedings. I was joined by two other Canadian pediatric rheumatologists, Dr. Ron Laxer and Dr. Ross Petty, both of whom have contributed significantly to the education and training of pediatric rheumatologists around the world.

The Juvenile Idiopathic Arthritis Management for Less Resourced Countries initiative (fondly known as "JAMLess") was brought about by Drs. Christiaan Scott (Cape Town, South Africa) and Ricardo Russo (Buenos Aires, Argentina) and includes representatives from India to Tanzania, Brazil to the United Kingdom, as well as Italy and Belgium, among other countries. Funded by a grant from the International League of Associations for Rheumatology (ILAR), work first began in early 2016 with Drs. Scott and Russo recognizing that the challenges they encountered in their clinical contexts were different from those of the developed world where they had both trained (Dr. Scott in Leuven, Belgium, and Dr. Russo in Toronto, Canada). Furthermore, many published recommendations for the management of JIA were directed and mainly relevant to individuals practicing in developed countries, with little applicability to those working in the developing world. For example, in developing countries, endemic diseases such as malaria, tuberculosis and human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) commonly come into play in the differential diagnosis and management of JIA. In addition, poverty, conflict and lack of resources further complicate the challenge of accessing appropriate care.

The JAMLess recommendations will focus on four main areas: (1) clinical management (diagnosis, referral and monitoring); (2) education; (3) advocacy and networks; and (4) research. While they remain a work in progress, the hope is that the recommendations will serve as an educational, advocacy and clinical resource for all health practitioners in the developing world who may encounter a child with JIA. With rapid globalization and the increasing feasibility of world travel, it is likely that these recommendations will have utility and application in the developed world as well. Furthermore, documents such as this will be relevant to the many individuals from developing countries who pursue training in developed nations such as Canada. When they later return to work in their home countries, they are often faced with different standards of care and availability of resources.

There are many opportunities to be involved in this global rheumatology movement through training programs and institutions. Across Canada, there are many others who are contributing to rheumatology needs worldwide. Drs. Simon Huang, Ian Tsang and Barry Koehler take rheumatology fellows from the University of British Columbia (UBC) to teach a two-week rheumatology elective for medical students in Guangzhou, China, every year. Drs. Rosie Scuccimarri, Inés Colmegna and Carol Hitchon (McGill and University of Manitoba) have partnered with colleagues in Kenya to perform epidemiological studies in rheumatic diseases in East Africa. These are only two examples of how the Canadian rheumatology community is embracing the "Rheumatology Without Borders" movement[1] that has been advocated for, in an attempt to increase access to rheumatology care

The JAMLess working group, pictured in South Africa, in July 2017. From left to right, back row: Helen Foster (UK), Carine Wouters (Belgium), Nicola Ruperto (Italy), Ron Laxer (Canada), Ross Petty (Canada). Middle row: Gecilmara Peliggi (Brazil), Claudia Saal Magalhães (Brazil), James Chipeta (Zambia), Gail Faller (South Africa), Raju Khubchandani (India). Front row: Frances Furia (Tanzania), Ricardo Russo (Argentina), Chris Scott (South Africa), Mercedes Chan (Canada), Waheba Slamang (South Africa).

and education worldwide. Institutions and clinicians from developing countries are also keen to engage with faculty from around the world to participate in knowledge exchange, as well as to further educational, research and clinical networks.

Participating in the development of the JAMLess recommendations has been both educational and humbling. I hold immense respect for my colleagues who work in low-resource settings and continue to learn from and with them, constantly inspired by their perseverance and dedication to the rheumatology cause in their home countries and beyond. It may be a small world after all, but when it comes to rheumatology, there is still a lot of ground to cover.

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Mercedes Chan, MBBS, MHPE, FRCPC
Assistant Professor of Pediatrics, University of Alberta,
Pediatric Rheumatologist
Stollery Children's Hospital
Edmonton, Alberta

The Canadian Connection to Rheumatology in Nepal

By Stephen Aaron, MD, FRCPC

In 1977, the CRA established the Metro A. Ogryzlo International Fellowship in tribute to the founder of the *Journal of Rheumatology*, and for his other accomplishments. From 1981 through 2008, 26 physicians from around the world were able to undertake advanced training in rheumatology, most returning to their home countries to improve patient care, including in Nepal.

Nepal is remarkable for having seven of the ten tallest mountains in the world, and for its mystical blend of Buddhist and Hindu spiritualism. It is a poor, landlocked country of 30 million, sandwiched between the plains of Northern India and the Tibetan Plateau. It is ranked 157th in the world for per capita gross domestic product (GDP).

Dr. Buddhi Paudyal was born in a small town in the western plains of Nepal. During his youth, he pursued work in a United Mission hospital, where he met Dr. Helen Huston from Edmonton. He was keen to become a physician and was able to attend medical school, and then pursue a medical residency in Kathmandu. Driven by his experience with his father's rheumatoid arthritis, he applied for a position at the University of Toronto, and for the Ogryzlo Fellowship.

In Toronto, Buddhi was motivated by his teachers: Drs. Heather Mcdonald-Blumer, Peter Lee, Dafna Gladman, Art Bookman, Vivian Bykerk, and Simon Carette. He was to be the last Ogryzlo Fellow.

True to his word, Buddhi returned to Nepal and the Patan Hospital, near Kathmandu. He started the first public clinic in rheumatology in Nepal. Most doctors, including the only other five, part-time rheumatologists in the country, work in the private setting. Patan Hospital is a public hospital, with clinics that serve a wider population.

Patan Hospital soon became the site of a new medical school, the Patan Academy of Health Sciences (PAHS), supported by volunteers from around the world, including Canada. Its mission is to attract motivated students from under-served rural areas and encourage them to return to their home regions upon completion of their community-based training. Dr. Paudyal has been a leader in musculoskeletal (MSK) and Internal Medicine for this program.

Drs. Keshav Sigdel, Stephen Aaron, and Buddhi Paudyal at Patan Hospital in Nepal.

I met Buddhi while volunteering for the medical school in 2011 and have returned regularly since. Through his efforts and encouragement, he has just been joined by Dr. Keshav Sigdel, who has completed his rheumatology training in China.

Patan Hospital is starting its postgraduate programs in August. There is no certification for rheumatology in Nepal, but Dr. Paudyal has approval to begin the country's first fellowship program in 2018, as a centre for education, care, research and advocacy. For the first few years, until there are sufficient faculty, this program will require outside assistance in teaching.

If you would like to join me in providing help for patents with arthritis in Nepal, please email me at *stephen.aaron@ualberta.ca* and I would be happy to tell you more.

For more information on Patan Hospital and the PAHS, you may visit: *www.pahs.edu.np*.

Stephen Aaron, MD, FRCPC
Professor, Department of Medicine
Division of Rheumatology
Faculty of Medicine
University of Alberta
Edmonton, Alberta

Yukon

The Yukon has rheumatology services provided by a visiting rheumatologist, Dr. B. Daniel McLeod and rheumatology nurse, Ms. Lee Ash. Previously Dr. Graham Reid was the visiting rheumatologist. He negotiated the addition of the rheumatology nurse to the clinics. This has been extremely valuable and I would say indispensable.

The clinics are held in the visiting specialist clinic area in the Whitehorse General Hospital guided by the Outpatient services office manager, Jason Durand.

Mrs. Mary Gottshall provides us with clerical support. Clinics are scheduled every two months.

Additional support clinically is provided through referrals to rheumatologists in British Columbia and Alberta, because we are unable to meet the demand. A visiting consultant internist, Dr Kevin McLeod, also helps with decompressing the demand for rheumatology services. There are visiting specialist clinics in physiatry, orthopedics, dermatology, gastroenterology, neurology and nephrology. Access to echocardiography locally is very limited. Pulmonary function testing and bone densitometry are not available in the territory and patients need to be referred out for these services

–Dr. B. Daniel McLeod

Dr. B. Daniel McLeod and rheumatology nurse, Lee Ash, are pictured in front of Whitehorse General Hospital.

NT Northwest Territories

Photo credit : *aboriginalcanada.ca*

This summer marks the 20th year I have been traveling to the Northwest Territories to do the rheumatology outreach clinic. Back in 1997, merely a week out of residency, I started what has turned out to be the most challenging and rewarding aspect of my practice. It continues to amaze me that with a population of less than 50,000 I manage to still see such fascinating pathology. I have continued to do a four-day clinic four times per year, sometimes accompanied by one of our rheumatology trainees from Edmonton.

Over time the waitlist for routine appointments has increased to unacceptable levels. I have had productive meetings with senior administration to look at solutions to bring down waiting times. I have drafted a referral guideline document that should help reduce unnecessary referrals and allow for early identification and treatment of inflammatory arthritis at the primary care level. We are examining expanding the role of physical therapy (PT) and occupational therapy (OT) as well as nurse practitioners who already play a large role in providing services in the NWT. The territory-wide electronic medical record (EMR) has been a great help in improving efficiency, both in triage and case management.

I was very pleased when one of our new rheumatology grads, Dr. Carrie Ye, expressed interest in doing a couple of clinics this year to help shorten the waitlist. She had enjoyed her time up in Yellowknife with me as a resident that she wanted more. Our waitlist for routine referrals went from 2.5 years at the beginning of 2017 to a manageable 3-6 months now.

Photo credit: Carrie Ye

The mesmerizing Northern Highlights.

Moving forward the challenge will be to continue to provide timely access not only to new referrals, but also adequate follow up and support for the primary care providers looking after our arthritis patients. Access to echocardiography locally is very limited. Pulmonary function testing and bone densitometry are not available in the territory and patients need to be referred out for these services.

–Dr. Dale Sholter

Stanton Medical Centre with the new hospital under construction in the background.

Tribute to Dr. Jerry Tenenbaum

By Heather McDonald-Blumer, MD, MSc, FRCPC

Dr. Jerry Tenenbaum passed away on Thursday, July 6th, 2017. He succumbed to complications following surgery in late June. Jerry was known as a passionate rheumatologist who unreservedly threw himself into his work as a clinician, teacher, educator and mentor. He was a larger-than-life presence and he will be sorely missed.

1948–2017

Jerry was born in Germany and immigrated to Canada before his first birthday with his family settling in Toronto. He completed his undergraduate and medical school training at the University of Toronto (U of T), where he was admitted to the Alpha Omega Alpha Honour Medical Society. Jerry continued at U of T, completing his internal medicine training and his rheumatology residency, before moving to the University of Miami to complete two years of basic research in articular cartilage/osteoarthritis. He returned to Toronto to take a staff position in 1979.

While Jerry continued his research activities during his early career at U of T, he became increasingly involved in teaching, education and education administration. He held key leadership roles including those of Associate Dean of Continuing Medical Education, Director for Internal Medicine and Subspecialties and Director of the International Medical Graduate program for Ontario. He was recognized for his contributions and was granted Professor of Medicine status in 2002. He received multiple awards for his teaching excellence, including *Mount Sinai Hospital (MSH) Clinical Teacher Awards* on multiple occasions, the *Anderson Award* for outstanding contribution to the educational mission of MSH and UHN, the *Aikens Award* for Undergraduate Education and the *Department of Medicine Teacher of the Year Award*.

Jerry has spent the latter part of his career and life working in both Toronto and Victoria. He continued to see his patients in both offices – somehow managing the "commute" with apparent ease and grace. He also continued to teach within the Divisions of Rheumatology in Victoria and Toronto. He maintained his relationship with the U of T and was also appointed an Adjunct Professor in the Division of Rheumatology at the University of British Columbia. He has had an important and palpable impact on several generations of rheumatologists across the country.

Outside of medicine and rheumatology, Jerry was a great historian of all things related to the contemporary music scene and, in particular, was a Bob Dylan fan like no other. He was equally passionate and supportive of the Maple Leafs, and his optimism for their eventual comeback was ever present. But greater than all of these was Jerry's love of his family, who made him light up like nothing else. In addition to his mother, two sisters, and a large and connected extended family, Jerry leaves behind his partner, Lucretia van den Berg and Jerry's two sons and their families.

As one of Jerry's nephews so aptly said, "[Jerry] will be remembered for his work ethic, dedication to his patients and to teaching, promotion of his specialty, and amongst other things, his booming voice."

The rheumatology community will most certainly miss Jerry's presence and contributions.

Heather McDonald-Blumer, MD, MSc, FRCPC
Division Director,
Rheumatology
University of Toronto
Toronto, Ontario

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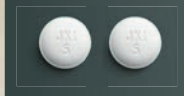


Simple, twice-daily oral dosing

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.

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

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 and patients with diabetes because of an increased risk of serious infections.
- 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.

Pfizer

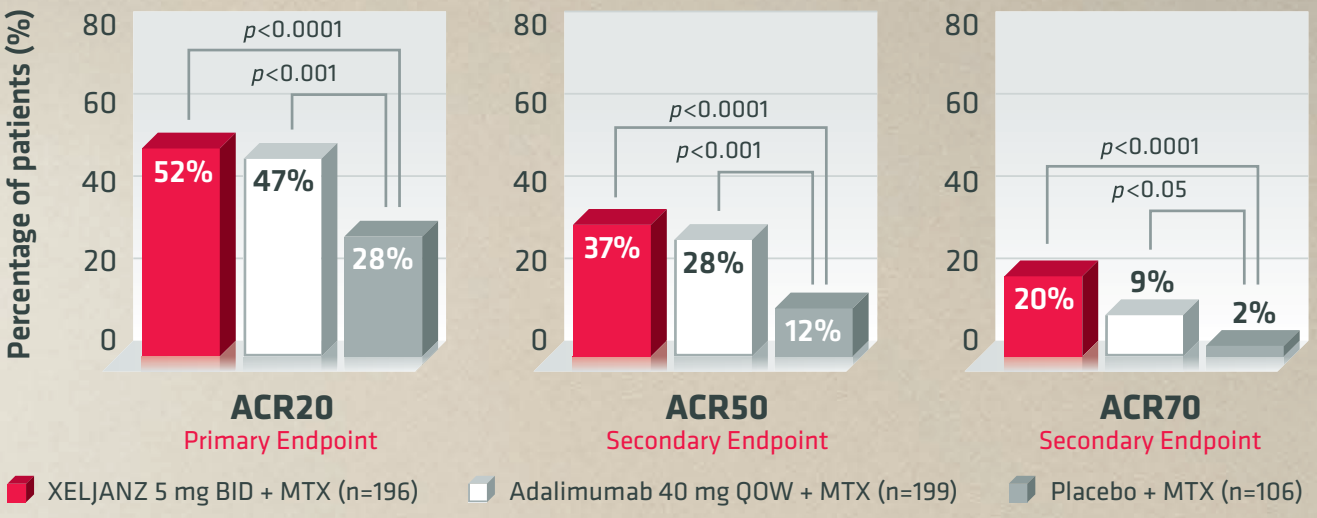
CA0116TOF024E

Demonstrated efficacy where response to methotrexate was inadequate

In MTX-IR patients, XELJANZ + MTX showed significantly greater symptom reduction vs. placebo + MTX at 6 months (as measured by ACR response rates).[1*]

This study was not designed to compare XELJANZ to adalimumab.

ACR response rates at 6 months



Improvements from baseline in physical functioning were significantly greater in patients receiving XELJANZ + MTX vs. placebo + MTX at 3 months (as measured by decreases in HAQ-DI scores).[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.

- 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://pfizer.ca/pm/en/XELJANZ.pdf 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. September 15, 2015. **2.** Arthritis Society. June 2014 Impact - Ease of Use. Available at http://www.arthritis.ca/page.aspx?pid~7650. Accessed July 22, 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 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.

† The Arthritis Society's Ease-of-Use Commendation recognizes products, like the XELJANZ bottle cap, that have been independently tested for easy use and handling for people living with arthritis. The Arthritis Society does not determine the therapeutic value of products and the designation is not intended as a general product endorsement that are designed for ease of use in patients with arthritis.

The XELJANZ bottle cap was awarded The Arthritis Society's Ease-of-Use Commendation.[2†]

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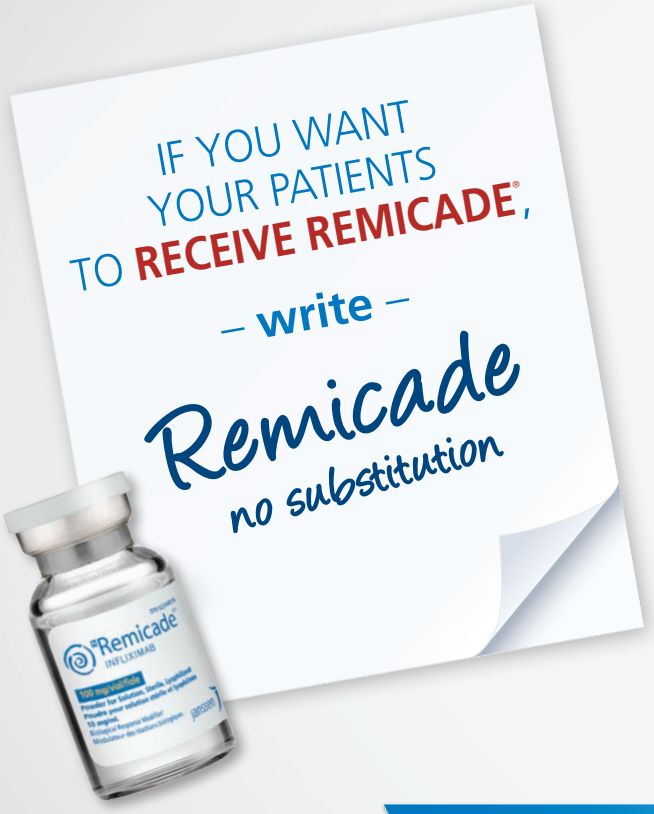

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REMICADE® is indicated:

- In combination with methotrexate (MTX), for the reduction in signs and symptoms, inhibition of the progression of structural damage and improvement in physical function in adult patients with moderately to severely active rheumatoid arthritis (RA)
- Reduction of signs and symptoms and improvement in physical function in patients with active ankylosing spondylitis (AS) who have responded inadequately, or are intolerant, to conventional therapies
- Reduction of signs and symptoms, induction and maintenance of clinical remission and mucosal healing and reduction of corticosteroid use in adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response to a corticosteroid and/or aminosalicylate; REMICADE® can be used alone or in combination with conventional therapy
- Reduction of signs and symptoms and induction and maintenance of clinical remission in pediatric patients with moderately to severely active CD who have had an inadequate response to conventional therapy (i.e., corticosteroid and/or aminosalicylate and/or an immunosuppressant)
- Treatment of fistulizing CD in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment
- Reduction of signs and symptoms, induction and maintenance of clinical remission and mucosal healing and reduction or elimination of corticosteroid use in adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant)
- Reduction of signs and symptoms, induction and maintenance of clinical remission and induction of mucosal healing in pediatric patients with moderately to severely active UC who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant)
- Reduction of signs and symptoms, induction of major clinical response, inhibition of the progression of structural damage of active arthritis and improvement in physical function in patients with psoriatic arthritis (PsA)
- Treatment of adult patients with chronic moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy. For patients with chronic moderate PsO, REMICADE® should be used after phototherapy has been shown to be ineffective or inappropriate. When assessing the severity of psoriasis, the physician should consider the extent of involvement, location of lesions, response to previous treatments and impact of disease on the patient's quality of life.

Please consult the product monograph at http://www.janssen.com/canada/products#prod-420 for important information on conditions of clinical use, contraindications, warnings, precautions, adverse reactions, drug interactions and dosing information, which have not been discussed in this piece. The product monograph is also available by calling 1-800-567-3331.

References: 1. Data on file, Janssen Inc.
2. REMICADE® Product Monograph, Janssen Inc., April 26, 2016.

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