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The Journal of the Canadian Rheumatology Association

Spotlight on: Training the Rheumatologists of Tomorrow

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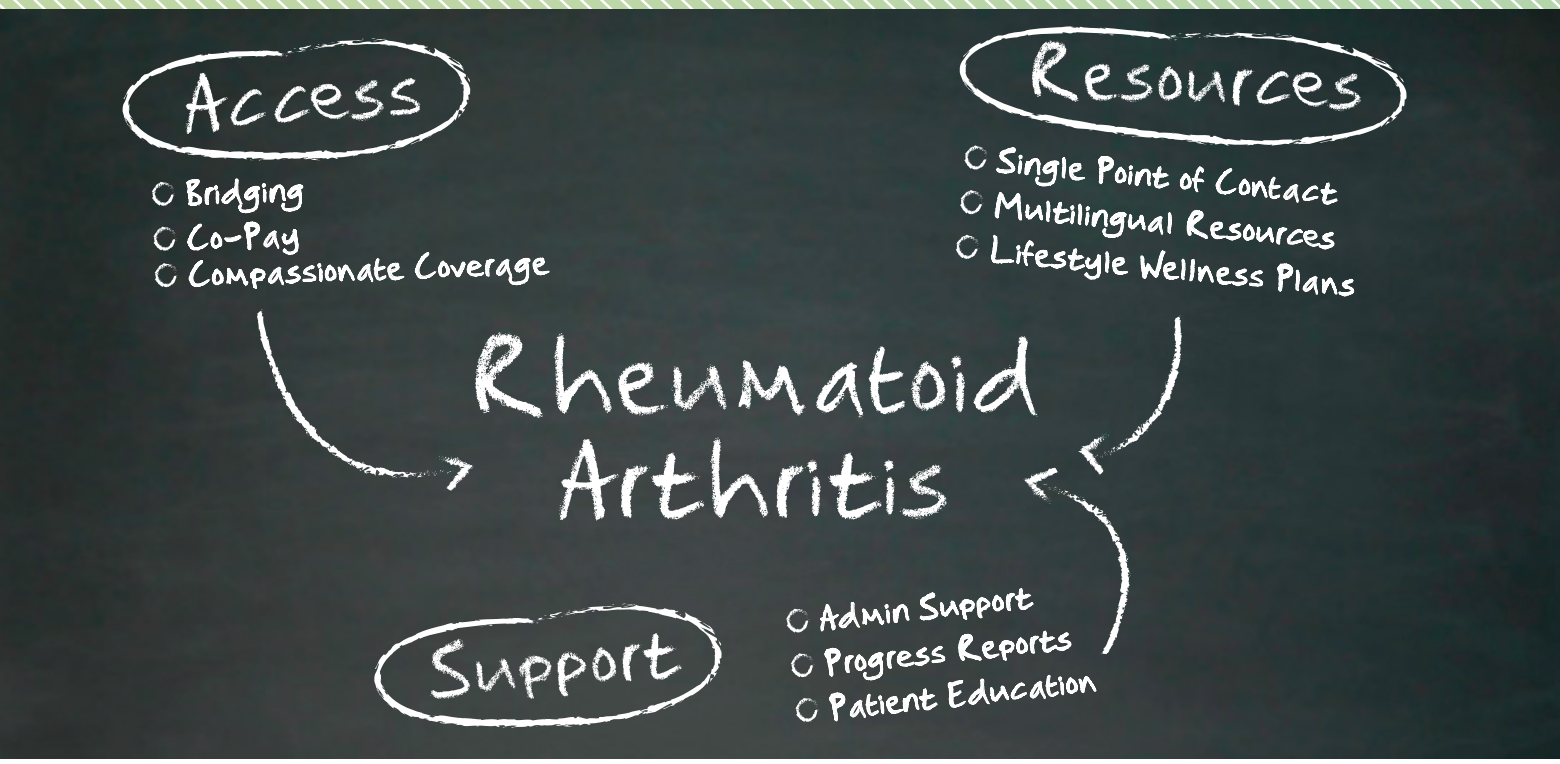

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PAAB

The Happy Warrior

By Philip A. Baer, MDCM, FRCPC, FACR

Who is the Happy Warrior? Who is he
What every man in arms should wish to be?
—It is the generous Spirit, who, when brought
Among the tasks of real life, hath wrought
Upon the plan that pleased his childish thought:
Whose high endeavours are an inward light
That makes the path before him always bright:
Who, with a natural instinct to discern
What knowledge can perform, is diligent to learn,
Abides by this resolve, and stops not there,
But makes his moral being his prime care.

- William Wordsworth, "Character of the Happy Warrior," written following the death of British war hero Lord Nelson.

I looked back on my recent and upcoming columns written for the *CRAJ* and noticed a theme. I seem to be complaining a lot these days, whether about difficulties with surveys, payments, lunch engagements or retail pharmacists. Yet I am very happy in my work and in day-to-day life. Maybe venting about certain frustrations keeps me feeling positive? The concept of the Happy Warrior resonated with me, so I researched it a bit further.

While the poem is British, the Happy Warrior label is most associated with American presidential politics. The American Spectator magazine noted in 2006 that Grover Cleveland "loved the poem, would gladly recite it to friends, and directed that it be read at his funeral." Franklin D. Roosevelt used it in a speech nominating New York Governor Al Smith for president at the 1924 Democratic National Convention. The Al Smith charity dinner in October 2016 in New York City featured the two presidential candidates, Trump and Clinton, attempting to make humorous speeches about each other. Neither one came across as a Happy Warrior. Most often, the label has been used to describe American vice-presidents, from Hubert Humphrey in the 1960s to Joe Biden most recently. Others tagged with the moniker include current U.S. House Speaker Paul Ryan and the late Senator Ted Kennedy.

Clearly, a rheumatology office/clinic is not always a happy place. There are pressures to see more patients, fit people in quickly and deal with paperwork, as well as managing interactions with staff. Bad news has to be delivered honestly and with empathy, from diagnosing a young woman with systemic lupus to a middle-aged man with rapidly progressive scleroderma and pulmonary fibrosis.

However, many of our interactions are typical of chronic disease management: stable patients doing well, who require periodic reassessments of clinical status, handling of inter-current flareups and comorbidities, adjustment of medication and monitoring of labwork and other indices of disease activity. These visits can be enjoyable for all involved parties, and "laughter being the best medicine" may come into play. A few examples come to mind:

My long-time rheumatoid arthritis patient who is now aged 90-plus, mentally sharp, and always comes to the office with her daughter. I was checking her pulse, which was 52, not unexpected as she was taking a beta-blocker. She asked me the number and when I divulged it, she looked at me and, in deadpan fashion, told her daughter it was low because "the doctor doesn't excite me." So now even nonagenarians are having a laugh at my expense! We all had a good chuckle over that one.

Another featured a young man who started to see me at age 16 with anemia, short stature and lower extremity pain of several years duration. He turned out to have juvenile-onset spondyloarthropathy, with hip damage and recurrent knee effusions. Nonsteroidal anti-inflammatory drugs (NSAIDs), physiotherapy and steroid injections to both knees were very effective. A few years later, he showed up for an appointment quite excited. He was taking some computer courses in college and showed me one of his assignments, an animation entitled "The Magic Needle." He said it was based on his first visits to my office, and the relief he experienced from intra-articular steroids. The storyline fit, but I noticed he had changed my name and his, for privacy reasons I assumed. It was only on further review that I noticed my name was now Dr. Cooper, and my image looked a lot like Dr. Sheldon Cooper of "Big Bang Theory" fame. Now, I am left to wonder if he is commenting on my intelligence and diagnostic acumen, or my social skills or lack thereof. I can laugh at it, but I am not going to ask him what he was really trying to say.

Medicine is serious business, but there is scope to enjoy the work and be a Happy Warrior. Just don't smile broadly as you are plunging a needle into a patient's joint; people don't appreciate that at all.

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

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An Update on the CRA's Programs for Students and Young Rheumatologists

By Christine Charnock, CEO of the CRA

Since it was founded, the CRA has worked to promote and advance the field of rheumatology by organizing networking, training, and educational opportunities for clinicians, students, allied health professionals and researchers alike. The following programs are just a few of our initiatives to help highlight rheumatology to students and residents and to support residents and early-in-career rheumatologists.

FLIRT

The Future Leaders in Rheumatology Training (FLIRT) is a mentorship program designed for rheumatologists at an early career stage who are likely to become leaders in research and/or education and/or advocacy in Canada.

This program seeks to identify and promote leadership in community, research, and academic rheumatologists early in their career. It is comprised of a variety of initiatives identified via a needs assessment conducted with participants, and a collaboration with Canadian mentors and expert advisors. This program is presented by leaders in academic centres and community practice and covers topics relevant to all "rising stars" regardless of their practice setting.

To learn more, visit *https://rheum.ca/en/members/flirt*, and turn to page 11 for Dr. Janet Pope's description of this popular mentorship program.

The Dilemma Rheum

The Dilemma Rheum is a series of educational teleconferences designed for recently certified rheumatologists and trainees. Each session features an expert on a particular topic who will discuss and answer questions on cases brought forward by participants. Topics discussed during these educational teleconferences are always changing, and future topic suggestions are welcome.

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Upcoming sessions include:

- Sarcoidosis and other problem cases – May 10, 2017 at 8:00 pm ET
- Autoinflammatory Diseases, Behcet's and other problem cases – June 6, 2017 at 8:00 pm ET

Our feedback from attendees has been fabulous; they love the opportunity to be able to ask questions directly to experts in the field. To register, please visit *https://rheum.ca/en/education/dilemma_rheum*. To read more about a former Dilemma Rheum participant's thoughts on this program, read Dr. Tom Appleton's article on page 12.

NRRW

We are in the midst of planning the next iteration of the National Rheumatology Residents' Weekend (NRRW) designed to bring together all of the residents and program directors from across Canada to address topics that are better suited to a larger group education session and discussion. It is also an opportunity for rheumatology residents to network with their colleagues and form lifelong working and personal relationships.

Residents' Pre-course

We continue to support the highly valued Residents' Precourse, which welcomes any students who attend the CRA Annual Scientific Meeting (ASM). It covers topics that both

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The CRA would also like to announce that the 2018 CRA Annual Scientific Meeting (ASM) and Arthritis Health Professions Association (AHPA) Annual Meeting will be held in Vancouver, British Columbia. Please stay tuned for more details.

Training the Rheumatologists of Tomorrow (TROT)

By Diane Craswhaw, TROT Project Coordinator

"You can't KNOW rheumatology unless you DO rheumatology."

Canada faces a critical shortage of rheumatologists overall, and this shortage is even more pronounced in communities outside of large urban centres. To address this problem, the CRA has supported various initiatives, including Training the Rheumatologists of Tomorrow (TROT)–a pan-Canadian consortium of researchers who came together to survey and interview 103 learners and faculty/administrators in 11 Canadian rheumatology programs. The data obtained was used to identify key messages to relay to medical students and residents about rheumatology. This information was used to develop the *#MakeRheum* campaign, consisting of a range of material in French and English that includes posters, banners, PowerPoint slides and a QuickTime video, available singly or as a collection that is posted on the CRA website under "educational resources". The aim is to inform medical students and residents about rheumatology in an upbeat and interesting way and to encourage learners to consider an experience in rheumatology.

The uneven distribution of rheumatologists in Canada is a problem that to date has not been addressed in a comprehensive, national manner. One initiative that is being explored in Ontario is to partner with the Rural Ontario Medical Program (ROMP), which provides distributed medical education training. This program has the infrastructure to facilitate experiences for all levels of trainees. There are similar programs nationally: the Rural Coordination Centre of British Columbia (RCCBC), the Alberta Rural Physician Action Plan (RPAP) and Manitoba's Office of Rural and Northern Health (ORNH). The Atlantic provinces are also in the process of developing strategies. Individual rheumatology programs would need to determine if they have generated learner interest and if there are community rheumatologists to facilitate these placements. This initiative will need to create a toolkit for the mentors to facilitate their development as educators. This is a significant undertaking that might benefit from a coordinated and comprehensive national approach.

With the support of the CRA, TROT will continue to develop, implement and evaluate programs to address the shortage of rheumatologists in Canada. The pan-Canadian TROT team will continue its work to increase interest in rheumatology and to generate opportunities for student experiences within this subspecialty.

Finally, you can also encourage your undergraduate students and internal medicine residents to visit and join our Facebook page (*https://www.facebook.com/MakeRheum-1071285439622810/*) and Twitter account (*https://twitter.com/MakeRheum*), so that they can find out more about this subspecialty and *#MakeRheum* for rheumatology!

Diane Crawshaw
TROT Project Coordinator
Hamilton, Ontario

So We Stood Up and Got Counted... Now What?

By Claire Barber, MD, PhD, FRCPC; Katie Lundon, BSc (P.T.), MSc, PhD; Rachel Shupak, MD, FRCPC; and Deborah Marshall, PhD

In 2015, the CRA launched the first national rheumatologist workforce survey in Canada, called Stand Up and Be Counted [1]. The survey highlighted regional disparities in the number of rheumatologists across Canada and also a current shortage of rheumatologists. This shortage is anticipated to worsen given that one-third of rheumatologists surveyed planned to retire within the next five-to-ten years[1]. As response rates were excellent but not complete, Canadian Medical Association (CMA) data were used to develop estimates of the number of rheumatologists per a population of 75,000, after adjusting the CMA raw numbers based on a national estimate of the amount of time rheumatologists devoted to patient care from the workforce survey. Using these parameters there is a current deficit of between one and 77 full-time equivalent (FTE) rheumatologists per province/territory to meet the CRA benchmark, with the most underserviced regions including Canada's territories as well as the provinces of Saskatchewan and Prince Edward Island, followed by Alberta, Manitoba, New Brunswick and Newfoundland.

There were a number of challenges to this work. First, it was difficult to determine who the rheumatologists in Canada were, as not all rheumatologists in Canada are members of the CRA. Prior to launching the workforce survey, we conducted a review of the literature to identify all published resources about rheumatologists available in Canada[2]. At a national level, there were three identified databases with information on numbers: The Canadian Institutes of Health Information (CIHI), the CMA and the Royal College of Physicians and Surgeons of Canada (RCPSC), which all had slightly different estimates, with some differences accounted for by the time of year the estimates were produced. However, none of these sources had an estimate of the number of FTE rheumatologists, highlighting the importance of the workforce survey.

Recently, the American College of Rheumatology (ACR) disclosed the results of the ACR workforce study conducted in 2015[3]. The report describes a number of methods used to estimate the rheumatology workforce including supply-based, demand-based, needs-based and integrated methods. The ACR study also demonstrated regional maldistribution of rheumatologists in the United States (U.S.), with the greatest shortages of adult rheumatologists projected for the South Central, North Central and Northwest regions[4]. Similar to the CRA data, in the United States there were high rates of projected retirements (upwards of 50%) which will worsen access to care in the near future. The ACR study also postulated that additional factors may reduce workforce capacity, including the number of women in rheumatology and a workforce shifting from baby boomers to millennials.

In Canada, it is hard to determine what effect these shifting demographics may have on our workforce. Recently, additional analysis of the Stand Up and Be Counted data, presented at the 2017 CRA Annual Scientific Meeting (ASM), suggests that age is not a predictor of rheumatologist-work volumes but that location of practice is a major factor associated with rheumatologist-work volumes, with community-based rheumatologists seeing significantly greater volumes of patients than rheumatologists based in a university practice. Physician gender had a smaller effect on practice volumes[5].

Understanding the distribution and work characteristics of rheumatologists is important to plan for projected workforce shortages. Additional work is underway to better assess supply and demand for rheumatology care based on more detailed data about the location of rheumatologists and rheumatology patients in Alberta (Canadian Initiative for Outcomes in Rheumatology Care [CIORA]-funded project: Principal Investigators [PIs] Claire Barber and Deborah Marshall). Based on this work, we anticipate a better understanding of whether the benchmark of one rheumatologist per population of 75,000 is appropriate based on the demand for rheumatology services. Furthermore, some

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workforce shortages may be addressed by implementing different models of care to increase capacity. To that end, Stand Up and Be Counted Too! is a survey of extended-role health discipline professionals working in advanced musculoskeletal care that is planned for launch in 2017 (PIs Katie Lundon and Rachel Shupak). The primary objective of this study is to estimate the number and location (and FTE status) of advanced- or extended-role health discipline professionals working in arthritis and/or musculoskeletal care in Canada. The ultimate goal is to gather this information to enable the future development of a network of arthritis-care health professionals working with rheumatologists across Canada.

Overall, the Stand up and Be Counted survey was a valuable endeavour that gave us detailed information on our workforce, which has been of use to the CRA (including the Human Resources Committee), as well as regional stakeholders. We are planning to repeat the rheumatologist workforce survey in 2020 to evaluate the impact of demographic changes over time.

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on behalf of Katie Lundon, BSc (P.T.), MSc, PhD;
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Expanding Rheumatology Care in British Columbia

By Jason Kur, MD, FRCPC, ABIM

By now, many will have seen the recent release of Canada's updated census data. These data point to the fact that some of the largest population increases in recent years have been in Western Canada. Not surprisingly, the population of British Columbia (B.C.) has been growing and, so too has the population of rheumatologists in the province.

Over the past two-to-three years, we have seen recruitment successes on a few fronts. There has been a net positive migration of rheumatologists from other parts of Canada and the world to B.C. In addition we have seen the graduation and retention of several trainees from the University of British Columbia (UBC) rheumatology program.

But, the ceaseless challenge that we experience, as mimicked by many other jurisdictions, is meeting the needs of patients in all geographic regions of the province. The distribution of specialists in relation to the demand for services is a continuing struggle.

However, there have been some new, constructive developments on the rheumatology human-resources front. For instance, Chilliwack in the Fraser Valley now benefits from the rheumatologic services of Dr. Markus Klaus.

The City of Surrey, with a population that is nearing Vancouver, traditionally has not had a single full-time rheumatologist in practice. That is rapidly evolving as a combination of new graduates and established physicians are now practicing in the area. As a corollary, the rheumatologists in the Fraser Health Authority, which includes Surrey and New Westminster, are working to form a more cohesive group in their dealings with their health region.

The Mary Pack Arthritis Centre travelling consultation service continues its excellent outreach work for the more remote communities in the province.

Areas of the B.C. interior still would be considered underserviced by provincial standards, as wait times there for assessments continue to be the longest in the province. In addition, there are no rheumatologists in Prince George/ Northern B.C.

Fortunately, the outlook for rheumatologic patient care has improved considerably in recent years in the province of British Columbia, and we look forward to further alleviating unmet regional needs.

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University of British Columbia
President,
British Columbia Society of Rheumatologists
Co-Director, Artus Health Center
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Excuse Me, Would You Like to Be a Rheumatologist?

By Volodko Bakowsky, MD, FRCPC

I have been asked to write about the challenges of attracting new trainees to rheumatology from the Atlantic-Canadian perspective. I suspect our perspective is much the same as that of the rest of Canada, only we are more polite, hence the title of this article.

Challenge #1: Branding

I apologize if this offends some of you traditionalists out there (see the politeness at play here?), but I do believe the name of our profession does little to establish our "brand". If we were to name ourselves today, would we really come up with *rheumatology*? The "ology" part is obviously fine. But the "rheum" does little to help our recognition. If I google the word "rheum", I come up with the following definition: "a watery discharge from a mucous membrane, especially the eyes and nose." Hmm…I wonder if there was a focus group before that term was chosen. Yes, there are historical reasons behind choosing the term, but perhaps the time has come for us to rebrand ourselves with a name that captures the essence of our expertise. I used to joke that even my mother didn't know what a rheumatologist was. How many times have we all had to explain what it is exactly that we do? I don't think cardiologists, orthopedic surgeons, pediatricians, neurosurgeons (and the list could go on) face the same challenges as we do. It is difficult to attract attention, when people don't even understand who you are and what you do.

Challenge #2: Exposure

When surveyed about what factors were most important in helping them decide on their career choice, medical students and residents typically highlight that early exposure to a field played a key role in attracting them to their eventual chosen profession. Exposure is also critically necessary for the development of role models, which is perhaps the biggest influencing factor of all reported in these surveys.

The challenge, then, is how to increase exposure at a time when the trend in medical education appears to be decreasing time within the curriculum for medical-science content. For example, at Dalhousie, when our curriculum was renewed several years ago, the musculoskeletal (MSK) component went from six weeks to five weeks that are now shared with dermatology. In addition, the number of lectures was roughly halved. These were replaced to some extent by case-based learning tutored by non-experts, i.e. non-rheumatologists, and in many cases, non-internists and non-MSK specialists. Similar changes occurred across the country.

The challenge continues even after learners enter Internal Medicine residency. Rheumatology does not tend to be a required core rotation. Those residents that rotate through rheumatology often do so near the end of their core Internal Medicine training, after they have already picked a career path.

So, what is the solution? The Training the Rheumatologists of Tomorrow (TROT) group, under the leadership of Drs. Cividino and Legault, are working on our branding. For example, they are reaching out to learners via social media (*#MakeRheum* anyone?) and are exploring other opportunities for increasing exposure to our field. We all need to be efficient with the time we have. We need to volunteer, to teach, and to be preceptors and tutors. We need to maximize our "role-modelness." We need to share the joy of our field of medicine and the rewards of being kind, compassionate, cerebral diagnosticians!

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Nuit Rheum: A Night to Remember

By Lori Albert, MD, FRCP(C)

Coincident with the introduction of Nuit Blanche to Toronto in 2006 (a free, all-night, contemporary art event), Nuit Rheum was brought to University of Toronto (U of T) medical students in 2007. This free, two-and-a-half-hour contemporary rheumatology event marked its tenth anniversary on February 6th, 2017.

Nuit Rheum was designed to provide students with an informal and fun opportunity to meet and chat with rheumatologists and trainees, and to learn more about a career in rheumatology. Each year, approximately 50 medical students sign up to attend this soirée in early February, which follows "Rheumatology Week" in the undergraduate curriculum.

The original format of Nuit Rheum was an informal reception followed by dinner and speeches, held at the beautiful Faculty Club of the U of T. Speakers included the Division Head, Program Director, a rheumatology trainee and representative faculty from different career pathways.

Students received a "loot bag" with an information sheet about the U of T program and elective opportunities, contact information for The Arthritis Society (TAS) and the Canadian Rheumatology Association (CRA), a copy of the Canadian Clinician's Rheumatology Handbook and, of course, a U of T rheumatology pen.

After a number of years, it became apparent that the most effective part of Nuit Rheum was the direct one-on-one and small-group discussions between faculty and students. Thus, in 2016, the speeches and formal presentations were phased out and a "cocktail-reception" format was initiated. Now at the event, students move around to "Meet the Professor"stations where they can speak directly with faculty in specific career pathways or chat informally with faculty and trainees who move through the crowd wearing nametags declaring "Ask Me: I'm a Rheumatologist". There is also a station hosted by the Ontario Rheumatology Association (ORA) and CRA (represented by Dr. Jane Purvis), with promotional materials, including the "Rheumatology Heroes" posters, cards and pens. Our loot bag is now virtual, with a Quick Response (QR) code bearing the important program and contact information, and a code for a free download of the e-version of the Rheumatology Handbook (but they still get a pen!)

We have had an excellent response to the Nuit Rheum initiative, with all faculty noting an uptick in requests for electives and CRA summer studentships after each event. Here is an email I received on February 8th:

"Hi Dr. Albert,

I just wanted to reach out and say thank you for organizing Nuit Rheum last night! I had a great time getting to know the different rheumatologists, and I especially enjoyed the informal setting because it made it easier to approach people and learn what the work-life balance is like. Everyone was so kind and down-to-earth. It definitely made me (and many of my peers) much more interested in rheumatology. I wish every specialty organized a similar event!"

Nuit Rheum is also a great opportunity for faculty, who enjoy meeting some of the stellar young trainees interested in immunology, research and clinical rheumatology. Some productive research and clinical collaborations have had

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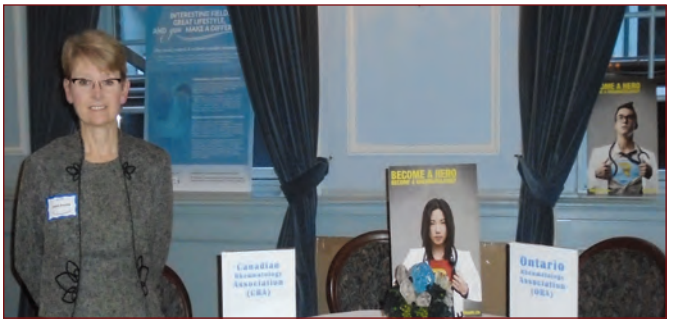
Students talking to professors at "Meet the Professor" stations.



Dr. Jane Purvis at the Ontario Rheumatology Association (ORA) station.

Young Rheumatologists Love to FLIRT

By Janet Pope, MD, MPH, FRCPC

Proudly, the CRA has taken the Future Leaders in Rheumatology (FLIRT) program under its wings. This is the third group of rheumatologists who are undertaking the program, which is a mentorship program designed for rheumatologists at an early career stage who are likely to become leaders in research, education, and or advocacy in Canada. There has already been one highly successful meeting, with another one booked for April 2017. There are 20 candidates enrolled, representing adult and pediatric rheumatology from across the country. Highlights to date include discussions on mentorship, promotion (for the academic group), and the delivery and critique of talks. Up next will be the communication wheel, time management and industry relations. The enthusiasm is palpable: Nearly all participants (96%) would recommend this program to others. Feedback reveals FLIRT is a resounding, unequivocal success.

Here are some of the comments we have received:
"Well organized and relevant"
"Excellent, timely and applicable talks"
"You made the most of our day"
"Wonderful experience for networking and leadership exercises"
"Well put together and great lectures and learning. Thank you for a wonderful session!"

We will need to keep an eye out for graduates of this two-year program who will represent the CRA of tomorrow.

Janet Pope, MD, MPH, FRCPC
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FLIRT participants (and a potential future FLIRT) at the most recent meeting, which took place at the ALT hotel in Toronto in November 2016.

Nuit Rheum: A Night to Remember *(Continued from page 10)*

their start at Nuit Rheum! It is also somewhat magical when faculty and students come together and get a glimpse into the world of the other. Nuit Rheum seems to have a positive impact on everyone who attends. The generous support of our Division Director (Dr. Claire Bombardier formerly, now Dr. Heather McDonald-Blumer) has allowed this event to succeed and thrive.

Lori Albert, MD, FRCP(C)
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The Dilemma Rheum: *You Used to Call Me on My Cell Phone**

By Tom Appleton, MD, PhD, FRCPC

Actually, I called The Dilemma Rheum. Close enough.

When you start out in practice, no amount of preparation can make the transition from trainee to independent rheumatologist a completely seamless and self-assured experience. Of course, our training makes the transition feasible but, at some point, you must simply jump in–carefully–and learn by adapting to a myriad of situations from which you were buffered as a trainee. This is the natural order of things.

Dr. Tom Appleton and Dr. Janet Pope

Yet, as rheumatologists, at the heart of what we do are people with rheumatic diseases. Our central purpose is to help, to heal and to provide the best care possible. In this context, there is simply no way to reconcile the difference between my zero years of experience in independent practice with that of the seasoned mid-to-late career-rheumatologist colleague in the next office. That is, if you're lucky enough to have one nearby for advice and reassurance.

When the opportunity arose to participate in the Dilemma Rheum series, I jumped at it. Dilemma Rheum is aimed at people like me, who are starting out in practice. Providing care for patients is both exciting and humbling and many of the conclusions reached in the Dilemma Rheum reflect the excellent training of rheumatologists in the Canadian system, while others reflect the challenging nature of rheumatology where uncertainty is the rule, not the exception. So far, there hasn't been a day (half-day?) in clinic without at least one case of "I'm really not sure what you have". These are the cases my colleagues and I brought to the Dilemma Rheum sessions every four-to-six weeks for discussion with an expert–usually Dr. Janet Pope. Everyone on the call contributes their ideas too, which was interesting and beneficial; it was useful to hear how others at my stage in practice think about problems.

Sometimes there were clear answers with new ideas to take back to the clinic. For many cases, though, I came away reassured that rheumatology is unwaveringly complex, and we may never have all the answers. In many ways, this is what drew me to rheumatology in the first place. That complexity is both a blessing and a curse, but you will never lack stimulation in this profession. Recognizing the challenge of real-world rheumatology also inspires a healthy respect for what can be missed or misinterpreted. Hence, the opportunity to review cases with others in the field holds great value–even if that means giving up an hour or more of your late evening in Eastern Standard Time.

The ability to access senior colleagues' experience to review the most difficult cases is a unique advantage of those in group rheumatology practices, but not universally available to many of us starting out. For the motivated senior rheumatologist looking for a project, a "curbside consult" hotline bling version of Dilemma Rheum (i.e., call when you need to) could be a good idea and the service would be even more valuable for new rheumatologists looking for a sounding board and/or advice in real time. While such blue-sky propositions may be too resource-intensive to be practical, Dilemma Rheum is available freely to young rheumatologists and I highly recommend it to my peers. The real dilemma before us, though, is how to recruit and train more rheumatologists in Canada. With our senior colleagues in various stages of retirement contemplation and pre-contemplation, that could only mean one thing: we have work to do.

**Refers to "Hotline Bling" (2016) by Drake*

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The Journey from CRA Summer Student to Rheumatologist

By Mohammed Osman, MD, PhD, FRCPC

If you asked me, before I entered medical school, whether I would become a rheumatologist, I would have honestly not known what a rheumatologist was or what conditions they treat. Now, I can certainly say that it is the best fit for me all around, whether in the clinic, in the lab, or in the classroom.

Prior to pursuing medicine, I was trained as a researcher in immunology. Naturally, I had an affinity for hematology and infectious diseases. My first exposure to rheumatology was during my second year of medical school when I was listening to Dr. Anna Oswald describe the pathogenesis of gout with all the lovely diagrams involving interleukins and inflammatory cells. I was inspired to learn more about this intriguing specialty and eventually applied to become a CRA summer student with Dr. Elaine Yacyshyn. If you have worked with her, you will know what I mean when I say her enthusiasm for rheumatology is contagious. During that summer, I spent most of my time in the clinic, but I also learned about the vasculitides, which continue to be a large interest of mine.

After the summer was over, I had learned about rheumatology and had fallen in love with it. I spent countless hours reading about immunology and the pathogenesis of the diseases I had seen in clinic. During the rest of my time in medical school, I continued to learn more about the rheumatologic diseases. I was excited whenever I saw a patient that had an ailment that was like those I had seen in patients I had met as a CRA student–such as the patient whose knee I aspirated at midnight with Dr. A. Kydd (the senior medical resident on-call at the time). My feelings of belonging were further validated when I went to my first CRA Annual Scientific Meeting in Quebec City.

As a fellow and now a rheumatologist, I have been fortunate enough to meet CRA students and medical residents interested in our specialty. I have tried to convey my experience and passion for rheumatology to them, and I know at least one of them is on their way to becoming a rheumatologist. The summer I spent with Dr. Yacyshyn was when I had started to realize that I wanted to become a rheumatologist.

Because I have always been pre-occupied with understanding why and how diseases happen, I spend much of my time in the lab. Being both at the bench and in the clinic, it can sometimes be hard to find balance. I am fortunate to have the support of my wife, Wassila, and my family. I am also lucky to have colleagues in Edmonton and mentors across the country who are very supportive. I am truly lucky to have picked this specialty with its inspiring patients, amazing colleagues, and so many questions to answer.

Mohammed Osman MD, PhD, FRCPC
Clinical Lecturer, Department of Medicine
Specialist in Rheumatology and Immunology,
Vascular Biology Fellow, University of Alberta
University of Alberta Hospital, Edmonton, Alberta

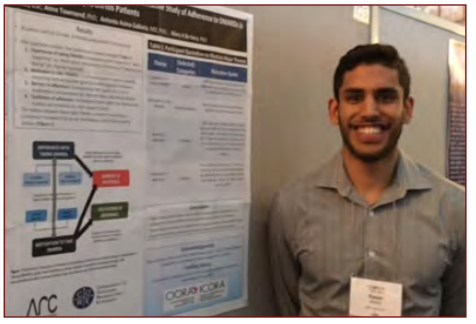
WELCOME TO THE RHEUM

Welcome to the following new members:

Sima Abu Alsaoud, Toronto ON
Husain Bahbahani, Richmond, BC
Nicola Berman, Brooklyn, NY, USA
Bailey Dyck, London, ON
Daniel Ennis, Vancouver, BC
Tahir Kanji, Kingston, ON
Jennifer Lee, Toronto, ON
Alexandra Legge, Halifax, NS
Sarah Malaekah, Montreal, QC
Nancy Maltez, Ottawa, ON
Matthew Piche, London, ON
Ceri Richards, Winnipeg, MB
Fergus To, Vancouver, BC
Richard Tse, Saskatoon, SK
Victoria YY Xu, Toronto, ON

A CRA Mentee's Experience of the 2016 Annual Scientific Meeting (ASM)

By Pavan Mehat, BSc, MSc



How can I describe the experience of attending my first-ever Canadian Rheumatology Association (CRA) conference and having the invaluable opportunity to present my research? There is no way to do justice with words alone about how transformational and educational this experience has been, but I will do my best.

Travelling to Lake Louise for the 2016 CRA Annual Scientific Meeting was a delightful trip. Upon my arrival, I was absolutely astounded by the awe-inspiring beauty that was the backdrop to this meeting. I quickly settled into my room and jetted off to the keynote speech about sleep by Dr. James Maas, otherwise known as "The Sleep Doctor". I was especially excited regarding this talk because I had read one of his books, "Sleep to Win." His talk was more entertaining and informative than I could have hoped for. It was a great way to launch all the learning that was going to take place over the next few days.

Following the talk, I was excited to have dinner at the Brewster Barn. I was pleasantly surprised to learn that we were being offered complimentary horse-drawn sleigh rides to and from the barn. I was truly in a winter wonderland.

Since I did not have to present my poster the next day, I attended a plethora of engaging and informative workshops and sessions. The highlight was another talk from Dr. James Maas, *The Things That Go Bump in the Night*.

I was thrilled not only to be exposed to so much cutting-edge research, but to also directly engage with the researchers who had completed this brilliant work. In addition, it was lots of fun to interact with my mentor, Dr. Philip Baer, and to learn more about the great research work he does and how he seems to balance it all.

The next morning, I woke up early to make sure I was ready for the jam-packed day, during which I would present my two posters. However, before I could shift my focus to preparing for my presentations, I was excited about the workshop: *Procreation: Timing is Everything*. Like most things during this conference, my expectations were exceeded. Dr. Laskin did an incredible job of disseminating a lot of crucial information, while fostering an interactive environment. It gave me a behind-the-scenes look at what my potential future career as a physician might look like.

As the poster session drew closer, I was becoming increasingly nervous. I blocked off a couple of hours beforehand to ensure that I would be able to review my posters and research to ensure I could provide a cogent presentation.

The time quickly flew by, and I was flattered to see people waiting to learn about my work before I even got the chance to put my poster up. I enjoyed in-depth discussions about my work and the field during my presentation. This was one of the highlights of this trip, as I was able to receive feedback about how to improve my work, while being able to connect with other researchers regarding future collaborations.

This productive day was capped off with an eventful gala dinner. We were all ravenous, as we had not eaten lunch, so the food and desserts were gobbled down as soon as they were served. Afterwards, there was a dance-off, where everyone let loose and lost themselves in the music.

Attending my first-ever CRA conference has not only been extremely beneficial, but also an enjoyable opportunity, during which I have been able to connect with many like-minded peers and mentors. I am especially grateful for being connected with such a great mentor, Dr. Baer, who took the time and initiative to meet up with me multiple times throughout the conference and answered my questions. I will definitely be planning on attending and presenting at this conference next year.

Pavan Mehat, BSc, MSc
MD Candidate, Class of 2020
University of British Columbia, School of Medicine
Vancouver, British Columbia

My Path to Becoming a Rheumatologist

By Stephanie Garner, MD, MSc

At the 2015 CRA meeting in Quebec City, the Training the Rheumatologists of Tomorrow (TROT) group presented an abstract discussing the positive impact of early exposure to rheumatology. As I stood there, it struck me that in my case, (very) early exposure had influenced my decision to not only go into rheumatology but to become a physician.

At the tender age of 12, my choices for "Take Your Kid to Work Day" were to go to the school where my father was a principal or to spend the day with my mother who was an accountant. Luckily, my neighbour, Dr. Mary Bell, offered an alternative and brought me with her to Sunnybrook Health Sciences Centre to spend the day at her clinic. I loved it and, during my undergraduate studies, when an opportunity came up to work with Dr. Bell and the Patient Partners program on a knowledge-translation project, I jumped at it. I was fascinated by medicine and the patients and felt rheumatology was an area I could contribute to. This experience heavily influenced my decision to go into medicine.

After completing my undergraduate degree at McGill University, I moved to Calgary to pursue research training and had the privilege of working on a master's degree with Dr. Steven Edworthy. My area of research interest has been challenging the traditional model of care to look for ways to deliver better care for patients within the limitations of our healthcare system. With the national shortage of rheumatologists, using allied health providers, particularly nurses, in expanded clinical roles is crucial.

While attending medical school in South Australia and residency at the University of Calgary, I had the opportunity to undertake several electives in both community and academic rheumatology. Working with Dr. Carter Thorne and his team at The Arthritis Program (TAP) in Newmarket, Ontario, was an amazing experience and taught me the importance of collaboration. Dr. Chris Penney in Calgary showed me the role of educator, and Drs. Cheryl Barnabe and Deborah Marshall have mentored me in pursuing scholarship.

The transition from internal medicine resident to rheumatology fellow was a welcome one. My husband, son and

Dr. Garner with her husband and son.

I moved from Calgary to Hamilton at the end of June 2016 and, with zealous support from family, settled into Hamilton. My experience here has been fantastic. Whether it be aspirating and injecting a patient's knee with gout or collaborating with a large team regarding a sick patient with vasculitis, I'm finding my career choice rewarding and challenging.

Amazing mentorship and early exposure have been such an important part of my career path, and I look forward to taking on this role as I move forward with my career.

Stephanie Garner, MD, MSc
Rheumatology PGY4
McMaster University
Hamilton, Ontario

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* Non-radiographic axial spondyloarthritis
† Comparative clinical significance has not been established.

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Training Our Colleagues–McMaster Clinical Day in Rheumatology

By Raj Carmona, MBBS, FRCPC

In addition to training the rheumatologists of tomorrow, the McMaster Division of Rheumatology recognizes the need to equip our primary care allies to better care for patients with rheumatic diseases. In pursuit of this goal, the inaugural McMaster Clinical Day in Rheumatology was held on November 4th, 2016, at the Hamilton Convention Centre.

The idea of this clinical day originated from discussions at our annual divisional retreat, and planning began eight months prior to the day. I had the esteemed privilege of leading the Planning Committee and co-chairing the conference with Dr. Alf Cividino, our divisional chair. Given that primary care allies were a main target, we invited two family-physician colleagues (Dr. Lauren Cameron and Dr. Rick Black) to join us on the committee. Their perspectives were important in shaping the contents of the program. To assist with advertising, behind-the-scenes logistics and actual roll-out of the conference, we recruited the McMaster Faculty for Continuing Health Sciences Education (CHSE). Rennée Tremblay, our Rheumatology Program Coordinator, was also instrumental in these roles. We partnered with a number of industry sponsors whose contributions were invaluable to the delivery of the program.

Since I am certain that no one will accuse me of any bias whatsoever, I can declare that the program's agenda was super stellar! Equally stellar was the theme of the day – "The Pearls You Need To Know". This theme guided all sessions, as we sought to provide our attendees with high-yield pearls to benefit their daily clinical practice. Topics included Approach to Inflammatory Arthritis (Dr. Kim Legault), Lab Tests in Rheumatic Diseases (Dr. Mark Matsos), Treatment of Rheumatoid Arthritis (Dr. Alf Cividino), Biologics and Safety (Dr. Raj Carmona), Connective Tissue Diseases in Primary Care (Dr. Maggie Larché), Vasculitis in Primary Care (Dr. Nader Khalidi), Osteoporosis (Dr. Arthur Lau), Back Pain (Dr. Raj Carmona), Osteoarthritis (Dr. Lawrence Hart), and Emergencies in Rheumatology (Dr. Sankalp Bhavsar). Break-out sessions on physical examination skills were a major attraction. We focused on key examination pearls to help our participants detect swollen joints and diagnose common musculoskeletal conditions.

The rapid registration for the conference was also a testament to the stellar curriculum offered, and maybe, *just maybe*, the keen yearning for rheumatology knowledge among our primary care colleagues. Based on discussions with CHSE about inaugural events, we had anticipated about 125 registrants. However, we had to close off registration more than two weeks prior to the conference. This is usually when most programs accelerate their marketing to reach target registration. Due to the logistics of running break-out clinical skills sessions, we stopped registration at 210 participants. Amongst others, this included 114 physicians (mostly family doctors) and 61 allied healthcare professionals.

Feedback was overwhelmingly positive. The talks were all highly rated (as highly as the food, and probably better than the cannolis!) The clinical skills sessions were also highly valued. Many respondents indicated that the conference improved their skills in taking a rheumatological history, their confidence in musculoskeletal physical examinations, their ability to Choose Wisely in ordering investigations, and their confidence in interpreting test results. Many suggestions for future topics were received, as well as requests to make this an annual conference.

Continued on page 20

CanVasc Recommendations for the Management of ANCA-associated Vasculitides

By Christian Pagnoux, MD, MSc, MPH; Nader A. Khalidi, MD, FRCP(C); and Lillian Barra, MD, PhD, FRCPC

Vasculitides are potentially life-threatening diseases. Because of their relative rarity and heterogeneous clinical presentations, the management of individual patients can be extremely challenging.[1] Treatment strategies may vary across different geographical regions depending on the specifics of healthcare system delivery, access to services and drug treatments.[2]

The development of Canadian recommendations for the management of vasculitis is one of the means for the Canadian Vasculitis Network (CanVasc) to optimize and harmonize the care of patients with vasculitis in Canada and improve their outcomes. The first CanVasc recommendations, for the management of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitides (AAV), were published in January 2016.[3] Their dissemination is ongoing, and they are reaching larger audiences, including those abroad. Recently, Dr. Jack Cush picked them for a "news" vignette on *RheumNow.com*.[4] The German Society of Rheumatology, which also recently developed its own recommendations (submitted for publication), included them in an article comparing similar initiatives, including the European League Against Rheumatism (EULAR)/ European Renal Association (ERA)-European Dialysis and Transplant Association (EDTA) updated recommendations, published in June 2016.[5,6]

When recommendations are being developed by different groups across the world for the same conditions, one resounding question is whether these similar initiatives are needed and useful or redundant and hence an unnecessary use of resources.

Of note, before these first CanVasc recommendations, no guidelines had ever been developed specifically for vasculitis in North America. Existing recommendations were exclusively from Europe, Japan and Australia.[6-9] The international Kidney Disease: Improving Global Outcomes (KDIGO) clinical practice guidelines for management of glomerulonephritis included a section on pauci-immune glomerulonephritis, which is a frequent manifestation, but still only one aspect of AAV, which can affect many organ systems.[10]

Overall, the CanVasc and EULAR/ ERA-EDTA recommendations are similar, which is reassuring. However, subtle differences are worth noting. There are specific Canadian healthcare issues which are addressed in the CanVasc recommendations. The CanVasc recommendations include statements on pregnancy and pediatric issues, not covered by the EULAR/ERA-EDTA guidelines. On the other hand, the latter mention mycophenolate mofetil (MMF) as an alternative to methotrexate, for the treatment of non-severe granulomatosis with polyangiitis (GPA). Available data were lacking for CanVasc to support such a recommendation. Unpublished results from a single randomized European study comparing MMF and cyclophosphamide are of limited convincing value.

Based on the recently published Maintenance of Remission in ANCA-vasculitis (MAINRITSAN) study,[11] CanVasc mentioned rituximab as an "alternative to azathioprine for remission maintenance of [AAV], especially for patients with Proteinase 3 (PR3)-ANCA+ GPA."[3] The EULAR/ ERA-EDTA group listed azathioprine, methotrexate, rituximab and MMF as options for maintenance treatments.[6] Rituximab is not yet approved for maintenance therapy in Canada and coverage varies across providers and provinces. The results of another ongoing international trial

(RITAZAREM, ClinicalTrials.gov NCT01697267; last inclusion in November 2016) may confirm the role of rituximab for maintenance, but will not be available before late 2018.

The fact that more studies have been conducted and several recommendations developed over the past decade are good signs for patients with vasculitis, their physicians, and researchers. Those achievements may help vasculitis gain a more visible place in the Canadian rheumatology landscape, especially related to provincial payers and research funding agencies.

As new therapeutic options are currently under investigation, an update of the CanVasc recommendations will be needed when major developments occur. Until then, our medical community needs to be aware of and use the CanVasc recommendations for guidance in the management of patients with AAV. Several tools are under development to further promote their use and inclusion in the training and continuous learning of physicians managing vasculitis patients, including the forthcoming book, *Canadian Vasculitis Learning Initiative (CaVALI): An Approach to Vasculitis Through Interactive Clinical Cases*. For more information, please visit *www.canvasc.ca*.

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Training Our Colleagues–McMaster Clinical Day in Rheumatology *(Continued from page 18)*

By any measure, the inaugural McMaster Clinical Day in Rheumatology was a resounding success. Based on the feedback we received, we are confident that we fulfilled our overarching objective of equipping our primary care allies to better care for patients with rheumatic diseases. Planning is well underway for the 2017 iteration (*fhs.mcmaster.ca/conted*).

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CRA Survey Results: Guidelines for Guidelines?

Guidelines serve a very important role in healthcare and medical practice, particularly since the advances of evidence-based medicine over the past two decades. For the spring 2017 issue of Joint Count, we asked CRA members for their opinions on guidelines: why the CRA should develop them, what purposes they serve for CRA members, and the best ways to handle conflicts of interest (COI). The data below are based on responses from 140 CRA members, who are either academic and/or community rheumatologists.

When asked about why the CRA should develop high-quality clinical guidance documents, the majority of survey respondents agreed that the most important reasons are to help standardize clinical practices based on best evidence (79%); to provide guidance for CRA members on important clinical topics (77%); and to improve patient outcomes (76%).

According to CRA members, CRA guidelines are most often used in clinical practice (67%) and to improve knowledge (67%). They were also cited as being used in discussions with health policy experts or industry (33%); when writing research papers (25%); and as a reference for patients (16%). Many respondents also commented that they used CRA guidelines as teaching tools for medical students and trainees.

The most useful dissemination methods/products would be open-access to the full publication (71%), a short version of the guideline (67%) or a guidelines app (60%). Concerning a guidelines app, a quarter of respondents said summary tables of important risks and benefits for key recommendations would be helpful to have within the app.

Finally, with regard to how the CRA should handle COI within guidelines, most respondents (88%) agreed that there should be full disclosure of any COI or perceived COI, published alongside the guidelines. Almost half of respondents agreed that having guideline panelists excuse themselves (i.e., not vote) on recommendations where they have a real or perceived COI, could also help mitigate issues of COI.

While guidelines serve many uses in healthcare, their ultimate objectives are to improve patient care and health outcomes. With this in mind, it is paramount that they are rigorously developed by experts in the field who are using the best evidence available.

Table 1. **Which of the following do you feel are important reasons for the CRA to develop high-quality clinical guidance documents?**

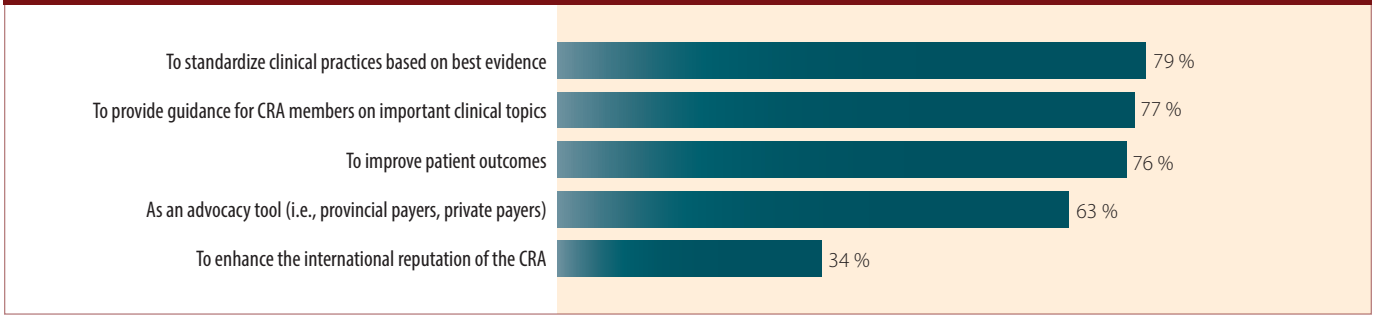
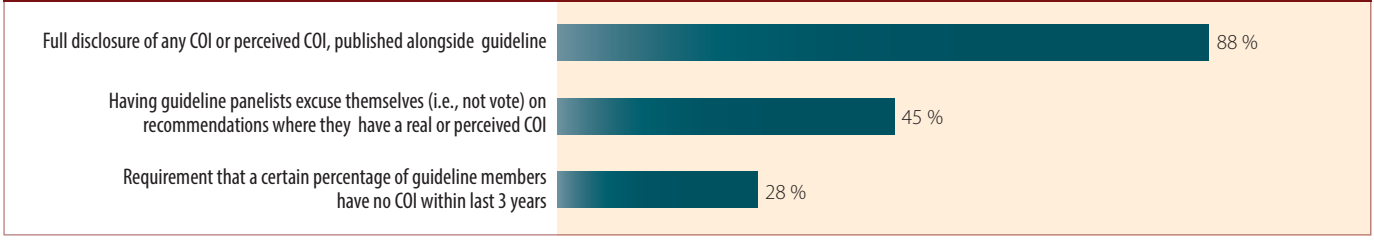


Table 2. **How do you think the CRA should handle conflicts of interest (COI)?**



Redefining Happiness: My Experiences in American and Canadian Health Systems

By Ashley Sterrett, MD, CCD

Is the grass always greener? As an American-educated and trained physician you are taught your healthcare system is the best in the world—why else would so many migrate from other countries to train and practice in the United States (U.S.)? However, while I worked in an academic and government setting in the United States' Veteran's Health system, I began to question that presumption. I attended medical school in the state of Georgia and then completed my training in internal medicine, followed by rheumatology at the University of South Florida (USF). After graduation, I joined as a staff rheumatologist with the Veteran's Health Administration (VHA) in Tampa, Florida, which is affiliated with USF. In my role, I had the privilege of caring for my nation's veterans, as well as training medical students, medical residents, and rheumatology fellows. My medical billing was simple: Only veterans could receive care at VHA. Thus, if they were referred to me, they had medical coverage. The coding was based on Medicare guidelines, and the formulary for medication and testing coverage was based on a national formulary, rather than the myriad of insurance plans most physicians struggle with in private practice. The electronic medical record (EMR) system used by the VHA has been active since the 1990s—it is the original EMR. It is also accessible from any Veteran's Affairs (VA) centre in the country; if a veteran who lives and receives care in Tampa presents to a VA medical centre in Texas for care, his or her records are accessible through a secure link. The only exception was Department of Defense and active duty veterans' medical records, as these were protected and not open to all healthcare providers with VA EMR access.

Seems too good to be true? Every system has pitfalls and the United States' Veteran's Health system is not without its share of issues, many of which have been publicized. For example, there are common issues you would expect with a massive healthcare system: not enough providers or services lead to long wait-times for appointments, tests, and even standard care, such as colonoscopies and surgeries. Another pitfall is the reliance on a national formulary, which does not account for regional disease needs—for example, one regional pharmacy used its entire annual budget within four months after a new Hepatitis C drug was approved for use, affecting all the other departments' access to medications. But I don't want to focus on the negative as this article is not about that, and honestly my experience as an employee of the VA for seven years was very positive.

Canada called to me with the promise of a better, safer life for my family, smaller student loans for my children when they attend university, and a seemingly similar system to the Veteran's Health system—a single payer with a provincial formulary. However, I soon found that the similarities ended there. My five months of practice in Ontario have been quite an adjustment. As expected, there are similarities as well as differences between both systems: the formulary is more liberal than I previously experienced at the VA in Florida; the wait-time for tests such as magnetic resonance imaging (MRIs) is similar in Ontario to the VA, but longer than in private practice in the United States; the access to complementary services such as physiotherapy is less in Ontario than in the VA, but not compared with private practice in the U.S. However the VA benefits were limited to veterans only, and I have ultimately found the healthcare system in Canada very good both as a physician and as a patient. While I was not in private practice during my time in Florida, I am well aware of the average pay for a

Continued on page 25

The Rheumatoid Arthritis Journey: *Flipping the Switch! – Reverse Thinking*

By Michael Starr, MD, rheumatologist, McGill University Health Center, Montreal, Canada

Today is another day of pain and despair
And I won't be fooled into thinking that
I can cope physically and emotionally
I have changed
My spouse and kids have noticed
Because
Fatigue owns me
And I don't want to be complaining that
Life is a chore
I don't want to believe that
My future is anything but bleak
Believe it, ASK me
Because if your Global is better than mine
I may be suffering more than you think
I am not feeling fine, It's not a lie
Just because I look normal to you
I put on a brave face
I'll surely take my meds
If you say
It's the encouragement I crave
To have hope where there has been none before
You ask as if there is truly a light
I need to believe you
I need a partner on this journey
It's not enough to just write a script
Enjoyment, Play, Work, Love, Self-esteem
The things I have lost
You tell me I will regain, even if it's hard
I am feeling out of control
And I'll never believe that
People are listening to me and ready to help
I have Rheumatoid Arthritis
What is going on
Help me understand
Maybe
I am depressed, and
Perhaps
Not thinking that
Something can be done
My daily activities can progressively get better, and
I can be me again ❖

Now read this in reverse for a different perspective:

I can be me again
My daily activities can progressively get better, and
Something can be done
Not thinking that
Perhaps
I am depressed, and
Maybe
Help me understand
What is going on
I have Rheumatoid Arthritis
People are listening to me and ready to help
And I'll never believe that
I am feeling out of control
You tell me I will regain, even if it's hard
The things I have lost
Enjoyment, Play, Work, Love, Self-esteem
It's not enough to just write a script,
I need a partner on this journey
I need to believe you
You ask as if there is truly a light
To have hope where there has been none before
It's the encouragement I crave
If you say
I'll surely take my meds
I put on a brave face
Just because I look normal to you
I am not feeling fine, It's not a lie
I may be suffering more than you think
Beacuase if your Global is better than mine
Believe it, ASK me
My future is anything but bleak
I don't want to believe that
Life is a chore
And I don't want to be complaining that
Fatigue owns me
Because
My spouse and kids have noticed
I have changed
I can cope physically and emotionally
And I won't be fooled into thinking that
Today is another day of pain and despair ❖

Top Ten Things Rheumatologists Should Know About the Inflammatory Bowel Diseases

By Heba M. Al-Farhan, MD, MRCP; and Gilaad G. Kaplan, MD, MPH, FRCPC

Joint diseases are the most common extra-intestinal manifestations of the inflammatory bowel diseases (IBD), occurring in 13% of patients with Crohn's disease (CD) or ulcerative colitis (UC).[1] This article reviews considerations for patients with arthritis and a co-existing IBD diagnosis.

1. Peripheral arthritis associated with IBD.
Two different types of arthritis can be identified. Type 1 is non-erosive, asymmetrical, and affects less than five large joints. The arthritis is related to activity of the underlying bowel disease, potentially occurring prior to onset of bowel symptoms. The arthritis is managed by treating the acute flare of CD or UC. [2] Type 2 is polyarticular and symmetrical, and is less often correlated with bowel disease activity.

2. Axial arthropathy and IBD.
The risk of sacroiliitis and ankylosing spondylitis in IBD patients is 10% and 3%, respectively.[1] Similarly, 4.1% of patients with ankylosing spondylitis will have a co-existing diagnosis of IBD.[3] Treating the IBD does not influence the natural history of the axial arthritis.[2]

3. Investigating a new diagnosis of IBD.
Patients with spondyloarthritis may present with active gastrointestinal symptoms (e.g., abdominal pain, diarrhea, rectal bleeding). Non-IBD considerations include non-steroidal anti-inflammatory drug (NSAID) enteropathy, gastrointestinal infections including *Clostridium difficile*, and celiac disease.[4]

4. Diagnosing IBD.
Colonoscopy with biopsies is necessary for an IBD diagnosis. Modalities for imaging the small bowel include contrast-enhanced ultrasound, magnetic resonance (MR) enterography, and computed tomography (CT) enterography. General CT scans of the abdomen for IBD should be avoided unless ruling out an intestinal complication (e.g., perforation or obstruction).

5. Pain Management.
NSAIDs are associated with an increased risk of triggering a flare of IBD. Acetaminophen is safe for managing joint pain in IBD patients.[5]

6. Treating an acute flare with steroids.
Prednisone is prescribed at 40 mg daily for one week followed by dose tapering by 5 mg per week. Patients with CD limited to the ileum or right colon can use oral budesonide, which has fewer systemic side effects. Budesonide multi-matrix (MMX) is a formulation of budesonide that extends budesonide release throughout the colon using MMX system technology and can treat a UC flare.[6]

7. Treating IBD with sulfasalazine and 5-aminosalicylates (5-ASA).
Sulfasalazine and 5-ASA (mesalamine) are effective in treating UC with weaker evidence for Crohn's colitis. Five-aminosalicylate medications are available as oral tablets, rectal enemas and suppositories. Each medication has a slightly different formulation and coating that allow it to reach different parts of the bowel. [7]

8. Immunomodulators.
Methotrexate, azathioprine, and 6-mercaptopurine are ineffective in inducing remission in IBD. They are used following induction (e.g., with steroids) or in combination with an anti-tumor necrosis factor (anti-TNF) agent to reduce immunogenicity. Patients with a genetic mutation affecting the thiopurine methyltransferase (TMPT) enzyme need dose reduction (heterozygote) or avoidance (homozygote) of azathioprine or 6-mercaptopurine.[8]

9. Anti-TNF Therapies.

Infliximab is used in CD and UC: 5 mg/kg at weeks 0, 2, 6, followed by maintenance dosing every 8 weeks. Adalimumab is used in CD and UC: week 0, 160 mg; week 2, 80 mg; then 40 mg every 2 weeks. Golimumab is used in UC: week 0, 200 mg; week 2, 100 mg; then 100 mg every 4 weeks. Certolizumab is not approved in Canada for IBD. Etanercept is not effective in IBD.[8,9]

10. New biologics in IBD.

Vedolizumab is an antibody against $\alpha_4\beta_7$ integrin for CD and UC. Vedolizumab is the first gut selective biologic.[8,9] Its role in managing co-existing spondyloarthritis is unknown.

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Redefining Happiness: My Experiences in American and Canadian Health Systems *(Continued from page 22)*

rheumatologist in the U.S. From what I have learned from recent Ontario Rheumatology Association (ORA) stats, the pay in Ontario is similar. As I am no longer part of a massive interconnected healthcare system, I do not have access to my patients' records from their family doctor, their hospital visits, etc. without a lot of requests and waiting. This does not differ from any physician in private practice in most countries, but both Canada and the U.S are testing options that create a comprehensive health record that is accessible from any site using the Internet.

In the U.S, some foreign-trained physicians are required to repeat training or pass the U.S. Medical Boards for their specialty, but once this is done, they can practice without restriction. In general, Canadian-trained physicians do not require any additional testing or training as their training is considered equivalent to the U.S. While Canada considers U.S. physician training equivalent, the College of Physicians and Surgeons of Ontario requires a year of supervised practice in your specialty to assist one with the transition to the Canadian system. While obtaining a supervisor was initially difficult, I have greatly appreciated Dr. Mary Lee's guidance and expertise as I learn about the Canadian medical system, and I could not imagine trying to care for patients without her assistance.

In summary, I have found the Canadian system similar to the United States' Veteran's Health system, but with some differences as I mentioned and others you are more familiar with than I am. However, while I cannot determine this for you, for me and my family, the grass is greener in Canada.

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Imaging of Spondyloarthritis – What Does the Rheumatologist Need to Know?

By Walter Maksymowych, FRCPC

Case: The patient was a 23-year-old male who was referred because of a 3-year history of back pain after lifting heavy equipment during his work as a framer. After his acute pain had resolved, he continued to complain of lower-back and left-buttock pain to the point that he was unable to return to work and reported a claim to the Workers Compensation Board (WCB). His family physician had ordered a B27 analysis, which was positive, and pelvic and lumbar spine radiography, which were reported as normal. The WCB physician had additionally ordered pelvic and lumbar spine magnetic resonance imaging (MRI). The former was reported to have "nonspecific bone contusion" in the left iliac bone on a "water-sensitive sequence" while the T1-weighted spin echo (T1W-SE) had "non-specific sclerosis".

Two years later, the patient is still drawing disability benefits for what is considered back pain related to an injury sustained at work. With the referral from the WCB, a repeat pelvic radiograph reported "slight irregularity of the left iliac cortex in the left sacroiliac joint (SIJ) and mild, non-specific joint space narrowing on the right side". A repeat pelvic MRI was also ordered and reported as being unremarkable.

The patient described back and right-buttock symptoms that felt worse when rising from bed, morning stiffness of an hour's duration, symptoms exacerbated by activity but also not alleviated by rest. He had been awakening in the early hours of the morning with back pain and stiffness and no alleviation of his symptoms with over-the-counter ibuprofen and naproxen, or anti-inflammatory agents prescribed by his family physician. However, he was unable to tolerate these medications for more than a few days due to gastric upset. His medical history noted only a 4-pack-years history of smoking. The physical exam showed only mild muscular tenderness in the lower lumbar spine. C-reactive protein was normal.

Review of both pelvic MRI scans in the context of this clinical presentation indicated a diagnosis of spondyloarthritis (SpA) with MRI features being more typical on the first scan (figures B and C). The scans were reviewed with the patient, and he was informed that the onset of his condition at the same time as his job-related back strain was coincidental, not causal, but a reflection of the typical presentation of this condition in the third decade of life. Since his Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score was 6.9 and he was intolerant of nonsteroidal anti-inflammatory drug (NSAID) therapy, he was offered treatment with a tumor necrosis factor inhibitor. He was advised to discontinue smoking as this would impair his response to treatment. Four months after treatment, his symptoms subsided, his BASDAI score was 2.6, and he returned to work.

MRI of the SIJ is a major advance in the field because it not only detects inflammation soon after disease onset but may also depict a variety of structural lesions, even without radiographic changes of sacroiliitis. Routine clinical evaluation combines information visualized simultaneously on two types of MRI scans. The T1W-SE sequence detects signal from fat, so adult bone marrow of iliac and sacral bones is bright due to its fat content. The signal from fat can be suppressed to allow visualization of inflammation in the bone marrow using fat-suppressed sequences, such as short tau inversion recovery (STIR), which is also a water-sensitive sequence. Bright signal on the STIR sequence therefore indicates water-related to edema and cellular infiltration associated with inflammation. Cortical bone is dark on both sequences. Both sequences should be routinely ordered as part of a SpA-specific imaging protocol for MRI, and a printout for the radiology department can be downloaded from the Imaging Portal at *www.carearthritis.com*.

When the possibility of SpA is considered on clinical grounds, when major treatment decisions are at stake, when objective evidence will be essential in changing the patient's understanding of their illness, and where routine reporting of findings on radiographic imaging is negative and/or non-committal, the rheumatologist is called upon to order and evaluate MRI. Radiography of the sacroiliac joints, a third-world tool for diagnostic evaluation of this condition, is unreliable in early disease and reliance on

Figure A: Pelvic Radiograph

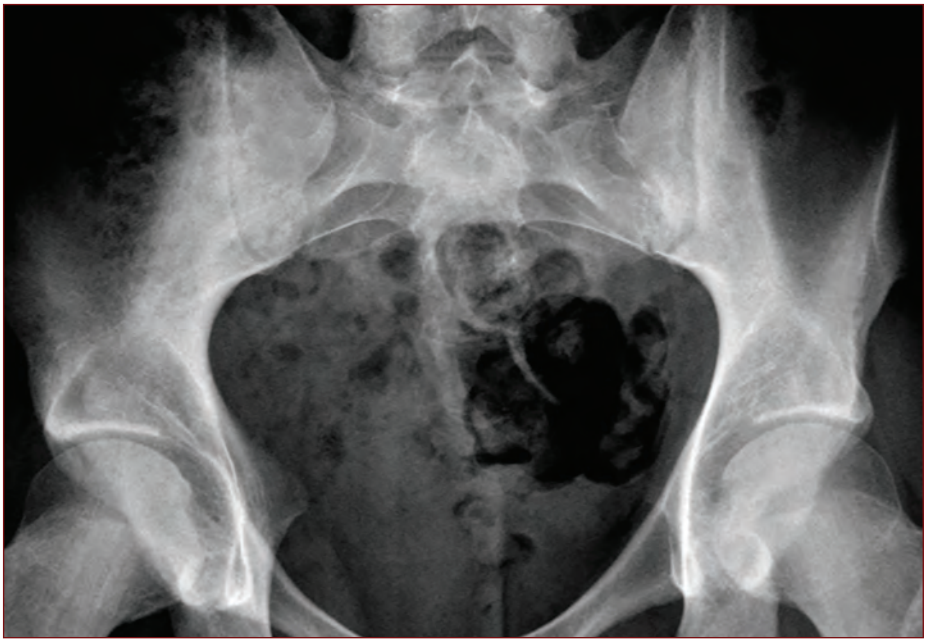

Figure A. The pelvic radiograph at presentation shows slight irregularity of the left iliac cortex and mild joint space narrowing on the right side. It does not show any definitive features of sacroiliitis.

Figures B-E: MRI Scans

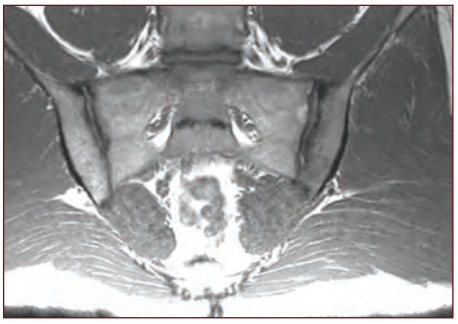

Figure B. The T1W-SE sequence of the first MRI scan shows some irregularity of the left iliac cortex but without definite structural change.

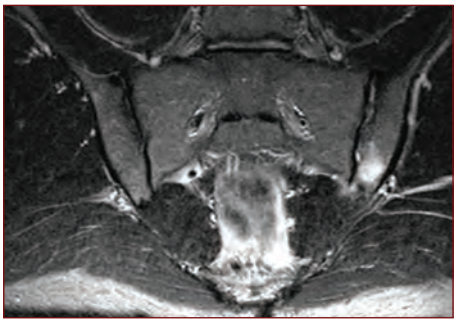

Figure C. The STIR sequence of the first MRI scan shows bone marrow edema in the left lower iliac bone that is intense and should prompt strong suspicion.

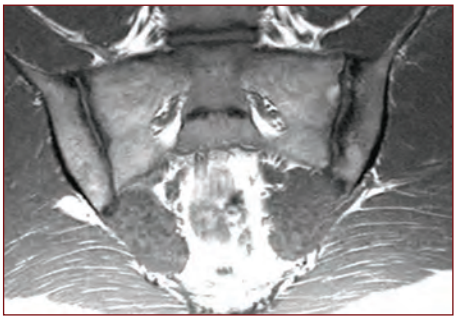

Figure D. 2-year follow up T1W-SE scan shows erosion of the left iliac cortex with joint space widening and fat metaplasia in the left lower iliac bone.

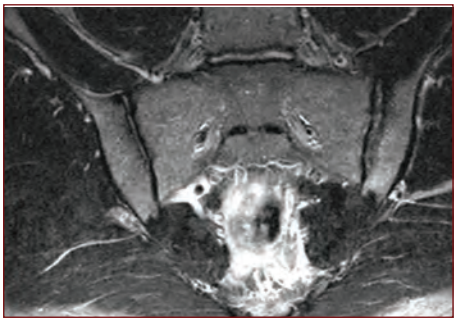

Figure E. 2-year follow up STIR scan shows some resolution of bone marrow edema though with residual increased signal on the scan.

radiography is a primary factor in delayed diagnosis. It is incumbent on the rheumatologist to learn the language of MRI and to understand basic aspects of interpretation of Digital Imaging and Communications in Medicine (DICOM) images in order to engage in an informed dialogue with the radiologist. Radiologists receive little or no training in the interpretation of MRI features in SpA and are often unaware of the key clinical scenarios where MRI may change the management of patients with SpA.

An online training module based on the DICOM image format is available through the Imaging Portal at CaRE Arthritis (*www.carearthritis.com*) to provide rheumatologists with essential basic knowledge on MRI interpretation of SpA and other conditions that often fall under the differential diagnosis. A simplified DICOM image-viewing tool allows intuitive learning in how to set up a DICOM image. Each of the 20 cases is highly annotated and experience with MRI interpretation is rapidly acquired through experiential learning, a proven way to acquire new skills. The module is based on the seven years of experience that I and colleagues in musculoskeletal radiology have acquired in providing hands-on training workshops to rheumatologists and radiologists all over the world. Workshop participants have often reported the satisfaction of having acquired a new skill through this experiential learning technique. Maintenance of skills is reinforced through presentation of case-of-the-month content based on images submitted to the Imaging Portal for second-opinion review.

MRI has an indispensable role in the management of patients with SpA and the rheumatologist who is not familiar with basic interpretation of MRI cannot be practising to standard. It is not appropriate or realistic to transfer sole responsibility for interpretation to the radiologist. The presented case illustrates the potential consequences of this strategy.

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An Update on the CRA's Programs for Students and Young Rheumatologists *(Continued from page 5)*

residents and program directors suggest be covered. Popular sessions include those on career planning, practice set-up, x-ray interpretation and other disease-specific topics.

ASM Mentorship Program

The mentorship program has been developed to ensure that students and residents are made to feel part of the CRA Annual Scientific Meeting and rheumatology community and to introduce them to people and sessions at our meeting. It enables our "seasoned" members to connect with up-and-coming members, to share their wisdom as well as learn from our "newbies." This is where great partnerships and connections are made to support careers and foster learning.

TROT

The objective of the Training the Rheumatologists of Tomorrow (TROT) program is to increase awareness and interest in rheumatology among medical students, internal medicine residents, and pediatric residents. The program aims to produce and disseminate evidence-based messages about rheumatology, so that students' future career choices take into account first-hand knowledge about the subspecialty.

With an impending severe shortage of rheumatologists in Canada, TROT's mandate is as important as ever. For more information on TROT and their initiatives, turn to page 6 or contact Dr. Alf Cividino at *civi@cogeco.ca*.

The CRA is very keen to meet the needs of our future members, so if you have any suggestions…please send them our way!

Christine Charnock
CEO, Canadian Rheumatology Association
Newmarket, Ontario

Tribute to Dr. Guy Germain

By Jean-Luc Senécal, MD, FRCPC

Dr. Guy Germain, a rheumatologist at Hôpital Notre-Dame of the Centre hospitalier de l'Université de Montréal (CHUM), passed away on December 24, 2016, at the age of 91. He was one of the founding fathers of rheumatology in Quebec and Canada.

1925 - 2016

Dr. Germain was appointed geographical full-time associate professor in the Faculty of Medicine of Université de Montréal in 1968, where he was Director of the Rheumatic Disease Unit. He was also Head of the Division of Rheumatology at Hôpital Notre-Dame. Dr. Germain played a major role in establishing rheumatology in Quebec and having it recognized as a medical specialty. With his colleagues, André Lussier (deceased) at the Université de Sherbrooke and Drs. Roger Demers, De Guise-Vaillancourt and Jacques Durivage at the Hôtel-Dieu de Montréal (deceased), as well as with Dr. Claude Blondin at Saint-Luc Hospital, and his colleagues, Jacques Gascon and Alain Prat at Hôpital Notre-Dame, Dr. Germain established bases of excellence in academic rheumatology, which allowed the next generations of rheumatologists to be trained and put French Canada, including the Université de Montréal, Hôpital Notre-Dame and the CHUM, on the rheumatology world stage.

Dr. Germain's professional merits were recognized on numerous occasions. In particular, in 1995, the Laurentian Conference of Rheumatology awarded him the *Marie-Thérèse Fortin Award* in recognition of his professional skills and compassion in the care of patients. At Hôpital Notre-Dame, the Guy Germain Conference Room on the 4th floor of Pavillon Mailloux keeps his memory alive.

Although Dr. Germain was not a researcher himself, he understood very well that, without research, rheumatology would not spread beyond our borders. "Every patient is a paper," he said to us time after time. Dr. Germain recruited several researchers. The Osteoarthritis Chair and the Scleroderma Chair, of which Dr. Germain was very proud, ensure that rheumatology research will continue at the Université de Montréal for decades to come.

Dr. Germain was an outstanding clinician with exceptional experience, from which countless patients, dozens of rheumatology residents and many residents in other specialties benefited. He taught the residents the importance of listening to and respecting the patient, as well as gentleness and finesse during the physical examination, and he was a role model for everyone. Guy Germain was a *magister*, a latin word meaning authority, leader, commander, caretaker, teacher, master, adviser, guide and mentor all together. Toward his patients, he was generous with his time and his willingness to help; he provided them with an exceptional level of service and dedication. Many patients said he was a second father to them and that he had helped them personally, as well as medically.

Dr. Germain's exceptional generosity says a lot about his commitment in the service of academic rheumatology and his long-term vision for its development. Dr. Germain had two passions: his family and medicine. Hôpital Notre-Dame was his second home and he was one of its pillars.

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- 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.
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- Treatment with XELJANZ was associated with increases in creatine kinase.

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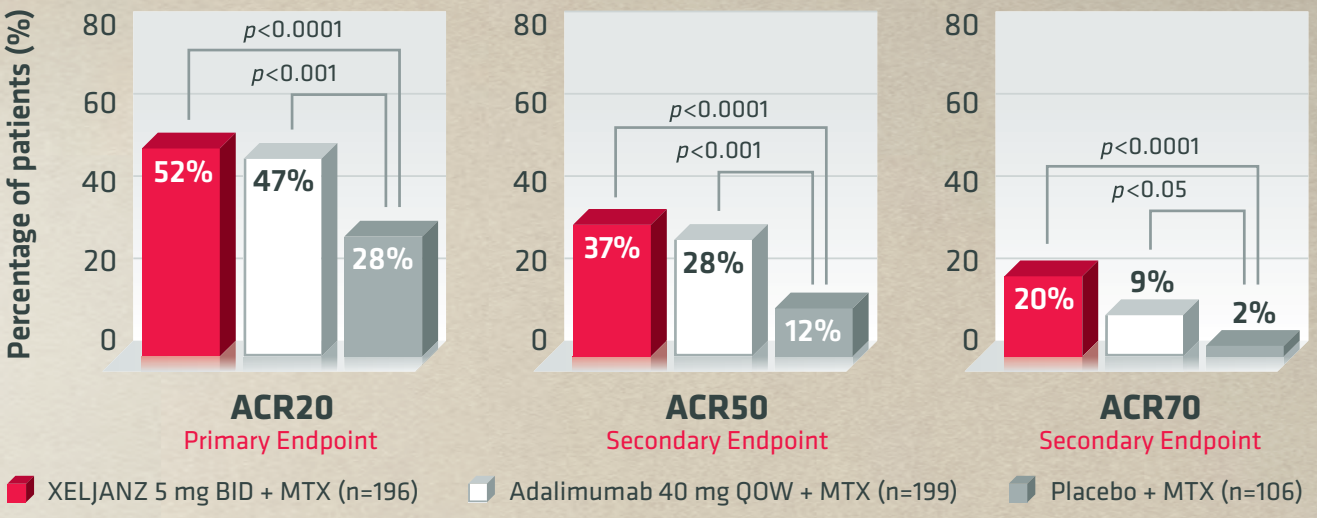
This study was not designed to compare XELJANZ to adalimumab.

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.
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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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- 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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