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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on:

CRA Committee & Regional Association Reports

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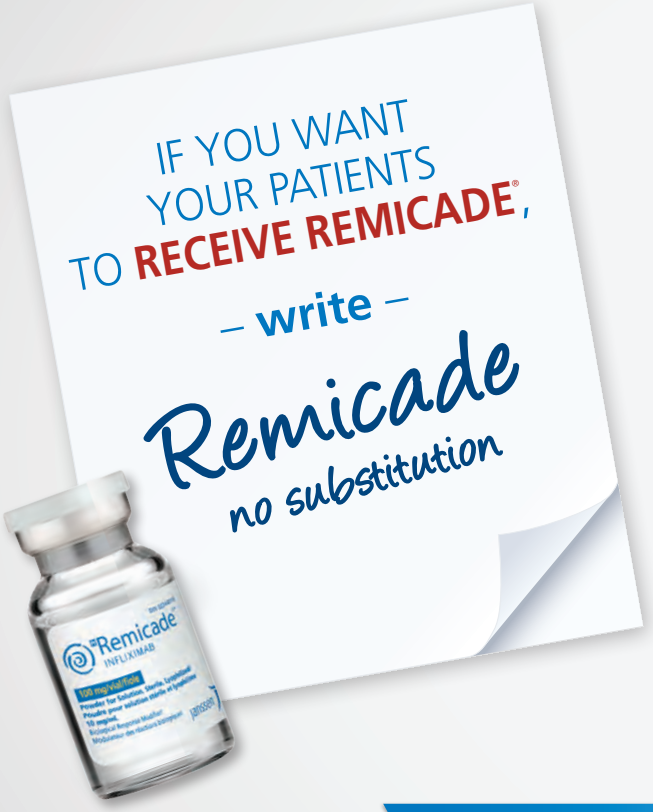

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References: 1. Data on file, Janssen Inc.
2. REMICADE® Product Monograph, Janssen Inc., April 26, 2016.

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Maud Lewis

By Philip A. Baer, MDCM, FRCPC, FACR

Twice a year, the CRAJ Editorial Board meets and brainstorms regarding ideas for future themes and individual articles. Fortunately, we have more good suggestions than room to print them for the foreseeable future. Of course, some come to fruition and others languish.

One of the laggards was an article on the Canadian folk art painter Maud Lewis (1903-1970). A great suggestion, and at various times we had leads to people who knew people who had known her and could write about her remarkable life, overcoming the burden of juvenile inflammatory arthritis and a life of material deprivation to produce art of remarkable depth and beauty. However, nothing ever was produced.

Recently, an opportunity to correct this deficiency presented itself. A new movie about Maud Lewis' life debuted in Canada in the autumn of 2016 at the Toronto International Film Festival (TIFF). The film, Maudie, was directed by Aisling Walsh, and stars Sally Hawkins as Maud, and Ethan Hawke as Everett Lewis, her husband. Newfoundland substitutes for Nova Scotia, where Maud Lewis lived her entire life in the counties of Yarmouth and Digby. She had learned to paint from her mother and was largely self-taught. After her parents died, her brother made little provision for her, and she ended up living unhappily with her aunt. Eventually, she found work as a live-in housekeeper for Everett Lewis, a local fisherman. They married soon after and lived in a tiny house with no indoor plumbing or other conveniences. Maud Lewis began painting the interior and exterior surfaces of the house, as well as postcards and small paintings which she sold to passersby for $2-5. Her difficulties with the physical aspects of painting are reminiscent of those of Pierre-Auguste Renoir, who suffered from rheumatoid arthritis (RA) during the last 25 years of his life. She painted mainly from memory, focusing on scenes from her childhood in Nova Scotia, often featuring flowers, boats, animals and the sea. Her art style has been compared to Grandma Moses, the American folk art painter. Late in life, she was discovered by the CBC and other media, and two of her paintings were purchased by the Nixon White House. She died of pneumonia and lung disease, likely related to exposure to fumes from paint and a wood-burning stove.

While Maud Lewis never sold a painting for more than $10 during her life, her larger works now sell for $10-20,000. With the popularity of Maudie, the painting Portrait of Eddie Barnes and Ed Murphy, Lobster Fishermen, Bay View, N.S., found in a thrift shop, was auctioned in the spring of 2017 with bids exceeding $125,000. Her house has been restored and is now on display at the Art Gallery of Nova Scotia in Halifax.

The movie is evocatively filmed, with moving performances by both leads. I highly recommend it, either in theatres, during a flight, or via online download or streaming.

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

CRA EDITORIAL BOARD

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

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Dr. Elizabeth Badley received the *Distinguished Scholar Award* from the Arthritis Health Professionals Association (ARHP) at the Annual Joint Meeting of the American College of Rheumatology and ARHP in November 2017. The award is given to an ARHP member who demonstrates exceptional achievements in scholarly activities pertinent to arthritis and the rheumatic diseases. As an epidemiologist and health services researcher she has primarily focused on using community-based data to understand issues relating to quality of life, aging, and access to health care for arthritis and musculoskeletal disorders. An underlying goal has been to put arthritis on the public health and policy map so that it gets the attention and funding that it deserves. One of the most rewarding aspects has been the privilege of inter-disciplinary collaborations with talented colleagues and students without whom none of this would have been possible.

Dr. Murray Urowitz was presented with the *Distinguished Clinical Investigator Award* from the American College of Rheumatology (ACR) at the 2017 Annual Meeting in November. This prestigious award is presented annually to a clinical investigator who has made outstanding contributions to the field of rheumatology. Dr. Urowitz established the University of Toronto Lupus Clinic and Lupus Databank Research Program early in his career. This extensive longitudinal database is one of the largest in the world, with over 1950 patients enrolled. His research program has enabled the establishment of new standardized approaches for measuring lupus outcomes, which are now widely used. The numerous resulting scientific findings have dramatically changed the way lupus is diagnosed and managed. He has published 386 peer-reviewed papers and 43 book chapters, and has supervised the training of over 130 fellows in rheumatology. On receiving this award, Dr. Urowitz said: "Being honoured with this award by my peers validates my work and makes me immensely proud."

Professor Johanne Martel-Pelletier was honoured with the designation of *Master of the American College of Rheumatology* at the 2017 Annual Meeting. This recognition is one of the highest honours that the ACR bestows on its members. This prestigious recognition was attributed to her outstanding contribution to the field of rheumatology. A pioneer and world leader in translational research on osteoarthritis, this recognition attests to her expertise in both basic and clinical research, which has led to many discoveries in terms of diagnosis and treatment towards personalized medicine. Her work has modified and expanded the understanding of the pathogenesis of osteoarthritis and the biology of the articular tissues, which has had a profound effect on shaping the contemporary understanding of this disease.

AWARDS, APPOINTMENTS, AND ACCOLADES

The *CRAJ* would like to recognize the contributions of its readers to the medical field and their local communities. To have any such awards, appointments, or accolades announced in an upcoming issue, please send recipient names, pertinent details, and a brief account of these honours to *jyotip@sta.ca*. Picture submissions are greatly encouraged.

The CRA's Summer Studentship Program

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.

Among our various programs and initiatives that help highlight rheumatology to students and residents is the Summer Studentship Program. This program is an excellent way for medical students to garner experience and interest in our sub-specialty. It also serves to develop physical exam skills in medical students as well as expose them to rheumatology, in the hopes that if they don't choose it, they will make excellent referrals.

Students can apply for both the clinical and research studentships, but can only accept one award if both applications are successful. The studentships take place between May and August and last anywhere from 4 to 12 weeks. To find out more about the CRA's Summer Studentship Program and how to apply, please visit *www.rheum.ca* or contact Claire McGowan at *claire@rheum.ca*. The application form for the next cycle will be available as of mid-January 2018.

Here is what some of our students and mentors have to say about this special program:

The CRA studentship program has been a magnificent entry point into rheumatology. I was able to learn and continue developing skills which will become very valuable in a future career that involves research. I will continue to be involved in the field of rheumatology as a direct result of this program.

– Leonardo Martin Calderon (2017 summer student)

What an amazing experience. The entire team at SickKids was so forthcoming with their teaching. Over these ten weeks, I was able to develop my knowledge, confidence and clinical exam skills in a safe and supportive environment. I gained an appreciation for the complexities of rheumatology. I am now more interested than ever in this career path!

– Neha Puri (2017 summer student)

An exciting program for students and mentors alike.

– Dr. Sasha Bernatsky (mentor)

I found out about the summer studentship through my school and decided to apply in order to experience hands-on a research project in this sub-specialty. It was after my first clinical exposure with a rheumatologist that I became interested in this field. I had the privilege of being mentored by a great clinician-researcher who gave me the opportunity to work autonomously. I was pleased to realize how rheumatology research in the context of epidemiology involves the collaboration between different fields of medicine. On one occasion, I had the chance to shadow my mentor at the lupus clinic. This enabled me to appreciate the clinical aspects of rheumatology and to meet patients who were directly involved in my study. Furthermore, I had the opportunity to present my preliminary results at a seminar in front of other researchers. The feedback lead me to better appreciate the significance of our results and guided me to explore other avenues. I am now assured I wish to pursue a career in rheumatology and research, and appreciate the importance of new findings, which can better improve the quality of care.

– Elvis-raymond Mukwikwi (2017 summer student)

The CRA Summer Studentship Program is fundamental in exposing new medical students to rheumatology.

– Dr. Zahi Touma (mentor)

An aspect I really like about the CRA summer studentship program is the continuity of learning/fun/mentorship that continues beyond the three months of internship.

– Yan Jiao Liu (2017 summer student)

This program provides valuable opportunities to gain insight into this gem of a profession . . . and helped me find a lifelong mentor.

– Ada Lo (2017 summer student)

It is a great opportunity to mentor a bright, fresh mind, and to rekindle the passion for medicine in ourselves.

– Dr. Volodko Bakowsky (mentor)

CIORA 2017 Summary

By Janet Pope, MD, MPH, FRCPC

The Canadian Initiative for Outcomes in Rheumatology Care (CIORA) is issuing another call for grants in 2018! The CRA Research committee will be launching the 11th CIORA Grant Competition. The grant application deadline is March 30th, 2018, and award winners will be notified at the beginning of June 2018.

As we head into our 11th grant competition, we would like to recognize the CRA Research Committee members for their hard work and dedication. Thank you to Drs. Vinod Chandran, Alfred Cividino, Boulos Haraoui, Marie Hudson, Niall Jones, Lily Lim, Laëtitia Michou, Mohammed Osman, Regina Taylor-Gjevre, Carter Thorne and John Wade.

CIORA has had many successes this year. Here are just a few examples of the outcomes of CIORA-funded research :

Poster and Podium Presentations

- A Needs-based Rheumatologist Education Program on Treating to Target in Psoriatic Arthritis and Spondyloarthropathy: Insights and Challenges, Principal Investigator: Pope J. (CRA 2017)*
- Adult Axial Spondyloarthritis Screening and Referral Practices amongst Primary Care Physicians, Physiotherapists, Chiropractors and Nurse Practitioners: Results from a Qualitative Study, Principal Investigator: Passalent, L. (CRA 2017)
- Assessing System-level Performance Measures for Early Rheumatoid Arthritis in the Canadian Early Arthritis Cohort Study (CATCH): An 8-Year Observational Cohort Study, Principal Investigator: Barber, C. (CRA 2017)*
- Effect of Personalized Diet and Exercise Recommendations in Early Inflammatory Arthritis: A Randomized Trial, Principal Investigator: Barnabe, C. (CRA 2017)
- eHealth Supported Collaborative Care for Gout Involving Rheumatology, Pharmacy, and Dietetics: Mid-Term Outcomes, Principal Investigator: De Vera, M. (CRA 2017)*

* *Recognized for Quality Improvements & Choosing Wisely*

Published Literature

- Do Patients and Health Care Providers Have Discordant Preferences About Which Aspects of Treatments Matter Most? Evidence From a Systematic Review of Discrete Choice Experiments, Principal Investigators: Harrison M, Hudson M, *BMJ Open*.
- Postpartum Complications in New Mothers with Juvenile Idiopathic Arthritis: a Population-based Cohort Study, Principal Investigator: Feldman D, *Rheumatology*.
- Heart Disease, Hypertension, Gestational Diabetes, Pre-eclampsia/Eclampsia in Mothers with Juvenile Arthritis: a Nested Case Control Study, Principal Investigator: Feldman, D, *Arthritis Care Res*.

CIORA's contribution to the advancement of rheumatology research in Canada is made possible by the unrestricted financial contributions of many industry partners. We would like to acknowledge their continuous support.

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

CIORA: Call for Grants

CIORA is Issuing Another Call for Grants in 2018!

The CIORA Online Grant Application System opens January 28, 2018.

Letter of intent must be submitted by February 28, 2018.

The CIORA Online Grant Application submission deadline is March 30, 2018 at 23:59 Pacific Time.

Please visit *https://rheum.ca/en/research/* for more information.

Any questions can be directed to Virginia Hopkins at *virginia@rheum.ca*.

ArthritisHack: Bringing Innovation to Arthritis

ORGANIZER

By Michelle Mika, ArthritisHack organizer from Hacking Health, Toronto Chapter

It takes courage to try something new. And that's exactly what the Arthritis Society (TAS) did. They partnered with Eli Lilly and Hacking Health in Toronto to explore how technology could generate innovative solutions to the challenges posed by arthritis. The format was a 48-hour-long hackathon called "ArthritisHack."

Watching healthcare providers, technology professionals and patients hunker down over an entire weekend to improve the lives of arthritis patients is inspiring. The energy, enthusiasm, and collaboration between disciplines is the real lesson of a health hackathon. Patients led tech-savvy developers and designers into a true understanding of the condition, while healthcare providers lent their deep knowledge. Eleven teams driven to help arthritis sufferers presented brand new ideas after multiple iterations over the course of the event. The result? Three winners with inspiring patient-centric solutions that no one could have developed alone. That's what I call courage!

PARTICIPANT

By Karim Mithani, MD candidate (2020), University of Toronto

From October 13–15th, I had the privilege of attending ArthritisHack at the MaRS Discovery District in Toronto. In interdisciplinary teams of programmers, designers, healthcare practitioners, and business professionals, we identified pressing challenges faced by arthritis patients, designed innovative solutions, and built working prototypes.

My team developed a mobile app to improve treatment and care for children suffering from juvenile idiopathic arthritis (JIA), called "Joint Space". One component of the app facilitates conversations between patients and caregivers about JIA symptoms and treatments through customizable, evidence-based, virtual storybooks. Another interactive feature allows for longitudinally tracking the symptoms and functional limitations of the disease, and includes a modified pediatric homunculus. Finally, a communal component of the app, designed to reduce stigma and enhance social support, allows users to interact with other JIA patients in the community using emojis. Events such as ArthritisHack underscore the remarkable potential for technological innovation in healthcare, and the importance of multidisciplinary teams in achieving it.

Karim Mithani with his team, *Joint Space.*

JUDGE

By Vandana Ahluwalia, MD, FRCPC

I have never been to a hackathon. I have heard of them. When the Arthritis Society asked me to be a judge at an event called ArthritisHack, I was intrigued and immediately said YES!

The weekend was managed by Hacking Health, with support from Arthritis Society staff, as well as the innovation sponsor, Eli Lilly Canada. The event brought together healthcare professionals, IT professionals, designers, policy analysts, entrepreneurs, and – most importantly – people with arthritis to produce solutions to empower people with arthritis in all aspects of their lives.

The event started with a kick-off meeting on Friday eve-

Pictured from left to right: Isabelle Vezina (Executive Director of Hacking Health Global), Dr. Philip Baer (editor-in-chief of the *CRAJ* and a mentor at the event), and Michelle Mika (Corporate partnerships, Hacking Health Toronto).

Janet Rodriguez, a mentor at the event and a person with lived experience.

ning where individuals "pitched" their ideas for innovations to help address common issues that people with arthritis experience. Participants formed teams around the ideas they found most interesting and could most benefit from their particular expertise, and then the "hacking" began in earnest – and continued for the next 36 hours. I am sure that many of the 11 teams stayed up all night munching on snacks, drinking coffee and happily writing code!

The judging occurred on Sunday afternoon. Each team had five minutes to present their prototype – working prototypes that covered everything from symptom tracking to emotional support to building a volunteer network to provide people with help when they need it. I was pleasantly surprised with the creativity and productivity that the teams achieved in such a short period of time. The judging

was not easy as many of the entries were superb. After careful deliberation, the cross-disciplinary panel selected three winning teams who were awarded cash and in-kind prizing to work – with the assistance of the Arthritis Society – to further develop their prototype and implement it.

I think this event was a great way to foster collaborative innovation in the arthritis community, and to find elegant solutions to improve patient self-care.

MENTOR

By Philip A. Baer, MDCM, FRCPC, FACR

This was the second such event hosted by TAS. The overarching theme was: "Innovative Thinking, Empowering Solutions: How can we help people overcome the challenges of living with Arthritis in all aspects of care and life?"

Friday keynote speakers included Janet Yale, CEO of TAS and Dawn Richards of CAPA. Elevator pitches led to 11 teams being formed, competing for three prizes of $2000-$5000, as well as mentoring and support to further develop their project.

The themes identified included: Communication, Emotional Health, Arthritis at Work and Hacker's Choice.

Team names included: *ArthWrite, JointSpace, AdaPT, Core365, Health Docker, 2020UGarden, Ari, Spoons, Arthritis Pursuance, and KIZUNA.*

I noted great interest in symptom trackers, mood trackers, and correlating sleep, mood, exercise and medication adherence with functional status. As a clinician, I was able to discuss clinical practice, patient-related outcomes tools like PROMIS and MDHAQ, websites like *www.rheuminfo.com*, and issues around medical information transfer and privacy issues.

I really enjoyed the chance to interact with medical students, other mentors, coding and IT experts, biomedical engineers, patients and other participants.

First-prize Winners:

"Kizuna"- an application to connect patients to volunteers who can help them.

Farewell Interview with Christine Charnock, Outgoing CEO of the CRA

You have been part of the CRA for a very long time (since 1997), and many members say that for them you are the "face of the CRA." What made you decide that the time had come to transition out of your role as CEO?

I thought that it would be a great change for the CRA and for me … new ideas, new opportunities, new experiences … I definitely wanted to leave on a high note when people still wanted me here. :)

Tell us about your career trajectory and about how you first got involved with the CRA.

I did graduate studies in International Development and worked in that area before I started having kids. I loved the work but didn't want to travel for a month at a time anymore when I had little ones at home. I was just looking around for something to do until I found my next opportunity and had sent my CV to Carter (Dr. Carter Thorne). He indicated that he was the Secretary-Treasurer of the organization and needed some help and it has just grown from there!

Christine pictured with Dr. Gunnar Kraag.

You must have had several mentors or role models throughout your career. Can you name a person(s) who has/have inspired you professionally?

There have been so many… and so many in the organization who have volunteered and have been engaged for a long, long time. The danger of mentioning any names means that I will inevitably leave someone out so I'll acknowledge them by first initial: C – making meaningful connections; M – being diplomatic but firm; J – thinking about the whole membership across the country; C – being governance-minded, not making the coffee; J – always coming up with new ideas and creating enthusiasm; J – jumping in and being the first resident on the board and contributing that younger and fresh perspectve; A – starting something new no matter your age; D – being the first female president; T – age doesn't matter, ability and commitment does; P – can be counted on to give feedback and in a very timely manner; T – fastest response time for emails; V&C – any email makes me laugh out loud; V – being very diplomatic in questioning the status quo; E – encouraging all to have a voice; C – being totally committed to a cause; E – being very pleasant, friendly, and down-to-earth; J – let's use our members' money very wisely; S – you're never too young to have a meaningful voice; M – being excited and happy makes every day a joy to you and those around you (and, nice shoes help too)!

What have been the most rewarding aspects of this job and what have been the most challenging aspects?

Connecting with people…connecting people with people, and connecting people with information! Keeping track of everything and doing the best job given limited time. And, of course, my favorite: The Annual Scientific Meeting.

Given your professional experience and success, what advice would you give to:

Christine with Dr. Gunnar Kraag (left) and Dr. Jamie Henderson (right).

Christine and Dr. Carter Thorne.

Christine with Dr. John Thomson (left) and Dr. Michel Zummer (right).

a) The next CEO of the CRA:

The members are what count. Without the members you don't have an organization, so always think about them first and that they are all across the country. What are their pain points, what will be their pain points in the future, and how can we help alleviate them?

b) Younger rheumatologists or rheumatologists-in-training:

Get involved and get engaged; you will meet some amazing people and make incredible life-long connections. Take the time to make the connections with others as I have seen people learn greatly from committee meetings and board meetings.

c) Seasoned members:

You can always learn something new and don't discount the value of learning from those referenced in "b" above. A fresh new perspective is sometimes the greatest learning tool.

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

I think technology is going to change the face of medicine as a whole. I did my thesis (a few years ago :)) on computer-aided medical diagnosis. IBM's "Watson" was part of it, and I thought we would be much farther than we are 27 years later!

What are your plans once you have officially left the CRA?

I am constantly looking for new opportunities but haven't decided on anything yet! It will have to involve doing new things/innovative things/creative things with a fun organization that has great people (that's something that has kept me here so long)!

What about once you retire?

Wow…retire…I have no idea when I will retire. Once upon a time I thought that I would love to go back to my former work, and go and work in emergency situations in different places around the world. We'll see if my body agrees when that time comes.

Complete this sentence:

I never anticipated that . . . I would stay here this long and that I would be given such fantastic opportunities to grow and create…

What will you miss most about the CRA?

The people!

News From the Scientific Committee

By Tom Appleton, MD, PhD, FRCPC

Join us in Vancouver for the 2018 CRA Annual Scientific Meeting (ASM)!

Advances in discovery, technology, and clinical sciences continue to propel our understanding of rheumatic diseases, motivated by our quest for improved care with greater certainty. The theme of the CRA 2018 ASM – *Precision and Personalized Medicine in Rheumatology* – was chosen to showcase just how far we have come as a field.

The 2018 ASM Committee has designed a meeting with outstanding speakers, workshops, scientific exchange, and (of course) time to network! One of our new priorities includes weaving in themes from prior meetings and offering next-level content in niche areas, providing the opportunity for savvy conference-goers to selectively deepen their professional expertise. This year, watch for a next-level workshop on Indigenous Health Competency!

From the vantage point of The DOUGLAS hotel, the gorgeous sea-to-sky landscapes of Vancouver will draw you in. While here, you will enjoy the ever-popular Great Debate: Be it resolved that precision diagnostic tools (biomarkers, advanced immunology, and artificial intelligence) will reduce the need for rheumatologists in the future. The program will engage you in practical and philosophical workshops, Dr. Philip Baer's *RheumJeopardy!*, quick-hitter updates from our national superstars, and interactive sessions including posters, Career Fair, and Meet-The-Expert. Last year's "Year in Preview" in Ottawa channeled the predictive abilities of experts in basic and clinical science, pediatrics, and models of care with rave reviews and will be a highlight yet again.

The ASM committee and I are very pleased to present the following renowned keynote speakers:

Professor Ranjeny Thomas is the Arthritis Queensland Chair in Rheumatology at the University of Queensland Diamantina Institute in Australia. Professor Thomas' work is focused on studying the biology of human dendritic cells in autoimmune diseases and their clinical application for treatments. Professor Thomas is known for her contributions to the field of immune tolerance and risk factors for rheumatoid arthritis and type I diabetes. This has led to an antigen-specific vaccine to treat rheumatoid arthritis, which is currently in clinical trials, a therapeutic platform for antigen-specific immunotherapy, and a new diagnostic test and immunotherapy for type I diabetes. She is also the founder and director of a spin-off company (Dendright), managing the development of vaccines to suppress autoimmune diseases.

Professor Linda Li is the Harold Robinson/Arthritis Society Chair in Arthritic Diseases, and Canada Research Chair in Patient-Oriented Knowledge Translation at the Department of Physical Therapy, University of British Columbia. She is also a Senior Scientist at Arthritis Research Canada. Dr. Li's research focus includes understanding the help-seeking experiences of people with early inflammatory arthritis and evaluating models of arthritis care. A key interest of hers, which ties in well to our meeting theme of Precision & Personalized Medicine in Rheumatology, are her collaborative efforts with digital media experts to develop and evaluate electronic tools for shared decision-making between clinicians and patients. She has been recognized for her outstanding work in the arthritis field with the Michael Smith Foundation Health Research Career Investigator award, among many others.

Dr. Ranjeny Thomas

Dr. Linda Li

Dr. Marvin Fritzler

Professor Marvin Fritzler is a prominent Canadian rheumatologist, recognized internationally for his contributions to the field of rheumatology by improving the diagnosis of autoimmune diseases. He was inducted as a Master of the American College of Rheumatology in 2013, ten years after being recognized by the CRA with the award for CRA Distinguished Investigator. Dr. Fritzler has served as Chair of the Alberta Research and Innovation Authority. He has published over 420 peer-reviewed manuscripts with more than eleven thousand citations. For his work in molecular diagnostics with autoantibodies, which underpin the precise diagnosis of several autoimmune conditions, Dr. Fritzler recently received the *Carl R. Jolliff Award for Lifetime Achievement in Clinical and Diagnostic Immunology* from the American Association of Clinical Chemistry. It is a tremendous pleasure to welcome him back this year as the CRA's prestigious 2018 Dunlop Dottridge Lecturer.

Save the date: February 21-24, 2018. I look forward to seeing you in Vancouver!

Tom Appleton, MD, PhD, FRCPC
ASM Program Chair,
Assistant Professor of Medicine and Rheumatology
The University of Western Ontario
London, Ontario

CRA SCR AHPA

ANNUAL SCIENTIFIC MEETING
L'ASSEMBLÉE SCIENTIFIQUE ANNUELLE

VANCOUVER • FEB 21-24 FÉV 2018

The CRA would also like to announce that the 2018 CRA Annual Scientific Meeting (ASM) and Arthritis Health Professionals Association (AHPA) Annual Meeting will be held in Vancouver, British Columbia from February 21-24th

For more conference information and important dates visit *rheum.ca.*

Update From the Abstract Committee

By Maggie Larché, MBChB, MRCP(UK), PhD

The abstract committee is once again gearing up to review all of the submitted abstracts for the 2018 meeting.

With over 200 abstracts submitted so far – and more to come from the PGY4 and PGY5 fellows – there will be diverse and interesting scientific and clinical posters, and oral presentations. Each abstract is vetted by three reviewers and scored. The top scoring abstracts are then selected for oral presentations. In a similar fashion to last year, there will be oral presentations on a wide variety of topics, from a selection of students, residents, fellows and practicing rheumatologists.

In order to nurture the trainees and young faculty, and foster enthusiasm amongst medical students and undergraduates, we have nine prizes to be awarded again in 2018. These are:

- Best Abstract on Research by Young Faculty
- Best Abstract on Basic Science Research by a Trainee
- Best Abstract on Clinical or Epidemiology Research by a Trainee - *Phil Rosen Award*
- Best Abstract on Systemic Lupus Erythematosus (SLE) Research by a Trainee - *Ian Watson Award*
- Best Abstract by a Medical Student
- Best Abstract by a Postgraduate Resident
- Best Abstract by a Rheumatology Resident
- Best Abstract by an Undergraduate Student
- Best Abstract by a Postgraduate Research Trainee

There will be two interactive poster sessions where delegates can quiz the poster presenters, and two podium sessions, during which there will be oral presentations of some of the best abstracts. Prize winners will be judged during the poster and oral presentation sessions.

I would like to extend a huge gratitude to the Abstract Sub-committee members who volunteer to review the abstracts and judge the presentations. Looking forward to seeing you there!

Maggie Larché, MBChB, MRCP(UK), PhD
CRA Abstract Committee Chair,
Associate Professor, Division of Rheumatology,
Departments of Medicine and Pediatrics
Staff Rheumatologist,
St. Joseph's Healthcare Hamilton and McMaster University
Hamilton, Ontario

Human Resources Committee Update

By Diane Crawshaw, TROT Project Coordinator

The CRA Human Resources Program, Training the Rheumatologists of Tomorrow (TROT), and the Manpower Committee of the Ontario Rheumatology Association (ORA) hosted a booth at the Ontario Medical Students Weekend (OMSW) in Sudbury, Ontario, on October 21st, 2017. This annual event is held in one of the six medical-school cities, and this year saw 450 first-year medical students in attendance.

This is the third year of our participation at the OMSW, and each year a portion of visitors to the booth have been asked to fill out a survey to help gauge impact. There have been a total of 115 surveys completed, with 53 from 2017. The data throughout the years seem consistent with the clear majority of respondents (70%; n=80/115) *not* having considered pursuing an opportunity for more exposure to rheumatology, such as clinical or research selective or shadowing a rheumatologist. However, this number rose to an impressive majority (94% n=92) considering an experience in rheumatology after interacting with a passionate and informative rheumatologist at the booth. Approximately half of the respondents provided their email addresses, saying that they would like to receive information about rheumatology education and events.

The combination of the large "Hero" posters, the now famous bone-shaped *RheumCareer* pens and the gloves that simulate deforming rheumatoid arthritis (RA) draws people into the booth. Having said that, it is the opportunity to speak to a passionate rheumatologist that has the most

Students buy into being a hero! Dr. Saara Rawn (3rd from left) and Dr. Jane Purvis (far right) pose with students and RA gloves.

WELCOME TO THE RHEUM

Welcome to the following new members:

Tariq Al Fanna Al Araimi, Toronto, ON
Anwar Albasri, Toronto, ON
Drew Bowie, Victoria, BC
Erin Butler, Calgary, AB
Natacha Cambray, Sherbrooke, QC
Sana Chambah, Montreal, QC
Sarah Cribby, Calgary, AB
Yassir Daghistani, Vancouver, BC
Dilan Dissanayake, Toronto, ON
Giordano Egiziano, Westmount, QC
Faranak Esmaeilbeigi, London, ON
Andreu Fernandez-Codina, London, ON
Stephanie Gottheil, Toronto, ON
Carly Hewson, London, ON
Faiza Khokhar, Mississauga, ON
Lauren King, Toronto, ON
Renée-Claude Loignon, Quebec, QC
Sabrina Lue, Kingston, ON
Alice Mai, Vancover, BC
Eilish McConville, Ottawa, ON
Tamara McMillan, Vancouver, BC
Stephen Morais, Providence, Rhode Island, USA
Dominic Poirier, Quebec, QC
Saurash Reddy, Edmonton, AB
Justin Shamis, Toronto, ON
Watchareewan (Taylor) Sonticha Toronto, ON
Manon Suitner, Montreal, QC
Herman Tam, Winnipeg, MB
Gael Villanueva-Charbonneau, Sherbrooke, QC
Kyle Walker, Ottawa, ON
Mary-Clair Yelovich, Hamilton, ON
Boyang Zheng, Montreal, QC

impact. Messaging included: rheumatology is the best, most interesting, most flexible medical subspecialty; it is academically interesting; patient function is improved; and the therapies are interesting and new. Students reported: "I didn't know how the field was expanding and how flexible the job prospects are" and "It sounds very interesting and with the possibility of good job opportunities." They are also swayed by the long-term relationships with patients and the intellectual challenge of the diseases.

It was helpful to be able to reference a document that was written by and for medical students, entitled "Insights into Physician Workforce Trends in Ontario" (*omsa.ca/sites/default/files/page/24/omsa_hhr_guide_2016.pdf*). It rates rheumatology as having excellent job prospects.

Participation in OMSW continues to be a valuable opportunity to reach medical students early in their careers and let them know that rheumatology is an excellent career choice, as we all know it to be.

Diane Crawshaw
TROT Project Coordinator,
Canadian Rheumatology Association
Hamilton, Ontario

Update From the Communications Committee

By Dax G. Rumsey, MD, FRCP(C)

Hear ye! Hear ye!

The CRA Communications Committee has an exciting year ahead! Our vision is to facilitate optimal and fluid communications between the CRA and its members, among members, and between the CRA and various other stakeholders, including industry, allied health professionals, patients and families, and the general public.

In line with the 2018 CRA Board's priorities for our committee, some of our goals for 2018 are to:

1. Disseminate guidelines via our new (and improved) CRA Website.

2. Develop strategies to encourage community rheumatologists to apply for CIORA grants and, thus, become more involved in research.

3. Implement a new feature of the eNewsletter called 'Who's in the Rheum?' wherein we interview different rheumatologists across the country so that we can get to know each other better.

4. Finalize the 'History Page' on the CRA website, working with various rheumatologists and a professional writer.

5. Expand the CRA Communications Committee. We are always looking for new physician members! We will also look to include an allied health professional(s) and plan to invite a patient/parent representative to be involved in select meetings/in a certain capacity.

We are a small but vibrant and engaged committee and invite others to join the fun!

Dax G. Rumsey, MD, FRCP(C)
Chair, CRA Communications Committee
Pediatric Rheumatologist and Assistant Professor,
Stollery Children's Hospital and University of Alberta
Edmonton, Alberta

WHEN METHOTREXATE ALONE IS NO LONGER ENOUGH, CONSIDER Pr XELJANZ®.

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

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

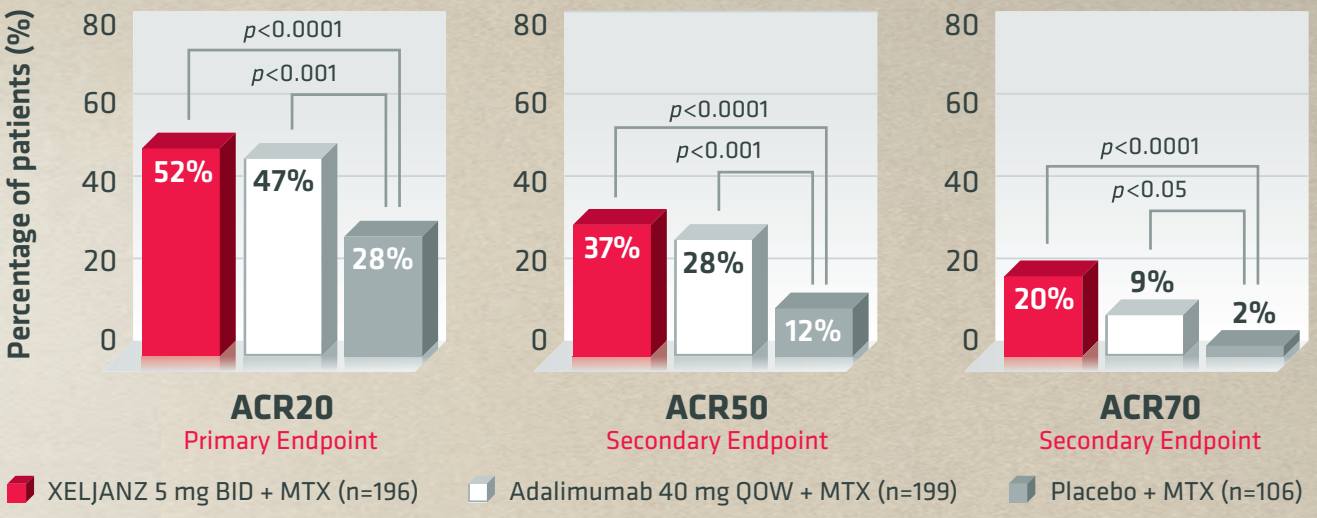
CA0116TOF024E

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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Update From the Optimal Care Committee

By Cheryl Barnabe, MD, FRCPC, MSc

What is optimal care? It is the end product when we aspire to provide the highest level of care with the best outcome, and ensure patient-centric and coordinated health systems. The flip side of the definition is to "not be bad," such as avoiding unproductive variations in practice, or only aiming to achieve minimal standards in our care. The Optimal Care Committee activities take the aspirational approach, and centre around access, quality patient management, equity, and resource stewardship. We collaborate with other CRA operational committees with complementary mandates.

Access: We continue to collaborate with the Arthritis Alliance of Canada (AAC) on identification and implementation of promising models of care that will support timely diagnosis, initiation of evidence-based therapies, and regular evaluation of disease activity. More on this will appear in the *CRAJ* in Spring 2018. Dr. Rachel Shupak and Dr. Katie Lundon are leading "Stand Up and Be Counted Too (2), "which will map allied health professional activities and distribution across Canada, and provide an important resource to the CRA membership.

Quality Patient Management: The core dataset was published by Dr. Claire Barber and the Arthritis Alliance of Canada and Optimal Care Committee in the *Journal of Rheumatology* this year (*www.jrheum.org/content/early/2017/09/26/jrheum.170421.long*). We are now working on processes of measurement that will adapt to clinical care settings across Canada. Dr. Claire LeBlanc has been representing the CRA on a collaboration led by the Canadian Academy of Sport and Exercise Medicine to promote the incorporation of physical activity recommendations in practice. A new award at the Annual Scientific Meeting (ASM) will recognize an outstanding abstract that addresses Quality Initiatives.

Equity: On October 26th, 2017, the Council of the Royal College of Physicians and Surgeons of Canada declared that Indigenous health is now a mandatory component of postgraduate medical education, including curriculum, assessment and accreditation. The Canadian Rheumatology Association is recognized as a leader in this (we were highlighted in the July 2017 Royal College Dialogue, *www.royalcollege.ca/rcsite/publications/dialogue/dialogue-july-2017-e*), through supporting members to participate in cultural competency education sessions online and in practice at a workshop at the ASM, while also providing a two-hour session to the rheumatology residents at the Basic Skills Week. Consolidative and expanded opportunities for this training are planned for the next year, in collaboration with the ASM and Education Committees. We also continue to meet with the Non-Insured Health Benefits (NIHB) branch around access to therapies for Status Indian and Inuk patients, and keep an up-to-date listing of formulary listings on the CRA website: *rheum.ca/en/members/non_insured_health_benefits_nihb*.

Resource Stewardship: Dr. Shirley Lake and Dr. Carter Thorne remain active with the Choosing Wisely initiative. Further resources are being developed to assist in identifying how we can make better informed and effective choices in our practices.

Cheryl Barnabe, MD, FRCPC, MSc
Chair, Optimal Care Committee
Associate Professor
University of Calgary
Calgary, Alberta

ORA 2017Annual Report

By Henry Averns, MB, ChB, FRCP(UK), FRCPC

We now have a record 207 members in our association, and thus we represent the vast majority of rheumatologists in the province. We are generously supported in our various initiatives by industry and, of course, members' annual fees. Some of our key current activities are described below.

Amongst the highlights of the year was the Annual General Meeting (AGM). We have always aimed at a high academic level and a strong social component for the meeting. This year we combined this with a practice Objective Structured Clinical Examination (OSCE) for trainees. This enabled us to benefit from the presence and enthusiasm of the new generation of rheumatologists.

We work closely with the Ontario Ministry of Health, with strong representation on the Exceptional Access Program (EAP) committee, advocating for access to medications and working with the ministry to help tackle drug shortages. We have consulted on the move to the Onatrio Health Insurance Plan (OHIP) + (funding of medications for patients up to 25 years of age) . In addition, we have a close and successful relationship with private payers, and recently met with the Canadian Life and Health Insurance Association (CHLIA) to facilitate the move towards standardized criteria for biologics (and their renewal), not only in Ontario but across the nation.

We have defined and developed our vision for an informatics platform and have developed a robust governance framework for this project, which is to create a central data repository for participating members. This will allow comparative analysis of outcome data for use in quality improvement and research. Continuing to help rheumatologists harness the potential of their electronic medical records (EMRs) to achieve the mission of the informatics project is a key principle.

The Manpower Committee is looking at ways to help rheumatologists both at the beginning and the end of their careers. Specifically, we are focusing on supporting our senior members as they approach retirement, as well as our early career members who are ready to establish their own practice.

We have chosen to honour the memory of Dr. Bill Bensen with an eponymous initiative to raise funds for grants to further the ORA's Models of Care work. We believe this fund will be a catalyst for change towards team-based models of care in the province over the next few years. Our relationship with the Arthritis Health Professionals Association (AHPA) represents an exciting transition towards truly working together and valuing the contributions made by all health professionals who care for patients with rheumatic diseases.

I am grateful to the Executive and Board who have invested a massive amount of their personal time and energy, which is how we have achieved so much this year on behalf of our member.

Henry Averns, MB, ChB, FRCP(UK), FRCPC
Consultant Rheumatologist,
President,
Ontario Rheumatology Association,
Kingston, Ontario

AMRQ Update

By Frédéric Massicotte, PhD, MD, FRCPC

I would have loved to have had the chance to begin my presidency at the Association des médecins rhumatologues du Québec (AMRQ) under a clear, blue sky, but the storm that is Quebec Health Minister Dr. Gaetan Barrette rages on in Quebec. Bombarded with successive Bills 10, 20, 92 and, most recently, 130, the Quebec medical network is struggling to stay afloat. Adopted two years ago, Bill 20 required general practitioners to use a different provincial consultation request form for each speciality. The establishment of this new impractical structure was obviously a disaster. Despite physicians' exemplary participation, and with one year of delay, we are still in the early stages of implementation. In fact, nearly two thirds of the specialties still have not even begun to use this so-called prioritized access. Far from being slowed down by this fiasco, the minister continued in his great wisdom and implemented Bill 130. This bill gives absolute power to the bureaucracy, which, as early as within the next six months, will be able to impose completely excessive obligations on hospital specialists. Never has our professional integrity been so severely threatened as it is by this Bill, which forces us to prioritize political will over the quality of patient care. This has created a chaotic climate for Quebec rheumatologists.

But after the rain comes the sun! So let's move on to happier things this holiday season. I would like to start by warmly thanking Dr. Frédéric Morin, our outgoing president, for his unconditional support and sound advice. We are coming off another year of highlights, including the awarding of the merit scholarship to Dr. Marie Hudson. Furthermore, the "Top 3 in Rheumatology" event, hosted by Drs. Anne St-Pierre and Angèle Turcotte, was a resounding success and will become an annual event. We were visited by fellow French rheumatologists last year during our annual conference, which also marked the beginning of a new tradition, with nearly thirty Quebec rheumatologists "reluctantly" accepting an invitation to the French national rheumatology conference in April 2018 in Bordeaux.

Finally, despite these austere times, the new generation of rheumatologists is doing very well with record years for recruitment. Like my predecessors, I intend to guide these newcomers through the storm, and to help them practice with passion the wonderful profession that is rheumatology.

Frédéric Massicotte, PhD, MD, FRCPC
President, Association des médecins rhumatologues du Quebec (AMRQ)
Montreal, Quebec

News From SOAR

By Volodko Bakowsky, MD, FRCPC

The 34th annual meeting of the Society of Atlantic Rheumatologists (SOAR) took place at Fox Harb'r, Nova Scotia, from June 23-25th, 2017. Once again, rheumatologists from the three Maritime provinces convened for a weekend of rejuvenation of the brain and spirit.

This year's David Hawkins Lecture in Rheumatology, "ANCA-associated Vasculitis: Lies I May Have Told You" was given by Dr. Phil Seo, MD, MHS, from Johns Hopkins in Baltimore, Maryland. He followed this up with a second myth-busting, paradigm-shifting lecture "Neglected Vasculitis".

Our second lecturer was Dr. Sindhu Johnson, MD, PhD, from the University of Toronto. She gave us two excellent talks, "Advances in Scleroderma" and "Scleroderma Mimics", and in her spare time infected us all with her unbridled enthusiasm and energy.

The meeting was rounded out by case and research presentations from the next generation of Atlantic Canadian Rheumatologists. The future looks bright!

The Bluegrass band, Big Country Ramblers, rounded out the meeting, and really shook up our normally staid group of rheumatologists with their alt-country rhythms. There was a "whole lot of shakin' goin' on" (some of it on tables), and I will leave it at that because what happens at SOAR, stays at SOAR!

We are all looking forward to SOAR 2017, which will be held June 22-24th, 2018, at Dalvay, Prince Edward Island. Rumour has it that the band will be back. Save the date!

SOAR members (from left to right): Dr. Elana Murphy, Dr. Caroline Barry, Dr. Volodko Bakowsky, Dr. Alex Legge, and Dr. Trudy Taylor.

Dr. Phil Seo (left) and Dr. Sindhu Johnson (right) were this year's guest speakers.

Volodko Bakowsky, MD, FRCPC
Interim Division Head/Chief, Associate Professor,
Division of Rheumatology, Department of Medicine
Dalhousie University
President,
SOAR,
Halifax, Nova Scotia

Arthritis Alliance Canada 2017 Annual Meeting Change is Good: Implementing Arthritis Models of Care

By Deborah Marshall, PhD; Vandana Ahluwalia, MD, FRCPC; Dianne Mosher, MD, FRCPC; Michel Zummer, MD, FRCPC; and Janet Yale, Arthritis Alliance of Canada Board Chair

On October 26-27th, 2017, the Arthritis Alliance of Canada (AAC) hosted its 5th Annual Meeting, "Change is Good: Implementing Arthritis Models of Care," in Vancouver, British Columbia.

The economic burden of arthritis is on the rise and expected to double within a generation. Availability of specialists in Canada – rheumatologists and orthopedic surgeons – are in short supply and already insufficient to provide timely care to patients.

The "Research Workshop Expert Panel," including Ms. Janet Yale, Arthritis Alliance of Canada Board Chair and President and CEO of The Arthritis Society (Toronto ON); Dr. Vandana Ahluwalia, Consultant Rheumatologist, William Osler Health System (Brampton ON); Dr. Jason Kur, Medical Director, Artus Health Centre, President, British Columbia Society of Rheumatologists (Vancouver BC) and Mr. Gordon Whitehead, Retired Diplomat/Immigration Refugee Board Judge; Consumer Representative, Former Co-Chair of the Arthritis Alliance of Canada (Vancouver BC), shared examples of successful models of care (MOC) in British Columbia and Ontario.

The overarching goal of the workshop was to seek guidance on how to achieve support from researchers and clinicians to adopt and implement an arthritis model of care with the goal of improving patient care. The recommendations from the expert panel included: 1) working with specialists, healthcare providers, health authorities and stakeholders/partners to support physician and patient engagement; 2) enabling health system improvement initiatives, and 3) providing physicians with appropriate training, incentives, tools and resources.

At the joint IA/OA MOC workshop, "Quality Improvement (QI) – Using the Model for Improvement to Implement IA and OA Models of Care," the experts in QI introduced participants to basic QI concepts and tools. Through a series of practical exercises, workshop participants discussed QI project ideas around implementing IA MOCs and OA tools at the local context. They brainstormed on potential quality problems in their practice, and tried to identify solutions using such practical quality improvement methods as Root Cause Analysis, the Fishbone (Ishikawa) diagram, Process Mapping and Pareto Charts.

Participants were also provided with recommendations on ways to engage stakeholders and work collaboratively with other healthcare providers to design and implement QI projects through: 1) identifying stakeholders with vested interest in a QI project; 2) classifying stakeholders (resisters, bystanders, helpers or champions), and; 3) engaging stakeholders by keeping them informed, soliciting their opinions and suggestions, and having them join the QI team.

The second interactive Models of Care Session for Early Career Rheumatologists, entitled "Setting up a Model of Care in Practice at the Start of Your Career," gathered young rheumatology graduates to showcase real-life examples of how various IA models of care, such as a nurse-led model in British Columbia, an AHP Triage Model in Ontario, a co-morbidity assessment and management model in Alberta and a telemedicine model in Northern Ontario, are being implemented into practice and how a collaborative team of healthcare professionals can optimize delivery of care to more patients and maximize patient outcomes.

We invite you to read more about the AAC MOC work in the upcoming Spring 2018 issue of the *CRAJ* publication in March 2018. Stay tuned!

Deborah Marshall, PhD;
Vandana Ahluwalia, MD, FRCPC;
Dianne Mosher, MD, FRCPC;
Michel Zummer, MD, FRCPC;
Janet Yale, Arthritis Alliance of Canada Board Chair

ACR 2017 in San Diego

By Philip A. Baer, MDCM, FRCPC, FACR

San Diego is a favoured venue for ACR's Annual Scientific Meeting. This year marked the 3rd time since 2005 we returned to the San Diego Convention Centre sandwiched between the historic Gaslamp quarter and the Pacific. Nostalgia buffs can relive the 2013 meeting at *www.craj.ca/archives/2014/English/Spring/Baer.html*.

The news leading up to the meeting was not the most auspicious. Dr. Jack Cush's *RheumNow* blog highlighted an intractable local outbreak of Hepatitis A (*rheumnow.com/content/hepatitis-outbreak-san-diego*).

Two weeks before the meeting, local temperatures were an uncomfortable 38-40 °C. Fortunately, they moderated by the time we arrived.

Finally, eight prototypes for the famous Trump US-Mexico border wall were unveiled near the Otay Mesa border crossing in San Diego (*www.cnbc.com/2017/10/24/prototypes-for-us-mexico-border-wall-unveiled.html*).

There were also rumours of lower ACR attendance figures given an atmosphere of travel bans, and fears of issues getting into and out of the US for some attendees. These proved not to be factual, as the 2017 meeting statistics showed: Over 3,000 accepted abstracts, 16,000 attendees with 12,000 scientific attendees, hailing from 110 countries.

The actual meeting was the usual three-ring circus requiring navigation through thousands of posters, hundreds of oral presentations, and many state-of-the-art lectures. The Great Debate on biosimilars was very topical. Roy Fleischmann faced off against Jonathan Kay, a highly published authority on the field. Much of the debate centred on the peculiar American drug pricing regime, which helped to explain the low penetrance of biosimilars in the US to date.

New draft ACR guidelines on psoriatic arthritis were helmed by one of our own, Dr. Dafna Gladman. These guidelines were the first to recommend a biologic (TNF inhibitor) over conventional DMARDs (retitled OSMs for oral small molecules to include apremilast) in treatment-naïve patients with active psoriatic arthritis. We had a spirited discussion at the ensuing press conference as to the practicality of implementing this particular recommendation in the Canadian health-care context.

Dr. Murray Urowitz received an *ACR Distinguished Clinical Investigator award*. Dr. Johanne Martel-Pelletier of Montreal osteoarthritis (OA) fame was designated an ACR Master, as was an ex-Montrealer, Dr. Robert Terkeltaub, whom I recall training with in Internal Medicine before he became a world expert in gout. Another ex-Montrealer, Dr. Simon Helfgott, won the *ACR Distinguished Fellowship Program Director Award*. Dr. Elizabeth Badley won the *ARHP Distinguished Scholar Award*.

The 2017 ACR meeting took place in San Diego's historic Gaslamp Quarter.

Both the CRA and *CRAJ* Boards met during the meeting. Canada Night at the San Diego Central Library was very well-attended.

Staying relatively far away from the Convention Centre kept me on-site and focused on the meeting. I had participated in authoring only one poster (efficacy of tofacitinib on pain, Abstract #614), but I was not the presenting author. I had hoped to meet up with one of my famous co-authors, Dr. Iain McInnes, but he was otherwise occupied apparently.

I was particularly pleased with the three free Poster Tours I signed up for. We had excellent leaders, including Drs. Jonathan Kay, Alexis Ogdie and Paul Emery. The tours focus on abstracts rated highly by the abstract selection committee, often featuring globally famous rheumatologists. We met up with Maxime Dougados, Ed Keystone and Artie Kavanaugh among others.

ACR Press conferences featured abstracts highlighting the negative impact of obesity on RA, SpA and SLE (Abstracts # 1898, 2263, 2372, and 2508), pitfalls in MRI imaging of the SI joints (frequently positive in healthy people and frequent runners, Abstract #1831), and issues around opioid use in rheumatology (Abstracts # 2235 and 2783). The ACR Annual Meeting app and the ACR2017 Twitter feed were very useful in navigating the meeting. Themes

Continued on page 25

Reaching Out with Arthritis Research: A Public Forum Combining Researcher Expertise and the Patient Voice

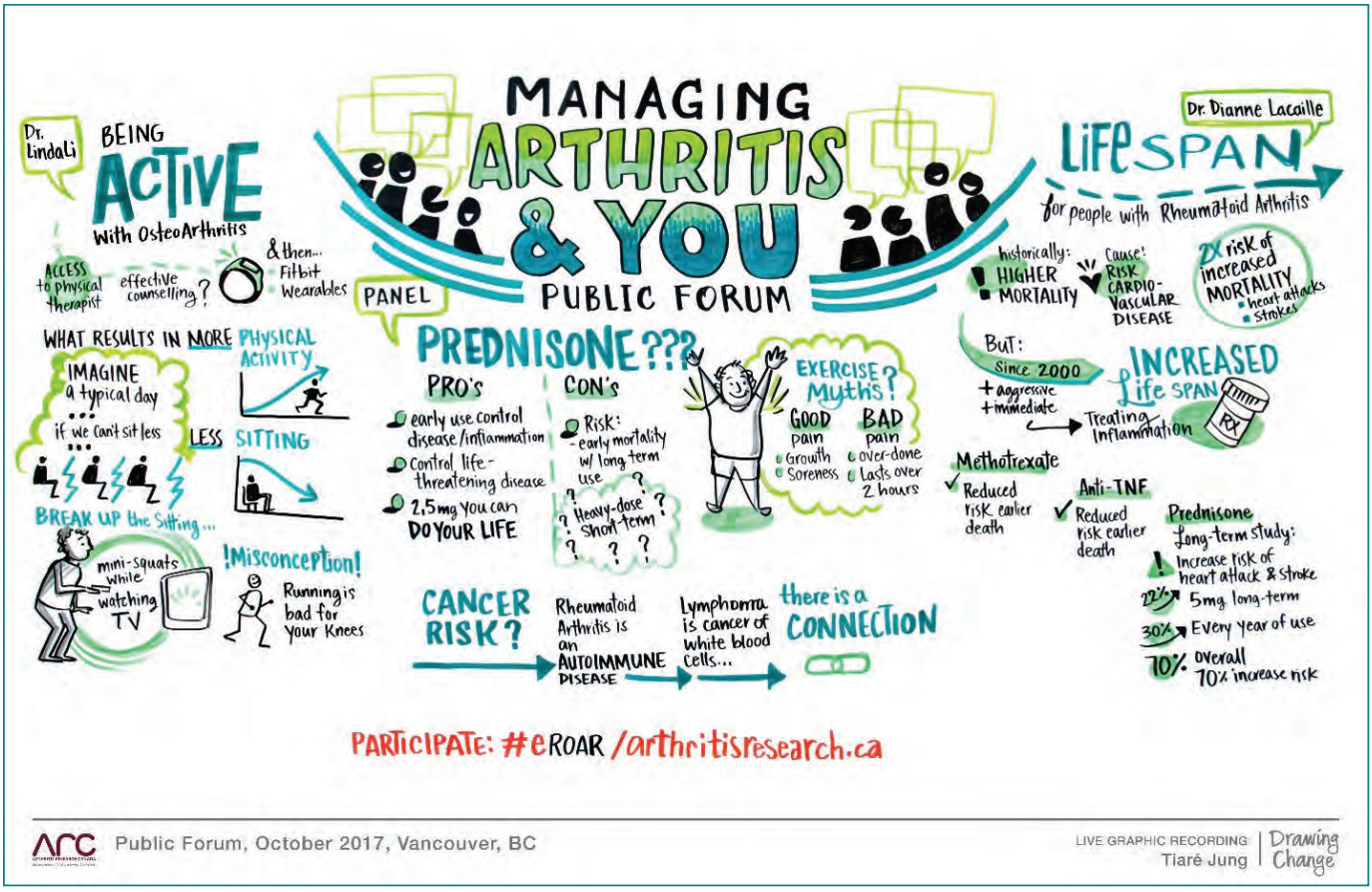
By Diane Lacaille, MD, FRCPC, MHSc

On October 21st, 2017, the 11th annual Reaching Out with Arthritis Research (ROAR) public forum was held at the Vancouver Public Library. This public forum underscores the importance of the patient voice as it is planned, led, and delivered by the Arthritis Patient Advisory Board (APAB) of Arthritis Research Canada (ARC). This year's event, entitled "Managing Arthritis and You," allowed scientists from Arthritis Research Canada to share the latest arthritis research with a worldwide audience. ROAR is accessible to everyone – participants attended in-person or joined online via a live webcast. This year, participants tuned in from across the country, the United States, Thailand, and Africa.

I was honoured to be alongside five other presenters to speak on what the latest research is telling us about arthritis care and self-management. Topics ranged from the importance of exercise to patient-focused mobile applications. Presentations by Dr. Linda Li and Cheryl Koehn stressed the importance of being active with the help of activity trackers and mobile apps. Between presentations, audience members were given plenty of opportunities to be active and learn various stretches from physiotherapist Karen Tsui. Other important topics focused on patient-centered apps that help with arthritis management, such as Dr. Paul Fortin's app designed to help manage lupus. The importance of the patient voice as partners in the research process was also given prominence in presentations by Dr. Clayon Hamilton and APAB member Kelly English, who were collaborators on a recent project that highlighted meaningful patient engagement in research.

My own presentation focused on recent research looking at mortality for people with rheumatoid arthritis (RA). Essentially, our studies have found that mortality in RA has improved in recent years, such that for people diagnosed after the year 2000, mortality did not differ from the general population over the first five years of their disease. I also discussed the effect of RA medications on mortality. A popular feature of the public forum is the final Speakers Panel, where we take questions from the live audience and online participants. It really makes it an interactive forum,

The ROAR panel (from left to right): Dr. John Esdaile (standing), Dr. Paul Fortin, Dr. Cheryl Koehn, Dr. Diane Lacaille, Dr. Linda Li, Dr. Clayon Hamilton, and Kelly English.



as it allows for the audience to join the dialogue and ask questions. In all, the annual Reaching Out with Arthritis Research forum is always a success – it allows us to share our work with the people it is intended for and gives the audience many real-world applications to take home and help manage arthritis. All presentations can be viewed online at *www.arthritisresearch.ca/roar*. Stay tuned for the next ROAR public forum in 2018!

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ACR 2017 in San Diego *Continued from page 23*

I focused on included benefits of s.c. vs oral MTX (no surprise to Carter Thorne, but apparently news to many US rheumatologists), benefits of HCQ on TNFi drug survival, and the hot topic of possible thromboembolic phenomena in studies of JAK inhibitors.

Overall, it was another excellent meeting, featuring great food, interesting science and valuable networking opportunities. A direct flight to and from Toronto was a bonus. Of course, as soon as I returned home, the meeting cycle spun another quarter turn and it was time to register for CRA and book flights and hotels for Vancouver. See you there and at ACR 2018 in Chicago next October.

Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
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Engaging Your Audience: Practical Tips for Presenting

By Heather McDonald-Blumer, MD, FRCPC; and Elaine Yacyshyn, MD, FRCPC

Many of us have been in lectures where someone is asleep during the presentation. There is something about the lull of the voice, the low lights and the passivity of a didactic presentation that sets the stage for someone to nod-off. As the presenter, it can be disquieting and potentially disruptive. As a member of the audience, we smile knowingly for most of us have been there, or nearly there, at some point in time. For the individual involved, the amount of learning is limited, at best.

It has become increasingly recognized that one-way lectures are of limited use in the adult learning context. A variety of educational strategies have been developed and trialed, and a few have been validated as more effective in engaging participants and, presumably, increasing content learned from a presentation.

To facilitate an interactive session, it is important to invite the audience to participate. Making it clear that questions are encouraged, and the input of the audience is valued, sets the stage for a collaborative presentation. "What do you think?" or "How would you manage this?" can be useful prompts and can be adapted to most talks.

Perhaps one of the simplest and yet effective techniques is to present a case at the beginning, and then pose related question(s) to the audience or ask what questions arise from the case. Ideally, these should be issues which require in-depth knowledge, prompt complex clinical decision-making or are controversial. This cues the audience as to what will be covered in the presentation. The questions can be re-addressed periodically throughout the talk. Content expertise is also important, and preparation is necessary to ensure mastery of the background knowledge.

Education experts suggest a number of relatively simple strategies to improve interactivity in large group settings. For example, the use of an Audience Response System (ARS) has been used effectively. Preplanned questions can prompt the audience to focus on key content elements and then present the "answer" with discussion after the content has been delivered. There are several online ARS systems that can be accessed easily. Through this technique, a teaching pearl of "say what you are going to say, say it and then say what you have said" (from McKeachie's Teaching Tips) can be carried out in a meaningful way.

When lacking technology, a "show of hands" can work to get a sense of audience knowledge or attitudes – assuming that there is a sufficient level of trust within the group or the questions are low risk. Alternatively, strategies such as "think-pair-share" can be done effectively by a skilled presenter. A question is posed, and audience members are asked to reflect individually, then discuss responses with the person sitting adjacent. Selected members of the audience can be called upon or volunteer to share their dyad's thoughts with the larger group. A variation on this theme can be undertaken by posing a question to the audience and then asking them to commit to an answer in writing - assuming they have pen and paper in hand (Known as the one-minute reply or one-minute paper technique).

Teaching through group interaction or by discussion can be challenging. One must plan for the unexpected, but participation often increases the rewards for the presenter and improves the experience for the audience.

Two great references to check out include:

- "McKeachie's Teaching Tips: Strategies, Research and Theory for College and University Teachers" by William McKeachie (Houghton, Mifflin Company)

- "A Practical Guide for Medical Teachers" edited by John Dent and Ronald Harden (Elsevier Churchill Livingstone)

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Survey Results on Medical Marijuana

For this quarter's issue, the CRA surveyed its members on medical marijuana. Marijuana, also known as cannabis, is currently a schedule II drug under the Canadian Controlled Drug and Substances Act. With the ongoing discussions about changing the laws surrounding marijuana, this issue is as pertinent as ever. Currently, Health Canada is working to create a strict legal framework for controlling the production, distribution, sale, and possession of cannabis across Canada.[1] A total of 180 responses were received from CRA members out of a possible 572, equating to a 31% response rate.[1]

The first question of our survey asked members how often in a week they were asked to give their opinion on medical marijuana. Forty-one percent of those surveyed responded that they were asked three or more times a week (see figure 1).

When asked what percentage of patients do they estimate are using marijuana for medical reasons, 12% of survey-takers indicated that greater than 10% of their patients were. The full breakdown is shown in figure 2.

The next question of the survey asked respondents how confident they were in advising patients of the current evidence for benefits and risks of medical marijuana. Only 3% of respondents said they felt very confident, with 30% saying they felt moderately unconfident and 26% saying they felt very unconfident (see figure 3).

Regarding the 2015, CRA position statement, approximately half of respondents indicated they had previously read or consulted it and nearly 40% said that they had not.

What's more, 67% believe the CRA should develop an updated position statement on medical marijuana (see figure 4).

As to whether the CRA should develop guidelines (as opposed to just a position statement), approximately 40% indicated guidelines would be preferred. Ninety percent of survey-takers indicated that they do not use other guidelines for medical marijuana use in patients.

References:

1. Government of Canada. Legalizing and strictly regulating cannabis: the facts. Available at https://www.canada.ca/en/services/health/campaigns/legalizing-strictly-regulating-cannabis-facts.html. Published May 5, 2017. Accessed Dec 7, 2017.

Figure 1. **How often in a week are you asked to give your medical opinion on medical marijuana (by patients, colleagues, or friends)?**

	Percent	Responses
Never or very rarely	18%	33
< 1-2 times	41%	73
3 or more times	41%	74
	Totals: 180	

Figure 2. **What % of your patients do you estimate are using marijuana for medical reasons?**

	Percent	Responses
0-5%	44%	79
5-10 %	33%	60
>10%	12%	21
No idea	11%	20
	Totals: 180	

Figure 3. **How confident are you in advising patients of the current evidence for benefits and risks of medical marijuana?**

	Percent	Responses
Very confident	3%	5
Moderately confident	18%	24
Neutral	23%	38
Moderately unconfident	30%	58
Very unconfident	26%	54
	Totals: 179	

Figure 4. **Do you believe the CRA should develop an updated position statement for medical marijuana?**

	Percent	Responses
Yes	67%	120
No	10%	18
Not sure	23%	40
	Totals: 178	

BC

Update From the Okanagan

We have six rheumatologists in the Okanagan, who are all extremely busy with long waiting lists, and are pleased to have a seventh rheumatologist just starting practice in Kelowna. We all have nurses working with us to assist with patient care. Dr. Stuart Seigel and Dr. Anick Godin are very pleased to welcome Dr. Evelyn Kwok to Kelowna, who will be working in their office. Evelyn will have her hands full with her seven-month-old son and establishing a new practice. Dr. Seigel and Dr. Godin are interested in teaching and have been running an elective for teaching Rheumatology Fellows. Dr. Dan Mcleod continues to provide clinics in Whitehorse, Yukon. Dr. Nima Shojania works in West Kelowna and also does outreach clinics in Dawson Creek and Fort St. John, which he finds very rewarding.

Drs. Kwok, Godin, and Seigel.

Dr Shojania and Dr. Godin also have a joint osteoporosis clinic. In Penticton, Dr. Michelle Teo works with a team of two nurses, which has allowed her to double the number of patient visits per year with their model of care. Dr. Michelle Teo also is interested in research and is the recipient of a two-year CIORA grant looking at a community-based multidisciplinary model of care for treatment of fibromyalgia. She is also interested in developing a fracture liaison service (FLS). I continue to be extremely busy in my role as President of the Medical Staff Association in Penticton, in addition to running a very full practice. I also do four clinics per year in Princeton, British Columbia, for patients who have difficulty with travelling and hold a once monthly osteoporosis clinic. In Penticton, we are most fortunate to have the Mary Pack Arthritis Program at our hospital, providing physiotherapy and occupational therapy services to our arthritis patients. We all enjoy the wonderful outdoor activities the Okanagan has to offer: Ski season is starting and we can't wait to get into that Okanagan powder, but many of us also enjoy the excellent cycling, hiking, and swimming this area has to offer.

Team Teo.

–Jackie Stewart, BSc (Hons), B ED, MD, FRCPC
Clinical Assistant Professor,
Department of Medicine,
University of British Columbia,
Rheumatologist,
Penticton Regional Hospital
Penticton, British Columbia

Team Stewart and the Infusion Clinic.

Update From Kamloops

My sister and I took my nieces to the Vernon waterslides the first day of the school summer vacation. It was a glorious day and we all left with the mantra we were "going to have the best summer ever." And then, British Columbia (B.C.) began to burn. It burned for the entire summer and well into September 2017. Nearly 900,000 hectares burned and more than 39,000 B.C. residents were evacuated.

By chance, I was in Cache Creek an hour before it was evacuated due to an explosive and aggressive fire. The entire hillsides surrounding the highway were on fire and the highway and sky were streaked with red from the fire retardant dropped by the bombers. It was an eerily beautiful sight and a clear declaration of what the summer of 2017 would be.

About one third of my practice was evacuated. This lead to interesting social situations. One of my patients was travelling and couldn't return to Williams Lake. He ended up in Kamloops with the dog, while his wife was in Quesnel with the cat. Due to road closures and poor visibility grounding flights, it was days until they were reunited.

Thompson Rivers University and our major arenas became evacuation centres complete with army cots. Many local residents took in complete strangers. I was very impressed by my physician colleagues who were willing to take in displaced physicians they didn't know and even their horses, etc. Kamloops was home to about 10,000 evacuees. My patients were so impressed with how well they were treated and the events that were organized for their entertainment and by the fundraisers and donations received.

The evacuations lead to some pretty interesting patient situations. One evacuated nurse practitioner was doing "hotel calls" to provide patient care. I drew the line at a new start gold injection though and yes, we do on occasion, use gold in B.C.! An evacuated physician ran a clinic for evacuees and our health authority extended privileges to evacuate physicians so they could still work while displaced.

Our air quality was hideous. On an air quality health index scale that usually goes from 1 to 7, we spent days in the 40s and 50s. I couldn't see the street from my office window, and some mornings I could see about 4 feet in front of my car. Our air quality was consistently worse than Beijing with a corresponding upswing in respiratory illnesses.

The ranchers were particularly devastated with the loss of cattle due to burned fences, loose cattle being chased off the highways and back into the fire zone, and destruction of grazing land. In typical rural fashion those who have intact pastures are caring for other farmers' cattle.

While the worst of the fire season is over, many continue to burn underground. We are hoping for a very cold winter with a lot of snow, so the fires will extinguish over the winter. We hope to be in the news next summer for our scenic surroundings rather then our raging fires.

– Barb Blumenauer, MD, FRCPC
Rheumatologist,
Royal Inland Hospital
Kamloops, British Columbia

The first and only anti-TNF indicated in nr-Ax SpA[1]*†

NOT ALL TYPES OF AXIAL SPA CAN BE SEEN WITH AN X-RAY[2]

Indications and clinical use which have not been discussed elsewhere in the piece:

SIMPONI® is also indicated:

- For reducing signs and symptoms in adult patients with active ankylosing spondylitis (AS) who have had an inadequate response to conventional therapies
- In combination with methotrexate (MTX): for reducing signs and symptoms and improving physical function in adult patients with moderately to severely active rheumatoid arthritis and inhibiting the progression of structural damage in adult patients with moderately to severely active rheumatoid arthritis who had not previously been treated with MTX.
- For reducing signs and symptoms, inhibiting the progression of structural damage and improving physical function in adult patients with moderately to severely active psoriatic arthritis. SIMPONI® can be used in combination with MTX in patients who do not respond adequately to MTX alone.
- In adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to, or have medical contraindications for, conventional therapy including corticosteroids, amino salicylates, azathioprine (AZA), or 6-mercaptopurine (6-MP), for inducing and maintaining clinical response (reduction in signs and symptoms); inducing clinical remission; achieving sustained clinical remission in induction responders; improving endoscopic appearance of the mucosa during induction.
- No studies have been performed in pediatric patients
- Caution should be used when treating the elderly, as there is a higher incidence of infections in this population. There were no patients ≥65 years in the nr-Ax SpA study

Contraindications:

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

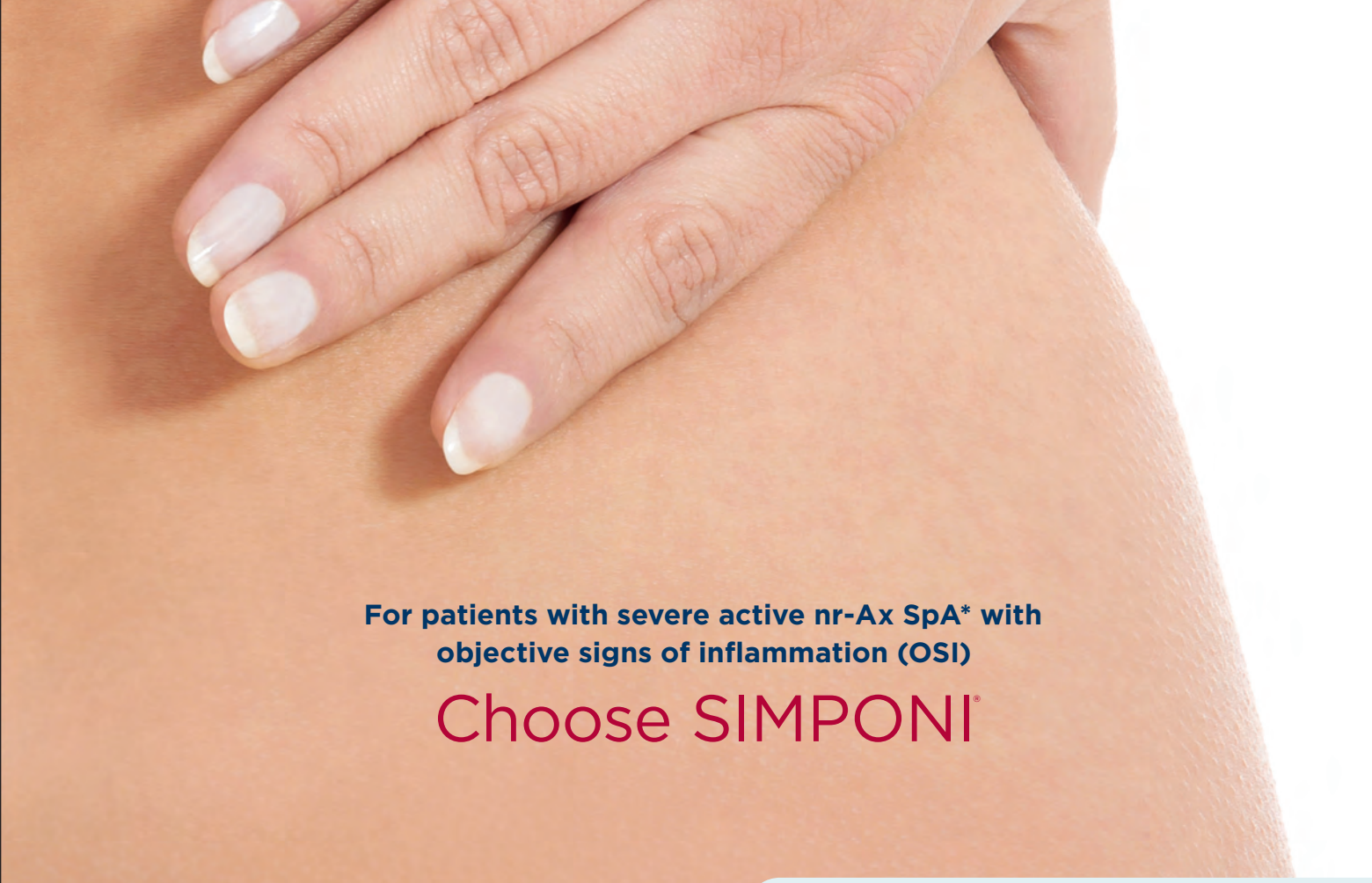
Most serious warnings and precautions:

Infections:

- Serious infections leading to hospitalization or death, including sepsis, tuberculosis (TB), invasive fungal, and other opportunistic infections have been observed with the use of TNF antagonists including golimumab. Administration of SIMPONI® should be discontinued if a patient develops a serious infection or sepsis. Treatment with SIMPONI® should not be initiated in patients with active infections including chronic or localized infections.
- Physicians should exercise caution when considering the use of SIMPONI® in patients with a history of recurring or latent infections, including TB, or with underlying conditions, which may predispose patients to infections, who have resided in regions where TB and invasive fungal infections such as histoplasmosis, coccidioidomycosis, or blastomycosis are endemic.
- Tuberculosis (frequently disseminated or extrapulmonary at clinical presentation) has been observed in patients receiving TNF-blocking agents, including golimumab. Tuberculosis may be due to reactivation of latent tuberculosis infection or to new infection.
- Before starting treatment with SIMPONI®, all patients should be evaluated for both active and latent tuberculosis.
- If latent tuberculosis is diagnosed, treatment for latent tuberculosis should be started with anti-tuberculosis therapy before initiation of SIMPONI®
- Physicians should monitor patients receiving SIMPONI® for signs and symptoms of active tuberculosis, including patients who tested negative for latent tuberculosis infection.

Malignancy:

- Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which golimumab is a member.



For patients with severe active nr-Ax SpA* with objective signs of inflammation (OSI)

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INDICATION

Treatment of adults with severe active non-radiographic axial spondyloarthritis (nr-Ax SpA) with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence who have had an inadequate response to, or are intolerant to nonsteroidal anti-inflammatory drugs (NSAIDs).

Other relevant warnings and precautions:

- Geriatrics (65 years of age or older): Caution should be used in treating the elderly
- Risk of hepatitis B virus reactivation
- Risk of worsening or new onset of congestive heart failure
- Risk of infection with concurrent use of anakinra, abatacept or other biologics; concurrent use is not recommended
- Risk of hematologic reactions
- Risk of hypersensitivity reactions
- Risk of latex sensitivity
- Risk of clinical infections, including disseminated infections, with live vaccines and therapeutic infectious agents; concurrent use is not recommended
- Risk of autoimmunity
- May cause immunosuppression; may affect host defences against infections and malignancies
- Potential for medication errors
- Risk of new onset or exacerbation of CNS demyelinating disorders
- Risk of infection in peri-operative patients
- Adequate contraception must be used to prevent pregnancy in women of childbearing potential for at least 6 months after last treatment
- Not to breast-feed during and for at least 6 months after treatment with SIMPONI®
- Use with caution in patients with impaired hepatic function
- May have a minor influence on the ability to drive due to dizziness following administration

For more information

Please consult the Product Monograph at http://www.janssen.com/canada/products#prod-425 for important information relating to adverse reactions, drug interactions, and dosing information which has not been discussed in this piece.

The Product Monograph is also available by calling 1-800-567-3331.

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

References: 1. SIMPONI® Product Monograph, Janssen Inc., August 21, 2017. **2.** Hochberg, MC, Silman, AJ, Smolen, JS, *et al.* (2015). Rheumatology. Philadelphia: Mosby/Elsevier.

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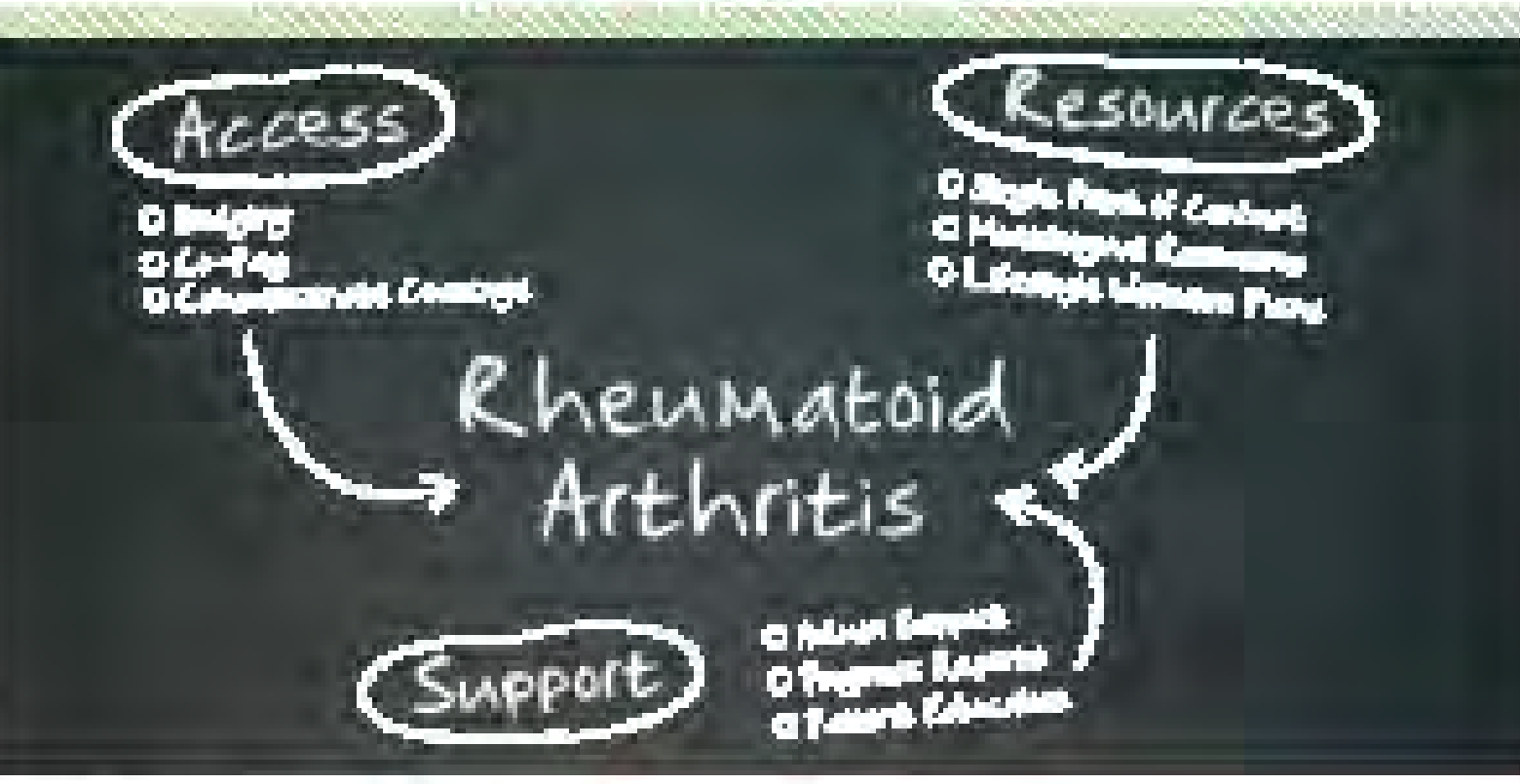

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