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The Journal of the Canadian Rheumatology Association

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DID YOU KNOW?



Adherence to long-term therapy for chronic illnesses in developed countries averages **50%**¹.



Across diseases, **adherence is the single most important** modifiable factor that compromises treatment outcome.



In studies of therapy-related interventions, the main barriers to adherence were found to be the **dose frequency** and the **incidence of side-effects**.

WHAT CAN YOU DO FOR YOUR PATIENTS TO HELP THEM MAINTAIN THEIR TREATMENT ADHERENCE?

Reference: 1. World Health Organization (2003). Adherence to long-term therapies: evidence for action.

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Mentoring Millennial Rheumatologists

By Philip A. Baer, MDCM, FRCPC, FACR

“Millennials don't want to be managed, they like to be led, coached and mentored. This generation is on fire and ready to go. Are you ready to change the world?”

– Farshad Asl, author of *The “No Excuses” Mindset*

Millennials and how to nurture them are topics which are becoming popular in medical news and literature. Recent articles have appeared in *The Journal of the American Medical Association (JAMA)*¹ and *The Canadian Medical Association Journal (CMAJ)*.² They dwell on how millennials have different learning and communication styles, are not really addicted to avocado toast (which I noticed was part of the catering menu at the 2018 CRA Annual Scientific Meeting [ASM] in Vancouver), and are often misunderstood by older generations. The example of a millennial surgical resident being mistaken for playing a video game on his phone while preparing to scrub in, while he was actually reviewing a video of the planned surgical procedure, illustrates the issue.

As a baby boomer blessed with twin millennial sons and their partners, I have some personal experience with the situation. Phones are ever-present, though rarely used for phone calls. Texting, instant messaging and social media keep us connected. Exchanging links to common touchpoints of interest, such as Toronto sports teams, legal absurdities, auto insurance scams, ticket scalping, doctors in trouble and controversies regarding sex education in Ontario is de rigueur. I only need to embrace podcasts more, and swap my Blackberry for an iPhone, to really get attuned with my burgeoning millennial family.

At the office, I can use what I learn at home to personalize patient interactions as well. The easiest people to connect with now are millennials and their parents, as we are experiencing the same concerns. Ten years ago, I had more shared experiences with graduating high school students (rarely seen in an adult rheumatology office) and their parents. Twenty-five years ago, it was parents of young children. In an age of high patient throughput, limited time and appropriate ongoing resistance to depersonalized assembly-line medicine, common interests and experiences are key to establishing rapport with patients who are stressed and battling the chronic illnesses which we deal with.

I have always enjoyed teaching. As opportunities on the continuing medical education (CME) circuit dwindle

for traditional dinner talks, opportunities to mentor new in-practice rheumatologists have exploded. Learning in these situations is truly bidirectional. I had a wonderful morning office recently with a local rheumatologist now two years into private practice. He certainly didn't need me to teach him the pathophysiology of rheumatoid arthritis (RA). As we used the same electronic medical records (EMR) system, the most practical things I could teach him were tips and tricks I had learned or created to make documentation faster and more comprehensive, as well as key forms and templates I had created to handle repetitive nuisance tasks (Rejected Referral letter, Rejected Prescription Refill letter, Request for More Information on a Referral letter, etc.) Useful phrases to start and end clinical encounters with and to handle diagnostic and therapeutic uncertainty were also part of my curriculum. In the other direction, I learned about the difficulties of modern hospital practice, a few Windows shortcuts and how to get a new computer keyboard to connect properly. Time well-spent on both ends.

In a group setting, I had another opportunity recently to spend an evening with a group of six millennial rheumatologists in practice for one to five years. The initial thought was to discuss difficult cases, and we may yet do that in future. For the inaugural session, I prepared about 25 slides covering practice tips, handling difficult patients and difficult office situations, and staying out of trouble with the provincial regulatory colleges. I also had slides on the “marathon vs. sprint” approach to a long medical career, and case studies on more unusual topics. These included my three personal encounters with the provincial regulator, lessons learned from being a medical expert for the Canadian Medical Protective Association (CMPA), and the cautionary tales of the three Ontario rheumatologists who have lost their licenses during my time in practice, and the one who went to jail. However, we had such a spirited roundtable discussion that, after 90 minutes, we had only reached slide #5! I always say when I speak that I am not wedded to getting through every slide in my deck, but for once it came true in a really organic and worthwhile session for all of us.

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(Continued from page 3)

I have a lot of empathy for millennial rheumatologists. As a baby boomer, I benefited from medical school tuition of \$800/year, no student debt on graduation (thanks to my parents on that score), a much better ratio of applicants to positions in the Canadian Resident Matching Service (CaRMS), multiple practice opportunities on completing fellowship, and a friendlier fee schedule which actually increased over time, at least initially. Houses were cheaper to buy, once I got over the sticker shock of moving from Montreal to Toronto. Later in practice, I benefited from a now-defunct government subsidy program to acquire and maintain an EMR as well.

If you are in the same position, I encourage you to get involved in mentoring our younger rheumatology colleagues. The CRA has many opportunities, including summer studentships and mentoring opportunities at the ASM, the latter of which I have participated in numerous times and highly recommend. In Ontario, Dr. Thanu Ruban is leading the Emerging Rheumatologists of Ontario (ERO) initiative of the Ontario Rheumatology Association (ORA) to connect mentors and mentees for learning, possible locum and permanent practice opportunities, and the creation of a practice handbook specific to rheumatology. Similar endeavours may be underway through other regional rheumatology associations across Canada. Leading Canadian rheumatologists, such as Dr. Mary Bell and Dr. Gillian Hawker, are pioneers and award winners for their mentorship work

in academic medicine. Future Leaders in Rheumatology Training (FLIRT) led by Dr. Janet Pope is another initiative in this direction.

Just as I was writing this article, the American College of Rheumatology (ACR) announced yet another program aimed at millennials: "Creating Adult Rheumatology Mentorship in Academia (CARMA) is a mentoring program to support career development and enhance decision-making and satisfaction for rheumatology trainees and junior faculty as they transition to independence after fellowship. Established ACR members will serve as mentors by providing remote career development guidance for early rheumatology investigators." You can email carma@rheumatology.org for more information.

I can assure you that being a mentor is a valuable and appreciated way to give back to the broader rheumatology community, and that you will learn at least as much as your mentees.

References:

1. Waljee JF, Chopra V, Saint S, et al. Mentoring millennials. *JAMA* 2018; 319(15):1547-48.
2. Mercer C.. How millennials are disrupting medicine. *CMAJ* 2018; 190(22): E696-E697.

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

WELCOME TO THE RHEUM

Welcome to the following new members:

Megan Barber, Caglary, AB

Mark Warwas, Vancouver, BC

Stephen Wong, Los Angeles, CA

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 jjotip@sta.ca. Picture submissions are greatly encouraged.

Check Out the CRA's New and Improved Website!

If you have visited the CRA website recently, you will notice a fresh new look! We asked the CRA a few questions about their new and improved site (rheum.ca) and the specific changes that that have been made.

Why did the CRA decide to revamp its website?

At the CRA, we continuously strive to offer the best service possible to our members. That's why recently we decided to update our membership management software to make it easier to register for events, update information and connect with other members. This new membership management software also comes with the option to implement modern, mobile-friendly templates to improve the experience on our website. With that in mind and combined with the fact that our website was starting to look a bit outdated, we decided that it was time we refresh our website.

What are some of the changes/improvements that you would like to highlight for your readership?

Our members are now able to access receipts for renewals and event registrations; add job postings; and access secure files all within their portal.

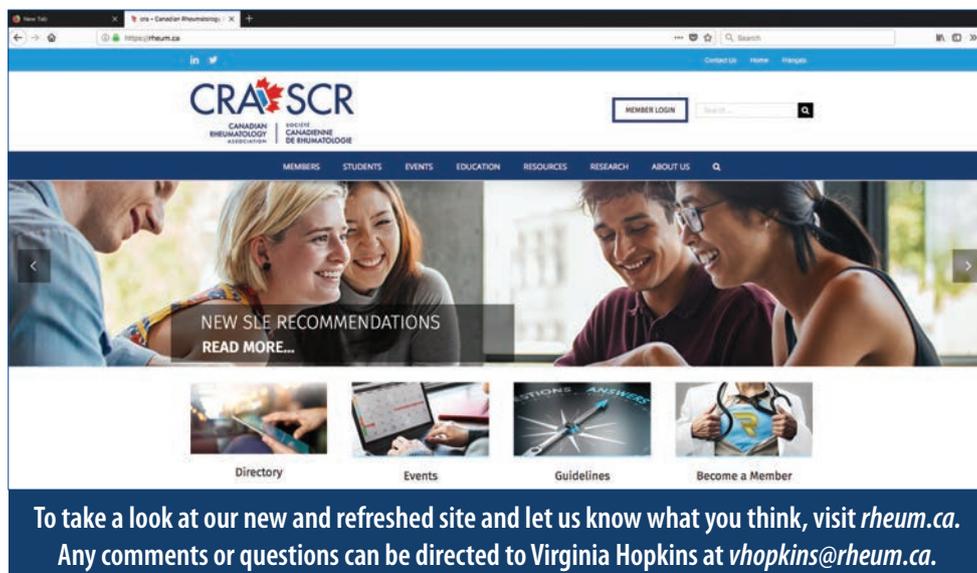
There is also easier access from the home page to the top four most frequently visited pages on our website. Members can also share job postings or news updates on social media. Finally, information has been reorganized and/or renamed to improve the user experience.

What important content is available on the website that Canadian rheumatologists should be aware of?

We update the website daily with new information.

These are just a few pages that have been updated recently:

- Choosing Wisely
- CRA Annual Scientific Meeting (ASM)
- Drug Shortages
- Annual Report
- Job postings



How do you see the CRA website evolving in the next five to ten years?

We see the website becoming a hub for all of what our members need. This will likely include the website becoming more interactive with discussion boards and live-streaming sessions.

How would you say the CRA website compares to other equivalent not-for-profit organizations?

The CRA website is generally comparable to other not-for-profit organizations in design and usability. That said, this new launch is just the beginning and our objective is to continue improving our website to optimize it based on the needs and wants of the various segments in our membership.

How are you planning to drive increased traffic to the website?

The best way to increase traffic is to offer value. In marketing, they say "content is king," and we intend to leverage that to the benefit of our members. After all, our objective is to be helpful and useful to our members and traffic to our website is a proxy for that.

There are of course some best practices also to ensure that our website and the pages it holds are easy to find. There is both art and science involved in leveraging the ever-changing search engine optimization techniques.

How many visitors visit the site per day?

This number varies depending on the time of year. It can range from almost 600 visits per day during our ASM to 130 per day during the summer months.

Executive Summary: CRA Recommendations for the Assessment and Monitoring of SLE

By Stephanie Keeling, MD, MSc, FRCPC, on behalf of the Canadian SLE Working Group

As an initiative of the CRA, the Canadian Systemic Lupus Erythematosus (SLE) Working Group developed 15 recommendations for the assessment and monitoring of people with SLE in Canada. These recommendations are based on the results of a CRA survey of SLE practice patterns and are the first guidelines for SLE assessment using the GRADE method (Grading of Recommendations,

Assessment, Development and Evaluation). The recommendations include best practice statements which include a complete history, physical and lab examination for all pediatric and adult lupus patients and careful coordination of care in the peripartum period. To view the guidelines, please visit rheum.ca/resources/publications/ or jrheum.org/content/early/2018/08/27/jrheum.171459.

Recommendation	Strength of recommendation, Quality of evidence
(1) We recommend that all adult patients suspected of SLE be referred to an SLE specialist, most often a rheumatologist, to confirm diagnosis and be involved in ongoing care.	Strong, Moderate quality
(2) For adult and pediatric patients with SLE, we suggest assessing disease activity with a validated instrument of disease activity during baseline and follow-up visits.	Conditional, Low quality
(3) For adult and pediatric patients with SLE, we suggest assessing disease damage annually with a validated measure.	Conditional, Low quality
(4) For adults with SLE, we recommend that indicators of obesity, smoking status, arterial hypertension, diabetes, and dyslipidemia be measured upon diagnosis of SLE, and be reassessed periodically according to current recommendations in the general population and be used to inform the cardiovascular (CV) risk assessment.	Strong, High quality
(5) For adults with SLE, we suggest that carotid ultrasonography not be a part of the CV risk assessment, except in highly selected cases where expertise is available.	Conditional, Low quality
(6) For all adult patients with SLE, we suggest assessing for risk of osteoporosis and fractures every 1 to 3 years using a detailed history and focused physical examination, and measuring bone mineral density in patients with other risk factors according to recommendations in the general population.	Conditional, Low quality
(7) For all adults with SLE, we suggest screening for 25-hydroxy vitamin D levels as part of the assessment for risk of osteoporosis and fractures.	Conditional, Low quality
(8) For patients who have suspected clinical symptoms of osteonecrosis, we suggest radiographs as the initial imaging modality rather than MRI or bone scan with SPECT, according to recommendations in the general population.	Conditional, Low quality
(9) For women with SLE, we recommend that anti-Ro and anti-La antibodies be measured prior to pregnancy or during the first trimester.	Strong, Low quality
(10) For pregnant women with SLE, we suggest that uterine and umbilical Doppler studies be performed in the second or third trimester, or at the time of a suspected flare.	Conditional, Low quality
(11) For women with prior or active lupus nephritis who are pregnant, we suggest measuring serum creatinine and urine protein to creatinine ratio every 4-6 weeks, or more frequently if clinically indicated. We suggest blood pressure and urinalysis be measured prior to pregnancy and every 4-6 weeks until 28 weeks, every 1-2 weeks until 36 weeks, and then weekly until delivery	Conditional, Low quality
(12) For all female adult patients with SLE who are or have been sexually active, regardless of sexual orientation, we suggest annual cervical cancer screening rather than screening every 3 years, at least up to the age of 69.	Conditional, Low quality
(13) We recommend that adults and children with SLE receive an annual inactivated influenza vaccination in a single dose.	Strong, Moderate quality
(14) For adult and pediatric patients with a diagnosis of SLE and high-risk behaviors for hepatitis B virus acquisition, we recommend screening for HbsAg and repeating according to recommendations for the general population. For patients being considered for immunomodulatory therapy, we suggest screening before starting treatment.	Conditional, Low quality
(15) For adults and pediatric patients with a diagnosis of SLE and high-risk behaviours for hepatitis C virus (HCV) acquisition, we recommend screening for HCV and repeating according to recommendations in the general population. For all other adult and pediatric patients with a diagnosis of SLE, we suggest screening for HCV and repeating according to recommendations in the general population.	Conditional, Low quality

The 2018 CIORA Grant Awards

By Janet Pope, MD, MPH, FRCPC

The Canadian Initiative for Outcomes in Rheumatology Care (CIORA) held its 11th grant competition in March, receiving 37 letters of intent as well as 31 grant applications.

Congratulations to the 2018 grant recipients! CIORA funded six two-year grants for a total of \$670,000. Among this year's grants, two were awarded for Awareness/Advocacy/Education, three for Multi-Disciplinary Care Teams and one for Health Economics/Sustainability of Health Care/Quality Improvement. Health Economics/Sustainability of Health Care/Quality Improvement is a new sub-pillar which encompasses proposals that focus on cost effectiveness, evaluating care using quality indicators and systems to sustain health care.

A special thanks to our sponsors for their continued 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 2019!

The CIORA Online Grant Application System opens January 28, 2019.

Letter of intent must be submitted by February 25, 2019.

The CIORA Online Grant Application submission deadline is April 1, 2019 at 23:59 Pacific Time.

Please visit rheum.ca/en/research/ for more information.

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



2018 CIORA Grant Awards

Power to the Patients: Reshaping Knee Osteoarthritis Diagnosis and Secondary Prevention with E-Health¹

Principal Investigators: Drs. Linda Li and John Esdaile
AWARD: \$115,000

Proof of Concept Study of an EMR Reminder Intervention to Optimize the Primary and Secondary Prevention of Comorbidities in People with Inflammatory Arthritis¹

Principal Investigator: Dr. Antonio Avina-Zubieta
AWARD: \$95,000

Raising Awareness of the Burden of Giant Cell Arteritis: Occurrence, Healthcare Use, Costs and Health Outcomes²

Principal Investigators: Drs. Jessica Widdifield and Lillian Barra
AWARD: \$115,000

An initiative to address Indigenous patient and community educational needs in rheumatic diseases³

Principal Investigators: Drs. Adalberto Loyola Sanchez and Cheryl Barnabe
AWARD: \$115,000

MyArthritisGuide for Rheumatoid Arthritis Will Improve Patient's Activation Towards Self-care³

Principal Investigator: Dr. Paul Fortin
AWARD: \$115,000

The iParent2Parent Program: Peer Mentoring for Parents of Children with Juvenile Idiopathic Arthritis³

Principal Investigator: Dr. Sara Ahola Kahut
AWARD: \$115,000

Pillars: 1. Awareness/Advocacy/Education; 2. Health Economics/Sustainability of Health Care/Quality Improvement; 3. Multi-disciplinary Care Teams

Building Rheumatology in East Africa

By Carol Hitchon, MD, FRCPC, on behalf of the ILAR-East Africa team

The East Africa region includes some of the most populated but most economically disadvantaged countries in the world. In this region, competing economic and healthcare priorities detract from chronic rheumatic disease management. Rheumatology clinical capacity is limited in most countries and completely lacking in others. In partnership with local physician champions in Kenya and Ethiopia, we are trying to raise awareness of this care disparity in order to optimize the management of people afflicted with rheumatic disorders.

Pediatric rheumatology in Kenya: Prior to 2015, there were no pediatric rheumatologists in Kenya. Today, there are two. Dr. Scuccimarri (McGill University) facilitated the training of and continues to provide mentorship for Dr. Migowa, one of these pediatric rheumatologists. With partial funding from a Canadian-African Research Exchange Grant (Association of Universities and Colleges of Canada), Drs. Scuccimarri, Colmegna and Migowa provided teaching locally; developed a teaching aid based on the pediatric Gait, Arms, Legs and Spine (pGALS) screening tool; and together with Drs. Hitchon and Bernatsky worked on describing the burden of pediatric musculoskeletal disorders at one of the main pediatric hospitals in Kenya. The funds also provided introductory epidemiology research training for a pediatrician. This work, which began in 2011, is being continued by the local faculty with ongoing support from the Canadian rheumatology group.

Adult rheumatology in Ethiopia: Ethiopia, a country of extreme need, has no practicing rheumatologists. The sole public rheumatology clinic in the country is located at Tikur Anbessa Hospital in Addis Ababa. Rheumatology care is provided by internists with limited experience in rheumatology. With highly engaged and supportive local faculty, Drs. Melkie and Tadese (current and past Internal Medicine department heads), our volunteer rheumatology team (Drs. Colmegna, Hitchon and Scuccimarri and our U.S. colleague Dr. Meltzer) has conducted several rheumatology seminars including



Dr. Ines Colmegna in Addis Ababa, Ethiopia.

hands-on MSK clinical skills training. Through a newly established registered charity in the U.S. (rheumatologyforall.org), we are now able to fund rheumatology training for two newly graduated internists. The identified candidates will begin their training in South Africa shortly. Informed by a model used for other medical specialties, we are establishing a rotation of visiting volunteer rheumatologists to provide teaching and mentorship to internal medicine trainees until the newly trained rheumatologists are able to take over.

Adapting recommendations for methotrexate in rheumatic disease to Africa: Most rheumatology management guidelines do not consider the realities of providing care in low-income countries such as Africa with their unique financial, social and medical concerns. With a small grant from ILAR, our team of Canadian, American and Ethiopian clinicians is undertaking the daunting task of adapting recommendations for using methotrexate in rheumatic disease to address the realities of low-income countries. Needs assessments with stakeholders in Ethiopia and across Africa, systematic literature reviews and Delphi processes to refine recommendations are in progress.

Through many years of commitment and dedication, small steps have been taken and very promising improvements have been realized. Yet significant challenges remain for rheumatology patients in Africa and other low-income regions of the world. It is our collective responsibility to work together to improve rheumatology care for all.

Submitted by Carol Hitchon for the ILAR-East Africa team:

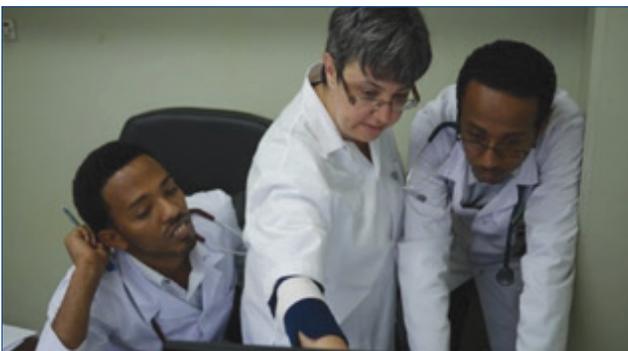
Canada: Ines Colmegna, Sasha Bernatsky, Rosie Scuccimarri, Carol Hitchon

Kenya: Angela Migowa, Thomas Ngwiri, John Wachira, Eugene Were

U.S.: Michele Meltzer, Candice Feldman, Michael Weinblatt

Ethiopia: Yewondwosen Tadese, Addisu Melkie, Zenebe Melaku

(with guidance from Professor Moots [U.K.] and Professor Mody [South Africa])



Dr. Rosie Scuccimarri in Addis Ababa, Ethiopia.

France and Canada: Rheumatology on Both Sides of the Atlantic

By Laëtitia Michou, MD, PhD

Never during my medical studies in France had I foreseen becoming a rheumatologist in Canada. And yet, in a few weeks, I will be starting my twelfth year as a clinical researcher in rheumatology in Québec. My passion for research gave me the courage to venture to the North American continent.

When I arrived here after several years in university hospitals in Paris, I was quite surprised to see such a large number of female rheumatologists, including in university settings. However, in absolute terms, there are 3.4 rheumatologists per 100,000 people in France, compared to only 1.2 in Canada. The absence of an intra-hospital hierarchy and the commitment to gender parity, regardless of seniority or type of practice (university vs. non-university hospital or a private office), were quite pleasant discoveries.

In France, rheumatology is a broad field that encompasses systemic inflammatory diseases, metabolic bone diseases, so-called interventional rheumatology with ultrasound/X-ray-guided injections and even vertebroplasties, and management of bone metastases and multiple myeloma, whereas collagen vascular diseases are frequently managed by internists rather than rheumatologists. The psychosocial dimension given to care in France undoubtedly contributes to rheumatology patients' well-being, for instance, by covering physiotherapy, occupational therapy, dietitian and psychological consultations, as well as prescription costs for medical devices such as orthoses.

In the last decade or so, rheumatologic management of patients in France has seen two very relevant improvements. Specifically, the creation of reference centres for rare diseases allows for hyperspecialized multidisciplinary management of these diseases, defined by a prevalence lower than



2 per 1,000 (for example, scleroderma, Sjogren's syndrome), with clinical research being an integral activity of these centres. Thanks to a directive from the European section of the World Health Organization, therapeutic education of patients with chronic diseases has become more accessible in France. These individual and group education programs are now integrated into the ongoing management of rheumatology patients.

In Canada, the practice of rheumatology is more individualized, sometimes with minimal multidisciplinary support, which makes it a more "responsible" practice in terms of health-care costs. It is a

given that the fee-for-service system for doctors, including those in university hospitals, and the desire to keep Canadian public hospital budgets balanced, largely explain these differences. Let us hope that the many reforms of the Quebec health care system will allow family doctors to be more actively involved in the co-management of patients with chronic diseases, and will help these patients better navigate a rather complex system that is not well known to the public.

In this era of globalization, rheumatologists' concerns are becoming standardized at a remarkable rate. On both sides of the Atlantic, we are now debating medical cannabis, medical assistance in dying, and disruptions in the supply of certain drugs and, of course, the shortage of rheumatologists.

Laëtitia Michou, MD, PhD

Associate Professor

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Québec, Québec

Rheumatology Here and Away: Rheumatology in Ireland

By Paul MacMullan, MD, MRCPI

Ireland is a funny place. Like an errant sibling, I can complain about it, but others can't! It's a mad country with a crazy history of occupation and rebellion, with all sorts of shenanigans and double-down back-stabbing, which serves almost as the modus operandi for general political life.

That said, Ireland was home to me for some 40-odd years; immigrating to Canada was a major life transformation. Emigration was never the plan for me, my wife, and our three boys, but became so when the Irish health service and my so-called senior colleagues decided it was a good idea to respond to the economic crisis by essentially halving the salaries of new entrant consultants, while simultaneously doubling their workload and barring them from private practice, something I was never really interested in anyway.

Healthcare in Ireland is (I won't say organized because it's anything but) let's say "arranged" in a very curious manner. Medical education is an export industry (there were more Canadians in my med school class than Irish) and "residency" is a never-ending saga of propping up a dysfunctional "system" until somebody dies. There are poorly funded public hospitals with long waiting lists and severe overcrowding that are essentially staffed by residents and fellows. Meanwhile the consultants who are supposedly full-time in the public hospitals are running a glut of private facilities that over-investigate the worried well and, once things get complicated, proceed to dump them back onto the nearest public hospital. Similar things happen in the National Health Service (NHS) in the U.K. but are also not publicized due to the hierarchical nature of the medical pyramid that exists in both countries. Having done ten years of up all night in-house call with 36 hour shifts once a week of unselected general internal medicine (GIM) admissions in addition to daily rheumatology clinics, I have the experience to say these things... and, experience, (as I tell the residents who come through our clinics), is what you get right after you just need it!

Anyway, I explored potential opportunities in other Commonwealth countries and the U.S., but really focused on Canada, as I had spent a summer in Vancouver many years ago and really liked the egalitarian nature of the country and the healthcare system. Fortunately, after some initial enquiries and a subsequent site visit, I was offered an alternative relationship plan (ARP) position at the University of Calgary and haven't looked back since. The licensing process was cumbersome but relatively straightforward and, after four years, I can now gladly say that my family and I have settled

**"To my mind losing is always better than never trying,
because you can never tell what may happen."**

– Jean Chrétien

**"Tales of songs and stories, heroes of renown...the
haunting tales and glories that once was Dublin town"**

– Pete St. John

"Now for my two cents..."

– Kent Brockman

here. The work environment is challenging but rewarding and services are extremely well integrated, in comparison to what I was used to. Furthermore, not having to do GIM and being able to focus on rheumatology has been liberating. While I sometimes miss the "whodunit" of internal medicine call, I don't miss the constant hassle and, as rheumatologists, we get enough GIM to keep us on our toes.

Alberta has been very forward thinking in developing the province-wide data repository that is Netcare and, along with the unique lifetime identifier (ULI), allows economies of scale that were heretofore unimagined to blossom. For example, our Division of Rheumatology has partnered with the primary care network of family doctors to provide a specialist link service for non-urgent telephone advice, and a recent opportunity cost-analysis has demonstrated each phone call, on average, saves the system almost \$200, data we will be presenting at the upcoming American College of Rheumatology (ACR) meeting in Chicago. Such initiatives are also great for patient care.

One thing I will say about the medical system here is that, in my humble but experienced opinion, training is too short, particularly for GPs. Two years ain't enough, because at that stage you don't even know what you don't know. That said, there are other avenues such as special competency certifications and special interest groups to build expertise in certain areas, such as rheumatology.

So "to get right back to where we started from" (Maxine Nightingale) I'm glad I listened to that Jean Chretien podcast many years ago.

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China Teachings: British Columbia Rheumatologists in China

By Simon Huang, MD, FRCPC; Ian Tsang, MB, FRCPC; and Barry Koehler, MD, FRCPC

How it all began

This program began after a chance meeting with Professor Zhongdao Wu, then Dean of Undergraduate Study at Zhongshan School of Medicine, Sun Yat-sen University, Guangzhou. He invited the three of us to teach a two-week elective to medical students at the beginning of their fifth year of an eight-year program. Professor Wu particularly wished that the students would have exposure to “Western-style” teaching.

It was restricted to students who had a working knowledge of English. Attendees averaged 80, out of a total class size of 100. The invitation was renewed for the next six years. For the last two years it has become part of the formal curriculum for the entire class, due to the efforts of Professors Wu and Dean Guoquan Gao.

What did we do?

We had planned a rheumatology course for medical students who were early in their clinical training, but soon realized that we needed to use this framework to teach a sound approach to history-taking, physical examination and differential diagnosis. Dr. Simon Huang’s expertise in teaching methods formed the foundation.

Mornings are devoted to review of the previous day’s topics, followed by two to three lectures. Afternoons are spent at various hospitals, with one of the faculty and ten to twelve medical students reviewing a patient. The students collaborate to obtain the history, followed by the faculty member leading them through relevant physical findings, and a subsequent exploration of the possible diagnoses.

Our faculty has been augmented in recent years by Dr. Antonio Avina-Zubieta and Dr. Mercedes Chan. For the past two years students also were offered a workshop on evidence-based medicine, under the guidance of Dr. Charles Goldsmith.

The medical school supplies translators for those of the faculty who did not speak Mandarin (for the afternoon bedside teaching), prepares a printed course syllabus, and arranges teaching rooms for the afternoon clinical sessions – and also room and board.

What did we achieve?

• Students

- Students were initially inhibited to be involved in a Socratic learning environment but quickly became



enthusiastic participants.

- They learned our approach to practice: Medicine is organized, consistent detective work, beginning and ending with the patient.
- Zhongshan Medical School has achieved first place in the national competition for clinical skills in recent years, a competition previously dominated by the Beijing medical schools.

• Fellows

- With the support of the University of British Columbia (UBC) Division of Rheumatology 17 fellows have had the opportunity of teaching learners from a different culture but, perhaps more importantly, to spend time immersed in a different culture.

• Faculty

- We were reinforced in our belief that, while medical students are always bright and always learn, the learning is enhanced by the right learning environment.
- Lectures were all done in English. This led to the recognition that the students found that those with English as a second language (Tsang, Huang) were easier to follow than someone for whom English is their mother tongue (Koehler), whose speech tends to be larded with ‘strange’ colloquialisms.
- Take into consideration the customs of another country. We learned that a two-hour break at midday is a necessity for medical students in China; it’s not just lunch but also nap-time!

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My Journey to Happiness as a Rheumatologist in Saskatoon

By Regan Arendse, MD, FRCPC

My decision to work as a rheumatologist in Saskatoon, seven years ago, is one of the best I have ever made. The people of Saskatchewan are warm, welcoming and sincere. My colleagues in the Division of Rheumatology and associated departments are supportive, accommodating and helpful. Being happy at work is perhaps one of the greatest blessings to have.

One of the main factors that contributed to my decision to work in Canada was my inability to find a state-supported position as a newly qualified rheumatologist in South Africa. While there is a huge need for rheumatology services in South Africa, there are extremely few state-funded positions available. At the time I had completed my training in rheumatology, all the available positions had been filled with no prospect of a vacancy opening for at least 5 to 10 years. The prospect of committing to a private practice, which posed the challenge of trying to provide services to patients who were compelled to pay hard-earned currency for expensive medications, was not appealing to me. After much discussion with my family, we made the difficult decision to leave Cape Town, one of the most beautiful cities in the world according to a recent CNN article, to explore employment opportunities internationally.

The Netherlands is an amazing place to work; from space-age offices that reminded me of scenes from the Starship Enterprise, to super-efficient colleagues and paramedical staff and the innovative incorporation of musculoskeletal ultrasound examination into routine clinical care. Most interesting was the pragmatic Dutch approach to problems. The university medical center, Erasmus MC in Rotterdam, where I worked, employed in excess of 13,000 people in 2011. To reduce the major strain placed on parking facilities, they decreed that all employees including the CEO would commute to work either by public transit or by bicycle, thus increasing the availability of parking for their patients. I learned many valuable practical lessons at



Dr. Arendse and his team: Rhovely Ross, Dr. Myat Tun-Nyo, Dr. Richard Tse, Dr. Regan Arendse, Dr. Germaine Arendse, Denise Carolus and Grace Castro

Erasmus MC on how to assess and manage complex rheumatology patients who were referred for quaternary care.

While working in the Netherlands, I received a call from a recruitment agency to discuss employment opportunities in Canada. I was notified of rheumatology vacancies in many provinces, extending from St. John's in Newfoundland all the way across to Victoria in British Columbia. Despite having travelled extensively, my wife Germaine and I had never visited Canada before. With my own work opportunities secured, we focused on finding a city that would provide Germaine the opportunity to enroll in a PhD program in immunology. Thus, it came to be that we both accepted positions at the University of Saskatchewan; I in the Division of Rheumatology and Germaine in the Department of Microbiology and Immunology. Upon completion of my required certification examination with the Royal College of Physicians of Canada (and of Germaine's PhD thesis) we decided to work in the same office in collaboration. A very satisfying ending to a long journey across the globe to find happiness in employment.

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China Teachings: British Columbia Rheumatologists in China *(Continued from page 12)*

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Khyber Medical College in Peshawar, Pakistan: A Collaborative Project with Dalhousie Medical School

By Siraj Ahmad, MD, FRCPC



Khyber Medical College (KMC), located near the Khyber Pass mountain range, was founded in 1955. Initially, the college was affiliated with nearby Peshawar University and had mostly guest faculty, including from King Edward Medical College (Lahore, Pakistan), Dacca Medical College, East Pakistan (now Bangladesh), The American University of Beirut and a professor/adviser from the University of Pennsylvania in the U.S. Over the years, it became successful in hiring and developing its own full-time faculty.

In the 1970s, KMC graduates working in North America started teaching programs at Peshawar. Dalhousie University's medical school participated by sending audiovisual slide-tape programs followed by a lecture/seminar series at KMC. Dr. Mohsin Rashid, a pediatric gastroenterologist, and Dr. Arif Samad, an ophthalmologist, were at the forefront of this initiative. At the same time, efforts were made to upgrade the library at KMC, initially by donating major journal subscriptions and, later through Dalhousie medical students' volunteer work to collect medical books from medical staff and sending a half-container load to Peshawar.

In the 2000s, we started looking at revision of the KMC curriculum. The Aga Khan Medical Institute conducted workshops on medical education. Dr. Mohsin Rashid conducted a workshop on student evaluation. Following the success of these efforts, the International Health Office

under the leadership of its director, Katie Orr, and the Department of Medical Education under the leadership of Professor Blye Frank became involved and made suggestions for revising the curriculum at KMC.

A joint meeting was organized in Pakistan. In his address, Dr. Blye Frank outlined the role and responsibilities of a medical school towards its community. Katie Orr discussed the opportunity for collaboration between the two institutes, KMC and Dalhousie Medical School. The efforts at KMC were spearheaded by the Students Learning Forum (SLF). Student members of SLF made all of the necessary contacts and arrangements for social programs. Two student members who were prominent in their efforts were Usman Ahmad and Munaza Anwar. That evening a memorandum of understanding (MOU) was signed by representatives of the two institutes.

The next day a workshop on medical curriculum was conducted by Dr. Blye Frank. To everyone's surprise, practically all the faculty attended and participated in discussions. The afternoon sessions were in the form of an open discussion headed by Dr. Sultan Mahmood, Head of the Department of Medicine at KMC. With some modification, the revised curriculum was voted upon and approved by the vast majority (59 to 1). In discussion, it was apparent that there was lack of sufficient bedside teaching. Here, the SLF helped again. There was a nearby outpatient clinic that could be used for student teaching. It turned out that the clinic was constructed by the Canadian International Development Agency (CIDA). The problem was that the clinic belonged to the provincial government and KMC to the university. SLF arranged a meeting with the governor of the province. Katie Orr made a case to the governor who ordered that the clinic should be handed over to KMC students.

While in Peshawar, we advised students to have a "Students' Learning Centre" for first-year students to learn cardiopulmonary resuscitation (CPR) and other clinical skills. The KMC designated space for the centre. One more thing



The team from Khyber Medical College and Dalhousie Medical School

Continued on page 15

New Arthritis Society Resource Helps Patients Become Empowered Self-Advocates



Effectively managing the symptoms of arthritis and their impact on your life can be a challenge for many patients. Learning to advocate for yourself and your needs is an essential skill for people who want to manage the disease and live their best possible life.

This September, as part of Arthritis Awareness Month, the Arthritis Society helped to address this need by releasing a new patient tool, the Self-Advocacy Guide, an exciting set of resources for people living with arthritis.

The Arthritis Society's Self-Advocacy Guide provides information and strategies to help patients become empowered advocates for their health-care needs, or for the needs of others who may be living with arthritis.

The guide is divided into three parts, each covering different but related aspects of self advocacy:

PART 1: Taking an active role in your treatment planning

Learn about your condition, communicate with your health-care team and make informed decisions about your health-care needs

PART 2: Understanding your coverage options

Learn about the different sources of coverage for health-care costs, and how to navigate them to get the support you need

PART 3: Advocating for change

Learn how our health-care system works, and how your voice can help influence policies that affect you and other patients

Encourage your patients to check out the guide at arthritis.ca/selfadvocacy, and start their journey towards becoming an empowered self-advocate for their health care needs.



Khyber Medical College in Peshawar, Pakistan (Continued from page 14)

missing at Peshawar was that there was no rheumatologist; rheumatology patients were being seen by orthopedic specialists. However, one of the internal medicine specialists in Peshawar had shown interest in rheumatology. He was provided with rheumatology case histories and other teaching material. Three years later, he filled the role of rheumatologist and became well known in the city for treating rheumatologic conditions.

Dr. Blye Frank in his address to faculty and students had emphasized that medical education and curriculum development are dynamic processes and would need constant revision. To that effect, it was suggested by the faculty of Dalhousie to have a separate Department of Medical Education. We had also stressed the need to incorporate courses in "critical thinking" and "ethics" but were not able to sell these

ideas to the faculty of Khyber Medical College. We were also not able to start a program for continuing medical education with proper evaluation for medical practitioners and community physicians. On a positive note, during a weekend away from Halifax, I came home to six voicemail messages from the Vice Chancellor of KMC. There was going to be a meeting of Vice Chancellors of all Pakistani medical universities in Peshawar, and he wanted to present the curriculum proposed by Dalhousie University for adoption by all the other medical colleges

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† Prescription and physician data were obtained from eXel™ support program enrollment forms collected from June 2014 to April 2018

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Building Bridges: From Rheumatology in Canada to Jamaica

By Taneisha K. McGhie, BSc (Hons), MBBS, DM

Jamaica is an island situated in the Caribbean Sea; world-renowned for its scenic beauty, dynamic culture, athletic exploits and warm people. Spanning 10,990 square kilometres, with a population of 2.9 million people, Jamaica is the third most populous anglophone country in the Americas.

Jamaica's primary healthcare system consists of more than 330 health centres and 24 public hospitals; the University Hospital of the West Indies (UHWI; a teaching institution partially funded by regional governments including Jamaica); and 10 private hospitals. Currently, there are only five adult rheumatologists serving our nation, all of whom do so on a full-time basis. This equates to one rheumatologist per 580,000 people, and this workforce is mainly concentrated in the southeastern region of the island. In the absence of a practicing pediatric rheumatologist on the island, adult rheumatologists are called upon to provide care to children of all ages.

My journey to becoming the only rheumatologist in western Jamaica began in 2012. Prompted by the need for internists, I relocated from the capital city, Kingston, to Montego Bay to work at the Cornwall Regional Hospital (CRH). At that time, the rheumatology void in the region was being filled by once-monthly visits by a single rheumatologist, Dr. Karel DeCeulaer, who journeyed for four hours from Kingston to Montego Bay. I became his apprentice and mentee. Upon my return to Jamaica following rheumatology fellowship training at the University of Toronto, the first public rheumatology clinic in the western region was established at CRH along with an in-patient consulting service.

The shortage and maldistribution of rheumatologists lead to long wait times for appointments in the private and public sectors. The workforce limitations in the public system cause waiting times of several hours, as patients are seen on a first-come, first-serve basis rather than by scheduled appointment slots during the day. This island-wide issue of wait times is currently being addressed by a Ministry of Health (MOH)-instituted pilot intervention programme. Other logistical deficiencies being addressed by the MOH include the lack of electronic patient health record systems, with the recent introduction of an electronic medical record (EMR) at UHWI. Having used several EMRs at various hospitals in Toronto, I anticipate that, with the proper training of users,



The staff of the rheumatology clinic, Cornwall Regional Hospital, Jamaica. From left to right: Dr. Taneisha McGhie (rheumatologist); Dr. Delanise Lawrence (internist); Allison Johnson (secretary); Mary Trought (Departmental nursing manager). Not present are rotating residents from the department of medicine.

efficiency will improve and there will be a greater potential for the gathering of medical data for research.

Until we are able to increase the number of rheumatologists in Jamaica, The Arthritis Program (TAP) developed by Dr. Carter Thorne in Newmarket, Ontario provides a model of enhanced care for patients through the engagement of allied health personnel. A similar structure in Jamaica could potentially offer counselling, dietary, social and other support services that would address the unfulfilled needs that five rheumatologists otherwise have difficulty meeting. Partnered investments in telemedicine may be needed as an interim measure until a sufficient workforce is a reality.

Another challenge for many patients here in Jamaica is medication access. There are subsidy programs, including the National Health Fund (NHF), through which residents obtain assistance to pay for prescription drugs, regardless of age, health and income status. However, drug shortages in the government system sometimes lead to interruption of treatment and some essential drugs for lupus, such as mycophenolate, are not covered. Currently, there are five parenteral biologic agents available. However, the uptake of these is low due to the prohibitive monthly cost of between \$300 and \$1,400 (Canadian dollars) even with NHF subsidy. In Jamaica, only an estimated 20% of the population have private insurance. The MOH is currently working to establish Jamaica's National Health Insurance Plan. This would greatly increase the affordability of specialist consultations, imaging and medication access, much like what is done by the Ontario Health Insurance Plan (OHIP).

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My Experience with Rheumatology in South Africa and in Canada

By Myat Tun Lin (Tun) Nyo, MBChB, FCPSA (Rheum), FRCPC

I obtained my Rheumatology subspecialty certificate from the Royal College of Physicians, South Africa, in 2012 and worked as a full-time rheumatologist for four years before moving to Canada in July 2017. It has been a year now since I began to practice adult general rheumatology in Saskatoon.

In this article I highlight the differences that I came to notice between the healthcare systems of Canada and South Africa in the field of rheumatology. South Africa has a two-tier healthcare system: one is the public system with limited funding which caters to the majority; and the other is the better-resourced private system. I worked at a tertiary hospital under the public system in South Africa, and my patients were almost entirely indigenous South Africans. I had no experience with the private system.

One major difference between the two countries is the way in which record-keeping and referrals are organized. Whereas in Saskatoon computers and the internet are used for keeping track of patient records and referrals, everything is hand-written in South Africa.

The spectrum of disease is also different. For example, I had never seen a case of polymyalgia rheumatica (PMR), remitting seronegative symmetrical synovitis with pitting edema (RS3PE), giant cell arthritis (GCA) or ANCA-associated vasculitis during my four years of practice in South Africa. All of these are frequently seen in Saskatoon, especially PMR, RS3PE and GCA. Ankylosing spondylitis and psoriatic arthritis were rarely seen in my South African patients over four years, yet I have diagnosed and managed several cases in just one year in Saskatoon. The most common inflammatory conditions that I treated in South Africa were rheumatoid arthritis and gout. Sjogren's syndrome is rarely seen among South African patients, with only one case over my four years of rheumatology practice.

Another significant difference I noticed between the two countries is the availability of treatment options. While I now have easy access to almost all appropriate biologic therapies here in Saskatoon, only two were available to me in South Africa (etanercept and rituximab for rheumatoid arthritis).

Lastly, but not least important, responsibility for treatment decisions is usually shared with patients here in Saskatoon, whereas it was mostly mine alone in South Africa. There is



The staff of the rheumatology unit at Dr. George Mukhari Academic Hospital. From left to right: S. Tselane, Dr. MTL (Tun) Nyo, D.J. Lebuso and M.C. Segoe.

generally a lot more discussion and negotiation with patients before treatment initiation in Saskatoon compared to South Africa, where patients tend to simply accept the treatment their physician thinks is best for them. I personally find satisfaction working in both places, albeit in slightly different ways.

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Rheumatology Practice on Both Sides of the Pond

By Brandusa Florica, MD, PhD, FRCPC

When I look back and try to compare the two periods of my life, I realize that it can only be done through the eye of my experience and my present way of thinking. I was very happy to start a residency in rheumatology and then to practice as a rheumatologist some years ago, when I finished my university degree in medicine in Romania. Before pursuing rheumatology, my alternatives were either to start off a surgery program, for which I did not feel any calling, or to work as a general practitioner in a remote place of the country, with minimal access to any investigative tools and minimal treatment options. My interest in rheumatology is linked to my inclination towards detective work, and the need for professional satisfaction from helping suffering people, as well as to my first medical mentor, who is a great personal and professional role model.

What was it like to work as a rheumatologist in Romania? There were, as you might expect, many similarities and many differences to working in Canada. I was surrounded by many enthusiastic rheumatologists who had very good knowledge and clinical practice experience. I worked with in-patients in a hospital setting and also with out-patients in a clinic within the same hospital. The pathology was similar: there were many patients with rheumatoid arthritis (RA), inflammatory spondyloarthritis, and osteoarthritis (OA), but we also saw the full breadth of other rheumatic diseases. My impression was that Romanian patients suffered from more severe forms of inflammatory arthritis (IA), with many related disabilities and more significant impact on their quality of life; however, these observations stem from work in a tertiary referral center 15 years ago, when early diagnosis and newer treatment options were relatively less available. Romania, an eastern European country, had a relatively poor health-care system, so diagnostic tools were limited. The positive aspect of that situation was that it provided the stimulus for medical doctors to become more attentive to clinical examination and develop useful clinical skills. I always admired the ability of my teachers to diagnose a condition based only on a detailed clinical examination and a focused history.

As opposed to a practice-based mainly on skillful interview and physical examination of the patient, the rheu-



Rheumatology group, led by Professor Rodica Chireac, at the University of Medicine in Iași, Romania, 2002.

matology practice I observed in Canada relied much more frequently on available investigative data. This is a practice driven by patient requests, and also by the need to document investigational findings as part of the qualification criteria for diagnosis or treatment imposed by governmental and non-governmental insurance programs. This gives the doctor only partial liberty to be creative and adapt to the specific condition of the patient, to challenge his/her diagnostic skills, or to try different treatment options. In other words, there was more opportunity for a “cowboy”-type medicine practice in Romania. Of course, each of these two types of practices has pros and cons. A standardized, guideline-based diagnosis and treatment of a medical condition is a far safer way of practicing medicine.

Another difference between the practice of rheumatology in Canada and Romania is in the doctor-patient relationship. Such interaction between a patient with a chronic disease and a rheumatologist is based on respect, trust and confidence wherever you are on earth. However, the initial patient-rheumatologist interaction in Canada is more frequently critically scrutinized by the patient. The physician may be considered a mere service provider, who may even be under-qualified compared to “Dr. Google”, as perceived by the patient. It takes good skills and dedicated time to develop a trust-based relationship, which is highly beneficial for effective treatment. In Romania, the physician is usually perceived as a highly qualified individual who is able to decide what is best for the patient, and provide the best advice in his field of expertise, without being challenged by the patient. This is based on a more traditional, paternal-

istic approach in the relationship between patient and physician.

At the same time, a Canadian physician has the advantage of exposure to a diversity of rheumatologic diseases, and also to the different cultural attitudes to diseases. To be able to understand the real meaning of different patients' behaviours, one needs to learn more about their specific culture and customs. I cannot forget an episode when I was amazed by one of my patients' reaction to bad news. He was an elderly person, originally from China, who was smiling continuously during our interview, despite the fact that I told him that he had developed a terminal condition. My first impression was that he did not understand my message; I found out later on that, in his own culture, a proud person should not show their real feelings on his or her face.

Despite some differences of practicing medicine in different areas of the world, the real reward for a rheumatologist is to be valued by the patients for the difference that they made in their quality of life. I remember with pleasure a thank you letter I received from a Romanian patient, after a period of treatment for RA. She was very happy to be able to write it with her newly recuperated hand. The hugging and the happiness of my Canadian patients is what helps keep me going through a long day of consults.

Overall, I feel blessed and honoured to be part of the community of rheumatology professionals in Canada, and to share the enthusiasm of practicing during this exciting time for our specialty.

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At the 1996 National Romanian Conference of Rheumatology in Iasi.

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The Caribbean Association for Rheumatology (CAR) 2018 Conference

By Raj Carmona, MBBS, FRCPC; and Carter Thorne, MD, FRCPC, FACP

The ninth annual meeting of the Caribbean Association for Rheumatology (the other CRA, but warmer) was held in May 2018 on the beautiful island of St. Lucia. The conference served not only to provide continuous medical education for regional practitioners, but also as a forum for networking, and promoting rheumatological care and research within the Caribbean.

On opening night, Dr. Thorne presented a well-received public lecture on models of care, followed by the plenary session demonstrating the efficacy of team-based care. Dr. Carmona reviewed the safety of biologic therapies and provided an update on osteoporosis, including risk stratification in a region where Bone Mineral Density (BMD) is not available on some islands. Two other Canadian speakers (Dr. Nicole Johnson and Dr. Aurore Fifi-Mah, both from Calgary) truly made this the other CRA. Unfortunately, the snow had all melted (leaving just gorgeous beaches and warm sand behind!).

The attendees, including the Caribbean's own Professor Eon Nigel Harris (yes, the doc who developed the anticardiolipin test and defined anti-phospholipid syndrome), were treated to a high-quality program. This included a pre-conference workshop on musculoskeletal ultrasound, delivered by a group of Scottish rheumatologists (who have become regulars at the CAR). The main part of the program included basic science topics, updates on several diseases, clinical research presentations by regional rheumatologists, as well as talks aimed at developing research and clinical databases within the Caribbean. The second part sought to educate primary care practitioners on a number of high-yield rheumatology topics.

Of course, this would not be the CAR without a party (this is the Caribbean after all!). Dr. Amanda King, president of CAR, opened her home to a pool-side party for all attendees on the second night. The DJ (whose day job happens to be obstetrics and gynecology), filled the air with infectious soca music, and also taught the crowd to dance bachata. The conference was capped off with a visit to the majestic Pitons mountains and nearby beach on a party boat (what else?).

Despite the party though, no one lost sight of the core mandate – improving rheumatological care in the Caribbean. In addition to the geographic challenges of providing care to patients dispersed across islands separated by great breadths of ocean, and the fact that there are no



Bringing the CRA to the CAR:

Dr. Carter Thorne (Newmarket, ON), Dr. Amanda King (CAR President),
Dr. Raj Carmona (Hamilton, ON)

rheumatologists on many islands, there are several other challenges. Investigational modalities such as bone mineral density (BMD), computed tomography, and magnetic resonance imaging are not available on many islands. Some serologies have to be sent overseas. You only order it if you really need it - it's Choosing Wisely incarnated. The cost of biologics renders such therapy simply inaccessible to the vast majority of patients. Even traditional DMARDs impose a cost barrier to many patients. What they lack in resources though, the local CAR rheumatologists (assisted by North American counterparts with Caribbean roots) make up in passion. With this group, the future of rheumatology in the Caribbean is as bright as its sunshine.

So, if you don't mind planning awesome vacations around educational events, you should consider the CAR annual conference. This also presents the opportunity to contribute to the advancement of rheumatological care in an area that truly needs it. Never mind the great food, parties, warm sunshine and awesome beaches!

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The British Society for Rheumatology Annual 2018 Meeting

By John Thomson, MD, FRCPC

I first attended the British Society for Rheumatology (BSR) annual meeting in Birmingham, U.K., in April 2013. I wrote an article for the CRAJ regarding that meeting that same year (*CRAJ* 2013, Volume 23, Number 4). In that article, I recommended attending this meeting and stated that I planned to return myself. Subsequently I have attended the BSR annual meeting in 2014, 2015, 2016 and this year, in Liverpool, May 1-May 3, 2018. I am a man of my word!

This is the second time since I have been attending this meeting that it has taken place in Liverpool. Liverpool is England's fifth largest city with a metropolitan population of over 2 million. It is situated in the northwest of England near the Atlantic Coast on the estuary of the Mersey River. Liverpool has historically been an important port. There has been a revitalization and renewal of the old port area of Liverpool. The lovely convention centre where the BSR meeting is held is in this old port region, as are many restaurants, shops, and museums (including a Beatles museum!). There are lots of hotels close by making for an easy few-minute walk to the convention centre. The city and the people have lots of character. If you can understand the local Liverpoolians (or colloquially Scousers as they are also affectionately known), you will find them an engaging and humorous lot.

The BSR meeting usually occurs the last week of April. The meetings start on the Tuesday morning and finish the Thursday afternoon. In the six years since I first attended, the conference has taken place twice in Liverpool, twice in Birmingham, once in Manchester, and once in Glasgow (sadly I missed the gathering in Scotland, home of my ancestors). The timing of the conference, Tuesday through Thursday, makes it relatively easy and efficient to access from North America: a Sunday evening flight to London and Friday afternoon flight back. You can get anywhere in Britain easily by train from London.

Presenters were mostly from the U.K. There were around 2,500 attendees mostly from the U.K., Ireland, and Continental Europe. There was a sizable contingent of Middle Eastern attendees and I believe two Canadians (Henry Aaverns and myself – always nice to have a native Brit around to help me understand the highly unusual British culture!).

The scientific program was very high quality. It included the usual mix of posters, oral abstracts, symposia, and



Dr. John Thomson at the British Society for Rheumatology meeting in Liverpool.

keynote addresses. I very much enjoyed attending special interest group (SIG) sessions and found the interstitial lung disease and myositis SIGs particularly enlightening.

Obviously, I really enjoy and value this meeting. It is a very good meeting. Logistically it is much easier to “manage” than the larger international meetings such as EULAR and ACR. The overall cost of the meeting remains reasonable. The higher airfare cost to the U.K. is offset by somewhat cheaper accommodations in the relatively smaller cities in which the conference is held. Again, I recommend this meeting and I plan to keep attending. I hope to see you there!

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Rheumatic Immune-related Adverse Events Associated with Immune Checkpoint Inhibitors for Cancer: Coming Soon to a Clinic Near You!

By Carrie Ye, MD, FRCPC; Shahin Jamal, MD, FRCPC; Marie Hudson, MD, FRCPC



Case:

Anna is a 71-year-old lady with metastatic non-small cell carcinoma of the lung with progressive disease despite three months of traditional chemotherapy. PD-L1 expression on her tumour was > 50%, and she was therefore started on IV pembrolizumab (an immune checkpoint inhibitor [ICI] that targets PD-1), every three weeks. Following the second infusion, she developed pain and swelling in the left ankle. With subsequent pembrolizumab infusions over the next six weeks, her symptoms progressed to involve both shoulders, wrists, metacarpophalangeal (MCP) joints and proximal interphalangeal (PIP) joints. She did not have any other adverse events from her ICI therapy.

She was seen by rheumatology and found to have inflammatory polyarthritis with 11 swollen joints and 14 tender joints. Systems review and physical exam were otherwise unremarkable and she looked generally well. Her blood work showed C-reactive protein (CRP) 40.0 mg/L (up from a baseline of 5.0 mg/L prior to starting pembrolizumab), negative anti-nuclear antibodies (ANA), negative rheumatoid factor (RF) and negative anti-CCP antibody. Ultrasound confirmed synovitis in the wrists and MCP joints. She was started on hydroxychloroquine (HCQ) 400mg po daily, without prednisone. Pembrolizumab was held for one dose and restarted once her arthritis symptoms improved. Within two months of starting HCQ, she was entirely asymptomatic with no further tender or swollen joints. Ultrasound confirmed resolution of previously seen grey-scale and Doppler changes. Eighteen months later, her Stage 4 non-small cell lung cancer remains stable. She has successfully had 14 cycles of pembrolizumab (in combination with HCQ) with no recurrence of inflammatory arthritis.

Discussion:

Immune checkpoint inhibitors (ICI) are monoclonal antibodies that modulate immune signals and use a person's immune system to fight cancer cells. Targets of these antibodies include cytotoxic T-lymphocyte-associated protein 4 (CTLA-4) and programmed cell death 1 (PD-1). The success of these novel agents has been astounding, revolutionizing cancer care. People with previously refractory metastatic malignancies are now achieving stabilization of their cancer and, sometimes, long-term remission. Since the first ICI, ipilimumab, was approved for the treatment of metastatic melanoma in 2011, several others have followed for multiple tumour types, setting a new standard for cancer care. This therapeutic paradigm shift in oncology is akin to the shift that occurred in rheumatology with the introduction of the tumour necrosis factor inhibitors (TNFi).

While ICIs have been lifesaving, it is not surprising that when the natural "brakes" of the immune system are inhibited, significant and often severe, immune-related adverse events (irAE) can occur. The development of irAEs is common with a reported prevalence of up to 60% in monotherapy, and up to 90% when used in combination. They can affect essentially every organ system, most commonly the skin, gastrointestinal tract, endocrine glands, kidneys and liver. Rheumatologic irAE that have been reported include inflammatory arthritis (IA), spondyloarthropathy, polymyalgia rheumatic-like syndrome, inflammatory myositis, vasculitis, sicca symptoms, Raynaud's phenomenon and sarcoidosis. These irAE can occur at any time during treatment, may occur in isolation or in combination (particularly with other organ systems), and may or may not resolve with cessation of ICI therapy.

Although rheumatologic irAE often resemble classic rheumatic diseases, the majority of cases are seronegative, and the natural history and prognosis remain largely unknown. For example, we do not know whether untreated inflammatory arthritis associated with ICIs will lead to erosive or deforming disease. Is there an urgency for early and aggressive treatment? Should we be employing the “treat-to-target” strategy? There are also many important questions regarding optimal treatment, including the type and duration of immune-suppressing treatment to be used, the effect of disease-modifying anti-rheumatic drugs (DMARDs) on irAEs and whether immunosuppression interferes with the anti-tumour benefits of ICIs. The latter is of particular concern since most studies suggest that patients who develop irAE from their ICI also have better tumour response. By initiating immunosuppression, will we be hurting their chance of tumour response?

There is also a paucity of data on patients with pre-existing autoimmune disease and their “eligibility” for ICI therapy for cancer. In the majority of studies, patients with underlying autoimmune disease were excluded. As we know in clinical practice, our patients are often at risk for development of cancers, particularly melanoma. Should they still be eligible for this potential lifesaving therapy for their cancer?

Severity of irAEs is graded based on the Common Terminology Criteria for Adverse Events (CTCAE), a scale that ranges from mild toxicity (Grade 1) to fatal toxicity (Grade 5). Most musculoskeletal irAE reported to date are Grade 1 to 3, although more severe ones have been described. Arthralgias are reported in 4-22% of patients on ICI therapy, with an estimated 1-7% having IA.

The Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group put together system specific recommendations for managing toxicities associated with ICIs. For Grade 1 IA, they recommend continuing ICI therapy, and treating with non-steroidal anti-inflammatories (NSAIDs), prednisone 10-20mg daily, or intra-articular corticosteroid injections. Grade 2 IA warrants consideration of holding ICI, rheumatology referral and prednisone 20mg/day, increasing up to 1mg/kg/day as needed. Grade 3 IA requires holding of ICI, rheumatology referral, prednisone 1mg/kg/day and consideration of additional immunosuppression such as methotrexate, sulfasalazine, leflunomide and TNFi.

In our case above, Anna’s irAE would be classified as Grade 2 IA. Her ICI was held for six weeks (skipped one dose) when her arthritis was at its worst. Fortunately, she responded to hydroxychloroquine, did not require prednisone or other DMARDs and was able to re-start pembrolizumab without recurrence of her arthritis or onset of other irAE. She continues to have good tumour response.



The CanRIO group in Toronto in June 2018 for their inaugural meeting.

Although the SITC recommendations are a good starting point for the management of irAE, they are derived from expert opinion and do not specifically address rheumatologic irAE other than IA. There is a need for broader recommendations to guide rheumatologists treating these patients and studies to help define optimal therapy. Thus, the Canadian Research Group of Rheumatology in Immuno-Oncology (CanRIO), was formed this year, with our inaugural meeting held in Toronto in June 2018. We are a working group primarily comprised of rheumatologists from across Canada with an interest in irAEs of ICI therapy. We hope that this collaboration will lead to sharing of knowledge between centres, development of rheumatology-specific management guidelines, and studies that will allow us to better define the natural history and optimal treatment of rheumatologic irAE.

References and Suggested Readings:

1. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer* 2017;5(1):95.
2. Naidoo J, Cappelli LC, Forde PM, et al. Inflammatory Arthritis: A Newly Recognized Adverse Event of Immune Checkpoint Blockade. *Oncologist* 2017 Jun;22(6):627-630.
3. Postow MA, Sidlow R, Hellman MD. Immune-Related Adverse Events Associated with Immune Checkpoint Blockade. *N Engl J Med* 2018; 378:158-168.

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Choosing Wisely Canada Clinical Audit of ANA Ordering Patterns in Community Rheumatology Referrals

By Nadil Zeiadin, MD, CM, FRCPC; Henry Aaverns, MB, ChB, FRCP (Lond), FRCPC

Anti-nuclear antibodies (ANA) can be found in the sera of many patients with rheumatic and non-rheumatic conditions, as well as in healthy people. While the average sensitivity of ANA in patients with systemic lupus erythematosus is 93%, up to 20% of healthy people will also test ANA positive.¹ Consequently, the testing of these autoantibodies must be done in the right clinical context, to avoid both unnecessary testing and erroneous interpretation of results.¹⁻³

Members of the Canadian Rheumatology Association (CRA) recently identified ANA as a test that was often inappropriately ordered in adults.⁴ This can result in further unnecessary testing, erroneous diagnosis or even inappropriate therapy.¹ As well, unnecessary testing of ANA contributes further to the growing Canadian healthcare budget, which was estimated to reach 11.5% of the gross domestic product (GDP) in 2017.⁵

In an effort to decrease unnecessary testing, the CRA published recommended indications for ANA testing in 2015 as part of the Choosing Wisely Canada campaign.⁴ These recommendations were in keeping with guidelines published in 2013 by the Government of British Columbia (BC).⁶ Principally, the recommendations outline that ANA testing should be ordered only if the clinician feels there is a reasonable clinical suspicion of systemic lupus erythematosus (SLE) or connective tissue disease (CTD) based on historical information, physical findings, and results of other laboratory tests. While recommendations aim to reduce the frequency of ANA testing, they have been shown to carry a very low risk of missing an underlying case of CTD.⁷

Since the publication of the Choosing Wisely recommendations two years ago, we have sought to evaluate the ANA ordering patterns within our local referral network, composed primarily of general practitioners. Additionally, we wanted to identify how often a positive ANA result triggered a rheumatology referral. Lastly, we assessed whether raising awareness of published recommendations would alter ANA ordering patterns within our community.

Methods

We conducted a retrospective chart review of consecutive new referrals received using a convenience sampling method. We excluded referrals sent for a second opinion, repeat referrals

or referrals for a specific procedure (*e.g.* joint injection). We determined from the information provided in the referral whether an ANA was indicated based on published Choosing Wisely criteria and BC recommendations (Table 1). We also determined if the clinical question pertained specifically to a positive ANA, and thus, triggered the referral. Following our baseline data, we mailed an information pamphlet highlighting the published Choosing Wisely and BC recommendations regarding ANA testing to offices of general practitioners (GPs) in the surrounding community. We also conducted two in-house educational sessions for community GP's and nurse practitioners covering the same information as the pamphlets. We subsequently repeated our baseline analysis on a second independent sample of referrals received approximately two months following our intervention.

Results

We reviewed 100 consecutive new referrals from October 2016 to March 2017. Forty-six per cent (46%) of referrals had an ANA measured. Of these, 81% did not meet the recommended indications for ANA testing. Of the ANA's done without an indication, 59% were negative compared to only 33% of the indicated ANA's (Figure 1). Twenty percent of referrals

Table 1.

Recommendations for ANA testing

Indications for ANA testing

Patients with specific signs or symptoms of systemic lupus erythematosus or other connective tissue disease

ANA testing not indicated

Patients without at least one of the following symptoms:

- Pleurisy or pericarditis
- Photosensitive rash
- Laboratory evidence of renal disorder
- Hemolytic anemia, immune thrombocytopenia or neutropenia
- Skin changes of scleroderma, dermatomyositis or vasculitis
- Clinical and laboratory evidence of myositis
- Raynaud's phenomenon
- Neurologic signs

To confirm a diagnosis of rheumatoid arthritis or osteoarthritis

To evaluate fatigue, back pain, or other musculoskeletal pain unless accompanied by one or more of the clinical findings listed above

Figure 1.

Serum ANA Titres in Indicated vs. Non-Indicated Group

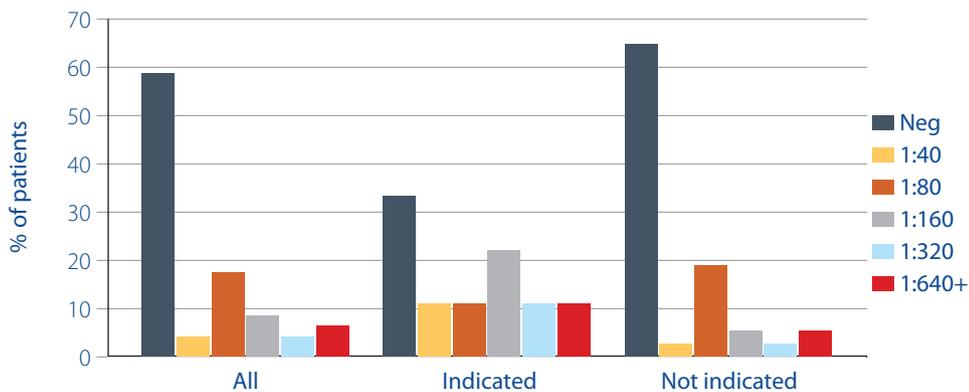


Table 2.

Pre- and Post-intervention Comparison

	Pre-intervention	Post-intervention	P-value
Age (SD)	53.1 (17.7)	56.1 (17.7)	0.194
Gender (% female)	61%	62%	0.906
Frequency of ANA (% referrals)	46%	48%	0.817
ANA indicated	19.5%	37.5%	0.046*
ANA mentioned in referral question	20%	20%	1.00
Indicated ANA mentioned in referral question	35%	70%	0.239

were requested primarily for interpretation of a positive ANA. Of these, 13 (65%) had an ANA test that was not indicated.

Following our intervention, we reviewed 50 consecutive new patient referrals using the same parameters as our initial sample. We found no significant difference in frequency of ANA testing; however, a significant improvement in the proportion of ANA's meeting indications for testing was noted (Table 2). There was no significant difference in the number of referrals for positive ANA, but again an overall trend towards improvement in adherence to recommended indications for ANA testing was observed.

Conclusion

We found serum ANA is frequently ordered among patients referred for rheumatology consultation. Despite published recommendations, we found that the majority of ANA testing is not indicated. This is consistent with results from other Canadian sites⁸ and the U.S.⁹ Apart from contributing to healthcare costs, we found that a large proportion of unnecessary ANA tests will also result in referral to the rheumatology clinic. This is of concern as access to rheumatologists is already limited within many parts of Canada, with wait times for patients with suspected rheumatic disease exceeding established benchmarks.¹⁰

With respect to reducing unnecessary ANA ordering, we found that raising awareness regarding the Choosing Wisely recommendations produced a significant reduction in the proportion of inappropriate ANA testing among our referrals. Nonetheless, there was no reduction in the frequency of ANA's ordered or the number of referrals for positive ANA. We suspect that this is most likely due to primary providers ensuring that they list an accepted indication within their referrals rather than ordering ANA less frequently. Thus, although further education for the use of ANA should be part of our strategy, a varied approach is likely required. Similar educational interventions have been successful to reduce the rate of unnecessary ANA testing among rheumatologists.¹¹

Other strategies, such as a laboratory algorithm for ANA testing, have also proven successful⁸ and should be considered. It is nonetheless clear that inappropriate ANA testing remains a common issue in rheumatology referrals and further research regarding both causes and effective intervention strategies is needed.

Limitations of our study include potential for observer bias. As well, conclusions regarding the intervention effect are limited due to lack of controls and potential for Hawthorne effect.

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References available online at www.craj.ca.

CRA Survey Results: Choosing Wisely

Choosing Wisely Canada is a national initiative to reduce unnecessary tests and treatments in health care using evidence-based data to support its recommendations. Started in 2012 in the U.S., it has grown into a global movement that seeks to empower health-care providers and patients to make wise choices in an effort to curb unnecessary testing and waste. This mandate is accomplished through partnerships with professional societies representing different specialties, medical associations and patient organizations.

For this issue's Joint Count survey, we asked CRA members for their thoughts on Choosing Wisely as it relates to rheumatology. Many respondents were already familiar with this initiative via the CRA Annual Scientific Meeting (ASM), word of mouth, and through the CRAJ and CRA emails.

When asked whether they were aware of the CRA list of 5 rheumatology recommendations to help physicians and patients choose wisely (available at choosingwiselycanada.org/rheumatology/), 66% of patients responded that they were already aware of these.

Queried as to whether they think the list of 5 rheumatology recommendations has changed their practice or will in the future, only a fifth responded affirmatively. While this may seem relatively low, many respondents noted that they already followed these guidelines and, therefore, had no changes to make.

Indeed, one commenter remarked that “the Choosing Wisely rheumatology list is probably more impactful for trainees and primary care physicians. The questions asking if I've re-evaluated do not reflect my feelings about The Choosing Wisely Campaign – I think it is great. But, I would suggest that most rheumatologists should already be doing those things in the list. The intended audience is important to consider in this survey.” For those whose practices had changed, this reflected being more careful about ordering ANA tests, as discussed in the article by Drs. Averno and Zeiadin in this issue (see page 26).

According to survey takers, barriers to implementation could include fear of missing a diagnosis and patient demands, though most commented that they already implemented the Choosing Wisely recommendations and that there were no barriers for them.

With that being said, nearly 80% of survey respondents weren't aware of patient information resources from Choosing Wisely Canada, and almost one-third were interested in learning more about this initiative. These patient resources can be found at choosingwiselycanada.org/resources/ and focus mainly on when to order a bone mineral density test and when to order biologic therapy.

Choosing Wisely in Rheumatology: 5 Things Physicians and Patients Should Question

1. Don't order ANA as a screening test in patients without specific signs of systemic lupus erythematosus (SLE) or another connective tissue disease.
2. Don't order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms.
3. Don't repeat dual energy X-ray absorptiometry (DEXA) scans more often than every 2 years.
4. Don't prescribe bisphosphonates for patients at low risk of fracture.
5. Don't perform whole body bone scans (e.g., scintigraphy) for diagnostic screening for peripheral and axial arthritis in the adults.

For more information on Choosing Wisely and the 5 recommendations, visit rheum.ca/resources/choosing-wisely/.

Chart 1.
Are you aware of the CRA list of 5 rheumatology recommendations to help physicians and patients choose wisely?

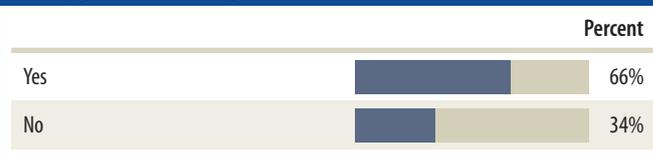


Chart 2.
How many times have you mentioned Choosing Wisely recommendations to a patient/trainee in the last week?

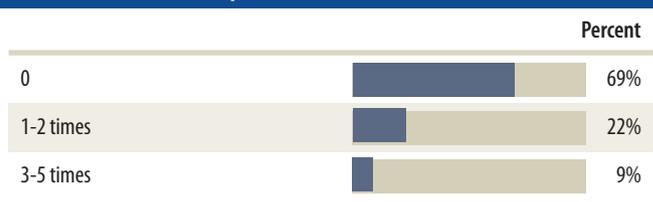
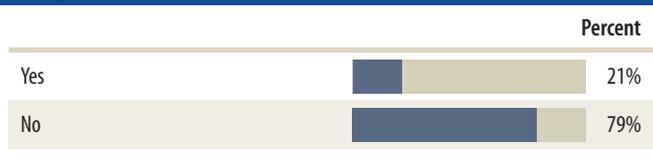


Chart 3.
Are you aware of patient information resources from Choosing Wisely Canada?





News from Manitoba

Update from Dr. Cory Baillie

Drs. Tim McCarthy and Cory Baillie are pleased to welcome Dr. Ada Man (as of July 2018), Drs. Ceri Richards and Mai Nguyen (as of November 2018) and Dr. Amber Cogar (as of January 2019) to their new practices at the Manitoba Clinic.

Update from Dr. David Robinson

After eight years as Section Head, Dr. David Robinson is stepping down to pursue other administrative roles in the Department of Medicine. Everyone was so pleased to see him go, they bought gifts including a number of very useful life-hacks. The scotch is gone so I guess I can't change my mind. Dr. Christine Peschken is stepping up to provide her excellent leadership skills to the Section.

After four years as Scientific Director of the Institute of Musculoskeletal Health and Arthritis (IMHA), Dr. Hani El-Gabalawy has returned full-time to the Section. While the Canadian Institute of Health Research (CIHR) gig was purportedly half-time he was travelling more than he was in town. The Section, his lovely wife Alda, and his two new grandchildren are happy to have him back. Finally, the section is happy to welcome Dr. Konstantin Jilkin to add to our clinical ranks.

Update from Dr. Kerstin Gerhold

The big news in these parts is our groundbreaking pain initiative "Every Child Every Time," to prevent and relieve pain in all children throughout the health region. This includes a collaborative clinic for chronic pain in children and adolescents. We have a new clinic for patients with systemic autoimmune and autoinflammatory diseases running in fourth gear. Overall, our patient numbers have almost doubled since 2014—and are still growing. Thankfully, we have a new excellent team of nursing, clerks, physiotherapists and occupational therapists in our clinic.



Building Bridges: From Rheumatology in Canada to Jamaica (Continued from page 18)

My tenure in Canada highlighted that, despite my country's many achievements, Jamaica is challenged with significant unmet needs within its healthcare sector, with the specialty of rheumatology being no exception. Notwithstanding these challenges, and despite the much-publicized infrastructure and air-quality issues at CRH, the rheumatology clinic, along with the other specialty clinics, is up and running in a safe and functional environment. As we look to a brighter future in healthcare with many new governmental initiatives on the horizon, Jamaica stands to benefit from collaborations with Canada for the training of rheumatologists, guidance with healthcare models including telemedicine, research collaborations, and visiting lec-

turers. Here's to hoping that the bridges built will expand and stand the test of time.

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Reference:

1. Pfizer Canada Inc. XELJANZ XR Product Monograph. December 11, 2017.
2. Health Canada. XELJANZ XR Notice of Compliance information.

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