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Reference: 1. Taltz Product Monograph. Eli Lilly Canada Inc., March 29, 2018.

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EDITORIAL

MAiD in Rheumatology

By Philip A. Baer, MDCM, FRCPC, FACR

"Without health life is not life; it is only a state of langour and suffering – an image of death."
– Buddha

"People fear death even more than pain. It's strange that they fear death. Life hurts a lot more than death. At the point of death, the pain is over. Yeah, I guess it is a friend."
– Jim Morrison

As I alluded to in our last issue, the applicability of medical assistance in dying (MAiD) to rheumatology may come as a surprise to many of our colleagues. While I followed the debate on euthanasia and assisted dying from the Sue Rodriguez case in the 1990s through the dying pleas of Dr. Donald Low and his wife Maureen Taylor more recently in 2013, I never really associated our specialty with this issue. My wife, who practiced palliative care medicine for decades, was far more likely to be involved, I thought. Certainly, no one was going to approach rheumatologists to actually provide MAiD services.

With the passage of Bill C-14 in June 2016 after the Supreme Court ruling in the Carter case, MAiD is a reality in Canada, now accounting for about 0.9% of all deaths, and over 2,000 deaths in total in the first year after legalization.[1] Cancer, neuro-degenerative disorders and circulatory or respiratory failure drive most requests. Controversies persist regarding MAiD for mature minors, those with psychiatric illnesses, and those who want to provide an advance directive fearing dementia or other incapacity.

The current law requires that adult patients must meet four criteria:

- Having a serious and incurable illness or disability;
- Being in an advanced state of irreversible decline;
- Enduring intolerable pain; and
- Facing a "reasonably foreseeable" death.

In 2017, an Ontario patient known as A.B. suffering from severe osteoarthritis with chronic pain applied for MAiD. She was initially turned down, as her physician did not feel that her death was reasonably foreseeable, as required by the law. She applied for judicial review, and Superior Court Justice Paul Perell ruled that a person does not need to have a terminal condition or be likely to die within a specific time frame to access medical assistance in dying. A.B.'s wishes were granted and implemented, with her death widely publicized, at least in Ontario, when it occurred in August 2017.

The latest development was reported on April 1, 2018, in The Globe and Mail.[2] In another somewhat controversial scenario, an elderly couple opted for a joint MAiD procedure, carried out in Toronto in the presence of two attending physicians and their families. This was only the second joint MAiD performed in Canada. Another couple had undergone the procedure four days apart on the advice of the CMPA, who were worried about the appearance of coercion of one spouse by the other in the case of a simultaneous MAiD procedure.

In this case, George and Shirley Brickenden were both well into their 90s and living together in a Toronto retirement home. According to the Globe, Mrs. Brickenden's body was "wracked by rheumatoid arthritis, an inflammatory condition that turned her hands into swollen purple claws." Combined with heart failure, the requisite two independent physicians concluded she was eligible for MAiD. However, she had to wait for her husband to deteriorate sufficiently, as only one of two physicians initially felt that his age and frailty alone qualified him for MAiD. After she broke her hip and he developed syncopal episodes, other heart issues and recurrent infections, they both were assessed as qualifying. Kelly Grant, the Globe reporter interviewing them and their family days before their planned deaths still found them "sharp, vibrant, and elegant …they seemed so happy…" and was perplexed by their plan to die now. However, Mrs. Brickenden called the reporter later to indicate she could not sleep "through rheumatoid arthritis pain that was like some sort of awful animal gnawing at her joints."

Within one year, two highly publicized cases of MAiD have focused on arthritic conditions. While pain is the cardinal symptom of arthritis, the portrayal of OA and RA as conditions warranting assisted dying may come as a surprise to most practicing rheumatologists. While more progress has been made in changing the natural history of RA than OA, I am sure most clinicians feel that we can deliver a management plan that can favourably impact pain, other symptoms, function and quality of life in both conditions for most of our patients. Yet we know that patient and physician thinking regarding RA may be discordant, as was highlighted by a recent Arthritis Society survey.[3] The lesson

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AWARDS, APPOINTMENTS, AND ACCOLADES

I (Dr. Kam Shojania) was honoured to have received the UBC *Fay R. Dirks Award for Excellence in Teaching* in 2017. I have been teaching medical students and residents for more than twenty years and am fortunate to have had outstanding teaching mentors and colleagues at UBC. Teaching is an important facet of our careers. Teaching forces us to keep up to date and improves our patient care. The interactions with trainees often result in important research questions. Our trainees later become our colleagues, and the bond that was forged by teaching them can last decades.

One piece of advice I have for my teaching colleagues is that you don't have to teach around a case with interesting clinical findings. Often the best and most memorable teaching moments can come from difficult patient encounters and our own mistakes.

Having spent my career in full-time patient care, the success and gratitude of patients is the most valued reward I (Dr. Bob Offer) could personally have imagined. My career has been very patient-centric, whether it be the patient in front of me or the need to bring about policy changes when these are required for patient care. For the latter I count as many failures as successes, so it came as a genuine surprise when I was presented with the 2017 *Wallace Wilson Leadership Award* by the UBC Medical Alumni Association. Nominees are judged on leadership and ethics.

While I have been blessed with many opportunities, great mentors and colleagues during my 49 years since graduation, I had considered myself less a leader than an advocate for best care. Over the years I served as Chief of Staff, President of Medical Staff, a member of community boards for arts, music, and sports, and medical advisor and director of the BC and Yukon Arthritis Society, as well as two terms on the CRA Board of Directors. My proudest achievements relate to developing the multidisciplinary arthritis program in Penticton which served as the main resource for the BC interior for many years, being a founding member of the Penticton High Schools' Scholarship and Bursary Foundation which raised more than one million dollars, and my 11 years managing and coaching an underprivileged girls' soccer team. Meeting community needs also spurred a BC Interior osteoporosis program and a fibromyalgia management program. From 2002 to June 2018, I initially chaired and remained committed to the BC PharmaCare Committee which adjudicates requests for biologic drugs, work that has been very worthwhile for individual patients and in breaking down the formidable barriers which formerly existed between the Ministry of Health and physicians. It is evident by this award that patient care and community medicine are valued, just as I value the colleagues and faculty members who have been so helpful during my career… a huge thank you to you all!

WELCOME TO THE RHEUM

Welcome to the following new members:

Ahmad Abdullah, Surrey, BC
Noura Al-Foraih, Edmonton, AB
Sangeeta Bajaj, Brampton, ON
Jan Willem Cohen-Tervaert, Edmonton, AB
Dalia Karol, Ottawa, ON
Ellen Miles , Vancouver, BC
Noura Mustapha, Montreal, QC
Amy Qi, Westmount, QC
Erkan Demirkaya, London, ON

Meet the CRA Team!

				
Name:	Sharon Brinkos	Virginia Hopkins	Claire McGowan	Christine Witlox
Role at the CRA:	Membership Engagement coordinator	Research & Technology coordinator	Project coordinator	Operations coordinator
Can you describe your role at the CRA?	• Working to break down CRA membership by segments so we can address specific needs of our members. • Sponsors – staff contact person for our Industry Sponsors.	I am responsible for the Research Committee; managing the CIORA Grant Competition and Abstracts; and updating the website and mobile app.	I provide support for all Operational Committees, Sub-Committees and Program Committees* and am responsible for membership communications and surveys. *excluding CRA Research, Abstract Review and CIORA Grant Review Committees	Some of what my role entails is directing the CRA's Summer Student Program, coordinating events and managing logistics as well as guiding best practices with respect to the organization's policies and processes.
When should you contact me:	Anytime you have any questions or require additional information – I will gladly put you in touch with the appropriate staff member if it isn't me.	You should contact me if you have any questions about CIORA, Abstracts, the website, mobile app or anything research or technology related.	Please feel free to contact me regarding any of the following: • Operational Committee inquiries • ASM, Residents' Pre-Course, FLIRT and NRRW programs • Membership communications (e-Newsletter, e-Blast and/or website requests) • Investigator-led surveys	I am the main contact for anything involving the Summer Student Program or event-related issues, but my line is open to anyone. My overall goal is to help the CRA operate as smoothly and efficiently as possible, allowing it to serve its members in the best possible way, so if I can't help I will find the person who can!
How long have you been at the CRA?	5 years as of June 2018.	6 ½ years	3 ½ years	I am a brand-new addition to the team, having started in March of 2018.
What do you love most about working for the CRA?	Working from home and my co-workers – we have a great team!	Everything! I really enjoy my job, working from home, my co-workers and the members.	The people I work with, both internally and externally. . . such an exceptionally dedicated and inspiring group of individuals.	I love the people that make up the CRA – from our Board Members to our operational staff. Everyone on the CRA team is so passionate about what they do, helpful and welcoming.
What is your favourite CRA memory to date?	I don't really have a favourite – great memories always come out of every ASM!	My favourite memory is spending the day after the ASM in Lake Louise with Sharon and Claire. We went for a horse-drawn sleigh ride along the lakeside trail and skating on the lake. It was the perfect way to end a very long and exhausting week!	A favourite recurring memory is the legendary dance floor at the ASM. . . always so much fun to watch everyone bust a move!	Hmm, I don't think I've been here long enough to have a favourite memory – I look forward to making many though!
If you could travel to any place in the world, where would you go?	Take an Alaskan cruise.	I've travelled to several breathtaking locations, but I still have Australia on my bucket list!	Nepal, it's my favourite place on the planet.	Italy and the Greek Isles one day – but in the meantime I'll take Disney World with my family in a heartbeat!!
If you had an extra hour in the day how would you spend it?	Cooking.	I'd like to do more volunteering.	Enjoying time at home with the people who matter most.	If I'm being honest – probably folding laundry! If I was daydreaming, definitely curled up with a good book.
All-time favourite quote:	"Don't do anything to anyone that you wouldn't want done to yourself."	"Reach for the moon and at least you'll land somewhere among the stars."	"When things don't go right, go left."	"When everything seems to be going against you, remember that the airplane takes off against the wind, not with it." – Henry Ford

Passing the Torch & a Presidential Address

Joanne Homik, Past-President of the CRA:

Now that there is a new President at the helm of the Canadian Rheumatology Association, I wanted to take this opportunity to reflect on my time with the organization. Taking on the role of President of the CRA was not a decision I took lightly. My predecessor, Cory Baillie, had left the CRA in a stronger position compared to how he found it because of all his hard work on governance and organization structure. Having been involved in the process, however, I felt equipped to assume the role of President with a clear understanding of my role and responsibilities.

Over the two years of my term, we have seen new challenges, as well as a lot of successes. There is a growing change to the sponsorship landscape, especially where it involves continuing medical education (CME) event planning. One of the reasons we did not follow through on the meeting in Mexico was the difficulty for all our partners to secure funding due to the location of the meeting. Even our usual Canadian location choices have been scrutinized under this process. Recent transparency initiatives in Ontario and *The Globe and Mail* article on Canadian Clinical Practice Guidelines have created greater awareness at the board regarding our role in maintaining the reputation of the CRA. This applies not only to our reputation among colleagues, but also as the general public sees us. We look forward to working within this new landscape with our new and familiar industry partners to continue to support our many initiatives.

We continued to provide excellent opportunities for education and networking for our members. Our annual scientific meeting is our premiere membership event, is highly rated by our members and stakeholders, and continues to grow in quality and size year after year.

The other significant task of the board this past year has been to oversee the change in organizational leadership. Our much beloved CEO, Christine Charnock, resigned from her position in May 2017. This necessitated not only a search for a replacement but a re-examination of our goals and priorities, so that we could identify the right individual for the position. Ahmad brings a fresh perspective and skill set to the role, and we are all excited to work with him.

It has been my honour to represent the membership as President of the Board over the last two years. I recognize that I am passing on to the new President, Vandana Ahluwalia, an organization that is still in transition, but I have full confidence in her ability to take the torch and run with it!

Joanne Homik, MD, MSc, FRCPC
Past-President,
Canadian Rheumatology Association
Associate Professor of Medicine,
University of Alberta
Edmonton, Alberta

Vandana Ahluwalia, President of the CRA:

Thank you, Joanne. Your work over the past two years at the CRA has developed a great foundation for the future of this organization.

The CRA's mission priorities include optimal care, workforce planning and management, building connections, research, stakeholder engagement and organizational viability. Annually, the CRA board sets the strategic priorities that reflect the membership's needs. This year, the three priorities that we will be focusing on are understanding rheumatology manpower needs; strengthening relationships with our major stakeholders; and ensuring organizational viability.

Based on our membership engagement surveys, we were tasked to understand the regional differences in rheumatology manpower and opportunities for employment. Our summer studentship program reports that 16% of those medical students that were exposed to rheumatology pursued rheumatology as a career choice. For this year, in order to continue to build on this success, in addition to industry support, we have secured funding for the research stream of this program from the government of Canada through the Canada Summer Jobs program. Our new HR chair and their committee's mandate will be to work on this priority over the next year.

Our organization continues to find ways to align our work with other major stakeholders, such as the AHPA, the AAC and The Arthritis Society (TAS). Furthermore, we need to understand how our expertise can help support other national organizations such as the pan-Canadian Pharmaceutical Alliance (pCPA) in this era of expanding therapeutics and escalating costs.

This is the year that the CRA takes full control over the board of the *Journal of Rheumatology.* We are excited about this new ownership opportunity which not only can help fund the activities of this organization but raises the profile of the association on the world stage. The sponsorship landscape is changing and we need to diversify our funding support. We are exploring innovative ways to ensure that we will have the support for all the ongoing and important activities of this organization in the future.

I will be the third female president in more than 70 years of this organization's existence. Our demographics are changing and more women are entering medicine. Our membership reflects this, with women accounting for 56% and men representing 44%. The learning and leadership styles of women will be different from their male counterparts. This needs to be taken into consideration when creating activities for our membership and programmes for leadership development.

Looking ahead, I am excited to work with our members, staff, partners and supporters to continue building on our incredible successes. I would like to help build an organization that is adaptable and ready to take on the challenges of the future, and I hope to anticipate and serve the evolving needs of our membership.

Vandana Ahluwalia, MD, FRCPC
President, Canadian Rheumatology Association
Former Corporate Chief of Rheumatology,
William Osler Health System, Brampton, Ontario

Interview with Ahmad Zbib: The New CEO of the CRA

Tell us a bit about your professional background?

The plan all along was to practice medicine, but then life happened. Right after graduating from med school and three months of internship in the ER and OR, I moved to Canada in 2003. Just like every other international medical student at the time, the road to certification and, in my case, residency, was fraught with lack of clarity, bureaucracy, expensive exams and endless discussions with people who just had nothing to offer me. Nevertheless, I decided to apply for residency in the United States. While preparing for the United States Medical Licensing Examination (USMLE), I got my first job with the Heart and Stroke Foundation. So, you can say, I have spent most of my career at mission-based organizations, during which I learned a lot and gathered skills that gave me what it takes to be interviewed here as the CEO of the CRA. I took on roles in research implementation, patient and public education, and digital health. I served on marketing leadership and strategy teams, led business development nationally and, most recently, as an executive lead for Canada's largest division at The Arthritis Society.

Can you tell us a bit about your work with The Arthritis Society (TAS)?

I started at The Society in a national role in business development – in fundraising – with responsibility for raising money primarily from corporations to help fund the mission of The Society. Shortly after my start, the Executive Director of the Ontario Division left the organization and that's when the CEO of The Arthritis Society tapped me on the shoulder and offered me the role. In that role, I led a team of fundraisers and program managers across Ontario; I had the honour of meeting people living with arthritis and learned first hand from them about how impactful these diseases can be. I was also inspired by their support of the cause to ensure that future generations stand a better chance at finding a cure.

You previously studied medicine, what initially drew you to a career in medicine?

As cliché as this may sound, I have always wanted to be a medical doctor – minus the phase when I almost gave my parents a heart attack when I declared I wanted to be a DJ. As far as I recall, I have always been fascinated by biology and being able to leverage my knowledge to help or heal others was very appealing. Growing up, I remember chatting with my dad about setting up a weekend clinic to help those less fortunate, and that was a great incentive for me to apply to med school.

Can you name a person or a mentor who has inspired you professionally?

I learned from my dad that you should always give more than you expect to receive, and this has always been a guiding principle for me professionally in every job I have had. I have learned from my mom that things happen for a reason and, if you just wait long enough, you will realize that a better option is around the corner. I had a few bosses who invested their time and resources in me, and that has shaped the person I am today.

What do you hope to bring to the CRA as CEO?

An almost obsessive attention to the wants and needs of our

current and future members, along with operational excellence, innovation and financial sustainability.

What have been the most rewarding aspects of this new role so far, and what have been the most challenging aspects?

Most rewarding is working with volunteers who are dedicated to the mission of this organization. Most challenging. . . working from home where you just never leave the office.

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

One of the biggest challenges I anticipate is a growing population without an increase in the number of rheumatology training spots. Add to that the fact that within the next 5-10 years, 30% of rheumatologists will be at retiring age. This will amplify the shortage of rheumatologists and, in turn, put a higher burden on already busy practices, which will only lead to increasing wait times for patients.

The CRA is already supporting multiple projects in models of care, which has the potential to alleviate this pressure. Furthermore, we are working on highlighting regional variations in access to rheumatologists; facilitating the discussion between trainees and community rheumatologists practicing in rural and underserved areas is another focus of ours.

If you had an extra hour in the day, how would you spend it?

Goofing around with my kids.

Ahmad M. Zbib, MD, CPHIMS-CA
Chief Executive Officer,
Canadian Rheumatology Association
Mississauga, Ontario

Editorial *(Continued from page 3)*

of these MAiD cases is not that rheumatologists will necessarily be much more involved in future MAiD cases, but that we may have to do better at examining the suffering wrought by rheumatic diseases from the perspective of our patients.[4,5]

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The CRA has launched a new and improved, mobile-friendly and easy-to-navigate website. See it here: ***www.rheum.ca***

Distinguished Rheumatologist:
Dr. Alan Rosenberg

Why did you become a rheumatologist? What or who influenced you along the way to do so?

As a medical student and pediatric trainee, I was startled each time I encountered a child with a rheumatic disease. Despite the dedicated care of many, it seemed that those children, debilitated by deformity and pain and whose afflictions were so poorly understood, deserved more. It was children afflicted with rheumatic diseases and their families, from whom I had the privilege of learning, who captivated and inspired my interest in pediatric rheumatology. I completed my pediatric residency at the University of Manitoba, fortuitously arriving there at the same time as Ross Petty. Ross, also a University of Saskatchewan graduate, after completing his pediatric and pediatric rheumatology training in Ann Arbor, returned to Canada to become this country's first formally trained pediatric rheumatologist. Ross's astute and compassionate patient care, his excellence in teaching, and his visionary and creative innovations were powerful influences that reinforced my passion for the discipline.

At the time I completed my training, there were many who believed that the discipline of pediatric rheumatology was unnecessary and silly. The late Dr. Don Mitchell, an adult rheumatologist at the University of Saskatchewan, thought otherwise. Don recognized that children and their diseases differed from adults in important ways and cajoled the Department of Pediatrics to recruit a pediatric rheumatologist. He was a memorable mentor during my formative medical school training and was influential in my returning to Saskatchewan.

The members of the Canadian pediatric rheumatology community are distinguished by an uncompromising commitment to the well-being of patients, to preparing the next generation of care providers, and to advancing knowledge through collaborative and creative research. So many of my pediatric rheumatology colleagues, too many unfortunately to mention by name, have been sources of inspiration, knowledge and wisdom.

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

Recent progress in both pediatric and adult rheumatology has been dramatic. We have our patients and families to thank for inspiring and contributing to this progress. Still, however, we are fundamentally far away from understanding these diseases. We do not know their causes, our understanding of their pathogeneses is still rudimentary, our treatments while dramatically better are still not as predictably effective or as safe as we desire, and we have no insight into cure and prevention. However, I believe that we are on the brink of a wondrous era of discovery, propelled by collective creativity and ingenuity and by astonishing new technologies that will expose the biologic, social, lifestyle, and environmental factors that conspire to produce disease. Achieving these transformative discoveries will be possible only by forging alliances with collaborators from an eclectic array of disciplines who will devise rationally-conceived and realistically achievable strategies for rheumatic disease cure and prevention.

As rheumatologists we must continue to accept the challenge to advocate with uncompromising vigour on behalf of our patients for the resources they deserve. As individuals and collectively through associations such as the CRA, we must advance the case that investing in rheumatic disease care, education and research will result in improved outcomes at lower patient, family and societal costs.

Our Canadian indigenous communities continue to be disproportionately burdened with rheumatic diseases. Effectively contending with the disturbing disparity in health

Dr. Alan Rosenberg receiving his award from Dr. Joanne Homik.

and healthcare for many indigenous peoples with rheumatic diseases remains a challenge. We must begin to engage more effectively with our indigenous communities and be guided by their wisdom and perspectives. Enticing young indigenous youth to pursue careers in healthcare in general and rheumatology in particular should be an important step to effective engagement and improved health.

What are the most important ideas which pediatric rheumatologists should impress on their adult rheumatology colleagues?

There is almost no disease that does not begin before it begins. That is to say, the origins of almost all disease, especially chronic diseases such as rheumatic diseases, have their origins long before the disease becomes overtly manifest. There is compelling and in many cases irrefutable evidence that the origins of those diseases is during childhood or prenatally. To improve and personalize patient care and to cure and prevent rheumatic diseases we must begin to invest more thoughtfully and vigorously in understanding the very earliest genetic, social, environmental, and lifestyle factors that influence rheumatic disease occurrence and outcomes.

As pediatric rheumatologists, we must be more attuned to our patients' long-term, adult outcomes so that we can effectively judge the future consequences of the interventions we choose for our pediatric patients. Promoting more cohesion between adult and pediatric rheumatologists will help optimize our pediatric patients' transitions to adulthood care and their long-term disease outcomes.

What do you most enjoy about living and working in Saskatchewan?

I was fortunate to return to Saskatchewan after my training. Although we had not anticipated remaining in Saskatoon for more than a few years we are, decades later, still happily ensconced in a thriving, vibrant, progressive community that teems with cultural and recreational activities. The academic environment is hugely supportive and is imbued with a powerful culture of collaboration. Having all the health sciences disciplines within the University campus and access to internationally renowned research facilities such as the Canadian Light Source offers unique opportunities for mingling with renowned scientists and unique technologies.

The warm, respectful prairie spirit is reflected in the colleagues with whom I work and the patients and families we have the privilege of serving.

Alan Rosenberg, MD, FRCPC
Professor,
Division of Pediatric Rheumatology
Department of Pediatrics
University of Saskatchewan
Saskatoon, Saskatchewan

Distinguished Investigator:
Dr. John G. Hanly

What was your first thought when you learned that you would receive this award?

I felt honoured and delighted to receive this prestigious award from the CRA, particularly in view of the calibre of previous recipients of the award. Being recognized by one's peers is the highest of compliments in an academic career. I also regarded the award as tangible recognition of the supportive research culture provided by my Division members at Dalhousie University, Halifax.

Why did you become a rheumatologist? What or who influenced you along the way to do so?

I have had the good fortune to work with many inspiring individuals, many of whom were rheumatologists in Ireland and in Canada. The individual most responsible for stimulating my interest in our specialty was Dr. Barry Bresnihan who was my supervisor during a two-year research fellowship in Dublin, Ireland (1982-1984). He was a gifted clinician and researcher with a strong commitment to advancing patient care through innovation and discovery. He was my mentor and friend up to the time of his untimely death at the age of 67.

What do you believe are the qualities of a distinguished investigator?

Excitement about one's subject, strategic planning with establishment of goals and milestones for success, persistence in the face of adversity, identifying good collaborators, mentoring of junior colleagues, perspective and a sense of humour.

Systemic lupus erythematosus (SLE) has been a major interest of yours, particularly its neuropsychiatric manifestations, but your work has touched on several areas of clinical rheumatology. With 230 publications to your credit, of which 150 are peer-reviewed original research, you have a notably prolific academic record. What are some of the major breakthroughs you've had with your research?

I do not claim to have had any "major breakthroughs" but I have attempted to advance the understanding of pathogenesis and clinical outcomes of rheumatic disease. In the field of neuropsychiatric SLE (NPSLE), my hope is that our work has provided a balanced assessment of both the positive and negative aspects of the illness and I hope that it will serve as a basis for future studies.

How do you manage your time to develop and publish so much original research?

Focus, persistence, prioritization and the good fortune to have excellent collaborators and supportive colleagues.

Are there other areas of interest you would like to investigate in the future? What projects will you be undertaking in the near future?

I continue to be interested in the nervous system manifestations of SLE. Currently, I am working with investigators at my own institution who have expertise in neuroimaging in order to gain insights into functional brain abnormalities in patients with SLE.

How does your research influence the clinical care of patients? What are you able to translate from research lab to examining room? What has been the most gratifying aspect of this knowledge translation?

Our studies on clinical outcomes of NPSLE have provided guidance for advising patients about what to expect from this particularly troubling manifestation of SLE and enhanced our abilities to manage it.

Dr. John Hanly receiving his award from Dr. Joanne Homik.

What have been the most rewarding aspects of going into the field of rheumatology and what have been some of the most challenging aspects?

The evolution of therapies for many rheumatic diseases from empiric compounds that were frequently ineffective to targeted therapies (biologics) with the ability to induce a sustained remission. Interacting with patients who cope so well with huge challenges imposed by their diseases. Terrific colleagues.

You were born in Ireland and obtained your medical degree at the National University of Ireland in Cork. Why did you eventually move to and stay in Canada? What do you most appreciate about Halifax?

Initially I came to Canada to gain additional training in rheumatology, but both my wife Noreen (also from Ireland and a physician) and I were open to the possibility of staying should the opportunity arise. Fortunately, we both obtained academic positions at Dalhousie University in Halifax and have never regretted our decision to sink anchor in this lovely part of the world.

You are marooned on a desert island? What book would you like to have on hand with you?

A year's subscription to *The Irish Times*, with the option to renew.

You are handed a plane ticket to anywhere in the world. Where do you go?

New Zealand – pristine countryside, great wine, fly fishing and rugby (All Blacks).

What advice would you give to someone looking to pursue a career as an academic rheumatologist?

If you like challenging cases, using clinical acumen to make a diagnosis, building relationships with patients who struggle with chronic disease, utilizing basic science to better understand illness, having novel drugs to induce and maintain clinical responses, working with great colleagues – then this is the one for you!

Your identical twin is a successful Canadian respirologist. How have you influenced each other in life and in your medical careers? Have you ever collaborated in research?

Siblings are usually close but identical twins are closer still. Although we are both keen to succeed in our respective fields, our professional endeavours have not overlapped. In contrast, our extracurricular interests keenly intersect when it comes to fly-fishing and rugby!

John G. Hanly, MD, FRCPC
Professor of Medicine and Pathology,
Research Director,
Department of Medicine and Division of Rheumatology,
Dalhousie University and
Queen Elizabeth II Health Sciences Center,
Halifax, Nova Scotia

Teacher-Educator:
Dr. Anna Elfiky Oswald

What do you believe are the qualities of a good educator? How do these apply to you?

I think a good educator is someone who has a long-term goal in mind, but is flexible enough to try different approaches based on the situation in front of them. I'm a real believer in teaching on the fly as we're running around looking after patients, using "justify" and "what if" types of questions. In the long game I want to make sure the students have the lifelong learning skills to identify problems that stump them in their practice and figure out a way to work it out using literature, resources and colleagues around them. I think teachers need to be willing to be vulnerable, to show their learners what staff do when things don't go their way or they don't know what is going on with a patient. That way we can all learn together.

Can you recall a teacher in your own past who inspired you and directed your own course into medical education?

I can think of so many, so it is hard to narrow it down. To name a few, I would say Evelyn Sutton who really took me under her wing and showed me how to be a great rheumatology educator; Steve Aaron who took the time and effort to share his network and link me with key players in the medical education field so I could thrive; and Paul Davis who gave me the courage to pursue my path in medical education as an academic career in a traditional research heavy university.

What was your first thought when you learned that you would receive this award?

I was truly delighted with the news, honoured to be joining the group of amazing educators who received this award before me, and grateful for the support of my colleagues here in Edmonton and nationally.

You hold a number of teaching and leadership positions. You are Clinician Educator for the Royal College of Physicians and Surgeons of Canada. At the University of Alberta, you are the Director of Competency-based Medical Education for the Faculty of Medicine and Dentistry (FoMD), as well as a coordinator for the Masters in Health Professions Education Curriculum Design course, and a co-director of pre-clerkship education for the MD program.

What aspects of teaching do you appreciate the most?

My favourite part of teaching is getting to know my students and residents over time and watching them at their "aha" moments as things start to click for them.

Can you tell us more about competency-based medicine?

Sure, competency-based medical education in residency is an approach to clinical training where training expectations are clearly linked to the skills needed in independent practice, where training experiences are organized progressively to allow residents to build on their existing skills, where clinical teachers give residents regular feedback to help them successfully acquire the skills, and then where teachers check if they actually can do what they are supposed to be able to do. For current teachers and programs that already give regular specific actionable feed-

Dr. Anna Oswald receiving her award from Dr. Joanne Homik and Dr. Stephanie Keeling.

back about how residents can improve their skills in the workplace and check that they have the skills they need, it won't be a huge shift, but for others I think it will really improve how we teach residents.

Given your extensive work in medical education, where do you anticipate medical education moving within the next decade?

I think in the next decade we'll see a lot more call for social accountability. In other words, I think there will be increased emphasis to ensure our graduates have the skills that are needed by the public and that they serve a larger range of our communities.

As a respected teacher-educator, what would your advice be to a prospective rheumatologist?

My biggest advice is to think carefully about the aspects of your job that you have enjoyed the most and then expand that area as a focus for your career – loving your job and looking forward to each day is an opportunity that is worth pursuing.

You are marooned on a desert island? What book would you like to have on hand with you?

Probably "Boat Building 101."

If you had an extra hour each day, how would you spend it?

Playing with my kids – tickle fights, dolls, board games, badminton, basketball, cards (but not Pokemon cards, I stink at that no matter how many times they try to teach me).

Anna Elfiky Oswald, MD, FRCPC
Associate Professor,
Division of Rheumatology
Department of Medicine
University of Alberta
Edmonton, Alberta

XELJANZ®
(tofacitinib citrate)

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

Simple, twice-daily oral dosing

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

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

Demonstrated efficacy where response to methotrexate alone 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).
This study was not designed to compare XELJANZ to adalimumab.

ACR response rates at 6 months

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

This study was not designed to compare XELJANZ to adalimumab.

The XELJANZ bottle cap was awarded the Arthritis Society's Ease-of-Use Commendation.

XELJANZ

Young Investigator:
Dr. Évelyne Vinet

What compelled/inspired you to become a rheumatologist and a medical-scientist?

My interest and fascination for lupus and other connective tissue diseases go back to how I came in contact, for the first time, with these conditions. As a medical student, the first patient I ever took care of suffered from systemic lupus erythematosus (SLE). And here, the word "suffered" has all its meaning. She was a 50-year-old woman who had developed SLE during her childbearing years. As most of her disease complications had already manifested when she was a young adult and had considerably impaired her life, she never married and never had children.

While I was rounding on her one day, her condition deteriorated quickly, and she kept telling me not to let her die, while I called the code team. I tried to resuscitate her, but she passed away. This woman and her condition made a big impression on me. Since then, I find nothing more gratifying than trying to better understand these conditions. And by attempting to do so, I think that, in a way, I'm not letting her down.

What would your advice be to a student considering the possibility of pursuing research into rheumatic diseases?

The same advice that Dr Henri Ménard once gave me: "Think outside the box". At first, I have to admit that what he said puzzled me, but eventually I realized what he meant; to make really novel discoveries, you need to think differently and find innovative approaches to problems. Not that easy though!

What are some of the highlights and challenges you have experienced thus far in your career? How have you overcome these challenges?

One of the highlights in my career is the extraordinary mentorship that I have received. I have been extremely privileged to have as mentors, two incredible women who are accomplished researchers, Drs. Sasha Bernatsky and Ann Clarke. I am particularly grateful to Sasha, who has always been there for me. There is no doubt that without her generous support and endless patience I would not have had the same success. Her commitment to help me succeed in my career has provided me with the best mentorship that I could have wished for. Sometimes, I tease her by saying that she is my Jedi master, showing me the way of The Force, keeping me away from the Dark side, like Yoda, but with better looks! I will always be in debt to her.

I remember a particular challenge, which came very early on, even before I started my career. When I was a resident, I was told that research would not be for me as I was a woman who wanted to have children. Fortunately, I persisted, and I was lucky enough to find two mentors who I could emulate. Both Ann and Sasha have shown me that it was possible to have a successful research career, while being a mother. They both have been extremely supportive when I had my two daughters.

In fact, my daughters Capucine and Eloïse are the highlights of my life. They know nothing about a Canadian Institutes of Health Research (CIHR) grant and they couldn't care less, but they have been my inspiration and my comfort at difficult times, helping me to put everything into

Dr. Évelyne Vinet receiving her award from Dr. Joanne Homik and Dr. Christian Pineau.

perspective, particularly after negative reviews and grant rejections.

Being so vital for me, my daughters made me realize how important it is to help our patients with rheumatic diseases be able to have the family they want. This has been the focus of my work over the past few years. And being a woman who wanted to have children made me pursue that goal. It did not limit my research opportunities; it helped me find my niche.

Évelyne Vinet, MD, PhD, FRCPC
Assistant Professor,
Divisions of Rheumatology and
Clinical Epidemiology
McGill University Health Centre
Montreal, Quebec

The 2018 Practice Reflection Award: Self-assessment

Co-winners of Gold
Shirley Lake, MD, FRCPC, MSc (QIPS); and
Natasha Gakhal, MD, FRCPC

Dr. Shirley Lake receiving her award from Dr. Joanne Homik and Dr. Raheem Kherani. Dr. Natasha Gakhal was not in attendance.

One of the challenges rheumatologists face is that rheumatoid arthritis (RA) patients get infections such as influenza. The Canadian Rheumatology Association (CRA) Guidelines for RA management recommends that all RA patients receive an influenza vaccination every year. An audit of our practice found only 40% of patients had documentation of vaccination for influenza. Along with the rheumatology trainees at the University of Toronto, we set out to raise the influenza vaccination rate of RA patients to at least 80% in one year. This project was completed as part of the rheumatology co-learning quality improvement curriculum, a program to teach rheumatology trainees about quality improvement and patient safety.

Initially we thought the low vaccination rate was only because rheumatologists were forgetting to remind their patients to get the vaccination. Another audit a few months later revealed no increase in uptake, and there was still no consistent documentation of patients being reminded to get the vaccine or receiving the vaccination. It's important to understand a problem first before rushing into a solution. We created a fishbone diagram and surveyed patients and this identified the most common reasons for patients not getting the influenza shot:

1) Patients did not know about the need for the influeza shot and its safety with their condition and while on their medication;
2) Patients did not know a convenient place to get the influenza shot; and
3) Rheumatologists were not reminding their patients due to forgetfulness or lack of time.

For our quality improvement intervention, we made a patient pamphlet to provide information on the need for the influenza vaccine. It also contained a walking map to the hospital pharmacy where they could not only refill their medications, but also receive the influenza shot. An audit showed this intervention only marginally improved uptake and was not sustained because the pamphlets were small and difficult to read. For our next Plan-Do-Study-Act cycle, we made the pamphlet more patient-friendly and also created neon stickers to be placed on prescriptions by the rheumatologist to remind pharmacists to administer the influenza vaccine when they renewed the patient's medications.

Our last audit showed that 60-90% of patients received the pamphlet and/or sticker and 65% of RA patients got the influenza shot. Although we did not achieve our 80% goal, we had a relative improvement of 60%. This continues to be a work in progress. More details on the process are described in the September 2017 edition of *The Journal of Rheumatology.*

Shirley Lake, MD, FRCPC, MSc (QIPS)
Assistant Professor,
Division of Rheumatology,
University of Toronto, Toronto, Ontario

Natasha Gakhal, MD, FRCPC
Rheumatologist,
Women's College Hospital,
Toronto, Ontario

RheumJeopardy! at the 2018 CRA ASM

By Philip A. Baer, MDCM, FRCPC, FACR

Gamification and rheumatology intersected for a third consecutive year at the 2018 CRA ASM in Vancouver. More than one hundred attendees actively participated in the traditional Friday afternoon timeslot for the event, using PollEverywhere technology. Once again, the audience was divided into East and West teams. Vinod Chandran, the winning team captain from 2017, chaired the session. David Robinson from Manitoba captained the West, and Rosie Scuccimarri from Montreal captained the East. Rosie brought boxing gloves for the pre-match captains' sparring session, and a dizzying array of hockey jerseys which she donned and doffed throughout the game. Toronto, Montreal and Ottawa were represented, and possibly others.

Categories this year included Rheumatology Potpourri, Rheumatology in Art, "Old Drugs, New Tricks", Osteoarthritis, Sight Diagnoses and Numbers. A new feature highlighted seven of the 30 questions as "Moderator's Favourites", which were my personal picks as the most interesting, challenging and/or humorous. The captains showed a distinct preference for the highest point value questions, however.

The CRA meeting theme this year was Personalized Medicine, which was featured in questions about tocilizumab as an antidote to side effects of CAR-T therapy in oncology, and on Medical Assistance in Dying (MAiD) for patients with osteoarthritis. The potential benefits of tequila for osteoporosis (a study from Mexico) and urinating in the standing position for women with knee OA (a study from China) were also explored. A question on pharmaceutical industry history confirmed that *Union Chimique Belge* (UCB) was started by Emmanuel Janssen, not the mythical Ulrich Carl Bilsberg, while Paul Janssen (no relation) founded Janssen Inc.

Drs. David Robinson and Rosie Scuccimarri battle it out during the pre-match captains' sparring session.

Dr. Philip Baer, host of *RheumJeopardy!* 2018, pictured with Dr. David Robinson (Team Captain of the West), Dr. Rosie Scuccimarri (Team Captain of the East), and Dr. Vinod Chandran (Chair of this year's event).

At the end of the allotted time, East led West 1,400 to 1,200 going into Final Jeopardy, which featured the traditional category of Famous Canadian Rheumatologists. This year's question paid tribute to those who have left us in recent years, including Drs. Jack Stein, Howard Stein, Bill Bensen and Jerry Tenenbaum.

Both teams wagered all they had, leaving the East victorious with 2,800 points and the West with the same score they had started the game with.

Special thanks to our captains and chair, and to Drs. Shelly Dunne and Shirley Tse for taking photos and keeping track of the questions used. Mark Atkinson and his technical team worked diligently to manage the required IT work, including a new feature which allowed us to hide the voting tallies until voting was complete.

Depending on the desires of CRA members and the ASM Planning Committee, and audience evaluations, we hope to be back for *RheumJeopardy!* at the 2019 CRA ASM in Montreal.

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

SPARCC: 2017 Meeting Summary

By the SPARCC Executive Committee

The Spondyloarthritis Research Consortium of Canada (SPARCC) facilitates knowledge transfer and dissemination of breakthroughs in spondyloarthritis (SpA) research by conducting annual scientific meetings and patient symposia in collaboration with the Canadian Spondylitis Association (CSA). In 2017, these events took place in Calgary, in a collaboration between the University of Calgary (spearheaded by Dr. Dianne P. Mosher) and the SPARCC Executive Committee.

In Calgary, SPARCC also conducted an event exploring new collaborative research opportunities. This highlighted important future directions in SpA research: (i) new disease taxonomies (ii) biomarker opportunities and challenges (iii) multi-omic platforms (iv) the gut-joint interface in chronic immune-mediated inflammatory conditions (v) advanced tools for imaging, and (vi) harnessing large databases for translational success. Members of the Snyder Institute and the McCaig Institute at the University of Calgary and SPARCC investigators joined forces in this initiative. In addition, a SPARCC Continuing Medical Education (CME) workshop for practicing rheumatologists was conducted, attended by rheumatologists and residents, nurses and allied health practitioners alike. This provided an update in the assessment of SpA, data collection and entry, and best practices for clinic policies and procedures. We shared the strategies used by SPARCC in the diagnosis and treatment of patients with ankylosing spondylitis (AS) and psoriatic arthritis (PsA), with a special focus on the role of new therapies. This workshop also covered the management of extra-articular manifestations of SpA particularly in the fields of dermatology, ophthalmology and gastroenterology. The outline of Calgary events was as follows:

- November 16th, 2017: Spondyloarthritis Research Workshop Building Blocks for a Precision Medicine Approach to Immune-mediated Inflammatory Diseases
- November 17th, 2017: SPARCC CME Workshop: (Optimal Management of Spondyloarthritis)
- November 17th, 2017: SPARCC Annual Scientific Meeting
- November 18th, 2017: SPARCC-CSA Patient Forum on Spondyloarthritis (SpA)

In addition, SPARCC expanded its horizons internationally and accepted the invitation of the Mexican College of Rheumatology (MCR) to partner in an international SpA symposium in Guadalajara, Mexico. This meeting focused on recent developments in SpA research, promoted interactions between clinicians and researchers, and prioritized future collaborative research goals.

SPARCC Pilot Projects

Since 2009, SPARCC provides seed funding annually to support research proposals aligned with its primary objective of advancing SpA-related research. These pilot project grants are awarded on a competitive basis to innovative proposals in the area of SpA research. The program is open to Canadian investigators and the maximum amount per award is $25,000 for one year; membership in SPARCC is not a prerequisite for submission. Priority is given to innovative new research themes in SpA with potential for capturing future peer-reviewed funding. For 2016-2017 periods, the following two pilot projects were funded and were discussed during the scientific meeting in Calgary November 17, 2017.

- Exploring the Disease-Modifying Effects of Psoriasis and/or Colitis on Disease Features and Severity in Axial Spondyloarthrits
  Principal Investigator: Sibel Zehra Aydin, University of Ottawa
  Co-investigators: Drs. Zaid Jibri and Sibel Ureyen

- Gadolinium Enhancement in Pediatric Sacroiliac Joint Magnetic Resonance Imaging: Is it Really Necessary?
  Principal Investigator: Dr. Dax G. Rumsey, University of Alberta
  Co-investigators: Drs. Jacob Jaremko, Shirley Tse, Jennifer Stimec, Vimarsha Swami, Nina Stein, Michele Batthish and Andrea Doria

The CRA (CIORA) TAS Clinician Investigator Award: Summary of Funded Work

Recipient of the 2015-17 CRA (CIORA) TAS Clinician Investigator Award:
Bindee Kuriya, MS, SM, FRCPC

Individuals with inflammatory arthritis experience significant psychological burden related to their illness. Mood disorders can negatively affect the disease course (*i.e.*, treatment response, treatment adherence) and significantly impact quality of life.

Rheumatoid arthritis (RA) and ankylosing spondylitis (AS) are the prototypical seropositive and seronegative conditions, each with differing clinical presentations and epidemiology. RA and AS are both associated with an increased risk of anxiety and depression. However, there are limited data on the risk of serious sequelae of mental illness, such as hospitalizations or deliberate self-harm attempts, for individuals living with RA or AS.

Our group was interested in studying this important clinical question. With the support of the CRA (CIORA) TAS Clinician Investigator Award, (on behalf of CIORA and The Arthritis Society [TAS]), we conducted two, retrospective, population-based cohort studies. We analyzed administrative health data for the province of Ontario between April 1, 2002, and March 31, 2014. Individuals with incident RA (N=53,240) and AS (N=13,964) were separately matched 1:4 by age, sex, and calendar year with comparators without RA or AS. We estimated hazard ratios (HR) and 95% confidence intervals (95% CI) for the risk of a first deliberate self-harm attempt (measured as emergency department presentations) in subjects with RA and AS compared to unaffected comparators, adjusting for demographic, clinical and health service utilization variables. We found that individuals with AS were significantly more likely to deliberately self-harm (crude incidence rate [IR] of 0.68/1,000 person-years [PY] versus 0.32/1,000 PY in comparators), with an adjusted HR of 1.59 (95% CI 1.156- 2.21). Deliberate self-harm was also increased for RA patients (IR 0.35/1,000 PY) versus comparators (IR 0.24/1,000 PY) before covariate adjustment (HR 1.43, 95% CI 1.16-1.75), but not after (HR 1.08, 95% CI 0.87-1.34).

From this preliminary work, we conclude that a diagnosis of AS, but not RA, carries a small, but significantly increased risk, for deliberate self-harm. Future efforts should focus on the characteristics of at-risk AS subjects and the health settings in which they seek care for mental illness to inform specific risk-reduction strategies. Additional work evaluating the types and patterns of mental health care use in RA and AS is ongoing and will help determine if targeted clinical or health policy interventions are needed in the care of patients with inflammatory arthritis.

Bindee Kuriya, MS, SM, FRCPC
Assistant Professor, Department of Medicine, University of Toronto
Director, Rapid Access Rheumatology Clinic
Toronto, Ontario

You are invited to submit abstracts for presentation during the 2019 CRA Annual Scientific Meeting and AHPA Annual Meeting!

Deadline for submissions is October 12, 2018.

Details will be available at ***www.rheum.ca.***

The Tale of a Snake-charming Rheumatologist

By Raman Joshi, MD, FRCPC

Sammy was a snake who lived a long, long time ago — the turn of this millenium. He wasn't one of those venomous snakes that could kill you, or that could squeeze you to a miserable death. He was a garter snake, and as far as garter snakes went, he was a good garter snake. But recently, Sammy was a sick snake. First, he started getting red rashes all over, then his eyes turned red and hurt, and he could barely keep them open. Then his back started to hurt.

This is a problem if you're a snake, because you're basically *all* back. Soon, it was hard for Sammy to slither around and catch mice, shrews and bugs to eat. He could barely sleep, because he kept waking up through the night with his aching back, which was basically his whole body. And, in the morning, when the mice and shrews were easiest to catch, Sammy was stiffest and sorest, and couldn't catch them!

Starving and lonely, Sammy started feeling sorry for himself. Once before, when he had felt this sad, he had coiled himself up into a circle and slept, and woke up feeling better the next day. But now he couldn't do that, and he was straight as a pole!

Not even the thought of visiting Swweet Sssinthia made him feel better. Seven days before his troubles started, he had visited her for a playdate and a sleepover. She might be able to make him feel better, but the thought of slithering across town to visit her was just too much to contemplate.

Sammy, the snake.

Sammy found a big box and slid into it, thinking that at least it would keep him warm and dry for the night. However, this was no ordinary box. In the box was a flat-screen television. The next morning, Sammy rolled and rattled around his new box. Bruised and battered, he peered through a hole in the box to discover that he was in the office of a group of rheumatologists — the kindest and wisest of all doctors! They had purchased the big screen TV to watch videos and learn how to better inject all manners of weird and obscure joints (in their spare time). Sammy pulled back from the edge of the box not a moment too soon, for an instant later, an X-Acto knife sliced its way down the edge of the box, and Sammy rolled out into the middle of the room."What's that stick?" asked one of the secretaries as she stepped toward Sammy.

"AAAH!! A snake!" another yelled, jumping atop a chair. Sammy, stiff as a pole, just lay there, flicking his tongue out occasionally.

Soon, all six of the secretaries were standing on the chairs in the waiting room, screaming.

"Hey, let's cut him up and fry him for lunch!" one of the secretaries finally said. After all, it was lunch time for the humans.

"I don't want to eat snake!" said another, the others nodded along with her.

"What's going on here?" asked one of the rheumatologists, entering the room, hearing the commotion. She saw the secretaries all standing on chairs, and followed their gaze to the centre of the room, where her eyes lighted upon Sammy.

"A snake!" How did he get here?"

"He was in the box that the new TV came in!"

"He's hurt!" said the rheumatologist, gingerly taking a step towards him. She bent down and picked him up by the back of the head, as she had seen a snakecharmer do once when she was a kid.

"He's stiff as a pole!" she said.

By this time, the other rheumatologists in the office had gathered around.

"It's a garter snake."

"I've never seen such a thin snake."

"He must be starving."

"What are we going to do with him?"

They all looked at each other and realized that, being rheumatologists, they lacked the financial resources to take him to even an ordinary veterinarian, let alone a snake specialist. But, being amongst the wisest of physicians, and with some considerable experience dealing with back pain amongst them, they knew they would figure out what to do.

"We better get him something to eat first. What do snakes eat anyway?"

"They're carnivores — rats, grasshoppers, shrews" said one.

"We don't have any of those here."

"Hey, maybe we can find something from the drug lunch yesterday," said one of the rheumatologists, running to the fridge in the back room.

Sammy could smell the chicken even before the man came back. This rheumatologist, Sammy thought to himself, was different from the others. Not only was he the only male rheumatologist there, and ruggedly handsome in a human kind of way, but he had a certain cunning that only he, as a snake, could sense.

"This is chicken from yesterday's lunch," the man said. "I warmed it up and cut it into little pieces for him." Sammy's soul stirred as he wolfed down the chicken. From that day on, even though the doctors were all vegetarians, they made sure they brought something non-vegetarian to lunch, which they later shared with Sammy. They decided to keep him in the back room in a little box, so that patients wouldn't see him and get scared. Using techniques and therapies they and other rheumatologists like them had used for millennia, they slowly helped Sammy regain some of his strength and energy — yet Sammy remained stiff as a pole, and was beginning to think that this might represent his future life…forever.

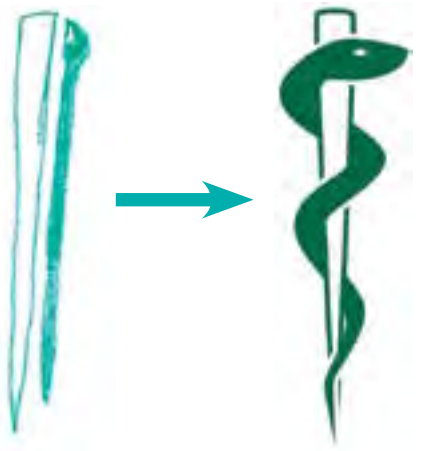
However, this was the dawn of a new millennium. And the rheumatologist who had fed him chicken the first day had an idea. For in this golden new millennium, new molecules had been discovered. Marvellous molecules that could help humans with problems much like Sammy's. If these molecules could help humans, perhaps they could do the same thing for Sammy. So he obtained some of these molecules, carefully put Sammy on a scale, and calculated how much of the medicine he should give Sammy. With aseptic technique, he divided the dose a human normally takes in a month into a two-year supply for Sammy, and gave him the first injection (Phase 1 study, first-in-snake trial, N of 1).

Within a few weeks, Sammy was feeling much better, and was able to move like he had when he was a young snake. Everyone was so happy! Even the secretary who wanted to fry him for lunch!

And so, over the winter months, Sammy continued to get more and more agile and faster. When the winter snow gave way to the warmer, longer days of springtime, and his X-rays had returned normal, the rheumatologists decided it was time to set Sammy free. With equal measure of joy and sorrow in their hearts, they watched as Sammy slipped across the parking lot through the grass, to the school next door. Ordinarily, a snake appearing at school would be a source of fear and tears for the little children. But this is a happy story, and Sammy's presence made the children laugh and play. Sammy lived in the playground until a ripe old age.

As for the rheumatologists, Sammy not only made them happy when he was there, but long after he left. Shortly after Sammy left, the rheumatologists decided to make a new sign for their practice. One of them wanted to put a drawing of a knee degenerated from years of heavy work. Another wanted to show a picture of a spine fused like bamboo. Others wanted to put up a picture of a syringe. The best idea, the one they all liked and would all remember, was the idea from the male rheumatologist. Tired of telling people what had happened with Sammy, he decided to make it visible.

At a glance, everyone would know that Sammy with his fused spine had been helped back to full health. Coincidentally, the symbol also turned out to be an ancient symbol of the medical arts.



The rheumatologists' new symbol became so popular that many pharmaceutical companies started to approach them. One eventually bought the rights to the drawings from the rheumatologists. The rheumatologists took this money and kept it in their medical professional corporations, where it continued to grow and allowed them all to retire quite comfortably at an age earlier than even the cardiologists, and to send their children to really good schools. Perhaps this is not unsurprising, since if you look at the symbol they had created,

it also looks a bit like another symbol. . . $

Ultimately, even though many of the rheumatologists' patients did not suffer as much as Sammy; and although many patients did not do as well as Sammy, many patients did do well with their treatments. And this knowledge, beyond any other and beyond the money they had made, gave the kind rheumatologists great joy and satisfaction, few others had the privilege to experience.

Raman Joshi, MD, FRCPC
Rheumatologist,
Brampton, Ontario

From the Arthritis Society:

Tools to Help Patients Understand Their Treatment Options

For patients living with inflammatory arthritis, the range of treatments can be confusing. These resources from the Arthritis Society can help your patients better understand their treatment options:

Inflammatory Arthritis Medications Simplified

This whiteboard video provides a high-level explanation of what inflammatory arthritis is, how the different medications that are used to manage inflammatory arthritis work, and what the patient can expect. Find it at *arthritis.ca/healthcare-professionals/professional-education/tools-and-resources.*

Biologics and Biosimilars for the Treatment of Inflammatory Arthritis

If your patient needs more information about biologics and biosimilars in particular, this online resource provides answers to twelve of the most common questions around these medications. Check it out at *www.arthritis.ca/biologic.*

For more information about how the Arthritis Society supports your patients, come visit us at *www.arthritis.ca.*

CRA Survey Results: Education and CPD

Continuing professional development (CPD) is an important part of being a rheumatologist. CPD activities help keep rheumatologists up to date with the latest developments and advances in the field. For the summer 2018 issue of the *CRAJ*, the CRA Education and ASM Program Committees teamed up to conduct a survey about members' CPD activities.

More than a third of the survey respondents indicated that the role the CRA plays in their CPD activities was significant, with another 39% answering the role was modest. According to members, the top 5 CPD activities for Sections 1 and 2 were national/international meetings, journal articles, grand rounds, journal clubs, UptoDate, and regional/local meetings (Chart 1). With regard to Section 3 credits, the top-rated activities were university-related, self-developed, CRA-related, or related to the Royal College or provincial colleges (Chart 2).

When asked about their top priority areas for medical expert CPDs, the most popular response was new treatments, followed closely by new drugs or new applications of existing drugs (Chart 3). Concerning non-medical expert CPDs, the highest-rated priorities were quality care and patient safety (Chart 4). Fifty-six percent of participants rated health economics and health policy as a second priority.

Finally, when queried about how the CRA could further assist with CPD requirements, members noted that advice and options for Section 3 credits would be of great help. Indeed, the CRA Education Committee Chair (Dr. Raheem Kherani) has recently co-authored a series of articles for *CRAJ* (CPD for the Busy Rheumatologist) available at *craj.ca*. The articles in the series are as follows:

- "Practice Reflection: Can I Improve My Patient Outcomes with MOC Section 3 Credits?"
- "Effective and Efficient Clinical Learning: Is Real-time Learning Possible to Build Your MOC Credits?"
- "What Makes a Good Triology: Maximizing Your Learning and Building Your MOC Credits"

The CRA Education and ASM Program Committees work closely throughout the year to incorporate the recommendations and needs of the CRA membership into ongoing programming and the ASM, which will be hosted in Montreal in February 2019. For any additional feedback or comments on CPD, you may contact Claire McGowan at *cmcgowan@rheum.ca*.

Chart 1. **Top 5 Sections 1 and 2 CPDs**

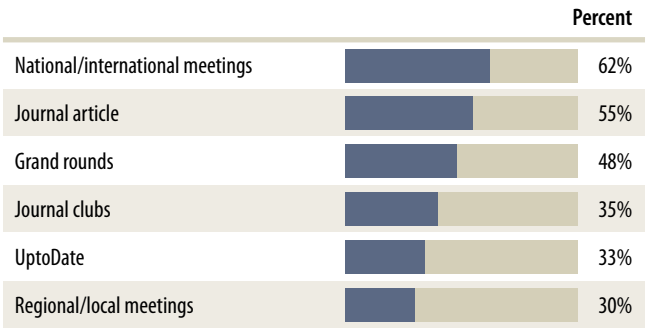


Chart 2. **Top 5 Sections 3 CPDs**

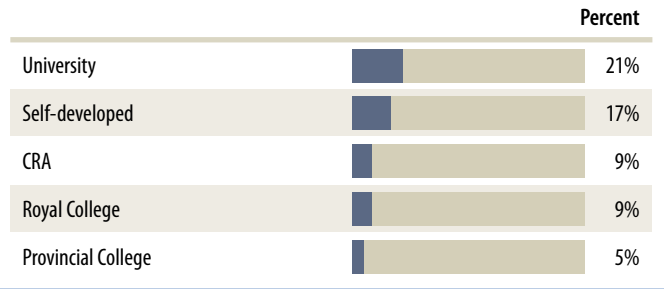


Chart 3. **Top 3 Priority Areas for Medical-expert CPDs**

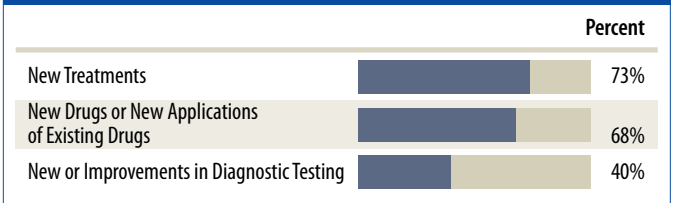
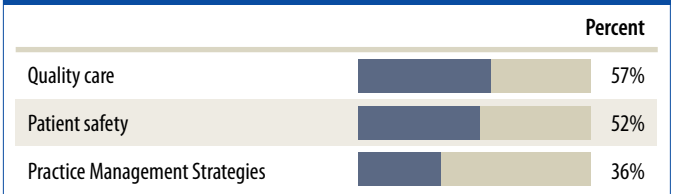


Chart 4. **Top 3 Priority Areas for Non-medical-expert CPDs**



News from Saskatchewan

Update from Dr. Regan Arendse

2018 has been an eventful year for the rheumatologists in Saskatchewan. We are excited to have recruited Dr. Myat Tun Lin Nyo in July 2017 from South Africa. Dr. Nyo brings with him a wealth of experience and expertise in musculoskeletal ultrasound. He has joined Dr. Regan Arendse in the newly formed Community Rheumatology Care clinic in downtown Saskatoon. Dr. Dale Peffer is a family physician who does sessional work with Drs. Nyo and Arendse and provides counselling on the use of biologic and disease-modifying antirheumatic drug (DMARD) therapies for inflammatory disease in the practice. He also undertakes minor surgical procedures including skin punch biopsies. The Community Rheumatology Care clinic eagerly awaits the arrival of the soon-to-be qualified rheumatologist Dr. Richard Tse in July 2018 who will add to rheumatology capacity in the province.

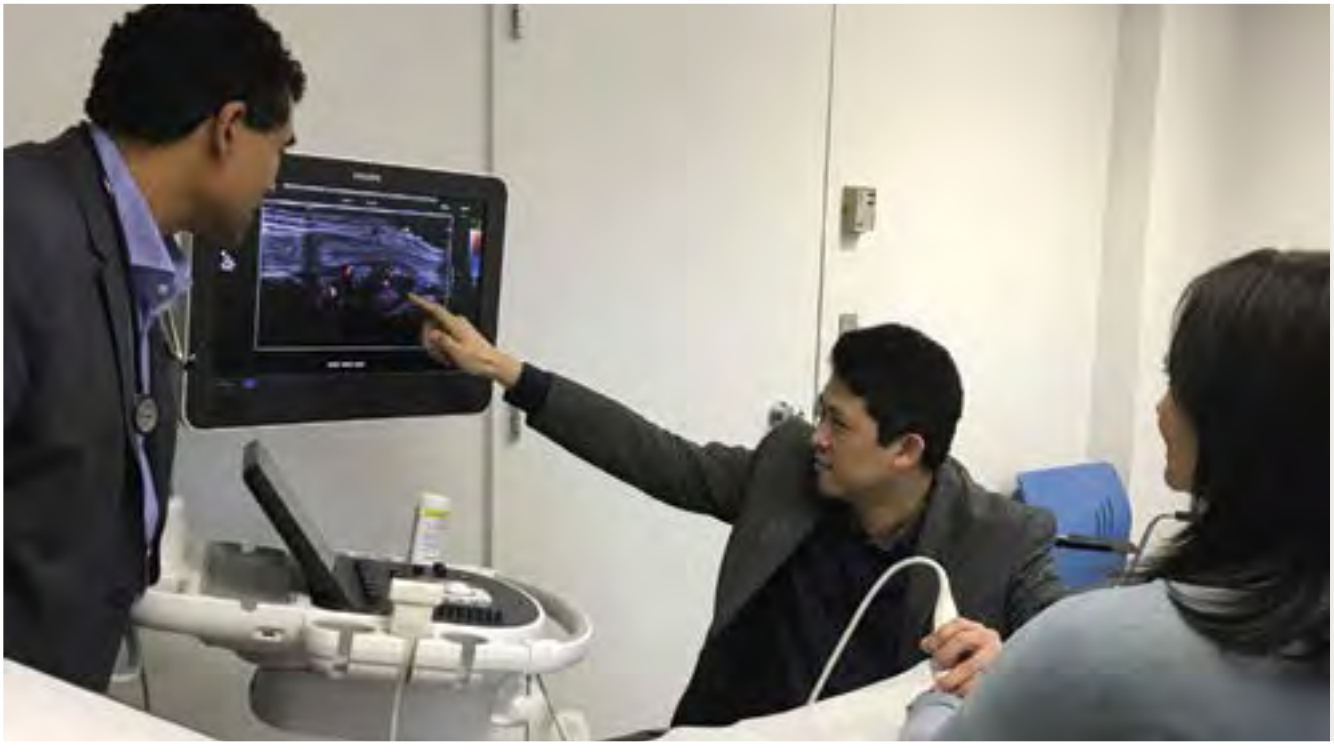
– Regan Arendse, MD, FRCPC

Update from Dr. Bindu Nair

Our grand rounds are now a provincial affair with videoconferencing connecting us (ten rheumatologists in Saskatoon and three rheumatologists in Regina) on a weekly basis to discuss educational, clinical and research topics. Videoconferencing also allows us to meet as a provincial group for quarterly business meetings, which are led by Dr. Regina Taylor-Gjevre, Head of Rheumatology of the Saskatoon Division.

On May 5, Dr. Latha Naik chaired the Rheumatologists of Saskatchewan (ROS) meeting and we were pleased to have Dr. David Robinson from Manitoba provide the keynote talk. New undergraduate educational initiatives were introduced and rated highly satisfactory by medical students including a Joint Injection Workshop hosted by Dr. Regina Taylor-Gjevre and Dr. Bindu Nair in Saskatoon, and Dr. Nicole Fahlman and Dr. Ardyth Milne in Regina.

– Bindu Nair, MD, MSc, FRCPC



Dr. Tun Nyo (middle) and his colleagues discuss an ultrasound.

Tribute to Dr. Sydney Gershon

The Division of Rheumatology in Toronto lost one of its senior statesmen on April 30, 2018, with the passing of Dr. Sydney Gershon.

Dr. Gershon graduated from the University of Ottawa in 1966. He was the first rheumatologist to join the staff at St. Michael's Hospital (SMH), holding a Courtesy Staff appointment from July 1973 until his recent passing. From all descriptions, he brought rheumatology care to SMH and set the foundation for the division as it currently exists. For his first nine years at St Mike's, he managed a five bed in-patient rheumatic disease unit, performed all the in-patient consults and delivered undergraduate and postgraduate teaching. Dr. Gershon was joined by (I am told that he hired) Dr. Rachel Shupak in 1982, setting the stage for the others to join over time.

More recently, Dr. Gershon, in addition to his courtesy privileges at St. Michael's Hospital, was on staff at West Parry Sound Health Centre and continued his active office-based practices, both locally and in the North.

The unifying theme from all who knew him highlights his absolute joy in practicing medicine – he loved to learn and he loved to meet people. He practiced true patient-centred care, working to avoid long waiting lists, seeing patients when they perceived their needs were greatest and coaching patients as they navigated the health care system.

He was recognised for his generosity as a Pioneer in the Jonas Salk Circle of Friends, which celebrates extraordinary philanthropy. Twice yearly, Syd would fly to northern clinics in Timmins and Kirkland Lake to see patients for a few days, starting early in the morning and continuing to late in the day. He described his joy in meeting people from the North, hearing their stories and helping them. He did this for 45 years with his billings for all those visits going to the March of Dimes.

To all colleagues who knew him, Syd will be remembered for popularizing the homunculus and flow charts on patient records, but he will be especially remembered for his collegiality and dedication to his patients. Our division is saddened by his passing.

Collectively, we extend our deepest sympathy to his family, and also to his patients.

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

A monoclonal antibody that selectively binds interleukin-17A (IL-17A)[1]*

CONSIDER YOUR NEXT MOVE IN PsA TREATMENT

Taltz is indicated for the treatment of adult patients with active psoriatic arthritis who have responded inadequately to, or are intolerant to one or more disease-modifying antirheumatic drugs (DMARD). Taltz can be used alone or in combination with a conventional disease-modifying antirheumatic drug (cDMARD) (e.g., methotrexate).

Explore the efficacy results in ACR and PASI response

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ACR RESPONSE

AT WEEK 24

58% of Taltz 80 mg Q4W patients achieved **ACR20** vs. 30% on placebo (p<0.001; n=107 and 106, respectively)[1]

58%

AT WEEK 1

21% of Taltz 80 mg Q4W patients achieved **ACR20 as early as week 1** vs. 7% on placebo (p=0.004, unadjusted; n=107 and 106, respectively)[1,2]

21%

AT WEEK 52 (extension study)

81% of Taltz 80 mg Q4W patients who **achieved ACR20** at week 24 **maintained this response to week 52** (n=62)[1,3]

81%

PASI RESPONSE (secondary endpoint)

AT WEEK 12

75.3% of Taltz 80 mg Q4W patients with coexistent plaque psoriasis (≥3% BSA psoriasis skin involvement at baseline) achieved **PASI 75** vs. 7.5% on placebo (n=73 and 67, respectively)[1]

75.3%

Speak with a Lilly Representative about Taltz and its clinical studies, such as SPIRIT-P1 and SPIRIT-P2, at 1-888-545-5972 or visit lilly.ca/taltzPM/en.

Relevant warnings and precautions:

- May increase the risk of infection and should be used with caution in patients with clinically important chronic or active infection.
- Tuberculosis (TB): Should not be given to patients with active TB. Evaluate for TB infection prior to initiating treatment. Initiate treatment of latent TB infection prior to administering Taltz. Consider anti-TB therapy prior to initiating Taltz in patients with a history of latent or active TB and in whom an adequate course of treatment cannot be confirmed. Monitor patients closely for signs and symptoms of active TB during and after treatment with Taltz.
- Serious hypersensitivity reactions, including anaphylaxis, angioedema, and urticaria, have been reported in Taltz-treated patients in clinical trials.
- Caution should be exercised in patients with inflammatory bowel disease, including Crohn's disease and ulcerative colitis; monitor patients who have inflammatory bowel disease.
- Prior to initiating therapy, consider completion of all age appropriate immunizations; patients treated with Taltz should not receive live vaccines.
- No clinical studies have been conducted in pregnant women to establish safety during pregnancy.
- Caution should be exercised when administered to nursing women.
- No data are available on the effect of Taltz on human fertility.
- Safety and effectiveness in patients <18 years of age have not been evaluated.
- There is insufficient data to determine whether patients ≥65 years of age respond differently from younger patients.

For more information:

Please consult the product monograph at www.lilly.ca/taltzpm/en for important information relating to adverse reactions, drug interactions, and dosing information which have not been discussed in this piece. The product monograph is also available by calling us at 1-888-545-5972.

ACR20=improvement in American College of Rheumatology response criteria ≥20%;
PASI 75=improvement in Psoriasis Area Severity Index ≥75%.

* Clinical significance has not been established.

† SPIRIT-P1: 24-week (extended to 52-week), multicentre, randomized, double-blind, placebo-controlled, active-reference trial of 417 adult patients with active psoriatic arthritis despite nonsteroidal anti-inflammatory drug, corticosteroid or disease-modifying antirheumatic drug therapy, at least 1 disease-related definite joint erosion on hand or foot x-rays or C-reactive protein (CRP) >6 mg/L, and active psoriatic skin lesions or a documented history of plaque psoriasis. Patients were randomized to: Taltz 160 mg followed by 80 mg every 2 weeks; Taltz 160 mg followed by 80 mg every 4 weeks; adalimumab 40 mg every 2 weeks (active reference arm); placebo. Patients who received placebo or adalimumab were re-randomized to Taltz 80 mg Q2W or Q4W at week 16, if they were inadequate responsers, or at week 24. Primary endpoint was the percentage of patients achieving ≥20% improvement in ACR criteria (ACR20) at week 24.
Baseline characteristics: The mean age was 49.5 years, 46.0% were male, 85.3% were cDMARD experienced, 64% were currently using cDMARDs and 54.2% reported current methotrexate use. Overall, 69.5% had psoriasis involving ≥3% of BSA, 58% had enthesitis and 37.6% had dactylitis at baseline. Mean (SD) baseline PASI total score was 6.2 (7.5) in the placebo group, 6.9 (6.6) in the Taltz every 4 weeks group, 6.0 (7.0) in the Taltz every 2 weeks group, and 5.5 (6.5) in the adalimumab group.

References: 1. Taltz Product Monograph. Lilly Canada Inc., March 29, 2018. **2.** Data on File [t_acrcat_nri_itt_db-RHAP]. Eli Lilly and Company; 2016. **3.** Data on File [ad8_t_acr_cat_nri_msp_ex-RHAP]. Eli Lilly and Company; 2016.

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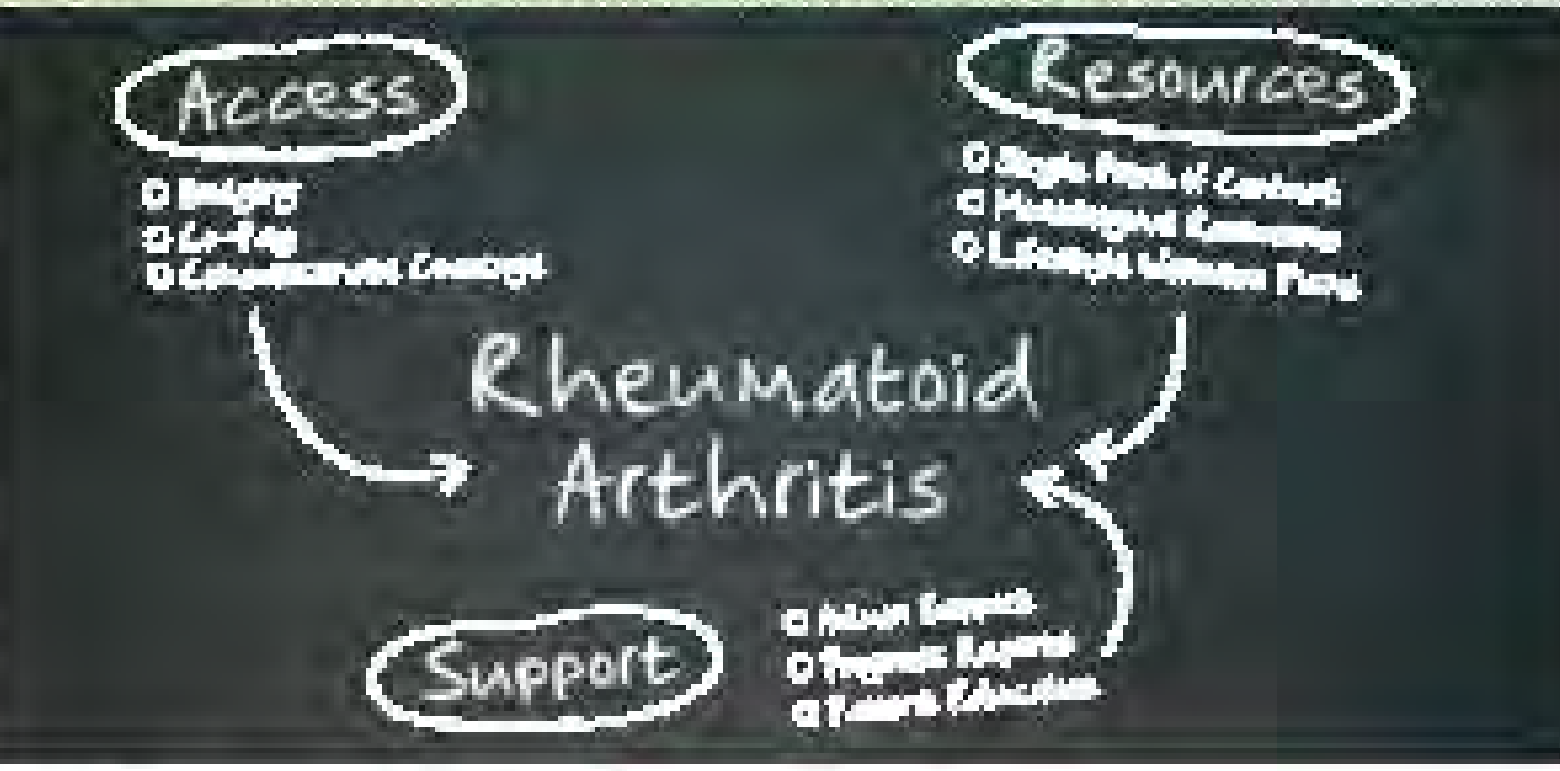

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