Winter 2019, Volume 29, Number 4

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on: CRA Committee & Regional Association Reports

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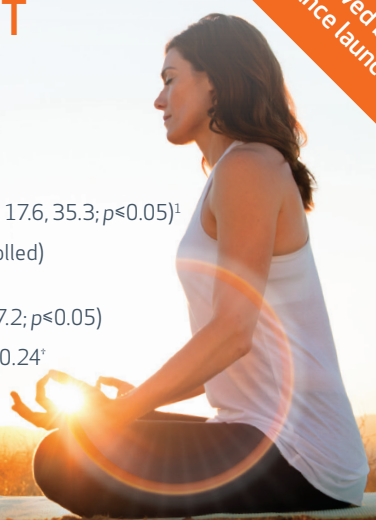
olumiant®
(baricitinib) tablets

CONSIDER OLUMIANT IN THE MANAGEMENT OF RHEUMATOID ARTHRITIS (RA)[1]

An estimated 95,100 patients have received baricitinib worldwide since launch.§



In adults who inadequately responded to one or more conventional disease-modifying anti-rheumatic drugs (cDMARDs), Olumiant demonstrated:[1*]

- Significant improvement in ACR20 response rate vs. placebo at Week 12: 66%† vs. 39% (95% CI: 17.6, 35.3; $p \leq 0.05$)[1]
- Improvements in disease activity scores (DAS28-hsCRP <2.6) vs. placebo (type I error not controlled) (secondary endpoints)[1]:
  - Week 12: 26% vs. 9% (95% CI: 10.2, 23.7; $p \leq 0.05$)
  - Week 24: 31% vs. 11% (95% CI: 12.9, 27.2; $p \leq 0.05$)
- Significant improvement in mean change from baseline in HAQ-DI score vs. placebo at Week 24: -0.24† (95% CI: -0.35, -0.14; $p \leq 0.05$) (secondary endpoint) [1,2]

Convenient once-daily dosing[1]

- Recommended dose: **2 mg once daily**, in combination with MTX
- May be used as monotherapy in cases of intolerance to MTX
- Can be taken any time of the day, with or without food

Olumiant is a selective and reversible inhibitor of Janus kinase (JAK)[1‡]

Indications and clinical use:
- Olumiant (baricitinib), in combination with methotrexate (MTX), is indicated for reducing the signs and symptoms of moderate to severe rheumatoid arthritis (RA) in adult patients who have responded inadequately to one or more disease-modifying anti-rheumatic drugs (DMARDs).
- Olumiant may be used as monotherapy in cases of intolerance to MTX.
- Use of Olumiant in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine is not recommended.
- Geriatrics (≥65 years of age): Use with caution.
- Pediatrics (<18 years of age): Olumiant should not be used in this patient population.

Contraindications:
- Patients with known hypersensitivity to baricitinib or any of its components.

Most serious warnings and precautions:
- **Serious infections:** Patients treated with Olumiant are at risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. If a serious infection develops, interrupt Olumiant until the infection is controlled. Reported infections include: active tuberculosis – patients should be tested for latent tuberculosis before initiating Olumiant and during therapy and treatment for latent infection should be initiated prior to Olumiant use; invasive fungal infections including cryptococcosis and pneumocystosis; bacterial, viral and other infections due to opportunistic pathogens. Do not initiate treatment with Olumiant in patients with active infections, including chronic or localized infection. Monitor closely for signs and symptoms of infection during and after treatment with Olumiant.
- **Malignancies:** Lymphoma and other malignancies have been observed in patients treated with Olumiant. Consider the risks and benefits of Olumiant prior to initiating treatment in patients with a known malignancy other than a successfully treated non-melanoma skin cancer, or when considering continuing Olumiant in patients who develop a malignancy.
- **Thrombosis:** An increased incidence of thrombosis, including deep venous thrombosis (DVT) and pulmonary embolism (PE), has been observed in patients treated with Olumiant. In addition, there were cases of arterial thrombosis. Patients with symptoms of thrombosis should be promptly evaluated.

Other relevant warnings and precautions:
- Use with caution in patients who may be at increased risk of gastrointestinal perforations.
- Patients presenting with new-onset abdominal symptoms should be evaluated promptly for early identification of gastrointestinal perforation.
- Evaluate liver enzymes before initiating Olumiant and thereafter according to routine patient management. If increases in alanine transaminase (ALT) or aspartate transaminase (AST) are observed and drug-induced liver injury (DILI) is suspected, interrupt Olumiant until diagnosis is excluded.
- Olumiant has not been studied in patients with severe hepatic impairment and is therefore not recommended.
- Combined use of Olumiant with potent immunosuppressants is not recommended.
- Not recommended for use with live vaccines.
- Avoid use of Olumiant in patients with an active infection, including localized infections.
- Closely monitor patients for the development of signs and symptoms of infection during and after treatment with Olumiant.
- Interrupt Olumiant if a patient develops a serious infection, an opportunistic infection, or sepsis.
- Use with caution in elderly and diabetic populations.
- Use with caution in patients with a history of chronic lung disease.
- Patients should be evaluated for latent or active tuberculosis infection prior to administration of Olumiant; the product should not be given to patients with active tuberculosis.
- If herpes zoster develops, Olumiant treatment should be interrupted until the episode resolves.
- Risk of increase in creatine phosphokinase (CPK) within one week of starting Olumiant.
- Avoid initiation, or interrupt Olumiant if hemoglobin <80 g/L.
- Avoid initiation, or interrupt Olumiant if absolute lymphocyte count (ALC) <0.5 x 10^9 cells/L.
- Avoid initiation, or interrupt Olumiant if absolute neutrophil count (ANC) <1 x 10^9 cells/L.
- Assessment of lipid parameters should be performed approximately 12 weeks following initiation of Olumiant and as needed thereafter.
- CPK levels should be checked in patients with symptoms of muscle weakness and/or muscle pain for evidence of rhabdomyolysis.
- Not recommended in moderate and severe renal impairment, including end-stage renal disease (ESRD).
- Use with caution in patients with risk factors for, or a history of, interstitial lung disease (ILD).
- Special populations: Should not be used during pregnancy. Women of reproductive potential should take appropriate precautions to avoid becoming pregnant during treatment, and for at least 1 week after the final treatment. Breastfeeding is not recommended during Olumiant treatment.
- Monitoring and laboratory tests: Assess lipid parameters prior to starting Olumiant therapy, approximately 12 weeks after initiation, and periodically thereafter. Liver enzyme tests are recommended. If drug-induced liver injury is suspected, interrupt therapy until this diagnosis has been excluded. Assess renal function prior to starting Olumiant therapy, approximately 4–8 weeks after initiation, and periodically thereafter. Assess lymphocytes, neutrophils and hemoglobin count at baseline, approximately 4–8 weeks after initiation, and periodically thereafter.

For more information:
Please consult the Product Monograph at http://pi.lilly.com/ca/olumiant-ca-pm.pdf for important information relating to adverse reactions, drug interactions and dosing that has not been discussed in this piece.

The Product Monograph is also available by calling 1-888-545-5972.

ACR = American College of Rheumatology; CI = confidence interval; DAS28-hsCRP = Disease Activity Score 28-high sensitivity C-reactive protein; HAQ-DI = Health Assessment Questionnaire-Disability Index.

* Phase 3, double-blind, 24-week study of 684 biologic DMARD-naïve patients with moderate to severe RA and inadequate response or intolerance to ≥1 cDMARDs. Patients were assigned 1:1:1 to placebo (n=228) or baricitinib 2 mg (n=229) or baricitinib 4 mg (n=227) once daily. The primary endpoint was American College of Rheumatology 20% response (ACR20) at Week 12 for baricitinib 4 mg.[2] Baricitinib 4 mg is not an approved dose in Canada.[1]

† Type I error controlled.

‡ **Clinical significance unknown.**

§ Estimated patient exposure for baricitinib based on cumulative sales. Clinical significance is unknown.

References: 1. Olumiant (baricitinib) Product Monograph, Eli Lilly Canada Inc., August 14, 2018. **2.** Dougados M, van der Heijde D, Chen Y-C, *et al*. Baricitinib in patients with inadequate response or intolerance to conventional synthetic DMARDs: results from the RA-BUILD study. *Ann Rheum Dis* 2017;76:88-95. **3.** Data on file. Eli Lilly Canada Inc.

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What is a Rheumatologist?

By Philip A. Baer, MDCM, FRCPC, FACR

"What's in a name? That which we call a rose
By any other name would smell as sweet."
– Juliet, Act 2 Scene 2 of "Romeo and Juliet" by William Shakespeare

In my one physician, one secretary rheumatology office setup, some of the most interesting one-sided conversations are those I overhear between my secretary and prospective patients. After a referral is received and approved, my secretary will call the patient to book a mutually agreeable time for a first consultation. While this should be simple in theory, in practice it seems to be frequently quite challenging.

For one, patients often seem to be astonished that we are calling them. "Didn't your family doctor tell you they were sending you to see a rheumatologist?" I hear her say. Apparently not. The unheard reply often seems to be, "What is a rheumatologist?" My secretary is ready for that one: "A rheumatologist is a specialist in arthritis." That usually works well for someone with peripheral joint pain. Of course, we have many referrals regarding abnormal serologic tests, high creatine kinases (CKs), new unilateral headaches and unusual rashes, and these patients often have no joint pain. The stock answer about what a rheumatologist does must mystify them.

While the CRA website is silent on the issue, the American College of Rheumatology (ACR) website answers the question this way: "A rheumatologist is an internist or pediatrician who received further training in the diagnosis (detection) and treatment of musculoskeletal disease and systemic autoimmune conditions commonly referred to as rheumatic diseases. These diseases can affect the joints, muscles, and bones causing pain, swelling, stiffness, and deformity." (*www.rheumatology.org/I-Am-A/Patient-Caregiver/Health-Care-Team/What-is-a-Rheumatologist*)

Maybe I need to give that scripted answer to my secretary.

The ACR has improved the definition of a rheumatologist over time. I still have a 1987 booklet from the American Rheumatism Association (now the ACR) entitled: "The Rheumatologist: The Doctor who Specializes in Treating Aches and Pains." Really! We have come a long way, though it was only recently that the ACR's premier journal was retitled *Arthritis and Rheumatology*, instead of *Arthritis and Rheumatism*.

I used to think that rheumatology, being a "back of the book" specialty in my old internal medicine textbooks, was unique in having this type of issue. However, even glamorous cardiology has websites explaining "What is a Cardiologist?" This includes the website of the American College of Cardiology (*www.cardiosmart.org/Heart-Basics/What-is-a-Cardiologist)*, which defines the question this way: "A cardiologist is a doctor with special training and skill in finding, treating and preventing diseases of the heart and blood vessels." They don't mention super-hero doctor, extremely well-paid doctor, or doctor most likely to save lives on TV.

Our no-show rate is fairly low, so eventually I meet most of these new patients face-to-face. Some confess they don't know why they were referred. "I saw several specialists and no one could find anything, so they sent me to see you." "Don't you do knee replacement surgery?" Apparently they didn't read the full ACR information piece: "Rheumatologists treat joint disease similar to orthopedists but do not perform surgeries." Actually, I don't see much similarity between how rheumatologists and orthopedic surgeons treat joint disease, but that may be a story for another day. Similarly, the ACR states that "Common diseases treated by rheumatologists include osteoarthritis, gout, rheumatoid arthritis, chronic back pain, tendinitis, and lupus." Overburdened Canadian rheumatologists would probably drop three of those diagnoses from the list.

Meanwhile, I keep listening to my secretary playing defense: "I'm sorry but the office is not open evenings and weekends." "Yes, the office is closed on Wednesdays, but that doesn't mean the doctor is not working." "Yes, the earliest routine appointment really is three months away." "No, we do not validate parking chits." I suspect access to care issues will be the subject of a future article in this series.

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

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All About the New CRA Review Course

A Q&A with co-chairs, Dr. Shahin Jamal and Dr. Trudy Taylor

What exactly is the CRA Review Course, and why should potential participants be interested?

The CRA Review Course is a full-day course aimed at the practicing clinical rheumatologist. It will take place on Wednesday, February 26, 2020, before the opening sessions of the CRA and Arthritis Health Professions Association (AHPA) Annual Scientific Meeting (ASM). The course will be comprised of dynamic expert speakers reviewing important clinical topics in rheumatology to look at what is available and what is coming in the pipeline. The main objective of the course is to provide an evidence-based clinical update on important conditions seen by rheumatologists, focusing on relevance to Canada.

Why did the committee decide to launch the CRA Review Course now?

There have been informal discussions about introducing a review course to run before the CRA and AHPA ASM over the years. The CRA Review Course was launched in response to positive feedback from CRA members, compiled from needs assessments completed both at the time of membership renewal as well as at the CRA Annual General Meeting. CRA members showed interest in attending such a course, so we felt it was an excellent time to offer it. Furthermore, the residents' review course has received very high ratings–so high, in fact, that many practicing rheumatologists have expressed an interest and even tried to attend. Needs assessments completed by residents stated that they are more comfortable learning without practicing faculty in the room; as such, the CRA decided to start a review course aimed at the clinician practicing in Canada.

What can participants expect to learn and interface with throughout the day?

Participants can expect to receive updates and pearls on various core clinical topics/diseases pertaining to clinical rheumatology. The sessions are going to be interactive, with time for questions from the audience. It will also be an opportunity to interact with experts in the field, and potentially get help with difficult clinical cases.

Can anyone sign up for the CRA Review Course, or is it designed with a specific audience in mind?

This is open to both CRA members and non-members. It has been designed to provide an update on clinical rheumatology topics, and will be most appealing to the practicing clinician. Trainees are required to attend the Residents' Pre-Course, which occurs at the same time, and will not be in attendance. Similarly, there is a concurrent AHPA course.

CRA SCR
CANADIAN RHEUMATOLOGY ASSOCIATION | SOCIÉTÉ CANADIENNE DE RHUMATOLOGIE

REVIEW COURSE | COURS DE RÉVISION
VICTORIA, BC • FEBRUARY 26 FÉVRIER 2020

Are there any other benefits of attending (*i.e.*, accreditation, certificates, *etc.*)?

This program is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada and approved by the Canadian Rheumatology Association. It will also be an opportunity to network with colleagues in clinical practice and experts in many fields.

Why are you launching the Review Course alongside the CRA and AHPA ASM?

The CRA believes this is a great value-added opportunity for delegates who may already be travelling to attend the CRA and AHPA ASM. You can simply add on an extra day to get very high-yield education on a selection of clinically relevant topics.

What should participants bring to the Review Course (*i.e.*, tools, laptop)? Is material being provided?

Participants may bring anything that they wish to take notes; however this is not mandatory. We plan to make speaker slides available on the CRA website for attendees after the course is completed. We encourage people to come well rested and ready to learn!

Is there anything else you would like to share?

CRA members are offered a registration discount for the Review Course, and early-bird discounts will be provided to ALL who register by January 17, 2020. Registration will have opened at the end of November (at the same time as ASM registration); industry registrations are limited and restricted to scientific and medical representatives exclusively.

For more information on the CRA Review Course, visit *asm.rheum.ca/review-course/*.

CRA SCR AHPA

ANNUAL SCIENTIFIC MEETING

ASSEMBLÉE SCIENTIFIQUE ANNUELLE

VICTORIA, BC • FEBRUARY 26–29 FÉVRIER 2020

Join us in Victoria, BC for a week of unparalleled education and networking opportunities centered around a scientific program that will deliver a comprehensive breadth of leading-edge content and feature keynote lectures, debates, interactive workshops, podium and poster presentations delivered by Canadian and internationally recognized experts.

NEW! Limited spots available

CRA SCR Canadian Rheumatology Association | Société canadienne de rhumatologie

REVIEW COURSE | COURS DE RÉVISION

The **Review Course** will be open to all practicing rheumatologists interested in updating their knowledge base and will focus on hot topics within the rheumatology world, held ahead of the ASM on **February 26, 2020**

NEW! Limited spots available

The Canadian Arthritis Research Conference: Taking Collaborative Action, co-presented by the CRA, the Arthritis Society and Canadian Institutes of Health Research/IMHA, will be held on **February 25-26, 2020**

This event, taking place right before the ASM, will bring together trainees, people living with arthritis, national and international scientists and clinicians, and others to collaboratively explore perspectives and advance Canadian leadership in the world of arthritis and rheumatic diseases.

Société Arthrite Arthritis Society

CRA SCR Canadian Rheumatology Association | Société canadienne de rhumatologie

IRSC CIHR Instituts de recherche en santé du Canada | Canadian Institutes of Health Research

REGISTRATION NOW OPEN

SIGN UP TODAY!

For more conference information and important dates, visit

ASM.RHEUM.CA

CIORA: A Call for Grants

By Janet Pope, MD, MPH, FRCPC

The Canadian Initiative for Outcomes in Rheumatology cAre (CIORA) is a unique granting division of the Canadian Rheumatology Association. CIORA is committed to being a catalyst to improve the care of Canadians living with all rheumatic diseases, and supports research initiatives related to three pillars: multidisciplinary care teams, early access for all rheumatic disease patients, and awareness/advocacy/education.

Diversity of research directions relevant to the field of clinical rheumatology supported expansion of the original three pillars established for CIORA funding.

For the 2020 grant competition, there has been a subcategory added within the awareness/advocacy/education pillar to include grant proposals for research on health economics, sustainability of health care and quality improvement. Proposals within this area can include determination of cost effectiveness, identification and utilization of quality indicators in monitoring patient care, and assessment of systems to sustain health care.

Details of proposal requirements towards the education domain within the awareness/advocacy/education pillar have been updated for this upcoming grant competition, as have the proposal requirements for the multidisciplinary care team pillar.

A member (in good standing) of the Canadian Rheumatology Association (CRA) must be either a principal investigator or co-investigator on all grant proposals submitted for CIORA grant competitions. A call for one- or two-year grant applications is upcoming for 2020, opening on January 27, 2020. Letters of intent must be submitted by February 21, 2020. More information on required components of the grant proposals, possible outcome measures for proposal categories, and review scoring systems can be found within the CIORA terms of reference at *rheum.ca/ciora/*.

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 2020!

- The CIORA Online Grant Application System opens January 27, 2020.
- Letter of intent must be submitted by February 21, 2020.
- The CIORA Online Grant Application submission deadline is March 27, 2020, at 17:00 (Pacific time).

Please visit *rheum.ca/research/ciora/* for more information. Any questions can be directed to Virginia Hopkins at *vhopkins@rheum.ca.*

News from the ASM Program Committee

By Tom Appleton, MD, PhD, FRCPC

Come to Victoria and Leave with 20/20 Vision!

2020 marks the start of a new decade in rheumatology. If the last two decades are any indication, exciting things await us in the field over the next 10 years!

Join us on February 26-29 in Victoria, B.C., at the Fairmont Empress & Victoria Conference Centre for the 2020 Annual Scientific Meeting (ASM) of the Canadian Rheumatology Association (CRA). Canadian and international colleagues across professional domains will be treated to an exciting and interactive opportunity to engage with new science and emerging themes in rheumatology in the picturesque setting of coastal B.C.

The 2020 ASM will build on the success of our new 2019 "state-of-the-art" workshops track, with exceptional content provided daily, developed by world leaders on practical clinical topics for immediate applicability to clinical practice.

New This Year!

The CRA is bringing you two completely new satellite sessions on the first day before the ASM begins. The new CRA Review Course will provide state-of-the-art clinical experience to established rheumatologists looking for new ways to stimulate their practice and provide best-possible patient care. For more information on the new CRA Review Course, please refer to page 5 of this issue of the *CRAJ*.

Beginning on the eve of the ASM, the new Canadian Arthritis Research Conference will bring the research community together to discuss how we can "take collaborative action" and advance the field together.

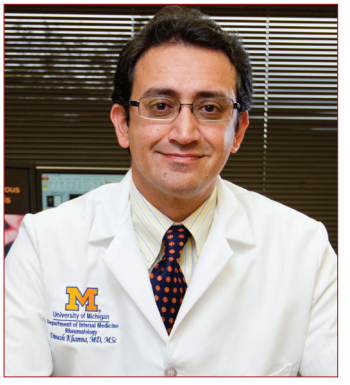
Crowd-sourced Workshops

Members of the CRA and Arthritis Health Professions Association (AHPA) were invited to submit proposals to share their knowledge at the ASM by presenting an interactive workshop session. Come and engage with our colleagues who are leading in various areas including allied health experts, practice management, pragmatic research, and much more!

You Told Us That CRA Members Love Controversy!

In 2020, we are bringing back Rheumatology Controversies, providing insights into how to address difficult clinical decisions based on the experience of thought leaders in rheumatology.

Dr. Betty Diamond



Dr. Dinesh Khanna

Professor Tim Spector

Trainees can continue to expect fantastic opportunities to learn from the best, including the Resident's Review Course. Trainees will also have the chance to provide top-line learning points for ASM attendees during the Mysterious Cases and Clinical Pearls session, a perennial highlight of the ASM!

Our ASM Headliners!

We are delighted to present an outstanding meeting that includes world-renowned speakers:

- Professor Tim Spector will kick off the ASM as our Keynote Speaker. As the author of the global phenomenon "The Diet Myth," he will address the role of the microbiome in human health and rheumatic diseases.
- Dr. Dinesh Khanna from the University of Michigan will present the State-of-the-Art Lecture on interstitial lung disease in scleroderma.
- Dr. Betty Diamond from the Feinstein Institutes for Medical Research will present the Dunlop-Dottridge Lecture. She will summarize the latest cutting-edge research in lupus, including how her work has led to new understanding of the cause of neuropsychiatric manifestations in lupus.

Registration opened November 29th! Old friends, new connections, important causes, Canadian content, and world-class opportunities in rheumatology await. I look forward to seeing you in Victoria. Bienvenue!

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

Update from the Abstract Review Committee

By Vinod Chandran, MBBS, MD, DM, PhD; and Marinka Twilt, MD, PhD

The abstracts are in, and the CRA Abstract Review Committee has begun the hard work of reading and scoring the abstracts, ably supported by Virginia Hopkins, our research and innovation coordinator. The committee selects the abstracts worthy of podium and poster presentations. Our meeting continues to garner interest from researchers, clinicians, trainees and industry. More than 280 abstracts were submitted this year on rheumatology-related topics ranging from basic science, clinical and translational medicine, education, and quality improvement to health services research. Each abstract will be scored by three reviewers, and the best in each category are chosen based on the average score; the chair and co-chair will break any tie for a spot at the podium by consensus. Thank you reviewers!

There will be two podium sessions, during which the top-ranked abstracts in each category will be presented and judged. There will also be two interactive poster sessions where attendees will be able to discuss posters with the presenters. Both podium and poster presentations will be judged for awards, available in the following categories:

- Best Abstract on Quality Care Initiatives in Rheumatology
- Best Abstract on Research by Young Faculty
- Best Abstract on Pediatric Research by Young Faculty
- Best Abstract on Basic Science Research by a Trainee
- Best Abstract on Clinical or Epidemiology Research by a Trainee – Phil Rosen Award
- Best Abstract on SLE Research by a Trainee – Ian Watson Award
- Best Abstract by a Medical Student
- Best Abstract by a Rheumatology Resident
- Best Abstract by an Undergraduate Student
- Best Abstract by a Post-Graduate Research Trainee
- Best Abstract by a Rheumatology Post-Graduate Research Trainee
- Best Abstract on Spondyloarthritis Research Award (New)

We look forward to seeing you all in beautiful Victoria!

Vinod Chandran, MBBS, MD, DM, PhD
Chair, CRA Abstract Review Committee
Associate Professor, Department of Medicine,
Division of Rheumatology, University of Toronto,
Affiliate Scientist, Krembil Research Institute,
University Health Network, Toronto, Ontario
Adjunct Professor, Memorial University, St. John's, Newfoundland

Marinka Twilt, MD, PhD
Co-chair, CRA Abstract Review Committee
Pediatric Rheumatologist, Clinician Scientist,
Alberta Children's Hospital
Assistant Professor, Department of Pediatrics,
Cumming School of Medicine,
University of Calgary, Calgary, Alberta

Improving How We Learn: Education Committee Update

By Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE

The newly restructured CRA Education Committee (Figure 1) has been actively engaging within one of the CRA's key pillars – education (with care and research). Thank you to all the subcommittee co-chairs, all 29 committee members, CRA board and CRA staff for making the transitions happen effectively. The meetings have attempted to be succinct, productive and utilize the variety of electronic tools available through the CRA.

Continuing Professional Development (CPD) Subcommittee – Accreditation Renewal

The CRA has recently been informed of Royal College Continuing Professional Development (CPD) accreditation renewal, valid until 2027, which will enable the CRA to continue to assist with delivery of high-caliber education. This process has enabled a review of all our procedures related to accreditation of CRA-delivered education to maximize opportunities for CRA member education. At the recent 11th National Accreditation Conference, the CRA collaborated with the Royal College in the delivery of a CPD accreditation workshop to participants from national specialist society-based and university-based CPD accreditors, on incorporation of CPD innovation into CPD programming. The CRA Indigenous Health Initiative (in collaboration with the CRA Quality Care and Annual Scientific Meeting [ASM] Program Committees) was highly praised during the presentation of this work at the same conference.

Postgraduate Subcommittee – CBD Transition, NRRW, and NWRITE

The pediatric and adult rheumatology programs are actively transitioning to the competence by design (CBD) format of competency-based medical education through the Royal College programs. The postgraduate subcommittee continues to explore strategies and to assist programs with support and collaboration. The National Rheumatology Residents' Weekend (NRRW) will be taking place January 10-12, 2020, in Toronto for all rheumatology residents. During this meeting, the National Written Rheumatology In-Training Examination (NWRITE) will be given to all adult rheumatology trainees.

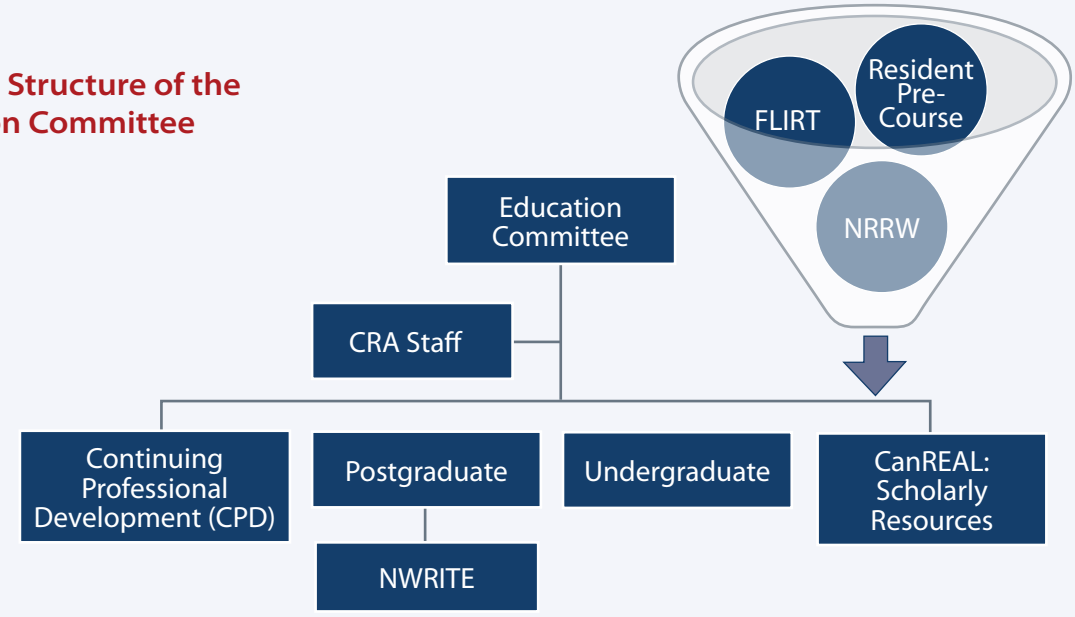
Undergraduate Subcommittee – NURC

The development of the National Undergraduate Rheuma-

Some of the members of the Education Committee at the 2019 CRA ASM. Pictured from left to right: Drs. Nicole Johnson, Shirley Tse, Mary Bell, Stephanie Yang, Janet Pope, Susan Humphrey-Murto, Marie Clements-Baker, Raheem Kherani, Gregory Choy, Elana Murphy, Mercedes Chan, Jennifer Lee, Marie-Paule Morin, Anna Oswald, Lori Albert, and Elishka Pek.

Figure 1.

The New Structure of the Education Committee



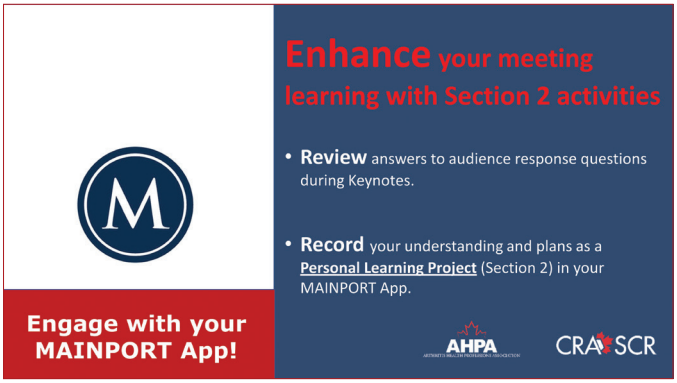
FLIRT: Future Leaders in Rheumatology Training; CanREAL: Canadian Rheumatology Education and Learning; NRRW: National Rheumatology Residents' Weekend; NWRITE: National Written Rheumatology In-Training Examination

tology Curriculum (NURC) is underway through the leadership of this committee. There will be input gathered from across the country with consultation, deliberations and recommendations that hope to positively impact delivery of Canadian musculoskeletal education.

CanREAL Subcommittee – Scholarly Input

Our experts in rheumatology medical education scholarship continue to provide input in a variety of projects. This resource is one for CRA staff, committees and members for the development of rheumatology-related medical education initiatives. The group is currently coordinating the Practice Reflection Award in addition to providing input in CBD, ASM, and Abstract Review Committee discussions.

With a looming deadline of January 31st, 2020, for Royal College Maintenance of Certification, I encourage members to revisit the series "CPD for the Busy Rheumatologist" previously published in the *CRAJ*, (in the summer 2017, fall 2017 and spring 2018 issues [available at *craj.ca*]), for tips on how to complete the requirements for your certification cycle. You can also enhance and extend your learning by engaging with the MAINPORT app.



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

CRA Members and CEO Hard at Work on Your Behalf at the 2019 NAC in Ottawa

At the 11th National CPD Accreditation Conference (NAC) in Ottawa, pictured from left to right: Dr. Ahmad Zbib, CEO of the CRA; Dr. Gregory Choy, Co-chair, CPD subcommittee; Heather Dow, CAE, CPhT, CRA Accreditation Consultant; and Dr. Raheem Kherani, Chair of the CRA Education Committee.

Highlights from the Guidelines Committee

By Glen Hazlewood, MD, FRCPC

The CRA put out its first recommendations (for rheumatoid arthritis [RA]) in 2012. Since then, through the hard work of our members, we have published guidelines across a wide range of topics, all of which can be found on the CRA website (*rheum.ca/resources/publications/*).

The Guidelines Committee recognizes the need to develop "Canadian-ized" recommendations, while at the same time not duplicating the work of others or sacrificing guideline quality. The CRA has now adopted Grading of Recommendations, Assessment, Development and Evaluation or GRADE as our preferred approach, in line with other major groups. As we move into the next decade, we are also constantly looking for new and novel approaches to improve the efficiency of our guidelines and increase their impact. Highlights include the following:

- Adopting or adapting recommendations of other groups, where possible;
- Transitioning to a "living" model of guideline development, where appropriate;
- Collaboration with other groups including Cochrane, the American College of Rheumatology (ACR), and the Australian Rheumatology Association, to coordinate efforts and reduce duplication;
- Incorporating novel approaches to improve the efficiency of reviews including machine learning and "crowdsourcing" with trainees in Canada and Australia;
- Incorporating health equity and patient preferences into our recommendations;
- Partnering with the CRA-supported rheumatoid arthritis (RA) registry initiative to use "real-world" data when contextualizing our recommendations.

We are grateful for the hard work of everyone involved. In particular, a big shout out to our engaged group of 22 trainees who have been helping review articles for the RA and spondyloarthritis (SpA) guidelines. We are always looking for more reviewers. If you are interested in joining our team, please e-mail Jordi Pardo at *jpardo@uottawa.ca*.

Stay tuned in 2020!

Glen Hazlewood, MD, FRCPC
Assistant Professor,
Departments of Medicine and Community Health Sciences,
Cumming School of Medicine,
University of Calgary,
Calgary, Alberta

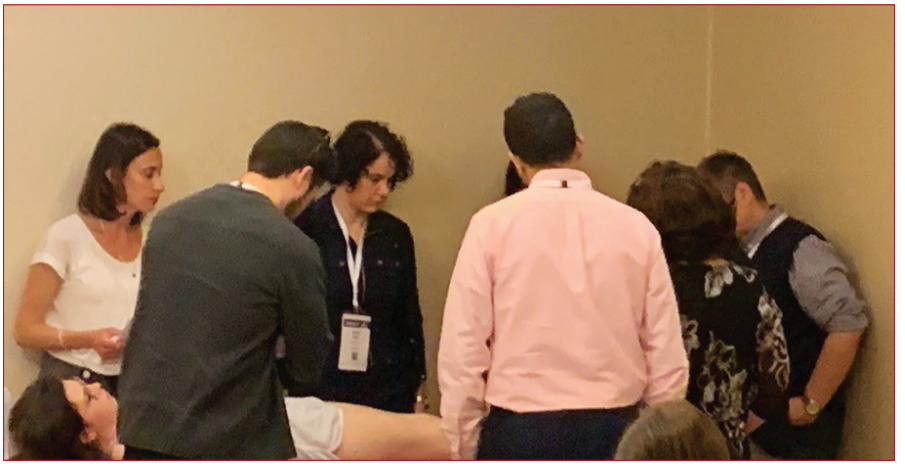
Pediatric Committee News

By Ron Laxer, MDCM, FRCPC

All pediatric rheumatologists and pediatric rheumatology trainees who are members of the CRA are automatically considered members of the CRA Pediatrics Committee, making this the largest committee of the CRA. Our committee has several subcommittees including 1) Advocacy, 2) Education, 3) Human Resources, and 4) Community Pediatric Rheumatology. In addition, our members also participate in other CRA committees including Research, Therapeutics, Quality Care, Human Resources, Guidelines, Education, Communications, and the ASM Program Committee. This allows important cross-fertilization among the committees, and further extends the input of pediatric rheumatology into CRA activities. Three recent activities will be highlighted briefly here.

The CRA Pediatrics Committee is busy with numerous ongoing and new initiatives. Two projects currently underway will help with physician resource planning, and assessing a number of issues relating to quality of care. The Human Resources subcommittee is currently looking at physician resources at each academic centre, as well as in the community. This will provide information regarding current and more distant needs, and is being led by Michelle Batthish from McMaster University. Deb Levy and Jennifer Lee from the University of Toronto are currently leading a project that examines variations in care processes at each pediatric rheumatology centre across Canada.

Drs. Evelyn Rozenblyum and Mercedes Chan presented a highly rated workshop, Pediatric Musculoskeletal Examination Skills, at the 2019 CPS meeting in June, in Toronto.



Participants at the Pediatric Musculoskeletal Examination Skills workshop were able to get hands-on experience.

Evelyn Rozenblyum from both McMaster University and the University of Toronto, and Mercedes Chan from the University of British Columbia, worked with the Canadian Pediatric Society (CPS) as part of our engagement strategy. They are leading the development of a "Special Interest Group" on pediatric rheumatology within the CPS. At the most recent CPS meeting in Toronto in June, they presented a highly rated workshop on pediatric musculoskeletal examination skills as well as a seminar entitled "Juvenile Idiopathic Arthritis: Everything You Ever Wanted to Know But Were Afraid to Ask!"

There are many more exciting and important initiatives underway which will be provided in our next update article!

Ronald M. Laxer, MDCM, FRCPC
Professor,
Departments of Pediatrics and Medicine,
University of Toronto
Staff Rheumatologist,
The Hospital for Sick Children
Toronto, Ontario

The Quality Care Committee Report

By Cheryl Barnabe, MD, FRCPC, MSc

The Quality Care committee continued to champion initiatives in equity (led by Cheryl Barnabe), quality (led by Claire Barber), access (led by Amanda Steiman) and resource stewardship (led by Shirley Lake) in 2019. Our committee activities are supported and guided by 25 committee members, representing academic and community practices, adult and pediatric, and the different regions of Canada, who are all passionate about issues in the field of optimal care for rheumatologic diseases relevant to Canadian practice.

On behalf of the committee members, I'd like to thank Michel Zummer, the original chair of this committee, who instigated our coming together to enact solutions to ensure access to care and implementation of models of care to support early inflammatory arthritis diagnosis and management, as well as Stephanie Tom, who had been contributing to this committee through residency and early practice, for their service to the committee.

I'd also like to extend a great big warm welcome to Amanda Steiman, who has agreed to step in as the new Chair in 2020. We are in great hands with Amanda's innovation and leadership in implementing models of care that reach rural and remote populations, and in supporting the training and distribution of advanced care practitioners.

Committee activities this year included presenting results of the 2018 Indigenous Health Initiative at the Annual Scientific Meeting (ASM) and the National Continuing Professional Development Accreditation Conference, and providing training to another cohort of rheumatologists. We launched the monthly Indigenous Health Rheumatology Rounds, a virtual journal club format, but are reconsidering better ways of uniting this community of practice to maximize equitable participation in the discussions. We continued to advocate for access to medications for patients with coverage through the Non-Insured Health Benefits (NIHB) program, including coverage for triamcinolone hexacetonide for joint injections in pediatric care.

Dr. Kherani presenting the Indigenous Health Initiative results at the National Accreditation Conference in October 2019.

We also launched a project undertaken in collaboration with the CRA Guidelines Committee, specifically informing the evidence-to-decision process in the RA Guidelines update through an equity lens. Six population groups of particular relevance to Canadian rheumatology are included in the project: i) rural and remote; ii) Indigenous; iii) non-binary gender identities; iv) low socioeconomic status; v) refugee and minority populations; and vi) age transitions. Patients, stakeholders and healthcare providers with expertise delivering care to these population groups were recruited for interviews and focus groups to highlight barriers and facilitators to RA management (thank you to the participants!), followed by the development of logic models that mitigate inequities arising from implementation of the guidelines. The results will be finalized and prepared for an open-access manuscript in 2020, while being used to support the ongoing guidelines update process.

A special thanks to the engaged CRA and rheumatology stakeholder community for your input and feedback on the quality care report card, which will undergo testing this year. We are also anticipating the outcomes of the business case to support innovative models of care for inflammatory arthritis, a project in collaboration with the Arthritis Alliance of Canada, as well as the Stand Up and Be Counted 2 Survey, which provides an overview of existing allied health resources in rheumatology across Canada. Both will be critical advocacy tools for Canadian rheumatologists. Finally, two new Choosing Wisely statements have been developed, addressing opioid and biologic appropriateness, which will be disseminated in 2020.

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

Announcing the Launch of the Canadian Rheumatology Workforce and Wellness Survey 2020

News from the Human Resources Committee

By Stephanie Kulhawy-Wibe, MD, MSc; Jessica Widdifield, PhD; and Claire Barber, MD, FRCPC, PhD

In 2015, the Canadian Rheumatology Association (CRA) conducted a national survey of Canadian rheumatologists to better understand the rheumatology workforce in Canada.[1] The survey helped to estimate the number and characteristics of Canadian rheumatologists, the full-time equivalent (FTE) clinical status of rheumatologists, and projected retirements over the next 5-10 years.[1] Beyond evaluating the FTE, projected retirements and demographics of the physician workforce, understanding the health and wellness of physicians has been gaining increasing attention over the last decade.[2]

Indeed, the Canadian Medical Association (CMA) suggests that the poor state of physicians' health is a threat to the workforce, as it can lead to negative physician and patient outcomes, and should be assessed and monitored at regular intervals.[3] An especially important aspect of physician health is burnout. This is a work-related syndrome that is characterized by three main elements: exhaustion, depersonalization, and lack of efficiency or personal accomplishment.[4] Burnout is prevalent among Canadian physicians as 30% of participants reported high levels of burnout in the National Physician Health Survey,[5] and it has been linked to suboptimal patient care and increased medical errors. Unfortunately, relatively little is known about the health and wellness of Canadian rheumatologists. This topic is relevant to the future of the rheumatology workforce because burnout is associated with reduced working hours and early retirement.

To that end, the CRA Human Resources Committee will be launching an electronic survey of Canadian rheumatologists in the Spring of 2020 to update our understanding of the current workforce characteristics and distribution, including an assessment of the health and wellness of rheumatologists. From a human resource planning perspective, it is crucial that all Canadian rheumatologists complete the survey, so that the CRA has up-to-date information on the numbers of rheumatologists in Canada, as well as changes to the characteristics of the workforce over time.

Look out for the launch of the Canadian Rheumatology Workforce and Wellness Survey in the spring of 2020!

Stephanie Kulhawy-Wibe, MD, MSc
Rheumatology Resident
Cumming School of Medicine,
University of Calgary
Calgary, Alberta

Jessica Widdifield, PhD
Scientist,
Sunnybrook Research Institute, ICES
Assistant Professor,
University of Toronto,
Institute of Health Policy, Management & Evaluation
Toronto, Ontario

Claire Barber, MD, PhD, FRCPC
Assistant Professor, Rheumatologist,
Cumming School of Medicine, University of Calgary,
Calgary, Alberta

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Consult the XELJANZ/XELJANZ XR Product Monograph at http://pfizer.ca/pm/en/XELJANZ.pdf and Important Safety Information Update available at https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/69336a-eng.php, for important information about:

- Contraindications during pregnancy and breastfeeding, and in patients with severe hepatic impairment.
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* Comparative clinical significance is unknown
† Prescription and physician data were obtained from eXel™ support program enrollment forms collected from June 2014 to November 2018

References:
1. Pfizer Canada ULC. XELJANZ/XELJANZ XR Product Monograph. February 4, 2019.
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4. Health Canada. XELJANZ Notice of Compliance information.

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Update from the Communications Committee

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

The Communications Committee of the CRA has an exciting year ahead for 2020! Our major project for the coming year is the launch of the first season of our very own CRA podcast! The name of the podcast will be "Around the Rheum," and it will be hosted by Dr. Daniel Ennis, a new rheumatologist practicing in Vancouver, British Columbia. The podcast will feature interviews with prominent rheumatologists from around the country on topics chosen by our membership. At the time of this writing, we are currently working on our pilot episode, which we hope to have released by the end of 2019. The plan is to then release a season of episodes througout 2020. We are working with a team of experts on this, including David McGuffin from "Explore Podcast Productions." David has extensive experience producing high quality, professional podcasts. So, stay tuned!

Some of our other current initiatives include working to improve our social media presence through such forums as Twitter and LinkedIn (please add/follow us!). Additionally, we will be starting a financial/accounting column in the CRA e-newsletter with articles of interest to our members, written by an accountant. We have received the first article, and it will be published soon.

Kevin, our Marketing and Communications Coordinator, has been a wonderful addition to our Committee. We have also added multiple new members over the past several months. We are open to new and fresh ideas/input and encourage any CRA members interested in joining our committee to drop us a line! You may contact me at *dax.rumsey@ahs.ca* or Kevin at *kbaijnauth@rheum.ca*.

Dax G. Rumsey, MD, MSc, FRCP(C)
Zone Section Chief, Pediatric Rheumatology,
Alberta Health Services – Edmonton Zone (Stollery Children's Hospital)
Division Director, Pediatric Rheumatology,
Assistant Professor, University of Alberta
Edmonton, Alberta

Report from the ORA

By Jane Purvis, MD, FRCPC

Ontario Rheumatology Association

The Ontario Rheumatology Association continues to actively represent the rheumatologists of our province on many fronts. We continue to work closely with the Ontario government on access to medications as well as lab test reforms, and with the Canadian Life and Health Insurance Association (CLHIA) on insurance issues. The Informatics committee is working on creating a dashboard for a rheumatology EMR, which will allow participants to view their own practice outcomes and compare themselves to the aggregate of participating rheumatologists within the province. We are planning workshops for rheumatologists who are new to practice and, this year, we are also planning ones for those looking to retire. The website *Rheumcareers* continues to connect those looking for locums or long-term positions with those who have openings. The *RheumOpportunities* committee has created a subcommittee to consider northern Ontario rheumatology, with representation from rheumatologists based in the south who travel up, as well as those working full-time in the North, along with allied health care practitioners and other stakeholders. Our hope is to be able to evaluate all the practice models being utilized in the north and find ways to foster and develop these to help create a sustainable practice format in the North.

The ORA board at their most recent meeting: From left to right; **Back row:** Dr. Carter Thorne, Dr. Tom Appleton, Dr. Henry Averns, Dr. Rick Adachi, and Dr. Imtiaz Khan; **Middle row:** Mr. Denis Morrice, Dr. Vinod Chandran, Dr. Art Karasik, Dr. Felix Leung, Dr. Philip Baer, Ms. Sandy Kennedy, Dr. Nikhil Chopra, and Dr. Deborah Levy; **Front Row:** Dr. Thanu Ruban, Dr. Janet Pope, Dr. Jane Purvis, Dr. Vandana Ahluwalia, and Dr. Julie Kovacs

Our annual meeting moved to a new location, Kingbridge Conference Centre in King City and was held May 24-26, 2019. This was our most successful and best-attended event yet, with a stellar list of speakers including Professor Dennis McGonagle, Dr. Arthur Kavanaugh, Dr. Iain McInnes, Dr. Rick Adachi, Dr. Tom Appleton, Dr. Janet Pope, Dr. Edward Keystone and Dr. Raashid Luqmani. We had more than 200 attendees, and all the plenaries, workshops and symposia were well attended. We are planning our next meeting, to be held at Kingbridge as well, on April 17-19, 2020. Save the date!

Jane Purvis, MD, FRCPC
President, Ontario Rheumatology Association
Rheumatologist,
Peterborough, Ontario

Update from the AMRQ

By Frédéric Massicotte, PhD, MD, FRCPC

Another year already! It seems to me that it was only yesterday that I summarized the Quebec rheumatology picture for you. I would really like to be able to choose a palette in pastel tones to paint this year's fresco, but admittedly, many clouds remain on the horizon. Our system is painfully recovering from the laws imposed by the former Minister of Health, Dr. Barrette, and now the new Premier has taken over. In recent months, Quebec doctors have been at the heart of political events, under the threat of special legislation aimed at massively reducing their remuneration. Fortunately, a last-minute agreement gives a little lull and finally allows for sunnier days. Amid this tumult, this year, the communications team at the *Fédération des Médecins Spécialistes du Québec* (FMSQ) is working to better inform citizens about the real issues, such as the relevance of the legislation and its impact on accessibility to care. Unfortunately, as far as pay equity within the FMSQ is concerned, there is still a great deal of work to be done to correct these injustices. However, a year has passed since the implementation of the new Quebec reference system, and despite many administrative problems, it is slowly improving.

On a happier note, the *Association des Médecins Rhumatologues du Québec* (AMRQ) is doing well. There has been no change in the directors on the general council. The AMRQ is made up of 130 active rheumatologists and more than 30 residents in rheumatology active in our subspecialty! We have a very active association which, like medicine, now includes more women and younger members. The young up-and-coming members actively put their shoulders to the wheel and are involved in several therapeutic areas, both clinically and in research.

Speaking of research, I had the pleasure of presenting the 2019 Merit Award to Dr. Jean-Pierre Pelletier (and his long-time partner, Dr. Johanne Martel Pelletier). For those who don't know Dr. Pelletier, in recent decades, his research team has become a world leader in the osteoarthritis field. His career includes more than 500 publications, nearly 1,000 abstracts, and a dozen national and international awards. Congratulations Jean-Pierre!

Otherwise, the Association's many activities are well under way. Our continuous professional development is always complemented by the half-day sessions covering the Top 3 in rheumatology, and our conferences. Our nurses benefit from their interdisciplinary meeting day, a training day created by rheumatologists especially for them. In addition, changes in resident teaching (competency-based approach) are occurring gradually, thanks to the ongoing and hard work of our program directors.

It will be our turn to welcome our French colleagues to the Fairmont Château Montebello in September 2020, during our annual conference. We'll be pleased to show them our gratitude for their impeccable hospitality in Bordeaux in 2018.

In a few words, we cannot summarize all the work done by my colleagues, young and old, to promote Quebec rheumatology. This soft light contrasts with the darker background that hovers over Quebec medicine, but it means that rheumatology is slowly taking a well-deserved place among the most sought-after medical specialties.

Frédéric Massicotte, PhD, MD, FRCPC
President,
Association des Médecins Rhumatologues du Quebec (AMRQ)
Montreal, Quebec

AWARDS, APPOINTMENTS, AND ACCOLADES

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

B.C. Society of Rheumatologists (BCSR) – Update from the Pacific

By Jason Kur, MD, FRCPC

At the BRIESE Conference in September 2019 : A panel discussion with (from left to right) Dr. John Wade, Dr. Mollie Carruthers, Dr. Mark Genovese, and Dr. Iain McInnes

British Columbia (B.C.) has continued to be a hotbed of activity over the past year. Nothing has been of more interest than the recent decision in spring 2019 by B.C. Pharmacare to mandate non-medical biosimilar switching for two originator products. Our membership was actively engaged in the design and roll-out of the policy to ensure it was as physician and patient friendly as possible. Thus far, the transition has been going well, despite the added administrative and clinical burden on many offices.

The Physician Master Agreement: This year saw a new master agreement between the Doctors of B.C. and the provincial government. Some major advances were achieved. The most notable however is the transition of our labour market adjustment codes (special codes that include the famous B.C. nursing code) from a special, fixed, uncertain, budget to the general fee guide. This is a momentous achievement after 10 years of hard work and lobbying. We are thrilled that this nursing model of care will be the new standard for rheumatology in B.C.

This round of negotiations also saw funds set aside for disparity correction (inter-sectional and inter-provincial). Once again, the BCSR will be involved in the process with an independent arbitrator assigned to this complicated file.

The BCSR had its annual meeting this September in conjunction with the British Columbia Rheumatology Invitation Educational Series (BRIESE) conference in Vancouver. Speakers included Dr. Antonio Avina-Zubieta, Dr. Mark Genovese, Dr. Rick Adachi and Professor Iain McInnes.

We also wish to congratulate Dr. Robert Rothwell who is retiring this year. Dr. Rothwell has had an illustrious career that took him from his training at McGill University to St. Paul's Hospital in Vancouver and, ultimately, a career in New Westminster, B.C. In addition to his clinical contributions, he has been a strong leader and philanthropist, funding medical bursaries at the University of British Columbia (UBC). We wish him well in the years ahead and will miss his wit, wisdom and knowledge of wine, food and art at our meetings.

Jason Kur, MD, FRCPC
Artus Health Centre
University of British Columbia
President,
B.C. Society of Rheumatologists
Vancouver, British Columbia

News from SOAR: Atlantic Update 2019

By Trudy Taylor, MD, FRCPC

Rheumatologists from across the Maritime provinces returned to Dalvay by the Sea on Prince Edward Island for the 36th annual meeting of the Society of Atlantic Rheumatologists (SOAR) from June 21-23, 2019. The meeting provided a combination of outstanding education along with an important opportunity to spend time with regional colleagues.

This year's David Hawkins Lecture in Rheumatology, "The New Frontier–Comparative Safety of JAK Inhibitors" was given by Dr. Kevin Winthrop, MD, MPH, from Oregon Health and Sciences University. He followed this up with a thought-provoking lecture on "Timings and Targets for the Rheumatologist–an Update on Vaccinations"

Our second expert lecturer was Dr. Alisa Femia, MD, from NYU Langone Health. She gave us two excellent talks, "What's in the Skin? Perspectives from the Derm-Rheum Clinic" and "Essentials of Skin Disease for the Rheumatologist: A Case-based Discussion."

Finally, there were original research and interesting case presentations from our bright and talented rheumatologists-to-be. We are very fortunate to have such promising talent in our region!

The Big Country Ramblers were back to entertain the crowd with their driving rhythms and infectious energy. We are looking forward to having them join us again next year!

SOAR members loved the venue so much that we unanimously decided to return to Dalvay by the Sea next year for the annual meeting from June 19-21, 2020. Save the date!

Trudy Taylor, MD, FRCPC
Associate Professor,
Division of Rheumatology,
Department of Medicine,
Dalhousie University
Halifax, Nova Scotia

WELCOME TO THE RHEUM

Welcome to the following new members:

Azin Ahrari, Vancouver, BC
Maha Anbar, Toronto, ON
Ariane Barbacki, Montreal, QC
Mena Bishay, Kingston, ON
Eric Campbell, Calgary, AB
Chantelle Carneiro, Hamilton, ON
Lu (Lucy) Chu, Toronto, ON
Philippe Desaulniers, Laval, QC
Sandeep Dhillon, Hamilton, ON
Leah Ellingwood, Vancouver, BC
Aldi Eski, St-Laurent, QC
Arpita Gantayet, London, ON
Ellen Go, Toronto, ON
Hart Goldhar, Ottawa, ON
Sarah Hansen, Vancouver, BC
Megan Himmel, Toronto, ON
Dahye (Jenny) Hong, Edmonton, AB
Greg Koller, Edmonton, AB
Alexandra Ladouceur, Montreal, QC
Lester Liao, Toronto, ON
Meghan McPherson, Vancouver, BC
Reza Mirza, Toronto, ON
Julie Mongeau, Halifax, NS
Sarah Oberholtzer, Saskatoon, SK
Jonathan Park, Vancouver, BC
Vanessa Rininsland, Saskatchewan, MN
Jessica Salituri, Hamilton, ON
Petagay Scott Brown, Montreal, QC
Kamran Shaikh, Toronto, ON
Tenneille Tana, Kingston, ON
Shahna Tariq, Edmonton, AB
Shivani Upadhyaya, London, ON
Karel Venne, Montreal, QC
Zachary Wolfmueller, Winnipeg, MN

SAVE THE DATE:

Canadian Arthritis Research Conference – Taking Collaborative Action

February 25-26 2020 • Victoria

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Arthritis Society

Looking for one more reason to make the trip to Victoria this February? Look no further!

Co-presented by the Arthritis Society, the CRA and Canadian Institutes of Health Research/Institute of Musculoskeletal Health and Arthritis (CIHR/IMHA), the inaugural Canadian Arthritis Research Conference takes place February 25-26 (right before the CRA AHPA Annual Scientific Meeting), and will bring together multidisciplinary stakeholders to explore perspectives, advance knowledge and enhance Canadian leadership in the world of arthritis and rheumatic diseases.

The program content focuses on three key themes in arthritis research: pain, inflammation and tissue repair, and big data science. An exciting array of presentations and discussions will identify current advances and explore priority areas for future investigation.

"The challenges of arthritis are too great for any one lab or organization to overcome," says Scientific Program Committee Chair Dr. Hani El-Gabalawy, Professor of Medicine and Immunology and Endowed Rheumatology Research Chair at the University of Manitoba, and former Scientific Director of CIHR-IMHA. "Opportunities like this to collaborate and share learnings among clinicians, scientists, patients and stakeholders are essential. We look forward to some very engaging discussions."

This event requires separate registration from the CRA-AHPA ASM. Spaces are limited, so please visit *www.arthritis.ca/researchday* for more information. Registration is now open.

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CANADIAN RHEUMATOLOGY ASSOCIATION | SOCIÉTÉ CANADIENNE DE RHUMATOLOGIE

Revisiting Idiopathic Inflammatory Myopathies

By Lucy Lu Chu, MD; and Ophir Vinik, MD, FRCPC, MScCH

Patient Case:

A 27-year-old woman, who used to be physically active, was referred to a rheumatologist by her family doctor for joint pain. She described six months of stiffness in the upper arms and thighs with progressive decrease in proximal muscle stamina and exercise tolerance. She was previously healthy with no medication, alcohol nor recreational drug use. Family history was negative for autoimmune or muscle disorders. On examination, she had mild weakness in the deltoids, biceps, and hip flexors rated as 4+/5 on the Medical Research Council (MRC) scale. There were no swollen joints. Dermatologic examination was negative for rashes, but mild nail-fold capillary dilatations were present. Initial bloodwork was normal including C-reactive protein of 0.7 (N < 5) and creatine kinase (CK) of 81 (N 20-210). Anti-nuclear antibodies (ANA), rheumatoid factor (RF), and anti-cyclic citrullinated peptide (anti-CCP) were negative. The only identified abnormalities were an erythrocyte sedimentation rate of 37 (N < 30), and lactate dehydrogenase of 292 (N 140-225).

Due to findings of proximal muscle weakness and abnormal nail-fold capillaries, additional tests were performed. Myositis-specific antibody (MSA) panel returned positive for anti-nuclear matrix protein 2 antibody (NXP2). Magnetic resonance imaging (MRI) demonstrated extensive patchy muscle edema involving the gluteal, iliopsoas and quadriceps musculature bilaterally. Subsequent quadriceps muscle biopsy revealed a distinct pattern of perifascicular atrophy, accompanied by perivascular and septal lymphohistiocytic inflammatory cell infiltrate, with numerous tubuloreticular inclusions. This confirmed a clinical-serological-pathological diagnosis of dermatomyositis.

Introduction

Idiopathic inflammatory myopathies (IIM) encompass a heterogeneous group of rare, autoimmune conditions characterized by various degrees of proximal muscle, cutaneous, and sometimes multi-organ involvement. There is growing recognition that IIM is not a single entity but rather a spectrum of clinical-serological-pathological entities.[1] Severity of the different manifestations, even within an entity, can vary widely. Incidence of IIM is estimated at 1 per 100,000 and can occur throughout the life span with overall female predilection.[2]

Clinical Features

Classical dermatomyositis is characterized by proximal muscle weakness and prototypical skin rashes, including Gottron's papules and poikilodermic changes, such as the heliotrope, shawl, V-neck and Holster signs. Diagnosis can become challenging in patients lacking overt muscle weakness or characteristic rashes.[3] Normal CK does not rule out active myositis, as about 15% of patients with active dermatomyositis can have normal CK.[4] Typical histological findings of classical dermatomyositis include perifascicular atrophy with inflammatory infiltrate and tubuloreticular inclusions on electron microscopy.[3] Dermatomyositis may also present as part of an overlap syndrome with features of other connective tissues diseases, such as systemic sclerosis.

Another clinical entity within the IIM spectrum is antisynthetase syndrome. It is a heterogeneous entity that may involve inflammatory arthritis, mechanic's hands, Raynaud's phenomenon, and interstitial lung disease. It is associated with the presence of antibodies directed against transfer ribonucleic acid (tRNA) synthetase enzymes.[3]

Immune-mediated necrotizing myositis (also known as necrotizing autoimmune myopathy, NAM) is generally characterized by severe weakness with markedly elevated CK levels but typically no skin rashes. While NAM can be idiopathic, some cases are induced by medication exposure, particularly statins. HMG-CoA reductase antibodies might be identified to help support the diagnosis. Muscle biopsy findings include macrophage-mediated necrotic muscle fibers with minimal or absent inflammatory infiltrate.[5]

Inclusion Body Myositis (IBM), previously included as one of the IIM, is a different disease entity, being a degenerative condition involving both proximal and distal muscles

and characterized by lack of response to immunosuppression. Histopathology shows rimmed vacuoles with inclusion bodies.[6] Polymyositis is vanishing as a discrete diagnostic entity. Traditionally, it was characterized by lack of typical skin rashes and histological findings of perimysial involvement.[7] Better clinical-serological-pathological evaluation would now commonly reclassify the disease as either IBM, necrotizing myopathy or antisynthetase syndrome.[8]

Diagnosis

Detailed clinical history and physical exam are crucial in assessment of patients with possible IIM. MSA are identified in up to 80% of IIM patients.[9] A negative ANA, seen in 40-60% of dermatomyositis patients, does not rule out the disease nor the possibility that MSA are present.[10]

Electromyography (EMG) can be helpful in identifying an underlying myopathic or neuropathic process. Used on its own, however, it cannot establish a diagnosis of IIM.[11] Muscle MRI is an increasingly employed diagnostic tool. T2 weighted images with fat suppression or short tau inversion recovery (STIR) sequencing can identify muscle edema.[11] While muscle edema is not specific to IIM, the presence of proximal and symmetric involvement in the appropriate clinical context can be helpful. MRI can also detect areas of atrophy and fat replacement, thus differentiating active from chronic changes of myositis. This can guide site selection for biopsy to reduce the rate of false-negative results, which may be as high as 45% in blind muscle biopsies for DM.[11] Proper sample processing is vital and pathological assessment should include electron microscopy to identify certain pathologic features such as tubuloreticular inclusions.[12]

The commonly used Bohan and Peter diagnostic criteria from 1975[13] are fraught with limitations. They do not capture many of the advances in the field such as the diagnosis of IBM or availability of MSA.[14] The more recent 2017 EULAR/ACR criteria, while providing a better framework with sensitivity and specificity of up to 93% and 88% respectively when muscle biopsy is included,[15] still do not adequately encapsulate the broad heterogeneity of these conditions. These criteria also do not incorporate MSA and still consider polymyositis as a distinct entity. Ongoing efforts to further improve classification and diagnostic tools for clinicians are needed.[16]

Management

IIM are treatable conditions requiring a combination of non-pharmacological and pharmacological interventions. The choice of treatment should be tailored based on clinical manifestations and severity. A multidisciplinary approach is recommended to manage the various systemic aspects. Physiotherapy, occupational therapy and rehabilitation services have well-established benefits.[18,19] Speech language therapists can assess the need for diet modification if there is dysphagia from striated muscle involvement in the upper one-third of the esophagus.

High-dose prednisone is the mainstay of initial pharmacotherapy. Typical starting dose is 1-1.5 mg/kg/day.[20] Steroid-sparing options include methotrexate, mycophenolate mofetil and azathioprine. Intravenous immunoglobulin is an adjunct treatment in patients presenting with more severe muscle and cutaneous disease.[21] Of note, the extent of CK elevation may not correspond to the clinical degree of muscle weakness, and normalization of CK with treatment does not necessarily define disease remission. In some patients, CK fluctuates or never fully normalizes despite clinical remission.

In adult-onset IIM, malignancy risk within the first five years of diagnosis is up to six-fold the average population, particularly with classical dermatomyositis.[22] No evidence-based guidelines exist for malignancy screening in IIM patients. Features found to have strong malignancy association in dermatomyositis include male gender; onset of disease after the age of 50; classical skin rashes; rapidly progressive disease; clinical features concerning for malignancy; and positive anti-nuclear matrix protein 2 (NXP2) or transcription intermediary factor 1-gamma (TIF1-γ) antibodies.[23] Computed tomography of chest/abdomen/pelvis, esophagogastroduodenoscopy, and colonoscopy should be considered in these patients.[23] The positron emission tomography (PET) scan has been shown to be equivalent to these screening modalities.[24] Treatment of malignancy, while essential, is commonly insufficient to treat the associated dermatomyositis manifestations. Concurrent immunosuppression is required in close collaboration with the treating oncology team. In cancer-associated dermatomyositis patients who are in remission, recurrence of cutaneous or muscle manifestations may signify cancer recurrence.[25]

Back to the Case:

The patient was started on high-dose prednisone and azathioprine alongside an exercise program for proximal muscle strengthening. She responded well to treatment with complete resolution of weakness and nail-fold capillary abnormalities. The patient tapered off prednisone with no recurrence of symptoms and remains on maintenance treatment with azathioprine.

Lucy Lu Chu, MD,
Rheumatology Resident,
University of Toronto,
Toronto, Ontario

Ophir Vinik, MD, FRCPC, MScCH
Rheumatologist,
St. Michael's Hospital
Toronto, Ontario

Revisiting Idiopathic Inflammatory Myopathies

(Continued from page 25)

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Rheumatology Here & Away: An 18-year Journey from Istanbul to Ottawa

By Sibel Zehra Aydin, MD

I am an adult rheumatologist, working at the University of Ottawa since 2015. Here is my personal journey through rheumatology, from Istanbul to Ottawa.

In 2001, I completed my rheumatology rotation within my internal medicine residency, at Marmara University, Istanbul, Turkey. From that moment on, I knew that I could not choose any other specialty. More specifically, I was curious about prognostic factors in spondyloarthritis. I started doing research in this area during my internal medicine training, with my very first projects being on biomarkers in spondyloarthritis, linking the gut with the radiographic damage. This was followed by my rheumatology residency in 2005, at the same university.

In 2006, in the first year of my rheumatology residency, I held an ultrasound probe for the first time. I immediately realized that I could never go back to practicing without it. I had to learn this technique, and I had to learn from the best teachers. That's why I went to Italy to work with Professors Walter Grassi and Emilio Filippucci, the two gurus of ultrasonography, who irreversibly changed my life. Since then, ultrasound not only has been an irreplaceable tool in my clinical practice, but also has changed the course of my research significantly.

In 2009, my chief, Prof. Haner Direskeneli wisely told me that I had to experience research abroad, if I wanted to be a good researcher. That is how I ended up in Leeds, UK, to work with Prof. Dennis McGonagle, shortly after he published the synovio-entheseal complex theory. This has been an extremely productive period in my life and brought a different perspective to my research. One research question led to another and I found myself spending a decade on imaging and how that improves our assessment and understanding of these diseases.

Then, in 2014, I was invited to meet with the Division of Rheumatology in Ottawa. How lucky I was to meet with all these very nice people who were interested in hearing what I was doing and what I could offer… After a few meetings, we shook hands and my family and I moved to Ottawa in 2015. There have been challenges along the way, but I always felt fortunate to be in Ottawa. Finally, I have found myself in a place where I could contribute, surrounded by open-minded people.

Last but not least, before any of this happened, in 1992, when I was in high school, I met a boy; I knew that he was the one, and he eventually became my husband and the father of my two sons.

Further to this brief introduction, I would like to share my transition process with you. While similar aspects between Canadian and Turkish healthcare systems made my life easier, some of the differences had been difficult to adjust to. Here are some similarities and differences:

1) What patients want and need:

The patients' needs are almost universal, therefore I have not struggled with patient care. One minor difference would be that in Turkey, medical decisions are more frequently made by the physicians, as the patients more often tend to leave the decisions to the experts. I recognize that, in Canada, there is more of a patient-centered system, reflecting cultural differences.

2) More about cultural differences:

Unfortunately, actual and attempted violence against physicians has become a major issue in Turkey. This has been recognized as a significant factor in the increase in burnout among physicians. Emotional reactions are a part of the Mediterranean culture, which may affect the patients' reactions to upsetting news, sadly sometimes leading to violent behavior.

3) Insurance:

In Turkey, all patients have public insurance, similar to Canada. Private insurance has a different meaning in Turkey, as there are also private hospitals which are not funded by the government. This gives options to patients, if they have private insurance or if they can afford it, to be able to receive service very quickly and more comfortably (five-star luxury hotel-type hospital services, if it matters). This may sound like inequality amongst people, and I believe it is; however, it also frees up space in the public system, leaving more time and spots for people who cannot afford private practice.

4) Drug coverage:

In Turkey, all drugs are covered by the public healthcare system; therefore, it would be rare to have a patient who could not afford medication.

5) Long letters:

Family physicians and rheumatologists do not communicate via letters in Turkey. Documentation is only for the specialist to be able to follow his/her own assessments, and to make sure that the physician is legally protected in case anything goes wrong, in most hospitals.

6) Waiting times to be seen by other specialists/ getting imaging done:

In Turkey, patients do not have to wait for more than two months to be seen by a specialist or to have surgery performed. Similarly, an MRI would be done within two weeks, at the latest. The burden of this fast access falls on the physicians, who have to see an unrealistic number of patients every day. Protected time for doing research is a privilege that is only given to a small group of physicians; many others have 10 clinics per week.

7) High number of physical therapy and rehabilitation (PTR) specialists across the country:

In Turkey, the number of PTR specialists are probably around 10 times more than rheumatologists, and they deal with non-inflammatory causes of musculoskeletal pain, including fibromyalgia and osteoarthritis.

8) Finding 100 excuses not to learn musculoskeletal ultrasound:

The barriers are universal… So are the benefits. Regardless of where I work, when people recognize the value, barriers are not too difficult to overcome. I am very happy to see the increased uptake of ultrasound in my division, and seeing that barriers are getting smaller and smaller as time goes by.

My journey started in Turkey, led to Italy and to the UK, and now continues in Canada. I am very happy and proud to be a part of this prestigious rheumatology community and will continue to contribute to patient care, education and research, as much as I can.

Sibel Zehra Aydin, MD
Associate Professor,
Faculty of Medicine, Division of Rheumatology
Senior Clinician Investigator,
Clinical Epidemiology Program,
Ottawa Hospital Research Institute (OHRI)
Director of Research, Arthritis Center
University of Ottawa,
Ottawa, Ontario

Survey Results: CPD and Educational Activities

"Assessment drives learning."
– Cees van der Vleuten, Director of the School of Health Profession Education, Maastricht University, Netherlands

For this issue's Joint Count survey, we asked our members about their continuing professional development (CPD) and educational activities. A total of 117 surveys were completed out of a possible 588, with a completion rate of 20%.

The first question of the survey asked members how often they attend the CRA Annual Scientific Meeting (ASM) as part of their CPD. Thirty-eight percent (38%) of participants attend annually, with 16% attending every second year, and 19% attending every few years. Only 10% answered that they never attend.

Other than the CRA ASM and other national/international conferences, members attend a wide-ranging variety of other types of CPD activities. More than 80% of respondents say they attend other in-person CPD activities, followed by 50% saying they also participate in online CPD activities. Seventeen percent (17%) of members answered that they attend the CRA ASM and other national/international conferences, exclusively.

Among different types of sessions, 50% have participated in at least one online group learning webinar and 55% in at least one online self-assessment module. Nearly 50% of respondents have also participated in medical podcasts and/or multisource/peer feedback reviews. Notably, 30% of respondents said they participate in more than 20 online journal reviews or presentations annually.

When asked about what other education opportunities they would participate in, if available from the CRA, popular responses included small group learning/in-person (59%); online self-assessment modules (54%); large group learning/in-person (51%); and online reviews of journals/presentations (49%). For more details, refer to Table 1 below.

Survey respondents were also appreciative of the CRA's continuing professional development opportunities, with one member commenting, "Thank you for the CRA support of educational activities from practicing members to trainees, and providing rigorous, thoughtfully sought educational opportunities for all of us. Thank you for continuing to explore and support more options for member education."

If you have any additional feedback for the CRA on their CPD and educational activities, please contact Claire McGowan at *cmcgowan@rheum.ca*.

Table 1.
What type of other education opportunities would you participate in, if available, from the CRA?

Education Activity	Percent
Small group learning, in-person	59 %
Online self-assessment modules	54%
Large group learning, in-person	51%
Online review of guidelines, position statements	50%
Online review of journals, presentations	49%
Medical podcasts	42%
Online group learning webinars	29%
Multisource/Peer feedback reviews	11%
Phone teleconference sessions	10%

News from Your Colleagues in Newfoundland and Labrador

By Sean Hamilton, MD, FRCPC

When I returned from my sabbatical in October 2018, our number of adult rheumatologists in Newfoundland and Labrador (NL) had grown to a total of six from just a nucleus of three for many years, which has increased greatly our capacity to improve rheumatic health care delivery in NL.

The old guard continues, though. These are Dr. Proton Rahman's words in the third person: "Proton has been a fixture for over 20 years as a rheumatologist at St. Clare's Mercy Hospital in St. John's. He has outlasted most of the furniture, ceiling and walls (three floods in his office during this time). He continues to see general rheumatology patients with a particular interest in spondyloarthritis. Along with his genetic and pharmacogenetic studies in psoriatic arthritis (still looking, but no clinically actionable genes have been identified), he has broadened his research program to look at real-world evidence and health services research in spondyloarthritis (strategies for wait-list management). His administrative duties are fewer now, as he is no longer Associate Dean of Clinical Research at Memorial University. In his leisure time, he is running the hills of St. John's, watching his daughter play tennis or pushing the Costco cart for his wife." In summary, Proton is beyond amazing and we are so lucky to have him in the fold.

Our three "newish" rheumatologists are Dr. Sam Aseer since 2014, Dr. Natalia Pittman since 2017, and Dr. Shaina Goudie since 2018. Here are a few comments from Sam and Shaina:

Dr. Aseer: "It has been almost five years that I have been in practice in St. John's, and I begin to realize how quickly time flies. I remember the jitters of transitioning from residency to staff and my anxiety-driven first month of seeing patients on my own. The last five years have been an incredible learning experience, which have given me opportunities for both professional and personal growth. I continue to engage in medical education at both the undergraduate and postgraduate level, which I find quite rewarding. I am also involved in a few clinical trials that we have undertaken at our institution. I hope to continue my current career path and serve the wonderful people of this province."

A few of Newfoundland's rheumatologists (clockwise from top left): Dr. Natalia Pittman, Dr. Shaina Goudie, Dr. Sam Aseer, Dr. Proton Rahman, and Dr. Sean Hamilton.

Dr. Goudie: "As the newest rheumatologist in Newfoundland and Labrador, I am very happy to be back home and kept busy by a steady flow of interesting consults. This last year marks a record for the most rheumatologists in the province that we have ever had, which is wonderful. I hope it will serve to foster more interest in rheumatology among our local trainees."

Dr. Majed Khraishi continues in private rheumatology practice and with his rheumatology research.

Dr. Paul Dancey continues his stellar performance looking after the children of NL with rheumatic diseases.

Sean Hamilton, MD, FRCPC
Divisional Chief of Rheumatology, Eastern Health
Memorial University, St. John's, Newfoundland & Labrador

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).

ACR20/50/70=improvement in American College of Rheumatology response criteria ≥20%/≥50%/≥70%.
* 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 responders, or at week 24. Primary endpoint was the percentage of patients achieving ≥20% improvement in ACR criteria (ACR20) at week 24.
‡ SPIRIT-P2: 24-week, multicentre, randomized, double-blind, placebo-controlled trial of 363 adult patients with active psoriatic arthritis despite nonsteroidal anti-inflammatory drug, corticosteroid, ≥1 conventional disease-modifying antirheumatic drug treatment, treatment (12 weeks minimum) followed by discontinuation with 1–2 anti-TNF-α agents (or documented intolerance), 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; placebo. At week 16, inadequate responders on placebo were re-randomized 1:1 to one of the Taltz regimens up to week 24. Primary endpoint was the percentage of patients achieving at least a 20% improvement in ACR criteria (ACR20) at week 24.

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Pr taltz® (ixekizumab)

ACR efficacy results in both biologic-naïve and anti-TNF-α-experienced patients

Biologic-naïve patients | *Week 24 results from the SPIRIT-P1 trial†*

ACR20
58%

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

ACR50
40%

40% of Taltz 80 mg Q4W patients achieved ACR50 vs. 15% on placebo ($p\leq0.001$ [not adjusted for multiplicity], secondary endpoint; n=107 and 106, respectively)[1]

ACR70
23%

23% of Taltz 80 mg Q4W patients achieved ACR70 vs. 6% on placebo ($p\leq0.001$ [not adjusted for multiplicity], secondary endpoint; n=107 and 106, respectively)[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]

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

Anti-TNF-α-experienced patients | *Week 24 results from the SPIRIT-P2 trial‡*

ACR20
53%

53% of Taltz 80 mg Q4W patients achieved ACR20 vs. 20% on placebo ($p<0.001$; n=122 and 118, respectively)[1]

ACR50
35%

35% of Taltz 80 mg Q4W patients achieved ACR50 vs. 5% on placebo ($p<0.0001$ [not adjusted for multiplicity], secondary endpoint; n=122 and 118, respectively)[1,4]

ACR70
22%

22% of Taltz 80 mg Q4W patients achieved ACR70 vs. 0% on placebo ($p<0.0001$ [not adjusted for multiplicity], secondary endpoint; n=122 and 118, respectively)[1,4]

Indication and clinical use:

Taltz is indicated for the treatment of:

- Adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.
- 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).

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.
- 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.

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