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CRA SCR

The Journal of the Canadian Rheumatology Association

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EDITORIAL

Virtual Rheumatology Practice Resembles Bitcoin Mining: Discuss

By Philip A. Baer, MDCM, FRCPC, FACR

Rheumatology written fellowship examinations with essay questions may be history post-pandemic but, even if they survive, I doubt the title question is likely to appear. If it does, feel free to use the information below.

In the tangible pre-COVID world, medicine was an outlier. While electronic medical records (EMRs) had gained ground, our digital transition lagged. Information transfer was still dominated by the fax machine, interconnection and interoperability of electronic health information was rare, and our work with patients was primarily fee-for-service piecework. Of course, the one-on-one interactions with patients, including close physical presence and actual physical examinations, are what we pride ourselves on as rheumatologists, helping patients navigate the course of their chronic diseases longitudinally.

Even then, in our financial dealings with payers, we had moved to the digital world. Governments no longer accept paper claims or even floppy disks; billing information is transmitted electronically and paid in similar fashion directly into our bank accounts monthly.

Now, practicing virtual medicine is the new normal. While that could be on a video platform mimicking real-life interactions, many of my visits are telephone-based. On a daily basis, I am sitting at my computer in my home office, with my EMR open, talking and pecking away at the keyboard patient after patient, sending prescriptions and requisition forms digitally to pharmacies, patients and health care institutions. At the end of the day, my billing for all that work is electronically sent to the Ministry of Health, with payment virtually guaranteed: absent the in-person interactions, I feel like I am creating money out of nowhere. This virtual and digital work somehow lacks the weight and substance of in-office interactions, even though the required decision-making is as challenging, if not more so. Being able to work without getting dressed or dressed up, managing one's appearance, and commuting to a workplace setting influences that perception.

Of course, digital money is nothing new. Cash transactions are steadily declining in popularity, as is the use of cheques. We are in a period of an accelerating transition to preauthorized payments, electronic fund transfers, Interac e-transfers and digital wallets. While governments and their central banks are said to be "printing money" currently, they are not actually running a physical printing press, as in the Netflix hit 'Money Heist.' The money funding pandemic government programs like the Canada Emergency Wage Subsidy (CEWS), Canada Emergency Business Account (CEBA), Temporary Wage Subsidy (TWS), Canada Emergency Response Benefit (CERB), and many others, is all being created and transferred digitally.

Bitcoin miners also appear to create money out of nowhere, by using computers to solve complex mathematical equations. How is that possible? I learned a lot about bitcoin, and the often-associated concept of blockchain, from articles on *www.investopedia.com*. Apparently, the chance of a computer solving one of these problems is currently about 1 in 13 trillion. I like my odds of correctly diagnosing an unseen virtual patient from home a lot better. Meanwhile, the "block reward" for solving these complex math problems keeps falling, from 50 Bitcoins in 2009 down to 3.125 Bitcoins as of May 2020. Canadian rheumatologists can relate to that, with fee freezes and rollbacks being common in recent years. In Ontario, the Ministry of Health created new fee codes for virtual billing at the start of the pandemic, but then took the position that most virtual follow-up visits should be paid at 33% less than in-person visits. That dispute lasted months before being resolved in our favour after intense lobbying.

Finally, mining for bitcoin requires massive amounts of energy and sophisticated computing setups. All I require is a phone, internet access, and a computer which can access my EMR in the cloud. So, my virtual work is environmentally friendly to the extreme, obviating commuting to the office by myself, my staff, and my patients. Bitcoin mining using pools of high-end computers requires electricity in large quantities which, if generated from coal or oil, is environmentally negative.

Bill Gates has been quoted as saying "Bitcoin is better than currency in that you don't have to be physically in the same place." With virtual rheumatology, you also don't have to be physically in the same place as your patient. Is it better than the real thing? That question could turn up on a future rheumatology exam, but you'll have to work out the answer on your own.

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

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Dr. May Choi

2019 Gary S. Gilkeson
Career Development Award

Dr. May Choi received the Lupus Foundation of America's *2019 Gary S. Gilkeson Career Development Award*, an award designed to support clinicians and fellows who are starting their lupus research career. With this award, Dr. Choi is obtaining a Master's degree in the Epidemiology Program at Harvard T.H. Chan School of Public Health and is pursuing further lupus training at the Brigham and Women's Hospital under the supervision and mentoring of Dr. Karen Costenbader, a Professor of Medicine at Harvard Medical School and lupus expert. Dr. Choi's research interests include identifying factors influencing anti-nuclear antibody (ANA) expression over time to inform systemic lupus erythematosus (SLE) classification and novel biomarkers to improve our ability to predict disease activity and outcomes.

Dr. Gillian Hawker

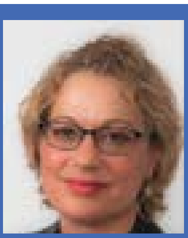
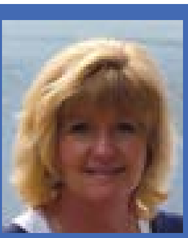
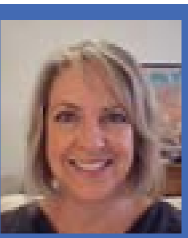
OARSI Clinical Research Award

Dr. Gillian Hawker is the Sir John and Lady Eaton Professor and Chair of the Department of Medicine at the University of Toronto and a Senior Scientist at the Women's College Research Institute. She is the recipient of the *2020 International Osteoarthritis Research Society (OARSI) Clinical Research Award*.

Dr. Hawker states: "As a health services researcher, my focus has largely been on investigating the determinants and outcomes of osteoarthritis (OA) care, or lack thereof, with an emphasis on joint replacement surgery and more recently on people with other common comorbid conditions, like diabetes. Those of us who are rheumatologists with a focus on osteoarthritis have always felt a little apart from our rheumatology peers. OARSI brings together researchers in all fields relevant to OA; the OARSI community has been invaluable to me as a researcher – challenging me to think differently and to think big. OARSI brings together the "who's who'" of OA research. So, to be honoured by my OARSI peers through receipt of the 2*020 Clinical Research Award* is, well, really nice! I am very grateful."

Who's in the Rheum? CRA Staff Edition (Part 1)

Welcome to the first part of our Who's in the Rheum? CRA Staff Edition series! We hope to share some of the personalities behind the CRA who work so hard to support our members. Interviews with other members of our staff will be published in the Winter issue.

	 Mona Bosinceanu	 Sharon Brinkos	 Sue Ranta
Please describe your role at the CRA in one sentence.	As an Office Manager reporting to the CEO, I am responsible for supporting the smooth and efficient running of the CRA, with a strong focus on administrative and operational excellence.	I am the Membership and Sponsor Coordinator; I also respond to all general inquiries.	I coordinate and support the activities of various operational committees and working groups.
How long have you been with the CRA?	Since November 2018.	Since June 2013.	Since October 2018.
What is your favourite CRA memory to date?	The successful Canada Night event in Atlanta, in 2019.	I can't say there is only one, as every year at the ASM something seems to happen that puts a smile on my face or sends our team into hysterics.	Claire LeBlanc's live performance at the 2020 gala dinner – she was incredible!
How has COVID-19 impacted your day-to-day operations?	Internet usage "black-outs" which occur quite frequently.	Yes – scheduling important meetings around my daughter's school schedule due to the strain on our internet.	Not really, aside from the welcome distraction of having my 2 girls under one roof again.
What were your summer plans this year pre-COVID?	Travel/Safari in Africa.	We were moving, so lots of unpacking to do and no actual travel plans.	Camping and cottaging . . . not much has changed!
Where is your next destination once it's safe to travel?	Hopefully the African Safari which was postponed.	I'm not a world traveller but hope to drive to eastern Canada (Newfoundland) to see family. A plane ride is not in my near future!	Australia to visit my sister.
If you were shipwrecked on a deserted island, what two items would you want to have with you (excluding basic necessities)?	My dog and a bottle of wine.	Magnifying glass and Swiss Army knife.	A notebook and a pen.
Can you share any of your hidden talents or hobbies?	Ping-pong/badminton/tennis.	I absolutely love to cook and have won a couple of baking awards. Butter tarts are my specialty!	Upcycling and refinishing furniture.
What are you watching or reading these days?	Modern Family	I read cookbooks. *Taste of Home* books are my favourite.	*Imperfect Birds* by Anne Lamott.
What's your favorite '80s or '90s jam?	Vanessa Paradis	I'm a country girl at heart so Garth Brooks, Reba McIntyre, Brooks & Dunn, and Alan Jackson were always playing on my radio.	Anything and everything by The Tragically Hip – it was the soundtrack to my life back then!

The Epidemiology of Giant Cell Arteritis in Ontario

By Jessica Widdifield, PhD; and Lillian Barra, MD, PhD, FRCPC

There is a paucity of data on the incidence and prevalence of giant cell arteritis (GCA) in Canada. Additionally, there have been conflicting reports on the risk of mortality among individuals with GCA.

We first carried out a health administrative data validation study to evaluate the accuracy of administrative data algorithms for ascertaining GCA patients in population-based data. Our top performing algorithm (81% positive predictive value [PPV], 60% sensitivity, 100% specificity, 99% negative predictive value [NPV]) defined GCA patients who had at least one hospitalization, or at least two diagnosis claims (with at least one diagnosis claim by a rheumatologist, internist, or ophthalmologist) and at least one glucocorticoid prescription or at least one fee code for temporal artery biopsy in a three-year period, and excluding those with fee codes for kidney, lung, skin, and nasal biopsies (associated with other forms of vasculitis).

Application of this algorithm to Ontario province-wide data identified the crude number of incident GCA patients to be 861 patients (0.03%) in 2000 and 1,662 patients (0.03%) in 2018 among residents 50 years and older. We observed the age- and sex-standardized incidence of GCA to be stable over time (around 25 new cases per 100,000 people annually over the age of 50 years). Age-standardized incidence rates were significantly higher among females than males. Trends in age-standardized incidence rates showed stable incidence among females, but an increase in incidence among males over time. Incidence rates were highest among those aged 70 years and older. The cumulative number of GCA patients increased from 4,306 patients in 2000 to 13,832 patients in 2018. Standardized prevalence rates increased from 125 (95% CI 121,129) to 235 (95% CI 231,239) cases per 100,000 people 50 years and older during the same time period.

Over a 19-year period, mortality has remained increased among GCA patients relative to the general population. GCA mortality rates were higher among males and more premature deaths were occurring in younger age groups. In our study, improvements to the relative excess mortality for GCA patients over time (mortality gap) also did not occur.

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

Lillian Barra, MD, PhD, FRCPC
Division of Rheumatology,
St. Joseph's Health Care
University of Western Ontario,
London, Ontario

News from the Rheumatology Specialty Committee at the Royal College: New Members, CBD Curriculum and Exams in the Time of COVID

By Trudy Taylor, MD, FRCPC; and Kristin Houghton, MD, MSc, FRCPC, Dip Sports Med

Before we discuss updates from the Rheumatology Specialty Committee at the Royal College of Physicians and Surgeons of Canada (RCPSC), we thought we would first remind and/or enlighten you on the role of the specialty committee. Each specialty and subspecialty has a specialty committee at the Royal College, which is responsible for setting the specialty standards on which training, accreditation, credentialing and examinations are based. In addition, the specialty committee is responsible for appointing the examination board, along with supporting the process of accreditation of residency training programs. Finally, the committee is responsible for reviewing the specialty for any change in scope of practice or overlap with other specialties.

There are two types of committee members: voting members (chair, vice-chair, voting member for each of the five geographic regions); and non-voting members (mainly program directors and examination committee chairs). Committee members serve a two-year mandate, renewable twice.

The past year has been a time of tremendous change at the Rheumatology Specialty Committee. We had a significant turnover in membership, including a new Chair (Trudy Taylor) and Vice-Chair (Kristin Houghton, pediatric) who took over from the steady leadership of David Robinson in July 2019. Also, we have several new voting members, including Rosie Scuccimarri (region 4, pediatric), Dharini Mahendira (region 3) and Robert McDougall (region 2). They join the "old guard" of Elana Murphy (region 5) and Raheem Kherani (region 1 and community rep) to round out the voting members on the committee who, in addition to standard-setting, play a significant role in reviewing accreditation documents for each of the rheumatology residency training programs.

After years of hard work and dedication, Elaine Yacyshyn and Shirley Tse have completed their terms as adult and pediatric chairs of the rheumatology examination board. Taking over the helm are Michael Stein (adult) and Tania Cellucci (pediatric). In addition to their usual work, the examination board has faced challenging last-minute changes to the Fall 2020 examinations due to the COVID-19 pandemic. There are no applied exams (OSCE) this year and all candidates will write a written exam.

The last round of updates on changes to the committee membership relates to our program directors. There are 15 adult and 3 pediatric rheumatology residency programs. There has also been a significant change in the adult program directors across the country, with new program directors at Dalhousie (Elana Murphy), Saskatchewan (Keltie Anderson), McMaster (Kimberly Legault), Manitoba (Ramandip Singh), Université Laval (Myriam Allen) and the University of British Columbia (Raheem Kherani). They join the strong group of program directors who have been our fearless leaders in implementing the Competence by Design (CBD) curriculum for our rheumatology residents.

This close-knit group of past and present rheumatology educators has spent countless hours designing and implementing the curriculum for our residency training programs. Together, they have ensured that our Canadian residency training programs equip our trainees with the best knowledge and experience, setting them up for success. The first cohort of residents in the CBD curriculum has now completed their first year! Feedback from program directors is primarily positive, despite the challenges that the COVID-19 pandemic posed since mid-March.

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

Kristin Houghton, MD, MSc, FRCPC, Dip Sports Med
Clinical Associate Professor,
Division of Rheumatology, Department of Pediatrics,
University of British Columbia
Vancouver, British Columbia

EULAR 2020

By Philip A. Baer, MDCM, FRCPC, FACR

After three months of pandemic-enforced social distancing, everyone has sat through webinars too numerous to count on Zoom, GoToMeeting, Adobe Connect, Microsoft Teams, Google Meet and probably other platforms as well. Manageable for an hour, but longer meetings require strategically turning off the webcam to do some stretching and walk around one's chair.

So, what would a virtual scientific conference over four days look like? After the CRA's narrow escape in February, and with the ORA's annual meeting cancelled in April, EULAR's 2020 e-Congress was my first chance to find out. The decision to go virtual was made fairly late, in my view, in late March 2020. At that point, the COVID-19 situation was far worse in Europe than in Canada. Regular registrations were converted to a much lower e-Congress fee of $175 US. I cancelled my hotel at no cost, and Air Canada kept only $150 of my flight cost. I booked off the three weekdays of EULAR from my virtual office: a welcome respite from 12 weeks of daily telephone calls and attempts at video visits with my patients.

One of the mysteries was whether there was actually anyone in Frankfurt for EULAR. Other than rheumatology health professionals who live there, probably not.

Communications were quite good. In late May, two weeks before the congress start, all the abstracts were released for review and conference planning. There was no EULAR app this time. I made sure I had my EULAR login credentials updated. Reviewing the scientific program, all sessions remained based on Central European Time, so the conference started for me in Toronto on Wednesday at 7 a.m., and on the other days at 4 a.m.

The program showed a mix of posters, live abstract presentations, and pre-recorded expert lectures. Each only becomes available on the day of presentation, and then will remain on the website until the end of August 2020. The posters were in e-poster format, with the abstract but not the e-poster being downloadable. Most posters included a short video commentary by the presenting author. At the live conference, problems can include no poster on display and no poster presenter available for discussion. In the e-Congress version, the counterpart issues are finding an abstract, but no e-poster and/or no video. Overall, however, this system worked well.

Of course, the key issue which cannot be resolved until the congress goes live is whether the platform has the capacity to deal with all the participants trying to access it. On Wednesday at 6 a.m., logging in resulted in messages about platform overload. Eventually, I could access the welcome ceremony and the press conference, but not the opening plenary. Fortunately, matters improved for the next three days. The prerecorded lectures on WIN (What is New) and HOT (How to Treat) worked as expected. The availability of material for three months mimics ACR Beyond and ACR SessionSelect and allows for later review, as well as catching up with sessions that were scheduled simultaneously.

Still, one misses the energy of a live conference, the chance interactions and networking, the Meet the Professor sessions and live poster tours. Sitting at a computer screen for hours is tiring in its own way. Industry symposia still occurred, but there were no exhibit booths, and no adventures in food and drink to be had.

Clinical abstract award winners included one from Canada by Andre Luquini, MD, of Arthritis Research Canada, Richmond, and a PhD candidate at the University of British Columbia, Vancouver, for investigating the effects of the Making-it-Work online self-management program for people with inflammatory arthritis on presenteeism and work cessation (abstract OP0010).

We also had a Canadian winner for the undergraduate abstract award: Hsin Yen Liu, a third-year medical student at Western University, London, was recognized for his investigation into risk factors for retinopathy induced by antimalarials in systemic lupus erythematosus (SLE) and other autoimmune disorders (abstract OP0333), supervised by Janet Pope.

The CRA also provided expert video commentary on EULAR abstracts this year, featuring Drs. Pope, Louis Bessette and Susa Benseler, all of whom provided thought-provoking and incisive reviews of key studies.

Highlights included many studies on JAK-inhibitors, featuring comparative effectiveness studies such as SELECT-CHOICE and JAK-pot, and multiple other trials of upadacitinib and filgotinib, both in RA and seronegative disorders such as psoriatic arthritis and ankylosing spondylitis. The correlation of VTE risk with high RA disease activity, and the reduction in VTE risk with TNF inhibitors vs. conventional DMARDs were also explored. Studies showed that JAK inhibitors could work after prior JAK failure, and that they could allow for steroid tapering.

A working group study called ASAS MRImagine, led by our own Dr. Walter Maksymowycz, has developed new definitions that showed a high degree of specificity in identifying structural lesions of the sacroiliac joints on MRI indicative of axial spondyloarthritis. A session on "Cardiovascular risk and management in IMIDS" featured Dr. Dafna Gladman providing her expert perspective on cardiovascular disease risk in patients with psoriasis and psoriatic arthritis.

The CONTROL trial results suggested that adalimumab introduction results in better outcomes than methotrexate escalation in psoriatic arthritis. On the other hand, methotrexate might actually prevent rather than exacerbate RA-ILD, according to another study.

I could go on, but you can access the EULAR e-Congress yourself if you want to learn more. With hopes of early successes with antivirals and vaccines fading, this is the new normal. ACR retitled its annual meeting as ACR Convergence in May, and in June announced that the 2020 meeting would also be entirely virtual in November. Difficult decisions loom for CRA 2021 in Quebec City, and EULAR 2021 scheduled for Paris.

The CRA's 2020 Emerging Investigator: Dr. Claire Barber

Your work to date focuses on measuring the quality of care provided to patients living with inflammatory arthritis, so that if there are gaps in processes of care or suboptimal outcomes, these can be readily identified and remedied. Can you tell us more about your research and how your findings are translated into the clinical context?

My interest in the area of quality of care really began while working with the Arthritis Alliance of Canada (AAC) on developing System-Level Performance Measures for Inflammatory Arthritis. The AAC Models of Care executive at the time was led by Dr. Vandana Ahluwalia, Dr. Dianne Mosher, Dr. Michel Zummer and Ms. Anne Lyddiatt. They developed the Pan-Canadian Approach to Inflammatory Models of Care and an associated toolkit to help promote high quality of care and improved outcomes for patients living with inflammatory arthritis. We then worked to develop the performance measures to test whether patients were getting timely access to care and treatment across five Canadian provinces. The results of this work have improved our understanding of how to examine quality of care in Canada using different data sources and have also demonstrated some areas where improvements could be made.[1-4] Building upon this work, we have recently collaborated with patients, healthcare providers and healthcare leaders nationally to define key strategic objectives and associated performance measures for a more comprehensive framework for monitoring rheumatoid arthritis (RA) care including patient outcomes. Locally, we have begun to test these measures and we have developed continuous reporting mechanisms to help monitor care on an ongoing basis through the University of Calgary Department of Medicine's Health Analytic Work Group (HAWG). We have collaborated with the Alberta Medical Association's Physician Learning Program (PLP) to develop individualized physician reports on the measures and have presented them to physicians for group feedback and are currently working on a number of projects to try and optimize care.

You have also collaborated internationally, working with the American College of Rheumatology (ACR) on measure development efforts and have recently led the American College of Rheumatology's update on Functional Status Assessment Measures. How would you describe your experience working with international organizations?

Early in my career, my PhD supervisor, Dr. John Esdaile, introduced me to Dr. Jinoos Yazdany who was the chair of the American College of Rheumatology's Quality Measure Subcommittee, and she invited me to join the committee. This was a critical moment for my career as I gained invaluable experience while serving on the committee under Dr. Yazdany, and later Dr. Lisa Suter and Dr. Alex Limanni. I learned about high-stakes quality measurement and contributed to a number of projects to further the science in this area including in outcome measurement and electronic e-specification of measures. I was eventually tasked with helping to lead the recent ACR update on Functional Status Assessment Measures with mentorship by Dr. Kaleb Michaud.[5] Meeting and working directly with these extraordinary individuals has been an enjoyable and highly rewarding experience.

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

My main focus for my research is really to work on closing gaps in quality of care that we have identified and to better understand how the gaps in care impact patient and health system outcomes. Some of my ongoing projects include the following:

Dr. Glen Hazlewood (co-PI) and I have a CIORA-funded grant to implement a decision aid for early RA to help improve shared decision-making between physicians and patients.

Co-PIs, Drs. Jessica Widdifield, Diane Lacaille and I are leading a team of researchers in three provinces through a CIHR-funded grant to better understand the impact of adherence to the AAC System-Level Performance Measures on patient and health system outcomes.

My research team has also developed a patient quality of care survey for RA which we will be testing shortly as an alternative to chart reviews for monitoring care.

I am a co-chair with Dr. Widdifield for the Canadian Rheumatology Association's HR committee, and along with Dr. Stephanie Kulhawy-Wibe and members of the committee we will soon be launching the CRA's Workforce survey for 2020, which will examine the impact of the pandemic on the rheumatology workforce.

Through my *STARS Career Development Award* (funded by the Canadian Institutes of Health Research – Institute of Musculoskeletal Health and Arthritis) I will be examining how to improve the delivery of care to patients through a better understanding of patient needs and complexity.

Dr. Barber receiving her award from then CRA President Dr. Vandana Ahluwalia and Dr. Raheem Kherani.

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

Having a career as a clinician-researcher is such a privilege and I am grateful for this opportunity every day. I have the time to take the knowledge and experiences from my clinical practice and think about how to improve patient care. I am a big believer in the concept of a Learning Healthcare System where we are constantly learning from every encounter and listening to every patient to improve care delivery and patient outcomes.

Every project, grant, and paper brings unique challenges and rewards. I try to approach each challenge by breaking it down into manageable pieces. There are frequent "failures" in health research including rejected grants and papers etc. Being persistent is the key to success!

My research mentors and colleagues have been instrumental in guiding my career and supporting my research. Drs. John Hanly, Paul Fortin, Dianne Mosher, Deborah Marshall, Diane Lacaille, Cheryl Barnabe, Glen Hazlewood, John Esdaile and Jessica Widdifield and many others have inspired and supported me along this journey.

What has been your proudest accomplishment to date in your research?

Winning the *CRA Emerging Investigator Award* has probably been the most memorable accomplishment to date, especially as it occurred in close proximity to being awarded a *STARS Career Development Award* and a CIHR grant, none of which would have been possible without my mentors and colleagues listed above. I also take immense pride in the successes of my students' accomplishments. They really help make an academic career worthwhile and fun!

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

I was very moved. What was especially moving was that my research mentor Dr. Fortin was also receiving the *CRA Distinguished Investigator Award*. Dr. Fortin was my research supervisor when I was a rheumatology resident at the University of Toronto (U of T). Without his encouragement and support, I would not have pursued or applied for advanced training in epidemiology, which subsequently launched my career. It was also exciting that my good friend and colleague Dr. Mahendira won the *CRA Emerging Teacher-Educator Award* as we were residents at the U of T in the same year.

For those wanting to pursue rheumatology and research, what advice would you give?

Surround yourself with amazing mentors (there are so many to choose from in Canadian rheumatology!) and work early to build networks. I am also happy to meet and talk to any prospective trainees!

If you weren't pursuing research as a career, what would you be doing?

My husband suggests that I would probably be a vegan chef. In all seriousness, probably a clinical rheumatologist. I really enjoy patient care.

What talent do you have that is not utilized successfully in your workplace?

When I was younger I spent a lot of time studying music and I played the cello, piano and sang in choirs. We should probably have more musical events at work as it helps people work as a team and have fun. During the pandemic I joined the Calgary Physicians Choir and we practiced via Zoom! It really helps reduce stress during an otherwise difficult time.

If you could eat one food for the rest of your life, what would it be?

I haven't met a vegetable I didn't like!

What is your favourite book of all time?

I have lots of favourite books, and it is a bit hard to rank them… one in the last year that was particularly memorable was by Dan Harris: "10% Happier – How I tamed the voice in my head, reduced stress without losing my edge, and found self-help that actually works – a true story." It is an easy and accessible introduction to meditation best suited to more cynical audiences. Little did I know how helpful it would be to have some additional tools to help with coping with stress during the pandemic. He also has a podcast with amazing guests and a meditation app (I promise I get no commission!)

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

References

1. Barber CEH, Marshall DA, Szefer E, Barnabe C, Shiff NJ, Bykerk V, et al. A population-based approach to reporting system-level performance measures for rheumatoid arthritis care. Arthritis Care Res (Hoboken). 2020; doi: 10.1002/acr.24178. [Epub ahead of print].
2. Barber CEH, Lix LM, Lacaille D, Marshall DA, Kroeker K, Benseler S, et al. Testing population-based performance measures identifies gaps in juvenile idiopathic arthritis (JIA) care. BMC Health Serv Res. 2019; 19(1):572.
3. Barber CEH, Thorne JC, Ahluwalia V, Burt J, Lacaille D, Marshall DA, et al. Feasibility of Measurement and Adherence to System Performance Measures for Rheumatoid Arthritis in 5 Models of Care. J Rheumatol. 2018; 45(11):1501-8.
4. Barber CEH, Schieir O, Lacaille D, Marshall DA, Barnabe C, Hazlewood G, et al. High Adherence to System-Level Performance Measures for Rheumatoid Arthritis in a National Early Arthritis Cohort Over Eight Years. Arthritis Care Res (Hoboken). 2018; 70(6):842-50.
5. Barber CEH, Zell J, Yazdany J, Davis AM, Cappelli L, Ehrlich-Jones L, et al. 2019 American College of Rheumatology Recommended Patient-Reported Functional Status Assessment Measures in Rheumatoid Arthritis. Arthritis Care Res (Hoboken). 2019; 71(12):1531-9.

The CRA's 2020 Distinguished Teacher-Educator: Dr. Rayfel Schneider

From where do you think your passion for medical education stemmed? Can you recall a teacher in your own past who inspired your direction into education?

My interest in medical education took root during my medical training. As one of the Chief Residents in Pediatrics, I had the opportunity to be engaged in organizing educational sessions for residents and in teaching junior residents and students. I also had the good fortune to work closely with the Chair of the Department of Pediatrics at the time, Dr. Bob Haslam. He was a master clinician and an outstanding educator, intensively engaged with learners at all levels. He more or less took me under his wing and inspired, encouraged and supported me to pursue a career with a strong interest in medical education. I could not have had a better mentor.

My fellowship in pediatric rheumatology turned out to be a good match for a focus in education since my rheumatology mentors were also among the most talented and engaged teachers in the department. I learned from the best!

As a Program Director, you've built the SickKids pediatric rheumatology training program into one of the largest and most successful in the world. What are some of the challenges you've faced?

Actually, being a Program Director in pediatric rheumatology was the most rewarding period of my career. As a Program Director, one has the privilege of accompanying the brightest and most passionate young men and women on their formative journeys in rheumatology and the opportunity to learn with and from them. It has been particularly gratifying to see residents and fellows transition from trainees to colleagues and collaborators, and to be able to cement long-standing friendships with them over the years. One of the very best aspects of working at a training hub for physicians from across Canada and around the world is to be part of a national and international network of alumni. Many former trainees have become leaders in their own centres and experts in specific diseases. It is wonderful to have far-flung friends I can readily call on to help with difficult diagnostic or treatment dilemmas.

Given your extensive work in medical education, where do you see the future of medical education moving?

We are in the midst of the most dramatic and exciting changes in medical education in decades – the shift to competency-based education, with a welcome focus on direct observation of clinical skills and coaching to competence, rather than an emphasis on high-stakes evaluation. We also have a long-overdue momentum to ensure that the learning environment is safe, respectful and welcoming for all.

You have been the recipient of many prestigious teaching awards, but what was your first thought when you learned that you would receive this particular award?

Gratitude for the efforts of my nominators, mentors and colleagues and for the opportunities to get to know and learn with so many residents and fellows who have spent time in our training program.

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

If you like a rapidly-evolving specialty that deals with a diverse spectrum of diseases, with increasingly effective treatment modalities and the opportunity to develop meaningful long-term relationships with patients and families, then rheumatology is a great choice. I find that, by and large, rheumatologists are kind, thoughtful, compassionate and

Dr. Schneider received his award via videoconference from then CRA President Dr. Vandana Ahluwalia and Dr. Raheem Kherani.

collaborative physicians, who derive a great deal of satisfaction from their work.

Are you more of morning or night person?

Definitely a morning person, particularly when I don't also try to be the night person.

How many cups of coffee does it take to make a productive day?

At least two; a third cup has to be balanced with the risk of a tremor.

Rayfel Schneider, MBBCh, FRCPC
Professor and Associate Chair (Education),
Staff, Division of Rheumatology
Department of Pediatrics
University of Toronto and The Hospital for Sick Children
Toronto, Ontario

Getting Action, Raising Voices

By Trish Barbato, President and CEO, Arthritis Society

As Canada continues to confront COVID-19, the Arthritis Society has been working hard to draw attention to the serious health challenge that is emerging – the alarming backlog of joint replacement surgeries.

More than 5,000 Canadians have so far joined our call, asking their elected representatives to make this a priority. We also began efforts this summer to convene a Pan-Canadian Working Group to recommend practical strategies for how we can swiftly increase surgeries and implement new and innovative models of care and prevention. CRA members can expect to hear more about this effort in the coming months.

Governments in Canada reacted with admirable speed and purpose to the economic fallout caused by the COVID-19 pandemic. We know it is now time to bring that same sense of urgency to this growing crisis in arthritis care.

Arthritis Awareness Month in September is providing us with an additional platform to raise awareness of these issues. Throughout the month, the Arthritis Society has been inviting Canadians from coast to coast to join us in raising one million voices and $1 million for the six million Canadians with arthritis. Look for news about our *#1for6million* campaign and please join in. Visit *arthritis.ca* to learn more.

Once Upon a Time in Canadian Rheumatology: 1974-84, a CRA Decade Long Before Biologics and JAK Inhibitors

By Dr. Manfred Harth, CRA President, 1982-1984

Remembrance of things past is not necessarily the remembrance of things as they were.
– Marcel Proust

I was asked to reminisce about the period when I was involved in the leadership of the CRA, that is the 1974-1984 decade. I was a member at-large of the Executive Committee from 1974 to 1976, out of office for two years, then Secretary in 1978-80, Vice-President in 1980-82, and President in 1982-84.

Some may remember that in those days CRA stood for Canadian Rheumatism Association, which was a name change from the original 1936 designation of Canadian Rheumatic Disease Association. The CRA from 1974-84 was a much smaller and poorer organization than the current CRA. Our meetings were initially short, lasting one day only, and on a modest scale. Eventually the Royal College asked us and other specialty societies to join their meeting. We welcomed this as the College paid for many of the meeting expenses involved.

It was not until 1972 that the Royal College introduced the fellowship examination for rheumatology. Until then, most rheumatologists were internists who usually had had one to two years of training in the specialty and spent at least 50% of their clinical time in rheumatology.

Metro Ogryzlo, who had founded the *Journal of Rheumatology* in 1974, hoped that the CRA could take it over, but we did not have the required financial resources. The CRA did adopt it as its official organ, leaving it to individual members to decide on whether they would subscribe.

Toronto had dominated Canadian rheumatology for years, but the 1970s and 1980s saw other Canadian academic rheumatology centres increasingly engaged in research and post-graduate training. A friendly (well, not always!) rivalry ensued and CRA meetings were the better for it.

There was a very close relation between the Arthritis Society (TAS) and CRA. TAS was led by Edward Dunlop, a blinded war hero and an extraordinary man whose contributions to Canadian rheumatology remain unequalled. The CRA instituted an annual lecture to honour him and Rita Dottridge, his close associate. It was thanks to TAS that Rheumatic Diseases Units were established with dedicated inpatient beds, and essential health care professionals attached to them. TAS paid for many rheumatology fellowships at a time when departments of medicine were somewhat reluctant to fully support the development of our specialty. TAS gave scholarships to newly appointed young faculty, and offered research grants assessed by peer review.

The CRA hosted the 1974 meeting of PANLAR (then the Pan-American League against Rheumatism, now the Pan-American League of Associations of Rheumatology) in Toronto, although the major organizing work was done by TAS.

It was in this decade that we started the *Ian Watson* and the *Phil Rosen Awards* (the latter honouring a CRA president with an outstanding record of service).

In 1976, a committee of CRA members who had participated in a Medical Manpower Study, sponsored by the Royal College and the Federal Department of Health, reported that the ratio of rheumatologists per population was 1/180,000. In 1983, the CRA Manpower Committee published a study of Canadian rheumatology training programs and found that 61 trainees had completed the required two years in the 1973-78 period, thus raising our hopes that the above ratio might improve slowly.

Rheumatology started attracting an increasing number of female trainees, and we began seeing more women with full-time or part-time academic appointments, or in independent practice.

Big Pharma's interest in rheumatology was modest. We were using antimalarials, gold, penicillamine, steroids, azathioprine, cyclophosphamide, and scores of different non-steroidal anti-inflammatory drugs (NSAIDs); we had just started prescribing sulfasalazine. A few daring souls had tried methotrexate. Nothing there to attract much support.

The available immunologic laboratory tests allowed better assessment of various rheumatologic conditions. Imaging in rheumatology had advanced somewhat with the introduction of CAT scans and scintigraphy. Magnetic resonance imaging (MRI) machines were starting to be installed in teaching hospitals. Diagnostic ultrasound in rheumatology was still in its infancy.

It was, overall, a time of modest progress in our organization, paralleled by modest advances in therapy. We were much better at diagnosis than treatment. Not quite the dark ages, but quite a few years away from the "Renaissance."

Manfred Harth, MD, FRCPC
Emeritus Professor of Medicine,
University of Western Ontario
London, Ontario

The Renaissance of the CRA

By Dr. Jean-Luc Senécal, CRA President, 1992-1994

At the request of the CRAJ Editorial Board, I am pleased to write about the achievements of the CRA during my tenure as President from 1992 to 1994.

In 1987, I received a phone call from André Lussier* (*Université de Sherbrooke*), President of the CRA. Dr. Lussier invited me to submit my candidacy to the Executive Committee of the CRA. To give you some background, I had completed a three-year rheumatology fellowship four years earlier focused on systemic autoimmune diseases at the University of Connecticut in Farmington, CT, in the U.S. Upon my return to *Hôpital Notre-Dame* in Montreal in 1983, I had founded the Autoimmunity Research Laboratory and the Connective Tissue Diseases Clinic, both of which exist to this day, and I was an Assistant Professor of Medicine at *Université de Montréal*. My research was funded by an operating grant from the Medical Research Council of Canada (the future CIHR) and I obtained an Associateship salary award from the Arthritis Society. I was deeply honoured by the invitation of the CRA Executive Committee and the national recognition that it implied, despite my young career as a rheumatologist. Therefore, I promptly accepted Dr Lussier's invitation. I did not expect the challenging mandate that awaited me!

After being elected, I served as a member of the Executive Committee from 1988 to 1990. In 1990, Paul Davis (University of Alberta) was elected President and served for the 1990-1992 term while I was elected to the Vice-Presidency and François Beaudet (*Université de Montréal*) was elected as Treasurer. At that time, computers were big and slow; the internet, cell phones, Zoom and Skype did not exist, and long distance calls were expensive. So, all our cross-Canada communications were essentially by letter and by fax.

Dr, Lussier was an outstanding and most clever rheumatologist. He had mentioned that the CRA had a tradition that the presidency should alternate between an anglophone and a francophone president. Therefore, I suspect he had foreseen in 1987 that perhaps I might eventually succeed Paul Davis.

Indeed, in 1992, I was elected to the Presidency of the CRA with an outstanding Executive Committee: Barry Koehler as Vice-President (Barry was then practising in Thunder Bay, Ontario), Paul Davis as Past President, François Beaudet as Treasurer and Dafna Gladman (University of Toronto) as Councillor. By then, my wife and I were the proud parents of three kids, aged 7, 5 and 1!

A key feature to understand the following events that led to the rebirth of the CRA is that autonomous annual meetings of the CRA did not exist at that time. The CRA annual meeting was held at the same time as the Annual Meeting of the Royal College of Physicians and Surgeons of Canada and participating specialty societies.

Under its previous mandates, the Executive Committee of the CRA had become progressively aware that this was not necessarily to the advantage of the CRA,

Continued on page 18

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

References:
1. Pfizer Inc. Data on file. 2019.
2. Pfizer Canada ULC. XELJANZ/XELJANZ XR Product Monograph.
3. XELJANZ XR Notice of Compliance information.
4. XELJANZ RA Notice of Compliance information.
5. XELJANZ PsA Notice of Compliance information.
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The Renaissance of the CRA

Continued from page 15

as we had noted with concern the dwindling attendance by rheumatologists. Also, running the CRA meeting with the Royal College was costly and, in retrospect, not necessarily good for the image of the CRA and our identity as rheumatologists, as we were lost in an ocean of other much larger specialties than our own.

A turning point was the Annual Meeting of the Royal College held in Ottawa from September 11 to 14, 1992, which was rather catastrophic from the CRA viewpoint. Only about 25 rheumatologists attended out of a membership greater than 200. As I recall, the CRA poster session was held in the labyrinthine second basement of the Convention Center, and was in essence almost unattended. At the end of the convention, only a few thousand dollars were left in the CRA bank account. The CRA was nearly bankrupt!

From my viewpoint and that of my colleagues, the CRA was moribund and, if nothing was done, it was at risk of dying by attrition of its membership and extinction of its treasury. What could be done?

I suggested to the Executive Committee that the only way out for a CRA renaissance was to hold its annual meeting independently from the Royal College meeting.

Oh là là! Such a viewpoint was anathema because of the very tight bonds between some of the academic members of the CRA membership who were very involved with the Royal College. Why then did I come up with this idea? Probably because certification for specialty practice in Quebec was different from the other provinces: In Quebec, the right to practice was granted by the *Collège des médecins du Québec*, and Royal College certification was not mandatory (although it was deemed so for university appointments). Also, I have often thought that being from a province used to toying with the idea of political independence, perhaps it was easier for me to envision holding the CRA annual meeting separately from the Royal College! After much discussion, and holding our ground despite opposition from the Royal College and some CRA members, the Executive Committee unanimously endorsed the principle of holding autonomously future CRA annual meetings, starting in 1994.

The corollary question was then, if the CRA annual meeting is to be held on its own, where and when should it be held? I suggested that the meetings should alternate between Western and Eastern Canada, with the 1994 meeting in Lake Louise, Alberta. The Executive Board nominated me as Organizer of the First Winter Conference of the CRA, which was held at Château Lake Louise, from February 24 to 26, 1994. And, under the presidency of Barry Koehler, the 1995 Second Winter Conference and Annual Meeting of the CRA was held at the newly built Château Mont-Tremblant Hotel, in Mont-Tremblant, Quebec. The pharmaceutical industry fully supported the CRA in this endeavour.

The success of these meetings was instantaneous and extraordinary. The 1994 meeting attracted over 200 participants from across Canada, many with their families. The resulting sense of belonging, bonding and empowerment was decisive in launching a rejuvenated, dynamic and proud CRA. These decisions were a turning point in the history of the CRA and, along with many other key decisions made by subsequent Presidents and Executive Committee members, they paved the way to the autonomous and thriving association that the CRA has become.

I was blessed to be advised by an outstanding and wise Executive Committee. To this day, the renaissance of the CRA initiated by the 1992-1994 Executive Committee is a collective achievement that I am most proud of. I am for ever grateful to the CRA members for their trust and allegiance.

Many thanks to Barry Koehler, MD, Professor Emeritus, University of British Columbia, for reviewing this text.

** Dr Lussier is deceased.*

Jean-Luc Senécal, MD, FRCPC
Master of the CRA
Professor of Medicine, Université de Montréal
Rheumatologist,
Centre hospitalier de l'Université de Montréal
Montréal, Quebec

A CRA Odyssey

By Dr. Glen T.D. Thomson, CRA President, 1998-2000

Adel Fam nominated me to the Board of the CRA in 1992 and gave me his assurance that it would not take up much of my time. This turned out not to be true. The odyssey that followed took two decades to complete.

A year later, I was the appointed chair of the Scientific Committee with the task of organizing the annual meeting of the CRA. I was on the board that separated the CRA meeting from the Royal College. A new meeting model was created and evolved over my five years as chair. The objective was to be inclusive of all Canadian rheumatologists. The structure of the meetings would include community and not just hospital-based rheumatologists chairing sessions, reviewing research and discussing the medical issues of the day.

Simon Carette and I co-hosted the first Town Hall meeting of the membership (Washington, American College of Rheumatology [ACR], at the Canadian Embassy) to discuss the new directions of the organization. Next year as President, the first CRA Executive retreat was held in Winnipeg. This meeting fundamentally changed the function of the CRA Board. A mandate was given to create committees to enhance the CRA's leadership role in a wide range of activities including continuing medical education (CME), recruitment, public engagement and scientific promotion. This structural change allowed more CRA members to actively participate in national programs and has contributed to the relevance and success of the CRA.

After my term as President, I was given the role of Editor-in-Chief of the *Journal of the Canadian Rheumatology Association (CRAJ)*. The format of the *CRAJ* was reimagined and grew over the next decade to not only broadcast the new initiatives of the CRA, but also to tell the stories of rheumatologists in their diverse practices from coast to coast.

It was my final honour and task to chair the Canadian-Mexican Rheumatology Meeting in Cancun in 2011. It was exhausting but gratifying. My tour with the CRA and *CRAJ* had been completed. It was a privilege to serve my colleagues from around the country and a joy to work with those who shared the vision and enthusiasm for innovation as the nascent CRA evolved. There are too many folks to thank individually, you know who you are; my appreciation is undiminished. My abiding gratitude goes to Janine, Shanleigh and Ian for allowing me the time and many absences to indulge this journey. Good luck to the CRA in its next 75 years!

Glen T.D. Thomson, MD, FRCPC
Winnipeg, Manitoba

Building Bridges

By Dr. Arthur Bookman,
CRA President, 2002-2004

I was the president of the CRA from 2002-2004. I worked with my predecessor Dianne Mosher the previous year to establish a new relationship with the Arthritis Society (TAS) and create a Medical and Scientific Advisory Council that would recognize rheumatologists and the CRA in leadership advisory roles for the treatment of arthritis. After stepping down from my presidency, I became the inaugural Chair of the Medical Advisory Council (MAC) and Medical Advisor to TAS.

Dr. Bookman at the Mayan Ruins in Mexico while scouting activities for the CRA-Mexican conference.

As CRA President, I initiated discussions with the Canadian Pediatric Rheumatology Association to facilitate their merger with the CRA in a manner that would guarantee their autonomy and financial health. I initiated the first discussions with the Mexican Rheumatology Association, which my colleague Michel Zummer brought to fruition in the form of a combined Mexican-Canadian Rheumatology Meeting in Acapulco in 2006. I was involved in the first application of Rx&D rules to our scientific meeting, the creation of certificates which we handed out to all previous CRA Presidents in 2003 at our Annual Meeting, and the creation of the posters honouring award winners to be displayed at our Annual Meetings.

In Mexico during winter 2003 to arrange a conjoint Mexican-Canadian Meeting. From left to right: Dr. Arthur Bookman, Sandra Zummer, Ann Bookman, and Dr. Michel Zummer.

My presidency was a lifetime highlight for me. I made many wonderful friends through the CRA and expanded my network of colleagues across the country.

Arthur Bookman, MD, FRCPC
Coordinator, Multidisciplinary Sjogren's Clinic
University Health Network
Associate Professor of Medicine,
University of Toronto,
Toronto, Ontario

At the 2008 Annual Meeting. From left to right: Drs. Michel Zummer, Anthony Russell, Gunnar Kraag, John Esdaile and Simon Carette.

CRA Past-Presidents at the diploma presentation at the Annual Banquet in 2003. From left to right: Drs. Paul Davis, André Lussier, Manfred Harth, Anthony Russell, Dianne Mosher, Barry Koehler, Simon Carette, Joseph Houpt, Jean-Luc Senécal, and Arthur Bookman.

Dancing at the Meetings

By Dr. Michel Zummer, CRA President, 2004-2006

During my presidency, the CRA was focused on improving care for our patients as well as attracting medical residents to rheumatology training programs. I am grateful to my Board which contributed to many projects during those two years. In 2004, the "Canadian Consensus Statement on Early Optimal Therapy in Early Rheumatoid Arthritis," a project of a subcommittee of the CRA Therapeutic Committee led by Vivian Bykerk, was released. The Frontiers in Inflammatory Joint Diseases Conference, expertly organized by Hani El-Gabalawy and Rob Inman set research goals. In 2005, I represented the CRA at The Summit on Arthritis Prevention and Care (SAPC) – Rock This Joint, co-chaired by Dianne Mosher, Gillian Hawker, John Esdaile and Cheryl Koehn, an important event that set standards for prevention and care of arthritis. Arthur Bookman and I represented the CRA at the Expert Panel to Health Canada on Coxibs following the withdrawal of Vioxx. This was followed by the CRA's Interim Statement About Anti-inflammatories.

The CRA Board in 2005. **Back row (from left to right):** Drs. Janet Markland, Jerry Tennenbaum, Michel Zummer, and Carter Thorne. **Second row:** Drs. Gunnar Kraag, Jackie Stewart, John Thomson, and Glen Thomson. **Third row:** Drs. Janet Pope, Christine Peschken, Dianne Mosher, Jamie Hendersen, and Alf Cividino. **Front row:** Jean-Claude Dairon and Drs. Liam Martin, Kam Shojania, Stephanie Ensworth, Gilles Boire, and Douglas Smith.

By far, the longest lasting legacy of my presidency has been the CRA dance after the dinner at the annual meetings. This was born after our first joint meeting with the Mexican College of Rheumatology in 2006, held in Acapulco but only after we were forced to move from Cancun when Hurricane Wilma hit three months before the meeting. We fostered good friendships, collaborations and a great meeting that I co-organized with Arthur Bookman. The scientific chair was Janet Pope – who heroically planned both the 2005 and 2006 meetings simultaneously. The closing gala that year hosted a live band poolside with a great dance that inspired holding the dance at our annual meetings since 2007. Despite the current circumstances, I hope that we will be able to continue dancing in future meetings.

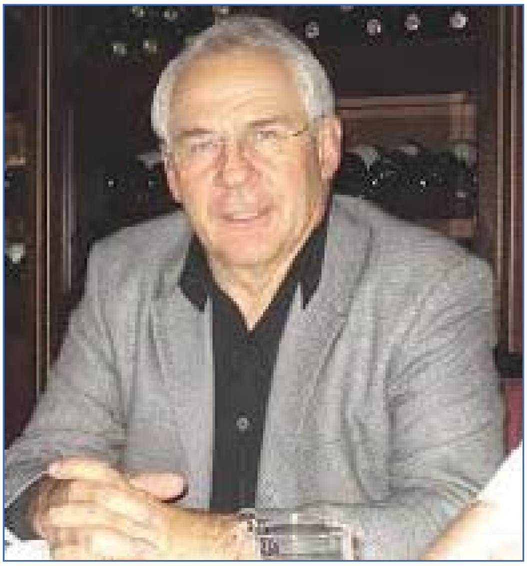
The first dance ever at a CRA meeting (in 2006). Pictured here: Dr. Evelyn Sutton, our current CRA President.

Michel Zummer, MD, FRCPC
Rheumatologist,
CH Maisonneuve-Rosemont
Associate Professor,
Université de Montréal
Montreal, Quebec

JRheum and the CRA: A Slam Dunk

By Dr. Gunnar Kraag, CRA President, 2006-2008

I have been asked along with other Past-Presidents of the CRA to provide some brief thoughts on my tenure as President from 2006 to 2008, in advance of the upcoming 75th anniversary of the CRA.



There is no question that the most significant event in my tenure began with a phone call from Murray Urowitz. After initial pleasantries, Murray got right to the point and asked if the CRA would be interested in purchasing the *Journal of Rheumatology*. The possible purchase of the *Journal of Rheumatology* would be the CRA's largest and most daring venture to date. Our discussion ended with my assurance that I would discuss this with the executive as soon as possible. One of the first people I called was Janet Pope to ask her what she thought of the idea. She replied that it was a "no-brainer" and that we should definitely pursue the purchase. The CRA executive agreed and Arthur Bookman was asked to chair a committee, which worked very hard exploring the feasibility of the purchase and then negotiating financial terms and issues such as governance. This culminated in the signing of a letter of intent to take the next step of developing and agreeing to a purchase agreement. The Board of the CRA unanimously recommended that the CRA proceed with the purchase and the membership supported this recommendation with an almost unanimous vote. It turns out that it was indeed a "no brainer".

Christine Charnock, who was previously Executive Coordinator and later CEO of the CRA, and Dr. Gunnar Kraag.

I cannot talk about my presidency without mentioning Christine Charnock who was then the Executive Coordinator of the CRA. I cannot imagine how we could have survived without her dedication and plain hard work. As our organization evolved, we realized that we would need a full-time Executive Director with proper administrative support. We did not have to search far or long. We already had the perfect candidate. Christine assumed that role and the organization thrived.

The strength of the CRA since the very beginning has been the membership. I anticipated that working with colleagues would be exciting, productive and fun. I was not disappointed. The executive, board, committee chairs, committee members and the members at-large work very hard on behalf of us all. Also, Canada's pediatric rheumatologists officially joined the CRA with Bianca Lang as chair during my tenure.

It really was a fun two years.

Gunnar Kraag, MD, FRCPC
Professor of Medicine (retired),
University of Ottawa
Ottawa, Ontario

Undertaking *JRheum* and Navigating the 2008 Economic Crisis

By Dr. John Thomson, CRA President, 2008-2010

When I first joined the CRA Board, I never imagined that I would become President. But there I was in early 2008, my new BlackBerry in hand, taking over the helm of what was to be a very busy but mostly enjoyable and satisfying two years.

The work of President of the CRA was like a second job. Emails of all levels of urgency arrived during the day and were dealt with on the fly between patients. Another couple of hours each and every night was spent dealing with more complex issues through emails, phone calls, and teleconferences. For the most part, my term was relatively uneventful, and much of my time was of an important housekeeping variety.

My term did, however, include the year 2008. As you may recall, and as we have been reminded of during the current COVID-19 crisis, 2008 had a major worldwide economic crisis all its own. This crisis paralyzed much economic activity globally, and the world economy was fraught with great uncertainty not dissimilar to that which we are currently experiencing. In the midst of this crisis, the CRA had to decide whether to proceed with a very major undertaking: The purchase of the *Journal of Rheumatology (JRheum)*. After a great deal of fretting, hand wringing, and discussion, bravely and (as it turns out) wisely the CRA proceeded with the transaction.

More than anything, it was the people. Membership on the Board tends to select out for individuals with a sense of volunteerism and personality strengths of collaboration and professionalism. As the President, I felt greatly supported and never alone. We worked together for the greater good of Canadian rheumatologists. This was truly a great honour and privilege.

I can't write about these years without special acknowledgment of a few people who helped me make it through: Christine Charnock, our Executive Director at the time; Gunnar Kraag the immediate Past-President; Michel Zummer, the *past* Past-President; Arthur Bookman, the *past past* Past-President; and Jamie Henderson, Vice-President.

John Thomson, MD, FRCPC,
Rheumatologist,
Ottawa, Ontario

A Joint Meeting with the Mexican College of Rheumatology

By Dr. Jamie Henderson, CRA President, 2010-2012

My time as President of the CRA was dominated by preparations for the 2011 joint meeting between the Mexican College of Rheumatology (MCR) and the CRA. This undertaking was planned as a repeat of the 2006 joint meeting. The planning was undertaken by an organizing committee, which included Drs. John Thomson, Cory Baillie, Michel Zummer and myself. Dr. Glen Thomson handled the Scientific Committee that organized the details of the program. Multiple organizing meetings were held at various venues including the American College of Rheumatology (ACR), MCR, and CRA annual meetings. We invited three members of the MCR to our annual CRA meeting and, in return, we sent three members of the organizing committee to the annual MCR meetings. We had to accommodate the annual change in leadership of the MCR, which often meant starting negotiations over again each time the leadership changed. Despite the challenges, the meeting took place in Cancun and was a success according to polling that took place after the meeting.

An undertaking that has stood the test of time was bringing the Canadian Initiatives for Outcomes in Rheumatology Care, also known as CIORA, under the umbrella of the CRA, after it originated as an industry-sponsored endeavour. The transition was facilitated through the leadership of Dr. Paul Haraoui and Dr. Alf Cividino.

Another legacy was the inclusion of the Arthritis Health Professions Association (AHPA) Annual Meeting as an appendage to the CRA Annual Scientific Meeting (ASM). The symbiosis of the two organizations has added to the success of our meetings.

Many details are a little hazy after 10 years, but the six-year commitment to the executive committee allowed me to meet fellow rheumatologists from across the country and forge bonds that exist to this day.

I would be remiss if I didn't acknowledge the contribution made by Christine Charnock, with her unfailing commitment and energy, that enabled all the above to be accomplished.

Jamie Henderson, MD, FRCPC
Rheumatologist (retired),
President,
The Journal of Rheumatology
Fredericton, New Brunswick

Reflections

By Dr. Carter Thorne, CRA President, 2012-2014

Colleagues:

The CRA will celebrate its 75th anniversary in 2021, and I will have been a dues-paying member for 40 years. I had the privilege of assuming the Presidency of the CRA in 2012, which represented my third epoch with the Association. From starting practice in 1981 through 1990, like most individuals, I had little interaction with the CRA, except to pay my annual dues.

In 1990, Paul Davis assumed Presidency of the CRA and, for the first time, community rheumatologists were invited to participate on the Board. As a member of the Board from 1990 to 2004, including the Executive (as Secretary-Treasurer) from 1996 to 2004, my second epoch allowed me to experience the excitement of the "new" CRA separate from the Royal College, and now both responsive and responsible to its members. At this time, I was also instrumental in initiating the Canadian Rheumatology Research Consortium (CRRC; which I am sad to say has recently disbanded); as well as the startup of the Ontario Rheumatology Association (ORA). My most recent re-engagement with the CRA began in 2010 when I was invited to re-join the CRA executive as VP and President-elect.

In my introductory address to members at the Annual General Meeting (AGM) in March 2012 I identified three imperatives:

1. Improve sustainability related to industry support. All of our industry partners have embraced our new innovative model of "corporate support," moving away from simply supporting the annual meeting, which is now recognized as prescient and in compliance with evolving Innovative Medicines Canada (IMC) and Royal College guidelines.
2. Modify the governance approach of our organization and develop a more effective Secretariat. The CRA was a "maturing" organization and this evolution, initiated during my tenure and fulfilled subsequently through the efforts of my immediate successor Cory Baillie, has resulted in our current robust and responsive organization.
3. Achieve accreditor status with the Royal College. This has enhanced our branding; we are indeed recognized as the "Experts in Arthritis." Noteworthy is our enhanced relationship with the Canadian Medical Association (CMA). Also, we were one of eight Canadian professional organizations invited to participate in the launch of the Choosing Wisely Canada initiative, championed by Dr. Shirley Lake. An additional new initiative was a focus on First Nations care through the Non-insured Health Benefits (NIHB) program.

Our annual meeting remains much in demand, with increasing attendance (1990=10 attendees; 1996=75; 2014=544; 2020=700) and not only of members and their families, but also allied health professionals, industry partners, and other interested parties.

The success of my tenure was in no small measure the result of the dedicated volunteers who preceded me, especially Paul Davis who identified the value and role of community rheumatologists in the CRA, my Executive including Cory Baillie (Vice-President), Jamie Henderson (Past-President) and Jacob Karsh (Secretary-Treasurer). Christine Charnock (whom I hired in 1997 as a part-time administrative assistant and subsequently became CRA Manager in 2012) and her dedicated team (all from Newmarket/Aurora) were instrumental in managing the ever-evolving required changes.

It was my privilege to serve you as President from 2012-2014, and I continue to participate in this vibrant organization in other roles.

Carter Thorne, MD, FRCPC, FACP, MACR, MCRA
Medical Director, The Arthritis Program &
Chief Division of Rheumatology,
Southlake Regional Health Centre
Newmarket, Ontario

Modernization in Governance

By Dr. Cory Baillie, CRA President, 2014-2016

By the time that I began my term as CRA President in February 2014, the organization had grown markedly in terms of numbers of members, and also in the activities and services that were provided to the membership. The CRA Annual Scientific Meeting was achieving record attendance. The CRA had numerous programs encompassing knowledge sharing and education, networking, advocacy and research support. However, the governance of the CRA had not yet kept up with the expansion of the organization. The Board had so much that it was responsible for. Board teleconferences seemed never ending and were impeding the ability to recruit new Board members. Who was accountable to whom and for what? Who had the authority to green light a new project, activity or expenditure? Clearly, we needed help.

During my term as CRA President, the CRA Board undertook an extensive governance review process, which was enlightening for the Board in clarifying its roles and responsibilities. The Board used this new knowledge to institute a number of changes which continue through to the present. The most visible was the creation of the position of CRA Chief Executive Officer (CEO) initially, Christine Charnock, and now, Ahmad Zbib. The CEO would now be responsible for the operations of the CRA, guided by a strategic plan developed by the Board, based on input from the membership.

The modernization of governance of the CRA was not without its hiccups. It took courage on the part of committee chairs who previously reported to the President and Board of Directors to adjust to being accountable to the CEO. We also feared a loss of engagement with the committee chairs no longer attending the regular Board meetings and the annual retreat. However, three CRA Presidents later, the CRA Board continues onward with the governance changes that were instituted, and I hope that they continue to bring the CRA success in the future.

Cory Baillie, MD, FRCPC
Assistant Professor,
University of Manitoba
President,
Doctors Manitoba
Winnipeg, Manitoba

Around the Rheum: The Official Podcast of the CRA

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

After several years of contemplation and preparation, the CRA Communications Committee's brainchild of a podcast by Canadian rheumatologists for Canadian rheumatologists (and hopefully beyond) has finally been born!

"Around the Rheum" was officially launched this year. Our host, Daniel Ennis, is a young rheumatologist working in Vancouver, B.C., with a special interest in vasculitis, who was (in the words of Leonard Cohen) "born with the gift of a golden voice." On the production side, we have been working closely with David McGuffin, a world-class broadcast journalist, podcast host, and podcast producer. David has extensive experience in journalism, including his previous role as Africa correspondent for the CBC, and his current roles as reporter on Canada for National Public Radio (NPR) and Canadian Geographic's Explore Podcast. In addition to David, we have benefitted from the expertise of Aaron Fontwell, a musician and producer, who has worked with the likes of Snoop Dogg and Tiesto!

Our first episode was an interview with Dr. Mary-Ann Fitzcharles, the lead author of the CRA's position statement on Medical Cannabis. Since then, we have recorded multiple other podcasts, including a mini-series on COVID-19 and rheumatology, which is being supported by the Canadian Medical Association (CMA), MD Management, and Scotiabank.

We have been working with David and Aaron to produce a high quality end-product. Our podcast has had great response so far with more than 1,000 downloads to date, and the feedback we have received has been very positive. "Around the Rheum" is available wherever fine podcasts are found, including Spotify, Apple Podcasts, and Google Play. So, please download, subscribe to, rate, and review our/your podcast! The more downloads and positive ratings we get, the better!

We would like to acknowledge the strong support of the CRA, especially Kevin Baijnauth for bringing all of us together, and Ahmad Zbib, our CEO, for his support.

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

Updates from Alberta

News from Calgary

By Cheryl Barnabe, MD, FRCPC, MSc; and May Choi, MD, FRCPC

Spring and summer 2020 have not been like any other year for us, with pandemic closures and redeployment to support COVID-19 efforts, the subsequent relaunch of clinical activities, the undertaking of numerous COVID-19 research studies, all while home schooling children, having the Calgary Stampede cancelled for the first time in nearly 100 years, and experiencing the fourth costliest natural disaster in Canadian history (a record setting hail storm). We do, however, get to experience the incredible parks in our province with far fewer people in them, and have seen our division strengthened by community and academic practitioners pulling together to ensure continuity in clinical care for the Calgary and South Zones, and ensuring education of trainees remained a priority.

In July 2019, Dr. Paul MacMullan became Division Chief for Adult Rheumatology, as Dr. Dianne Mosher moved to an Associate Dean position for Indigenous, Local and Global Health. Dr. Heinrike Schmeling became Division Chief for Pediatric Rheumatology, with Dr. Susa Benseler becoming the first female research institute director in Calgary as the Scientific Director for the Alberta Children's Hospital Research Institute. We would like to congratulate Drs. Aurore Fifi-Mah (Clinical Associate Professor), Glen Hazlewood (Associate Professor), Steven Thomson (Clinical Assistant Professor), and Cristina Moran-Toro (Clinical Assistant Professor) on their promotions last year. We would like to welcome our new colleagues Drs. Erin Butler, Mehveen Merchant and May Choi to the division. Drs. Martha Decker and Nathan Puhl have opened their practice in Lethbridge last summer, providing critical service in the South Zone.

Dr. Dianne Mosher gladly passing the division torch off to Dr. Paul MacMullan.

Update from Lethbridge

By Martha Decker, MD, FRCPC

Starting a new rheumatology clinic from scratch has had its challenges (particularly during a pandemic!), but we have been grateful to our mentors in both Calgary and Edmonton for helping us along the way. We both graduated from the University of Alberta's rheumatology program in June 2019. Nathan, being born and raised in Lethbridge, was excited to return home, while Martha (originally from Calgary) made the move to Lethbridge to be close to her husband Jeff's parents who live just outside of Pincher Creek. Southern Alberta is a true gem, and we couldn't be happier with the outdoor activities and proximity to the Rocky Mountains. We are looking forward to expanding our clinic in the future, hopefully with a third rheumatologist, to help care for southern Alberta patients.

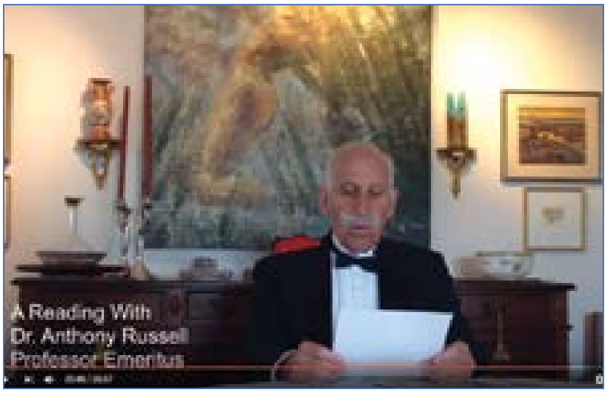
Dr. Nathan Puhl and Dr. Martha Decker at their new rheumatology clinic in Lethbridge.

News from Edmonton

By Stephanie Keeling, MD, FRCPC

Edmonton rheumatology continues to thrive despite the barriers imposed by COVID-19. Recent graduates from the University of Alberta's Division of Rheumatology Jason Soo, Tharindri Dissanayake, and Saurash Reddy have created a new rheumatology office across the street from the University of Alberta Hospital and are a wonderful addition to the Division. We are fortunate to be able to refer our pregnant rheumatic disease patients to Dr. Sarah Troster who continues to expand her Edmonton pregnancy clinic while collaborating across Canada to create a pregnancy registry. Patient encounters are now quite diverse and include telephone or virtual platforms such as Zoom, in addition to ongoing in-person consultations with COVID-19 precautions.

Northern Alberta rheumatologists are particularly proud of the recent "virtual get-together" launched on YouTube June 18, 2020, to virtually fundraise for the Anthony Russell Scholarship Fund with the Alberta Arthritis Society. Check it out at **www.youtube.com/watch?v=o-yqGOyTDz8.**



A reading with Dr. Anthony Russell.

Allied health professionals also performed in the virtual fundraiser.

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SIMPONI® is indicated for: 1) Reducing signs and symptoms, inhibiting the progression of structural damage and improving physical function in adult patients with moderately to severely active PsA. SIMPONI® can be used in combination with MTX in patients who do not respond adequately to MTX alone; 2) Reducing signs and symptoms in adult patients with active AS who have had an inadequate response to conventional therapies; 3) The treatment of adults with severe active nr-Ax SpA with objective signs of inflammation as indicated by elevated CRP and/or MRI evidence who have had an inadequate response to, or are intolerant to NSAIDs.

Most common adverse reactions:
Upper respiratory tract infection: SIMPONI® 7%, placebo 6%; Nasopharyngitis: SIMPONI® 6%, placebo 5%

CLINICAL USE:

Pediatrics: The safety and efficacy of SIMPONI® in pediatric patients have not been established.

Geriatrics (65 years of age or older): Caution should be used in treating the elderly.

CONTRAINDICATIONS:

- Severe infections such as sepsis, tuberculosis and opportunistic infections
- Moderate or severe (NYHA class III/IV) congestive heart failure

MOST SERIOUS WARNINGS AND PRECAUTIONS:

Infections:

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

Malignancy:

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

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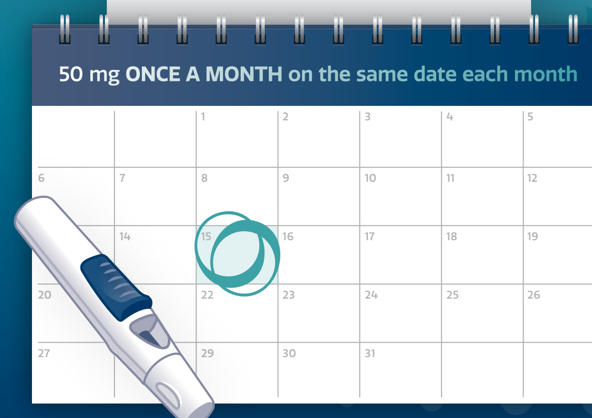

OTHER RELEVANT WARNINGS AND PRECAUTIONS:

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

FOR MORE INFORMATION:

Please consult the product monograph at www.janssen.com/canada/products 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 1-800-387-8781.

PsA = psoriatic arthritis | AS = ankylosing spondylitis | RA = rheumatoid arthritis | nr-Ax SpA = non-radiographic axial spondyloarthritis | MTX = methotrexate | CRP = C-reactive protein | MRI = magnetic resonance imaging | NSAIDS = nonsteroidal anti-inflammatory drugs

Reference:
1. SIMPONI® Product Monograph. Janssen Inc. June 20, 2019.

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PrXELJANZ®/PrXELJANZ® XR (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/XELJANZ XR as monotherapy.

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

PSORIATIC ARTHRITIS

PrXELJANZ® (tofacitinib) in combination with methotrexate (MTX) or another conventional synthetic disease-modifying antirheumatic drug (DMARD), is indicated for reducing the signs and symptoms of psoriatic arthritis (PsA) in adult patients with active PsA when the response to previous DMARD therapy has been inadequate.

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

ULCERATIVE COLITIS

PrXELJANZ® (tofacitinib) is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis (UC) with an inadequate response, loss of response or intolerance to either conventional UC therapy or a TNFα inhibitor.

Use of XELJANZ with biological UC therapies or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Consult the XELJANZ/XELJANZ XR Product Monograph at http://pfizer.ca/pm/en/XELJANZ.pdf for important information about:

- Contraindications during pregnancy and breastfeeding, and in patients with severe hepatic impairment.
- Most serious warnings and precautions regarding risk of serious infections, malignancies and thrombosis.
- Other relevant warnings and precautions regarding risk of infection and immunosuppression when co-administered with potent immunosuppressants, women of reproductive potential, hypersensitivity reactions, risk of viral reactivation, being up to date with all immunizations in accordance with current vaccination guidelines, live zoster vaccine, risk of malignancies, lymphoproliferative disorder, and nonmelanoma skin cancer, risk of lymphopenia, neutropenia, anemia, and lipid elevations, patients with hepatic and/or renal impairment, patients undergoing hemodialysis, liver enzyme elevations, patients with pre-existing severe gastrointestinal narrowing that are administered XELJANZ XR, patients with a risk or history of interstitial lung disease (ILD), pediatric patients, the elderly and patients with diabetes, patients with a history of chronic lung disease, lymphocyte counts, Asian patients, patients with risk of gastrointestinal perforation, increases in creatine kinase, decrease in heart rate and prolongation of the PR interval, patients that may be at an increased risk of thrombosis, patients with symptoms of thrombosis and dosing considerations in patients with ulcerative colitis (use XELJANZ at the lowest effective dose and for the shortest duration needed to achieve/maintain therapeutic response).
- Conditions of clinical use, adverse reactions, drug interactions and dosing instructions.

The Product Monograph is also available through our medical information department. Call 1-800-463-6001.

For more information, contact your Pfizer representative.

JAK = Janus kinase; PsA = Psoriatic arthritis; RA = Rheumatoid arthritis; UC = Ulcerative colitis
* Comparative clinical significance is unknown

References: 1. Pfizer Inc. Data on file. 2019. **2.** Health Canada. XELJANZ Notice of Compliance information. **3.** Pfizer Canada ULC. XELJANZ/XELJANZ XR Product Monograph.