Spring 2020, Volume 30, Number 1

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Spotlight on: Succession Planning & Transitions in Rheumatology

The CRAJ is online! You can find us at: *www.craj.ca*

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Our originator Biologics portfolio speaks to our ongoing commitment...

- to expanding physician treatment choice
- to providing numerous treatment options for patients
- to investing in the discovery and development of new therapies — both for today and the future

Simponi® golimumab | Simponi® I.V. golimumab for infusion | Stelara® ustekinumab | Stelara® I.V. ustekinumab | Tremfya™ (guselkumab) | Remicade® INFLIXIMAB

JANSSEN BIO ADVANCE®

The Janssen BioAdvance® progam
Patient-centered care, simplified for you.

Janssen BioAdvance® currently provides personalized and dedicated one-on-one support to over 55,000 patients across Canada...

The Janssen BioAdvance® Commitment:

- One BioAdvance® Coordinator as your point of contact across the Janssen biologic portfolio (**SIMPONI®**, **SIMPONI® I.V.**, **STELARA®**, **STELARA® I.V.**, **TREMFYA™** and **REMICADE®**).
- Simple enrolment that starts with just one call or e-mail.
- Support to help secure reimbursement or financial assistance.
- Education and tools for patients to help manage their treatment.

Janssen Inc. 19 Green Belt Drive | Toronto, Ontario | M3C 1L9
www.janssen.com/canada | SBBR190025E

PAAB | MEMBER OF INNOVATIVE MEDICINES CANADA | janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Virtual Care in Rheumatology

By Philip A. Baer, MDCM, FRCPC, FACR

"I like live audiences, with real people – virtual reality is no substitute."
– Hillary Clinton

"The incredible thing about the technology is that you feel like you're actually present in another place with other people. People who try it say it's different from anything they've ever experienced in their lives."
– Mark Zuckerberg

Rheumatologists seem to be in short supply across much of Canada, or at least not distributed very well: too many in some big cities, not enough everywhere else. I received a fax from one academic centre within the last year asking me to accept their overflow patients, who would have had to travel a minimum of four hours to reach me! I was more sympathetic to the next request for help: a smaller community which used to have five rheumatologists was down to one, and the patients were only 90 minutes away. So I accepted the first patient referred: a middle-aged man who was said to have "joint, neck and back pain." The referral letter was brief, and the only other information provided was a report of spinal X-rays showing degenerative disc disease (DDD). My intuition whispered that this was probably not an inflammatory rheumatic disease presentation, but we booked the patient nevertheless. The referring physician was unknown to me.

Upon arrival, the patient was very pleasant. He told me he had met the referring doctor virtually. The clinic displayed the doctor on a video monitor, and that was how they interacted. Fine for history taking, but no physical exam was conducted, other than asking the patient to demonstrate his range of motion in various joints. The history uncovered multiple fractures and other musculoskeletal (MSK) injuries and a lifetime of physical work, and now chronic pain.

Leaving my patient in a mental "waiting room" for now, virtual medicine is suddenly very fashionable. At the same time, it is also controversial. In some formats, such as through the Ontario Telemedicine Network and similar formats in other provinces, it is covered by provincial health plans. In other situations, patients may be charged for the convenience of immediate appointments without leaving home. Family doctors may wish to participate but, in other situations, bemoan the lack of continuity of care and the duplication of services these video encounters may generate, akin to what is seen with traditional walk-in clinics.

In the American context, virtual direct-to-consumer telemedicine clinics are springing up, targeting specific diagnoses and treatments, such as erectile dysfunction (Hims, Roman), acne (Curology) and contraception (The Pill Club, Nurx). A recent *Journal of the American Medical Association (JAMA)* article raised concerns about the focus on prescribing a medication rather than offering other treatment options, off-label prescribing, and the tradeoff between convenience and quality.[1]

So, back to my patient from the virtual clinic. Why was a rheumatology referral requested? Well, the patient was very clear on that: he had gone to the virtual clinic to have some disability forms completed, but apparently that required an in-person encounter with a physician. So the video doctor was unable to help, other than by making a referral to me.

I imagine prescribing opioids was also not feasible after such a virtual encounter, so the situation could have been worse. As it was, I completed the forms with the patient's input, making no guarantees as to whether his claim would be accepted, and he was quite satisfied. I also made a mental note to be very careful when reviewing any future referrals from video doctors.

Reference:
1. Jain T, et al. Prescriptions on Demand. JAMA Sept. 2019; 322(10):325-26. Doi:10.1001/jama.2019.9889

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

CRAJ EDITORIAL BOARD

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

The editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.

PUBLISHING STAFF

Paul F. Brand
Executive Editor

Jyoti Patel
Managing Editor

Catherine de Grandmont
Editor-proofreader
French

Donna Graham
Production Manager

Dan Oldfield
Design Director

Mélissa Drouin
Financial Services

Robert E. Passaretti
Publisher

Please address requests for subscriptions and correspondence to: THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION, 6500 Trans-Canada Highway, Suite 310, Pointe-Claire, Quebec, H9R 0A5.

Dr. Monique Gignac received the Association of Rheumatology Professional's (ARP) 2019 *Addie Thomas Service Award* at the recent American College of Rheumatology (ACR) meeting in Atlanta. The award is named after the association's first president and is given to an ARP member for sustained service and volunteer activities. Dr. Gignac was recognized for her ongoing service work with a number of organizations, including as Chair of the Advisory Board for the Institute for Musculoskeletal Health and Arthritis (IMHA) at the Canadian Institutes of Health Research (CIHR), Co-Scientific Director of the Canadian Arthritis Network (CAN), work with the Arthritis Society, and for her Associate Editor activities at *Arthritis Care & Research*. Dr. Gignac received the ARP's *Distinguished Lecturer Award* in 2014 and the *Distinguished Scholar Award* in 2013. She is Scientific Co-Director and a Senior Scientist at the Institute for Work & Health, a Professor in the Dalla Lana School of Public Health at the University of Toronto and an Affiliate Scientist at the Krembil Research Institute at the University Health Network.

Dr. Monique Gignac
Addie Thomas Service Award

Dr. Hani El-Gabalawy and Dr. Ronald Laxer were both recently honoured with the designation of *Master* by the American College of Rheumatology during the most recent ACR meeting in November 2019 in Atlanta. Recognition as a Master of the American College of Rheumatology is one of the highest honours the College bestows to members who have made outstanding contributions to the field of rheumatology through scholarly achievement and/or service to their patients, students, and profession.

"To be recognized by my ACR peers as a Master is not only a great honour, but one that gives me a deep sense of satisfaction that I have succeeded in meeting the high professional standards this organization has always represented and promoted, and that have inspired and guided me over the years. I could not be more grateful for having had the opportunities to achieve this," said Dr. El-Gabalawy.

Dr. Hani El-Gabalawy
ACR Master 2019

Dr. El-Gabalawy is currently Professor of Medicine & Immunology at the University of Manitoba in Winnipeg, and also holds the Endowed Rheumatology Research Chair at the same institution.

"The highest form of recognition is that received from one's peers. It was a wonderful honour to be designated an ACR Master and to be recognized for my clinical and academic contributions. I was particularly proud to join a group of Canadian pediatric rheumatologists designated as Masters including my mentor Ross Petty and good friends Kiem Oen, Alan Rosenberg and Earl Silverman," remarked Dr. Laxer.

Dr. Ronald Laxer
ACR Master 2019

Dr. Laxer is currently Professor of Pediatrics and Medicine within the Division of Rheumatology at the University of Toronto, and a rheumatologist at The Hospital for Sick Children (SickKids) in Toronto.

CIORA – A Sampling of Grants

At the most recent CRA Annual Scientific Meeting in February, Dr. Deborah Marshall and Ms. Laura Passalent presented their CIORA grants. Read on for more below.

Geographic Variation in Rheumatoid Arthritis (RA) Addressing Inequities in Access to Care

Presented by Deborah Marshall, on behalf of Xiaoxiao Liu, Stefania Bertazzon, Alka B. Patel, Dianne Mosher, Joanne Homik, Steven Katz, Christopher Smith, Jill Robert, and Claire E.H. Barber

Timely access to rheumatologists and equitable access to care remain a challenge, especially in Canada, where patients living in rural areas may need to travel long distances for care from specialists who are clustered in urban areas. Estimates of rheumatologists per capita do not provide sufficient information for determining gaps in rheumatology services due to the wide geographic distribution of patients with RA. Using geospatial analysis, our team assessed the geographic variability in RA prevalence across the rural urban continuum.

When analysed at the local geographic area level with 132 defined areas, we found a five-fold difference in RA prevalence. At the local geographic area level, we identified seven 'hotspots' (areas with clustered high prevalence rates) in rural and remote areas. These variations have the potential to create disparities in access to RA care, which should be considered when designing evidence-based interventions and planning programs to improve access to associated healthcare services and reduce inequities. Future work will examine geographic accessibility and social economic factors with respect to health care utilization and health outcomes, which may further help understand the rural-urban disparities and provide guidance for planning health services for patients with RA.

Deborah A Marshall is the Arthur J.E. Child Chair of Rheumatology Outcomes Research and former Canada Research Chair, Health Services and Systems Research (2008-2018). She is a professor at the University of Calgary.

CIORA ICORA
CANADIAN INITIATIVE FOR OUTCOMES IN RHEUMATOLOGY CARE | INITIATIVE CANADIENNE POUR DES RÉSULTATS EN SOINS RHUMATOLOGIQUES

Adult axial spondyloarthritis (axSpA) screening and referral practices amongst primary care physicians, nurse practitioners, physiotherapists and chiropractors working in community practice in the province of Ontario

Presented by Laura Passalent, on behalf of Christopher Hawke, Jeff Bloom, Andrew Bidos, Leslie Soever, Raj Rampersaud, Nigil Haroon and Robert D. Inman.

This multi-phase project examined primary care providers' clinical knowledge and screening and referral practices for patients with suspected axSpA. Primary care providers included family physicians (MDs), nurse practitioners (NPs), physiotherapists (PTs) and chiropractors (DCs) practicing in Ontario.

Phase 1: Semi-structured key informant interviews were conducted with 17 primary care providers. Screening practice themes included: clinical knowledge of axSpA; role of investigations and awareness of screening tools. Referral practice themes included: technology optimization; referral barriers and legislative hurdles.

Phase 2: Licensed primary care providers were electronically surveyed using a questionnaire developed from Phase 1 results. There were 276 respondents. Morning stiffness > 30 minutes and HLA-B27 presence were considered "very important" clinical features of axSpA. Most respondents "never used" or "were not familiar" with axSpA screening tools. MDs/NPs "always" or "often" refer to rheumatology, although wait times were identified as a substantial barrier. PTs and DCs "always" or "often" refer patients to their MD/NP to facilitate investigation and/or rheumatology referral.

The combined results suggest primary care providers have reasonable clinical knowledge of axSpA. There is little awareness of axSpA screening tools. PTs/DCs identified screening and referral barriers related to scope of practice that, if mitigated, may allow for better early detection. Targeted education strategies may improve axSpA screening and referral practices in primary care.

Laura Passalent, BScPT, MHSc, ACPAC, is a lecturer in the Department of Physical Therapy, in the Faculty of Medicine at the University of Toronto, and is a physiotherapist practitioner with the Arthritis Program at the Toronto Western Hospital. She is also a clinician investigator with the Krembil Research Institute.

A New Decade & Strategy for the CRA

Vision 2020 – An Impactful and Sustainable Future

The Canadian Rheumatology Association (CRA) recently presented its new strategic plan at its Annual General Meeting this past February.

As the CRA approaches its 75th anniversary in 2021, the organization has been developing a new strategy that is intended to cement its status as the national voice of Canadian rheumatologists, and build toward a sustainable future for decades to come. Thanks to the valiant efforts of leaders and volunteers, both past and present since the CRA's inception in 1946, the organization has grown to almost 600 members across Canada, with programs, services and events year-round.

This new strategy has been in development since as early as 2018, with feedback and input from various stakeholders, including our own members.

Here is a look at the five new CRA strategies:

1. Position the CRA as the leading national provider of rheumatology resources and continuing professional education.
2. Identify and influence issues of national relevance that affect rheumatologists' practices.
3. Build and nurture a vibrant national rheumatology community.
4. Champion the cause of rheumatology research in Canada.
5. Ensure continuing financial and operational sustainability of the CRA in a changing environment.

Stay tuned for more information as the CRA finalizes its new strategic plan for implementation in 2021.

FAQ:

1. Why do we need a new strategic plan now?

The Canadian Rheumatology Association is a 74-year-old, highly credible organization with a great reputation and a track record of success. Such a great legacy deserves an excellent future. With this in mind, the Board of Directors, volunteers and staff are working closely to position the CRA for a sustainable future.

This work is also timely, since it is occurring concurrently to the restructuring of the CRA to address the sustainable revenue aspects and fiduciary responsibilities of the organization. The result will be clear goals and direction for the CRA moving forward.

2. How different will this be from our current strategic priorities?

The overall priorities will not change significantly. That said, the new plan will be more detailed and specific.

Furthermore, our approach to implementing and managing the new strategic plan will be guided by a set of clearly defined criteria for selecting and evaluating programs which in turn will help us better deliver and report on our plans.

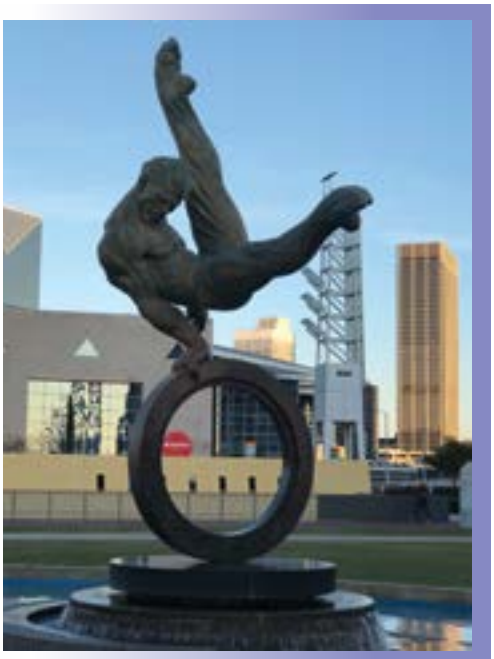
3. What will be the changes that are the most noticeable to members?

For 2020, very little changes will be visible to the general membership. In the spring and summer of 2020, we will be developing the operations plans with the committees. As those plans become clear, we will share information with the overall CRA community through our website and alert you through notifications in our newsletters.

The intention of this exercise is to align the key activities of the CRA and be clear on how we will define success. This means all CRA activities will need to align with one or more of our key priorities.

ACR 2019 in Atlanta

By Philip A. Baer, MDCM, FRCPC, FACR



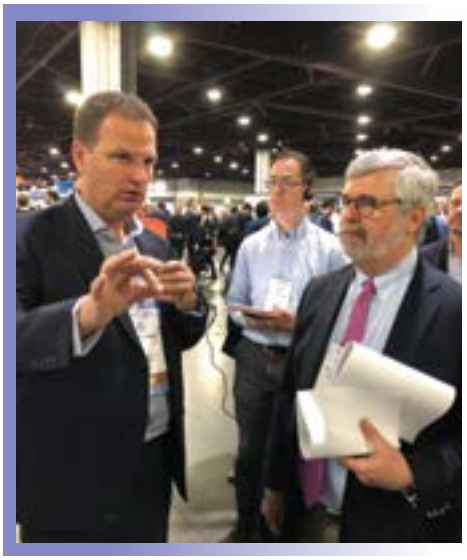
"I dare somebody to go to Atlanta and not have a good time."
– Brian Tyree Henry (actor and star of the show "Atlanta")

The last time the American College of Rheumatology's (ACR) annual scientific meeting was held in Atlanta was in 2010. Given that the ACR has its corporate headquarters in Atlanta, I was surprised the meeting is not held there more often. I missed ACR 2010 as we were on a CME trip in China. However, as we queued for customs on our return at Toronto Pearson Airport, I noticed that I knew dozens of people in the snaking line. They were all returning from ACR 2010, so I received a crash course on the meeting highlights while we waited.

While I had transited through the Atlanta airport, I had never actually been to the city. In addition to the conference at the Georgia World Congress Centre, I was hoping to see some of the city's highlights, including the headquarters of CNN and Coca-Cola, as well as the Chik-Fil-A College Football Hall of Fame (CCFHF). Despite the recent controversy surrounding the opening of a Chik-Fil-A restaurant in Toronto, the CRA chose to hold Canada Night at CCFHF, and the combination of colleagues, food, wine and the exhibits turned out to be a winner.

Most of my other touristy plans went up in smoke, as the conference agenda is so busy. This is a product of its own merits (over 15,000 participants and nearly 11,000 scientific attendees from 103 countries, thousands of posters, hundreds of podium presentations, and many very interesting lectures), and because it provides a venue for all sorts of other meetings to take place on the sidelines with colleagues from across Canada and around the world.

For those trying to get organized, the ACR meeting app was very helpful. I signed up for daily poster tours as well, which provide the views of an expert on key studies in various disease areas. I focused on rheumatoid arthritis (RA), enjoying small-group interaction with leaders such as Dr. Jonathan Kay and Professor Iain McInnes (see photo at top on page 9). I highly commend the attempts by ACR to make learning more fun and interactive, including the ACR Knowledge Bowl (won by the defending champion Neutrophil Nets with a highly vocal cheering section), The Great Debate, and Thieves Markets. The Great Debate proposition this year was "Anabolic agents are/are not appropriate first-line therapy for glucocorticoid-induced osteoporosis." This was timely given the recent approval of romosozumab in both Canada and the U.S., and the 2017 approval of abaloparitide in the U.S., in addition to the long-available teriparatide. New features included a Daily Digest wrap-up presentation which synthesized significant findings from the multiple concurrent sessions of the day. The roster of well-known speakers for this segment included Joe Craft, David Isenberg, Cornelia Weyand, Peter Merkel, Marian Hannan and Gregg Silverman. I also enjoyed the TED-style talks at the "In the Rheum" discussion, with Iain McInnes, John Stone and Liz Lightstone. The theme of minimizing



Dr. Iain McInnes and Dr. Jonathan Kay

steroid use in RA, lupus and vasculitis was intriguing and looks more feasible with advances in therapies. There was also a daily #ACR19 Tweet Up highlighting diverse participants' views on key topics and studies.

The kickoff Year in Review session is always worthwhile, as is the end of the conference summary with Jack Cush and Artie Kavanagh. Between them, they wished for fewer presentations on fibromyalgia (not wanting to paint rheumatologists as the subject matter experts) and on hydroxychloroquine drug monitoring. New ACR Guidelines were presented on gout, osteoarthritis (OA) of the hip, knee and hand, large vessel vasculitis (giant cell arteritis [GCA], polyarteritis nodosa [PAN] and Takayasu), and antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis. The gout guideline championed treat-to-target over the treat-to-symptom control advocated by other organizations. For osteoarthritis (OA), the term "nonpharmacologic" is on the way out, replaced by more positive terms to describe these essential therapies.

The Phillip Hench lecture by John Reveille was a tour de force on axial spondyloarthritis (SpA), B27 and personalized medicine. I heard the Immunology and Stats bootcamp sessions were also excellent, but there isn't time to attend every session personally. I also enjoyed the European League Against Rheumatism (EULAR) session on "The Road to Remission is Long and Bumpy, but Worth it in the End," featuring the ever-present and always entertaining Iain McInnes.

The ACR makes catching up easy, with free access to all sessions for all registrants for one year after the conference through ACR Beyond. This now includes videos, syllabi, and downloadable highlight slides. CME credits were much easier to document this year. They were even available for those who paid a registration fee and watched the conference from home via live streaming.

Late-breaking, pediatric, and patient perspective posters have gone digital, and were presented as e-posters which can also be viewed on the ACR website. Late-breaking abstracts covered a variety of novel therapies from anifrolumab and fenebrutinib for lupus to olokizumab for RA. Time will tell if these and other innovative therapies make it to our clinics.

Highlights:

Best session title: "You Give Me Fever: Case-based Approach to Autoinflammatory Syndromes."

The usual suspects were well-represented in abstracts: JAK inhibitors, adverse events of checkpoint inhibitors, comorbidities in rheumatic diseases, and FDA updates.

Abstracts presented at ACR plenary sessions included guselkumab in psoriatic arthritis (PsA), long-term GIACTA study results, methotrexate (MTX) in erosive hand OA, prednisolone in hand OA, anifrolumab in systemic lupus erythematosus (SLE), ixekizumab in non-radiographic AxSpA, upadacitinib in ankylosing spondylitis (AS), and romosozumab for osteoporosis in patients with kidney disease.

I had one poster this year, but I was interested to see that I was one of four Baers with abstracts–the others were Rebecca with two, Alan and Jean. None of us were related to any one of the others, as far as I can discern.

"Medical Education Beyond Rheumatology In 2019" included clinical sessions which explored non-rheumatologic diseases rheumatologists often encounter in their patients. For instance, the "NAFLD (non-alcoholic fatty liver disease) & Hepatotoxic Medications: What's a Rheumatologist to Do?" session covered non-alcoholic steato-hepatitis, and the medications we can and can't use with our patients who have this condition.

The strong Canadian contingent included Meet the Professor session leader Nigil Haroon, and workshop leaders Pari Basharat and Johannes Roth. Many Canadians also moderated sessions and presented their research findings. Ron Laxer and Hani El-Gabalawy were recognized as ACR Masters.

The next ACR meeting will be in Washington, D.C. in November 2020, just after the U.S. presidential election. That should be an exciting meeting. I look forward to seeing you there.

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

Retirement: "Goodbye to All That"

Reflections of a recent retiree (– not Robert Graves'!)

By Paul Davis, MB, ChB, FRCP(UK), FRCPC

It's 7:00 am Monday morning. It's still dark outside and it's raining. It's the beginning of another work week. But wait, not this week; you've just retired. You lie in bed trying to enjoy the extra relaxation time, but guilt begins to creep up on you until you feel obliged to rise. You shave and shower, but when all is said and done, you're still retired!

Dr. Paul Davis working in Italy.

It's important to recognize that the transition into retirement is no less challenging than your previous transitions from student to resident, to fellow and to consultant. There is, however, one critically important difference because, unlike previous experiences which were undertaken to enhance one's professional status, this one requires you to say "goodbye to all that" and plan for a new future.

There are many publications written on how to handle retirement, but I haven't read any of them. This is largely because I believe it to be a very personal transition that cannot be resolved by any one formula. There are, however, some common stages that have to be addressed. The first stage is accepting that all which has filled your professional life for 40 years is now gone (the bereavement phase). This will manifest itself in many different ways. Not surprisingly, the first is the loss of contact with colleagues and patients, but don't be surprised if you miss them less than you thought you ought to. There will be no meetings to attend and, therefore, no agendas and minutes to review. Invites to sit on advisory panels will cease, as will invitations to present at professional meetings. There will be no research grants to be applied for and no papers to write or present. (However, you may get an invite to write an article for the *CRAJ*!). Your once over-loaded e-mail inbox will dry up to the extent that you wonder whether the server is down. Some e-mails will still get through, including requests to participate in on-line surveys despite replying "unsubscribe" or "no longer in practice." Offers of cut-price male enhancement pills will still appear. (I've often wondered how they know I need them). During this time if you are ill-advisedly tempted to pop back to work and see how they're managing without you, you will find that your name has been removed from the door and someone else has already occupied your old office. People may stop to ask you how you're enjoying your retirement but move on before you have a chance to reply! The secret of successful transition through this stage is to realize that this is NOT the end but an opportunity for a new and fulfilling beginning.

The next stage of the transition is characterized by the realization that you have something you had little of before, and that is time for yourself (recovery phase). Effective utilization of this time is critical. It's not how you fill it that matters, providing you do so. There are many strategies and opportunities which will be very personal in nature. One approach is to do what Jack Nicholson's character did in the movie and develop a "bucket list." I personally drew the line at sky diving but did consider getting a tattoo! Now is the time to read a book or even write one; to start a new hobby or reactivate an old one; to make new friends or reconnect with past ones; to volunteer; to enroll in classes; to take the dog for a walk (if you don't have one, go anyway); to do the crossword; and to plan trips abroad even if you don't go on them. Social media provide a good source of entertaining and educational material providing you are selective. If you find yourself watching hospital soaps on TV, you have a problem and urgent desensitization is required.

When making your choices, it's important to acknowledge that your retirement plans are likely to affect other people, most notably your partner. Someone once said that "retirement is coming home from work and saying honey I'm home–forever." Don't be surprised if the response is not one of unbridled enthusiasm. A colleague's wife once confided in me that she dreaded her husband's retirement because he would just get in the way! If you do find that you have time to spare, brownie points can be obtained by learning how to load and unload the washer and dryer, or how to efficiently stack the dishwasher. Helping with the shopping and cooking is often appreciated and in itself can

Continued on next page

Preparing for Practice

By Alan Borowoy, MD, FRCPC

Completing fellowship, most freshly-minted rheumatologists feel the pressure to immediately start their own practice. And, like me, most feel their skills in what essentially amounts to opening a small business are woefully inadequate. I would have recurring visions of myself diligently touring clinic spaces, hiring staff, and figuring out which electronic medical record (EMR) to invest in, only to realize a week prior to my practice opening that I had no office phone line or examination tables for my clinic rooms! While we can and often do rise to this challenge, most would admit that opening the perfect practice on the first try and without experience is close to impossible.

At the end of the day, the practice of medicine is experiential: we learn in large part by doing. I believe the same holds true for the opening and running of a practice. As trainees, the bulk of our clinical experience is a hospital-based academic model. While this is necessary to gain competence in the full breadth of rheumatology, there is very little exposure to the full breadth of practice options. Locums bridge this gap in experience: they offer the ability to test drive our skills as physicians in a variety of practice environments.

Upon graduating fellowship, I was nervous about starting a new practice right away. As luck would have it, I was offered a short locum that summer. From that, other locum opportunities arose and I was eventually working full time. I provided coverage for a diverse range of colleagues from brand new part-time practices to decades-old busy full-time practices, solo to group practices, and community suburban practices to city centre practices with hospital privileges.

Not unlike Goldilocks sampling different bowls of porridge, locums afforded a sampling of a large cross section of clinical practices to determine which felt "just right" for me. In doing so, I was able to develop and hone my preferences for how I would ultimately run my own practice: from type of EMR, number and size of clinic rooms, and optimization of patient flow to communication with administration staff, tone of clinical notes, and brand of coffee maker.

Four years and seven locums later, I felt more than prepared to open my own practice in Barrie in 2017. The transition to my own practice was certainly less daunting by then, and was as smooth as I could ever have hoped for. I would encourage any freshly-minted rheumatologists to consider a locum as an alternative to immediately jumping into practice. While opening a clinic always presents its unique set of challenges, I for one am grateful for the opportunity to settle on one that is "just right" for me.

Alan Borowoy, MD, FRCPC
Rheumatology,
Barrie, Ontario

Retirement: "Goodbye to All That"

(Continued from page 10)

be quite therapeutic. However, in this rush of domesticity, beware asking the question "Is there anything I can do?" as you might get more than you bargained for.

In conclusion, is there any way to summarize how to handle this pivotal transition into retirement and effectively and painlessly say "goodbye to all that"? I think the advice of Lord Baden-Powell says it all–"Be Prepared."

Paul Davis, MB, ChB, FRCP(UK), FRCPC
Emeritus Professor of Medicine,
University of Alberta
Edmonton, Alberta

Retirement Takes Planning: Practical Advice

By Jamie Henderson, MD, FRCPC

Retirement takes planning. The finances will take care of themselves as long as you have been diligent about your Registered Retirement Savings Plan (RRSP). I will leave finances up to you and your financial advisers.

The next major decision is when to retire. This will be a personal decision, and I have no advice other than to not fear it.

Once you have an idea as to when you'll be retiring, I would check your office lease to see how much notice you have to give your landlord. Six months before my preferred date, I found I had to give one year's notice. A wrinkle I had to live with.

Finding someone to take over your practice is also a significant issue. It may require more than one person, as not everyone is keen to take on 5,000 patients. Networking at meetings, advertising on the CRA website, talking to many colleagues, looking for contacts and other techniques (like panic) still left me in a quandary, but eventually this was resolved.

A major issue was what to do with my charts. Today's practitioner wants to deal with an electronic practice. I did not have an electronic medical record (EMR). For the final year of practice I spent most, if not all, of my Sunday afternoons sitting in my office entering all my patient data on the patients I would be seeing that week, into a newly purchased EMR. I did not see another alternative as I felt only I could determine what was relevant.

After the EMR was complete, I still had to arrange for storage of the charts for the mandatory 10 years as per regulations of our Department of Health. They still reside in my basement!

Notifying patients of my decision was another dilemma. Some wished a referral to an alternate rheumatologist of their choice rather than simply agreeing to be followed by my replacement. Many were referred before a replacement was found to ensure continuity of care of complex cases.

Once retirement took place there was a void. I took out a membership at our local YMCA and obtained a library card. Both of these helped immensely in occupying my body and mind. There were still gardening, fishing and, above all else, grandchildren to fill in the time. Now, setting new objectives is an ongoing pursuit.

One word of advice: It took my wife and myself quite some time to determine where the money was going. There always seemed to be surprise bills that would arrive and evaporate our attempts to set money aside. We had to keep track of every expenditure every week for a year to finally be able to come up with a budget that accounts for all cash outflows. No more surprises!

I have found retirement a new beginning and not the end.

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

A Personal Path to (Pre)-Retirement

By Boulos Haraoui, MD, FRCPC

Retirement . . . A word you don't like to hear when you've spent a rewarding life practicing rheumatology during the best decades for our specialty.

But you have to at least resign yourself to planning for it!

Because after so many years of experiencing the pleasure and satisfaction of caring for the sick who occasionally become "accomplices," and exchanging with them various life experiences (marriages, children, work, travel), it is difficult to cut ties . . . especially when, like me, it is the only skill you have. I'm not a sportsman, let alone a golfer; I'm not a handyman either: The only thing I know how to do with my hands is to perform joint injections, and I've done hundreds, or rather, thousands of them in nearly 40 years of training and practice.

But more than planning what you would like to do during retirement, you need to think about the hundreds of patients who need to continue to see a rheumatologist.

So, my first priority has been to reduce the size of my practice. For more than a year and a half, I have not seen any new patients, and I have gradually started to transfer my "easiest" patients who are doing well to younger colleagues. I am blessed to have colleagues who are competent and generous enough to accept my transfers.

Admittedly, cutting ties is not always easy and is often very emotional with tears and several thank-you cards. This makes me think, and sometimes wonder, about the pace of transfers. But I say to myself that, sooner or later, this is what it has to come to! By my estimates, I will have exhausted my long list within the next two to three years, if my health allows me to continue doing so.

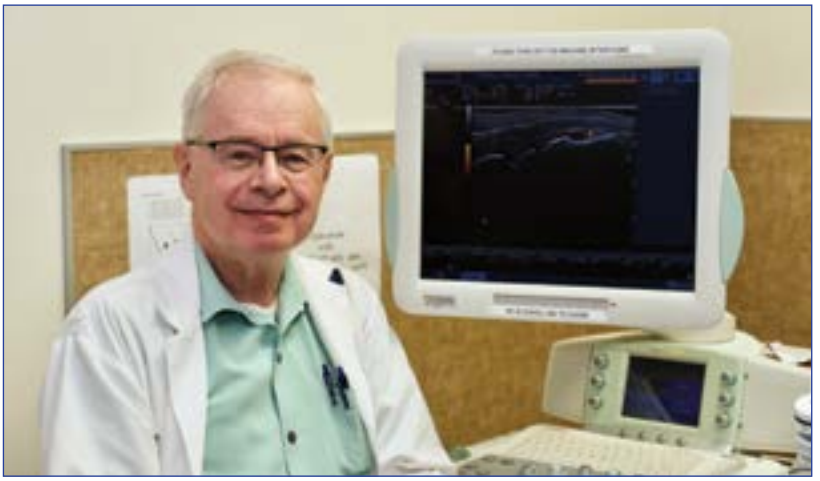
Along with the transfer of patients, I had to gradually reduce my other activities as well. Accordingly, I have reduced my clinical research projects as well as my participation in various committees, such as CATCH (the Canadian Early Arthritis Cohort) and soon the CRA Research Committee. However, I nevertheless continue to pursue certain intellectual and academic activities, such as screening and monitoring comorbidities in rheumatoid arthritis patients, and I often accept invitations to review articles submitted for publication. I continue to travel to attend conferences or take part in advisory committees and to give lectures on my areas of expertise.

The main thing I've realized since I made this decision 20 months ago is that it has to be done gradually, but well. At the same time, I am beginning to "enjoy" the other aspects of life that give me satisfaction: First, my two grandsons, who will soon be three; travelling more for pleasure than just to attend conventions and other meetings; and finally, starting to read the dozens of books that I had put aside for when I would have more time, *i.e.,* retirement or . . . pre-retirement, a word that is less hard to accept.

Boulos Haraoui, MD, FRCPC
Rheumatologist
Montreal, Quebec

Transition to a Successful Retirement: A Personal Perspective

By Christopher Penney, MD, FRCPC



The transition from a busy medical practice to retirement can be done in many ways and is subject to personal circumstances, planning, or lack thereof, and just plain luck. I have been fortunate to be able to plan a slow exit over the past three years. This slow exit has benefited both me and my patients.

To put things into context, after completing rheumatology training in London Ontario, I began private practice rheumatology in Calgary in 1982. In 2004, after receipt of an *Arthritis Society Clinician-Teacher Award*, I became a salaried clinician teacher at the University of Calgary. My passions have been bedside teaching, physical examination, photography at divisional events, and, for the past eight years, point-of-care musculoskeletal (MSK) ultrasound. My colleagues and I have kindled local interest in rheumatology to the point where there are now nearly enough rheumatologists in Southern Alberta.

I am in the third year of my transition to full retirement. A little more than two years ago, I resigned from my salaried position at the University of Calgary and transferred the care of all my patients to my colleagues. I was fortunate that the university hired Dr. Stephen Thomson, a young clinician teacher, to replace me and take over my teaching duties and many of my patients. Because my retirement was planned, I was able to give all my patients a big hug on their last visit and wish them the best. Drs. Stephen Thomson and Caylib Durand are taking over as the divisional event photographers.

There is a constant weight and strain to medical practice. Despite advances in therapeutics, most of our chronic systemic inflammatory patients become what in Chinese cooking are known as "pot stickers," and are with us for our practice lifetime. With my retirement from full-time practice came a sense of freedom.

What have I been doing in semi-retirment? For the first two years, I ran a triage clinic where I saw low-priority, mainly chronic soft-tissue pain patients. Those patients would otherwise have to wait six to 12 months. At least in Calgary, our resources have been mainly directed at inflammatory diseases, and these patients have been largely ignored. I do a point-of-care ultrasound clinic for my colleagues, and bang the drum for the usefulness of ultrasound in routine rheumatology practice. Because I have more free time, I am now able to exercise more and take better care of my own health. Betty, my dear wife, became quite ill one year ago, and I have been able to attend her doctors' appointments and help her.

This year, my plan is to do an MSK ultrasound clinic once a week, do as-needed temporal artery ultrasound exams, and help with ultrasound research projects. I have just pitched in to do some clinics for a colleague who is off for eight weeks on sick leave. I will also continue to do some physical examination teaching.

I would like to thank the University of Calgary for allowing my phased retirement. In particular, I thank Drs. Dianne Mosher and Paul MacMullan, the past and current Division of Rheumatology directors. Also special thanks to Dr. Susan Barr for her help and encouragement over the past eight years as we have both learned and are still learning to do point-of-care ultrasound.

Christopher Penney, MD, FRCPC
Rheumatologist,
Calgary, Alberta

Flying the Nest: Transitioning to Practice

By Stephanie Tom, MD, FRCPC

Life is full of change. One of the big milestones in a physician's journey is leaving the training phase for independent practice.

Ways to explore potential paths after residency may include:

a) **Electives:** Whether you are interested in pursuing a community, academic or mixed model, these rotations are an opportunity to visit different offices and see a range of practice styles.
b) **Locums:** From hospital shifts to clinic coverage, residents and early career physicians experience the juggle of work-life balance while researching potential work environments.

Locuming is a defined commitment to cover a colleague's practice. The locum duration can range from being short-term (*i.e.* a few weeks for an extended vacation or medical leave) to longer-term (*i.e.* parental leave). Locums are typically designed to provide time-limited but crucial clinical coverage, and may be a prelude to join an existing team.

It is recommended to have a contract, to provide a systematic approach regarding coverage duration, expectations, patient transfer-of-care process, and negotiation of a cost-sharing model. Contract templates may be found through colleagues, local institutions or even your provincial medical association resources. The contract should be customized to one's specific arrangement, and may even benefit from having formal legal review. Being a locum typically involves transfer of patient care back to the host physician after the defined period.

When ready to set up with one's own roster of patients, factors to consider may include:

- Professional and personal network and development opportunities: A professional network can expand beyond other rheumatologists to include primary care providers and other specialists for co-management and/or allied health professionals. Personal life commitments can also guide geographical preferences.
- Patient population and scope of practice, such as general rheumatology or a more niched scope based on expertise and interest.
- Practice setup: There are benefits and risks of solo (autonomy) vs. group-based practices (economies of scale, having colleagues, cross-coverage options). There is also a checklist of logistical tasks (i.e. electronic medical record [EMR] selection, lease duration, *etc*).
- Potential future opportunities to evolve one's practice such as having hospital and/or teaching privileges, participating in research, advocacy, administration and/or multidisciplinary models of care.

In addition to discussions with peers and mentors, it can also be helpful to attend provincial and local medical association workshops, and to review College expectations and the CMPA Good Practices Guide[1] as practice management resources. The learning phase of practice, however, doesn't stop once you open up your clinic doors. By staying connected with colleagues, having coaches, and mentoring others, you will be able to adapt to changing environments and help facilitate the exchange of resources and new ideas.[2] Life is a journey best travelled together.

Stephanie Tom, MD, FRCPC
Division Head, Rheumatology, Trillium Health Partners
Mississauga, Ontario

References:
1. CMPA Good Practices Guide. Available at *https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/index/index-e.html*. Accessed February 2020.
2. Gawande, Atul. Personal Best. The New Yorker 2011. Available at *https://www.newyorker.com/magazine/2011/10/03/personal-best*. Accessed February 2020.

Tofacitinib: The first JAK inhibitor in RA[1]*

PrXELJANZ® XR
(tofacitinib citrate)
extended release • 11 mg tablets

CONVENIENT ONCE-DAILY FORMULATION IN RA | 11 mg QD[2,3]

XELJANZ XR is not indicated in PsA and UC.

RHEUMATOID ARTHRITIS

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 (tofacitinib) as monotherapy.

Use of XELJANZ/XELJANZ XR in combination with biological disease-modifying anti-rheumatic drugs (bDMARDs) or 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 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 in combination 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.

Pr XELJANZ®
(tofacitinib citrate)
5 mg tablets

VAST **GLOBAL EXPERIENCE** COMBINED ACROSS ALL 3 INDICATIONS

EXPERIENCE IN RA 5 YEARS IN CANADA

- **5+ years** in Canada combined across all indications:[4-6]
  - **Since 2014** in RA
  - **Since 2018** in PsA and UC
- **Over 12,000 Canadian patients** enrolled in XELJANZ's patient support program.[1†]
- **Over 208,000 patients** have been prescribed XELJANZ worldwide, in over 80 countries.[1]
- Prescribed by **more than 500 physicians** in Canada through the XELJANZ patient support program†, a majority of whom are repeat prescribers (87%).[1‡]

- 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.

JAK = Janus kinase; PsA = Psoriatic arthritis; QD = Once daily; RA = Rheumatoid arthritis; UC = Ulcerative colitis

* Comparative clinical significance is unknown
† Patients enrolled in the formerly known eXel™ Patient Support Program, which was exclusive for patients taking XELJANZ and not XELJANZ XR. The eXel™ program has now been replaced with PfizerFlex.
‡ 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.
6. XELJANZ UC Notice of Compliance information.

Pr XELJANZ® (tofacitinib citrate) 5 mg tablets

Pr XELJANZ® XR (tofacitinib citrate) extended release • 11 mg tablets

PP-XEL-CAN-0465-EN

Succession Planning and Transitions in Rheumatology: My Experience

By Jacques P. Brown, MD, FRCPC

Retirement is a natural step in the professional life cycle, but it's not the end of one's personal life. In financial terms, early in my practice, like many of you, I had started contributing to a retirement savings plan to ensure adequate income for retirement. This long-term planning also applies to succession planning in a professional life.

As a research fellow of the Arthritis Society, I completed a two-year postdoctoral training in metabolic bone diseases at the *Institut national de la Santé et de la Recherche Médicale (*INSERM) unit directed by Professor Pierre J. Meunier in Lyon, France. Notwithstanding all the outstanding scientific knowledge that I received there, I also learned that everything could be done quite differently and still be well done! Early in my career, I had to leave my initial institution and, in doing so, I also learned that "nobody is irreplaceable."

These two personal experiences have been instrumental in my approach to clinical and research work during my active professional life, as well as in my succession planning: you leave, and you will be replaced by someone who will do things differently . . . and very well!

In my case, the succession planning started soon after I became head of our rheumatology division (1996-2013), while our division was facing serious challenges in human resources. This happened when I was successfully developing my research activities. At that point, the two "lessons" came back to mind, thanks to my wife Claude, and I realized that I had to start looking for collaborators.

Collaborators are key to our success since you can't have all the expertise needed in a single researcher, no matter how talented he or she is. More so, they do things differently and better.

In 2003, being highly involved as a Centre Director in the Canadian Multicentre Osteoporosis Study, I was looking for a collaborator in epidemiology to act as a Co-Director and help in developing and implementing another epidemiologic study on post-fracture care, ROCQ (Recognizing Osteoporosis and its Consequences in Quebec). This resulted in the return of an esteemed young researcher to our unit, Louis Bessette. Both studies provided unique epidemiological data on osteoporosis, defining fragility fractures, clinically meaningful vertebral fractures, morbidity and mortality, as well as financial costs associated with this debilitating disease. Later, Louis became an entrepreneurial partner in pharmaceutical clinical research, bringing his own expertise in inflammatory arthritides. Louis is now leading the team.

Another important contribution to research was the discovery in 2001, of the first and (still) only gene associated with Paget's disease of bone on Chromosome 5q35 tel: sequestosome 1 (SQSTM1/p62). In 2007, this discovery favoured the establishment in our institution of a young researcher, Laëtitia Michou, who now leads our research program on the genetics of Paget's disease of bone, atypical femoral fracture and rare genetic bone diseases.

Many other colleagues have or will contribute to my transition to retirement in June 2021. It is now time for me to get back to those who share my private life, my family.

Being a "bone head", I did things differently, but I always felt respected by my rheumatology colleagues, and I feel privileged to be a CRA member.

Jacques P. Brown, MD, FRCPC
Clinical Professor of Medicine, Department of Medicine, Laval University
Rheumatologist, CHU de Québec-Université Laval
Quebec City, Quebec

Dr. Brown with his grandchildren.

Transitioning Into Practice

By Thanu Ruban, MD, FRCPC

Medical training prepares us well to be medical experts. Transition into practice, however, can be challenging, particularly for those considering a community practice. This was the case for me when I completed fellowship and decided to become a community rheumatologist. There were a lot of options to decide amongst, including location (urban vs. suburban vs. rural), type of practice (solo practice vs. group vs. multi-disciplinary), hospital-based vs. private practice vs. mixed practice.

Choosing the right type of practice for me required a multi-faceted approach. I opted to start by locuming at hospitals as well as at private community practices. For hospital locums, I spoke to colleagues who were a few years ahead of me to see if there were any hospital-based job opportunities. I also reached out to my attending staff during training to connect me with rheumatologists at hospitals I was interested in working at. I found various helpful online resources from the Ontario Medical Association (OMA) as well as HealthForce Ontario (HFO) to help with this process. Locuming at various hospitals was an excellent way to observe the work environment and culture, and staff morale as well as patient demographics. It was also an excellent opportunity to meet other specialists/internists in the areas that I had short-listed for future practice. Networking helped with establishing possible leads for shared office space, office staffing needs, as well as creating an early referral base. With the help of the locuming process, I was able to prioritize interests/must-haves/goals of my future practice. In the end, I chose a mix of solo-private practice with hospital privileges and academic affiliation as the best fit for me.

The challenges of starting out in practice are faced by most, if not all, grads. With this in mind, I knew more could be done to engage and assist these individuals. I wanted to be able to provide new grads with a staple of resources that were not available when I was starting out in my practice. With the Ontario Rheumatology Association (ORA), I created the Emerging Rheumatologists of Ontario (ERO) Committee in 2018. I was fortunate enough to work with a number of enthusiastic early and seasoned rheumatologists. The ERO Committee has brought together rheumatology fellows and early career rheumatologists for networking events with more senior colleagues as well as practice management workshops. With the help of a hardworking sub-committee, we were able to create a rheumatology specific "Transition to Practice" handbook, with commonly asked topics and questions available online. This handbook is complemented by a Peer Mentor Forum, a secure discussion board for ORA members. Early career rheumatologists and trainees can use this forum to review archived conversations of topics of interest or post new queries for review by their colleagues. The ERO committee, co-chaired by myself and Dr. Yan Yeung, continue to work on new initiatives to engage and support early career rheumatologists in Ontario who are starting out and building their practice.

In looking back at my transition to practice, certainly having some of the resources above would have been an asset. I hope that new graduates and early career rheumatologists can take advantage of these resources that have been developed to help with a smooth transition into practice.

Thanu Ruban, MD, FRCPC
Consultant Rheumatologist,
Markham Stouffville Hospital
Markham, Ontario

Succession Planning in Rheumatology

By Sharon Wilkinson, MD, FRCPC

When considering succession planning and transitions in rheumatology the most important priority is time spent in advance planning. Advance planning will ensure better seamless transitions for your patients, your staff and yourself. The first considerations include whether you are planning complete retirement or some mosaic of parts of your previous practice or a new stage in your medical career. Realistically, some diagnoses in rheumatology do not lend themselves to part-time care that would be acceptable for all concerned (including the Canadian Medical Protective Association [CMPA]). Perhaps the transitioning physician may consider doing locums after closing their full-time practice. For some, medical education activities may be an avenue to explore. Others may wish to explore non-medical activities that would satisfy the stimulation lost from practice in daily life.

Continuity of Patient Care

In terms of continuity of patient care, options include:

- Replacement rheumatologist to overlap with your practice during the transition
- Local rheumatologists who may accept referred patients from your practice
- In some circumstances, enlisting family physicians to aid in the referral of patients outside your geographic location

Transition of Care – Cumulative Patient Profile

It may be very helpful to think of information necessary for transition to another rheumatologist long before the time for such a transition is needed. This is especially important for connective tissue disease and inflammatory arthritis diagnoses. Relevant information for any transfer of care in cumulative patient profiles may include:

- Medication history
- Serology/imaging/lab work
- Tuberculosis [TB] tests/chronic hepatitis screen
- Pertinent vaccine history
- Relevant pathology reports and specialist consultations
- Formulary access documents: EAP, private insurers

In many cases a summary letter would be helpful.

Staff Considerations and Timing

Experienced staff may want to stay with the practice. Familiarize yourself with the Employment Standards Act and consult with your accountant/lawyer. Review your lease agreement if applicable. A reasonable timeframe for transition is 6-12 months.

Checklist for the Practice Closure

1. Inform your staff first.
2. Notify patients. Options include:
   a. Individual discussion at follow-up when initiating referral process
   b. An individual letter to patients outlining the transfer of care
3. Notify colleagues.
4. Notify all licensing and professional organizations, including Canadian Medical Protective Association [CMPA], College of Physicians and Surgeons of Ontario [CPSO], Ministry of Health, and the Royal College. Know what is expected of you.
5. Make arrangements for storing or transfer of custody of medical records, including a process for retrieving medical records.

For more information visit **www.oma.org** for a Practice Closure Checklist.

Post Transition

CMPA Protection continues in retirement because CMPA provides occurrence-based protection.

A medical license is required for writing prescriptions, teaching or providing a medical opinion. Contact the College for specific questions.

Medical record requirements for adults include retention of records for 10 years from the date of last entry. The College recommends 15 years for legal reasons. It is important to know how to retrieve charts. Written authorization is necessary to release files. Keep a list of charts shredded and destroyed.

If the decision is made not to renew your license, it is necessary to provide written formal notice to the College to remain in good standing.

Sharon Wilkinson, MD, FRCPC
Rheumatologist (retired)
Burlington, Ontario

References:

CMPA. Winding down your practice. Revised July 2013. Available at *www.cmpa-acpm.ca/en/advice-publications/browse-articles*. Accessed Jan 2020.

CMPA. Considerations when leaving a medical practice. Revised April 2008. Available at *www.cmpa-acpm.ca/en/advice-publications/browse-articles*. Accessed Jan 2020.

CMPA. A matter of records: An overview of the retention, access, security, storage, disposal, and transfer of clinical records. Revised October 2019. Available at *www.cmpa-acpm.ca/en/advice-publications/browse-articles*. Accessed Jan 2020.

A Time of Change

By Janet Yale, outgoing President and CEO of the Arthritis Society

In January, after more than seven years, I retired from my position as President and CEO of the Arthritis Society. Coming from the private sector, some thought it might be an odd fit. But the challenge of leading one of the country's best-known national health charities turned out to be the great thrill of my professional life.

We all know these are not easy times for health charities. Particularly when we're talking about a chronic disease such as arthritis. Volunteers and dollars are harder to come by. Programming is difficult to execute and outreach is challenged by changes in everything from technology to demography.

When I took on the job, we committed to a plan to modernize and move forward. Our goal was simple: To boost our reach, our relevance and our return. And that meant change – to our organization's structure, our approach and mission, our use of technology, our fundraising and culture.

Working together with partners like the Canadian Rheumatology Association, we embraced that change. We may not be all the way there just yet – my successor Trish Barbato has plenty of work ahead. But I believe we are on our way.

Many elements went into that progress, but I always felt that transformation of our service model was vital. In that respect, one particular example stands out.

In 2013, the pediatric rheumatology clinic at Saskatoon's Royal University Hospital was treating about 300 children annually. But the clinic was woefully under-resourced. Its leader, Dr. Alan Rosenberg, wanted just one nurse to help sustain the load. But the Saskatoon Health Authority simply didn't have the funds.

We stepped in and agreed to support a pilot project, hiring a terrific nurse to serve the needs of those 300 kids and to build the business case for the Health Authority. Her mission, which we financed and helped shape, was to show that these kids deserved that support and should receive it permanently.

It worked. By the pilot's conclusion, the Health Authority acknowledged her impact and hired the nurse full-time, as the clinic moved into the new Jimmy Pattison Children's Hospital in Saskatoon.

What I love about this story is that it tells you what the modern Arthritis Society can be. We played a surgical and specific role. It wasn't about writing a cheque and delivering the service ourselves. That model is increasingly difficult to maintain. Instead, we used our dollars to address a clear systemic gap, to serve as a real voice for patients, and to leverage a lasting systemic improvement.

There are many other such examples, but the point is that today's Arthritis Society is a changed organization. It has a new model, a new approach and is achieving greater reach, relevance and results – on its own and with partners like the CRA. In the years ahead, I expect its success to grow even greater. And I feel so fortunate to have played a part in that process for these past seven years.

Janet Yale
Outgoing President and CEO,
Arthritis Society

Innovative Medicines Canada's Updated Code of Ethical Practices Sets the Bar Higher

By Lama Abi Khaled, Executive Director, Ethics, Legal and Regulatory at Innovative Medicines Canada

Innovative Medicines Canada (IMC), the national voice of Canada's innovative pharmaceutical industry, and its members have set a high standard for ethical, transparent and open practices that respect the relationships between members, the life sciences sector, healthcare professionals (HCPs) and the Canadian public. All members of IMC are bound by the association's Code of Ethical Practices (Code), which maintains strict standards on what is acceptable in their work with HCPs and other industry stakeholders. Compliance with the Code is a condition of membership in IMC.

IMC has recently made significant updates to its Code to ensure that the important working relationship between the industry and its stakeholders continues to reflect the highest ethical standards. The changes to the Code seek to clarify the language of certain sections and to address areas of perceived or actual conflict of interest or undue influence.

The updated Code introduces changes to Patient Support Programs (PSPs) and Medical Practice Activities (MPAs). PSPs are programs aimed at increasing or facilitating patients' understanding of a disease and/or treatment, bettering patient outcomes or improving adherence to treatments. PSPs encompass a broad scope of activities, ranging from patient support calls to the administration of drug products. MPAs are programs offered to a medical practice to contribute to the practice's goal of bettering health outcomes via a comprehensive/holistic approach to medicine.

The Code changes are intended to prohibit direct and indirect payments or other benefits to a patient's prescribing HCP or a person who is not at arm's length from the patient's prescribing HCP. Additionally, the changes prohibit third-party service providers, engaged by IMC members to deliver the PSP/MPA, from providing payments or other benefits to a patient's prescribing HCP or a person who is not at arm's length from the patient's prescribing HCP. Furthermore, the changes clarify the prohibition of payments or other benefits to an HCP for services reimbursable by the healthcare system.

In addition to the changes related to PSPs and MPAs, the updated Code addresses the appropriateness of locations and venues when IMC members sponsor third-party conferences and congresses. The changes provide that members should be guided by the same criteria for sponsoring those conferences and congresses as those that apply when they are organizing their own business meetings. For instance, locations should not be the main attraction of the event and cannot reasonably be perceived as such, and venues must not be lavish, extravagant or perceived as luxurious and must not be known for their entertainment, sports, leisure or vacation facilities. When deciding whether to sponsor a third-party conference or congress, IMC members should consider the proposed location and venue as well as review detailed agendas to evaluate the conference's medical or scientific value.

The updated Code is available on IMC's website and came into effect on January 1, 2020. However, the changes related to PSPs and MPAs will come into effect on July 1, 2020, while those related to sponsoring third-party conferences and congresses will come into effect on January 1, 2021. If you have any questions about the Code, please contact Lama Abi Khaled, IMC's Executive Director, Ethics, Legal and Regulatory.

A Review of Reviews: Commentary on the Role of Nutrition in Managing Rheumatic Conditions

By Inez Martincevic, RD, MSc

Beyond the traditional definition of "diet," there is much interest and discussion among both patients and clinicians regarding the role of foods and nutrients in the pathogenesis of and immune-modulating effects on autoimmune diseases, including rheumatoid arthritis (RA), osteoarthritis (OA), systemic lupus erythematosus (SLE), ankylosing spondylitis (AS) and other rheumatic conditions. The purpose of this commentary is to evaluate the current evidence for the role of diet and nutrients in the management of rheumatic conditions across all ages.

The mechanism by which autoimmune conditions develop remains to be elucidated. However recent studies and reviews share insights about the role of the microbiome in human disease. Of particular interest is the gut microbiome, and the potential to modify it with diet as a means to alter immune responses to the environment and, in turn, disease progression and/or activity.[1-4]

This data, together with epidemiological evidence, suggests an increased risk of developing RA with overweight/obesity, vitamin D deficiency, as well as diets rich in red meat, processed sugars, and limited in fruits, vegetables, whole grains, fibers and omega-3 fatty acids. Collectively the data suggests that diet can be an adjunctive therapy in managing rheumatic conditions. [5-9]

Furthermore, patients with autoimmune diseases are keen to implement lifestyle interventions as holistic or complementary means to manage disease. Diet and nutrients are often perceived by patients as natural, safe and effective.[10-12] Albeit, while food and nutrients are considered a part of the environment that one can control and alter, not all diets or supplements are necessarily beneficial for rheumatic conditions. As well, some diets can be limiting in nutrients and could compromise nutritional status and/or be linked with other comorbidities. As well, there is little evidence that food or nutrients can displace current approaches to treat disease.

Dietary patterns of Canadians

Increasing rates of overweight and obesity globally, as well as the associations between poor dietary intake and chronic diseases like rheumatic conditions, have stimulated researchers to evaluate dietary patterns.[13] Studies suggest that eating habits in industrialized nations have moved to highly processed convenience foods, which generally are not considered nutritionally dense options or choices that support optimal health.[14,15] Canadian-specific data supports such conclusions. Between 2007-2014, Canadians reported a frequency of fruit and vegetable intake that was consistently below recommended servings, as advised by Canada's Food Guide to Healthy Eating.[16] Canadians consume more calories from snacks daily than breakfast.[13] Snacks have been estimated to contribute to almost 23% of total energy intake among Canadians, a decent proportion of calories, which may not be healthy choices.[17] Additionally, based on the 2015 Canadian Community Health Survey, 63.5% of children and adolescents, as well as 59.2% of adults, consume diets that contain less than 20% of their total daily grain intake as whole grains, well below recommended.[18] Despite these data, 46% of Canadians believe they have excellent/very good eating habits.[13] Healthy eating patterns among Canadians can be optimized. Healthy eating patterns, like those advised by the recently updated Food Guide in Canada, might help with weight issues, important in managing OA, but also potentially help patients with rheumatic conditions feel better.[19-21]

Overweight/obesity

Countless studies have shown that weight reduction in overweight/obese patients with OA reduces joint pain and improves inflammation, thought to be driven by the adipokine secretion pathways.[22] Excessive body weight is associated with developing RA and may also exacerbate symptoms in RA[27], which may parallel other rheumatic conditions. There is much literature evaluating weight loss strategies as overweight/obesity impacts many chronic diseases. If weight loss is a goal, caution is advised, as some weight loss diets may not be effective, may be associated with other comorbidities, and may not be sustainable long term. Of particular interest are the Paleolithic diet (rich in vegetables, fruits, nuts, eggs, fish and lean meats; excludes refined sug-

ar salt, dairy and grains),[28] ketogenic diet (rich in fats and proteins; limited in grains and processed foods),[29] intermittent fasting (assumes a healthy diet but little or no food/drink are consumed over 16-24 hours),[30,31] or low calorie/fat diets (calorie restricted or fat restricted).[30,31] While it is well known that achieving an ideal body weight/body composition is important for health and should always be considered when counselling patients about disease, further studies evaluating which dietary approach will attain and maintain a healthy body weight, ideally without much restriction, as well as demonstrate a therapeutic benefit in other rheumatic conditions, need to be described.

Elemental diets

Elemental diets remove food antigens thought to be associated with an immune response and provide nutrition in the form of amino acids, thus removing the antigenic properties of proteins, and mono- and/or di-saccharides, fats and micronutrients as a formula to meet nutritional needs. While this therapy has been proven effective in treating other immune conditions, such as eosinophilic esophagitis and, decades ago, inflammatory bowel disease,[23, 24] recent reviews have highlighted that elemental diets have only been studied in RA and not all patients benefited from the intervention.[25-27] Further studies are required to determine if elemental diets can be therapeutic in rheumatic conditions, as well as what to do in the long term, as elemental diets are not considered sustainable.

Elimination diets

Elimination diets remove food(s) thought to be pro-inflammatory which may affect disease activity. This can include removing one and/or more foods such as dairy, nightshade vegetables (members of the Solanaceae family including tomatoes, potatoes, eggplant, bell and chili peppers) and animal sources of food. Foods are removed and/or reintroduced to monitor disease response. Recent reviews evaluating the benefit of elimination diets highlight that data are conflicting; some diets, like the vegetarian and vegan diet, were associated with a significant improvement in symptoms associated with RA and AS, while other results show no significant difference in disease response among patients following these diets compared to control groups.[25-27]

Heterogeneity, limited studies and subjective responses are considered the limiting factors to recommending elimination diets for treatment of rheumatic conditions. Still, patients may report positive symptoms with eliminations and may choose to adhere to food restrictions. As well, plant-based diets may be undertaken for healthy eating, or for other reasons, such as religion or environmental sustainability. In such cases, clinicians are encouraged to be supportive and foster patient-centered as well as holistic care. In doing so, clinicians should assess diets for nutritional adequacy and monitor nutritional status, because elimination diets, especially veganism, can be limiting in vital nutrients including protein, iron, B-vitamins, calcium and zinc, important for optimal growth in children and for overall health in adults.

The gluten-free diet can be considered a type of elimination diet (all sources of gluten, a protein found naturally in wheat, barley, rye and triticale, are removed). Sometimes processed foods with added gluten as an ingredient are eliminated. Studies have shown similarities between RA, SLE, and undifferentiated connective tissue disease, and celiac disease with respect to clinical, epidemiological, pathophysiological and non-HLA genetic aspects.[32-34] Thus screening for celiac disease in rheumatic conditions is warranted, especially in RA, SLE and connective tissue disorders, where a greater prevalence of celiac disease has been reported, even when there are no gastrointestinal symptoms.[27, 33-34] Studies evaluating the effect of a gluten-free diet in rheumatic conditions are limited because patients may report feeling better secondary to gluten sensitivity/intolerance.[35] Although the role of gluten as a disease-modifying factor in rheumatic conditions is unknown, exploring the effectiveness of a gluten-free diet in rheumatic conditions holds potential to manage disease.

The Mediterranean diet

The Mediterranean diet (rich in olive oil/omega-3 fatty acids, vegetables, fruits, whole grains, legumes, nuts, seeds; moderate in fish, shellfish, white meat, plain fermented dairy [yogurt, cheese], wine; limited in red meat, processed meats, sugar) has been associated with a significant reduction in pain, swelling, stiffness and disease activity in RA and psoriatic arthritis, but has not been shown to influence disease prevention.[11, 36-39] The Mediterranean diet may have a role in other rheumatic conditions, but data are scant. Overall the Mediterranean diet follows principles of general healthy eating and overlaps with a diet that would be associated with a lower risk of developing RA and perhaps other rheumatic conditions. Reviews highlight that the Mediterranean diet as adjunctive therapy can help manage RA and psoriatic arthritis; however higher quality and long-term studies are warranted, including more studies in other rheumatic conditions.

Supplements

Omega-3 fatty acids (eicosapentaenoic acid [EPA], docosahexaenoic acid [DHA], marine-sourced, versus alpha-linolenic acid [ALA], plant-sourced), provided as fish oil supplements appear to be safe and effective agents in managing RA and SLE, less so in OA.[40-42] However bleeding risk with omega-3 fatty acids has been described[43] and

needs to be considered if taken by patients with rheumatic conditions. While promising as adjunctive therapy, omega-3 fatty acids also come from food. So future trials examining total intake from food and supplement, to establish a holistic safe dose that can be used in conjunction with diet, is needed. Further studies are also needed to clearly establish the role of omega-3 fatty acids as a treatment option alone versus with other medications and among different ages.

Vitamin D deficiency has been associated with developing rheumatic conditions, but it remains to be clarified if vitamin D has a protective role.[44, 45] Furthermore, it is still unclear if vitamin D is beneficial in established autoimmune disease, as data regarding disease activity with supplementation are conflicting, despite widespread knowledge that vitamin D is important to immune health, not just bones. [44-46] Still, screening for deficiency and supplementing to reach normal levels, is strongly recommended. Achieving normal vitamin D levels in Canada can be challenging; vitamin D status is affected by variable sun exposure year round and diet, especially if dairy or enriched cow's milk alternatives are eliminated.

Probiotics and their use in modifying the gut microbiome in rheumatic conditions are promising. However, at this time, clinical trials have not shown a consistent or significant benefit on patient-reported symptoms or biochemical indices of disease burden.[25] More studies addressing strain, dose, as well as considering diet and prebiotic sources, are warranted before probiotics can be recommended.

Conclusions

It is an exciting time in the field of nutrition and health. Many reviews have demonstrated that food and nutrients can impact autoimmune disease.[1-4, 47-48] A group was recently inspired to create a diet for RA based on interventional studies, as well as information from animal models and other diseases.[49] However more work is needed to delineate the role of diet in all rheumatic conditions, not just RA or SLE, and across the ages, given that pediatric needs are different than adults. Moreover, reviews highlight different goals and contradictory results, which make it difficult to guide patients. Canadians, as well as patients with RA and OA, eat poorly.[50-52] As such a first-line intervention for helping patients with rheumatic conditions can be to help improve intake and encourage a diet rich in whole foods, vegetables, fruits, whole grains, more plant-based proteins, but limited in processed foods, sugars, meats, salt and coffee. This summarizes the essence of eating well and can likely improve body composition, but may also improve disease management. Diets to treat rheumatic conditions have also been studied, but the only diet to date with any evidence of benefit is the Mediterranean diet; a diet that emphasizes healthy eating principles and diverges from usual western eating habits. Rizzello et al. (2019) showcase the differences between the Mediterranean and western diet with illustrative figures that might be helpful in practice.[15] Omega-3 fatty acids and vitamin D can be consumed from foods, but supplementation with close monitoring of doses may be added as adjunctive therapy. As part of assessing nutritional intake and status, considerations not reviewed in this commentary, such as disability affecting food preparation and eating, diet sustainability, as well as food security and accessibility also need to be studied and addressed. As we learn more and appreciate the role of diet in managing rheumatic conditions, imagine a future where even personalized nutrition and enhanced treatment may be fulfilled.[53]

Inez Martincevic, RD, MSc
Department of Clinical Dietetics
Hospital for Sick Children
Toronto, Ontario

References
1. Bellucci E, Terenzi R, La Paglia GMC, et al. One year in review 2016: pathogenesis of rheumatoid arthritis. Clin Exp Rheumatol 2016; 34:793-801.
2. Jethwa H and Abraham S. The evidence for microbiome manipulation in inflammatory arthritis. Rheumatology 2017; 56:1452-1460.
3. Sandhya P, Danda D, Sharma D, et al. Does the buck stop with the bugs?: an overview of microbial dysbiosis in rheumatoid arthritis. Intl J Rheum Dis 2016; 19:8-20.
4. Abdollahi-Roodsaz S, Abramson SB, and Scher JU. The metabolic role of the gut microbiota in health and rheumatic disease: mechanisms and interventions. Nat Rev Rheumtol 2016; 12(8):446-455.
5. Semerano L, Julia C, Aitisha O, et al. Nutrition and chronic inflammatory rheumatic disease. Joint Bone Spine 2017; 84:547-552.
6. He J, Wang Y, Feng M, et al. Dietary intake and risk of rheumatoid arthritis - a cross section multicenter study. Clinical Rheumatology 2016; 35:2901-2908.
7. Sabbagh Z, Markland J and Vatanparast H. Vitamin D status is associated with disease activity among rheumatology outpatients. Nutrients 2013; 5:2268-2275.
8. Oliver JE and Silman AJ. What epidemiology has told us about risk factors and aetiopathogeesis in rheumatic diseases. Arth Res Therapy 2009; 11:223-235.
9. Pedersen M, Stripp C, Klarlund M, et al. Diet and risk of rheumatoid arthritis in a prospective cohort. Journal of Rheumatology 2005; 32: 1249-1252.
10. Nousiainen P, Merras-Salmio L, Aalto K, et al. Complementary and alternative medicine use in adolescents with inflammatory bowel disease and juvenile idiopathic arthritis. BMC Complem Alt Med 2014; 14:124-131.
11. Tedeschi SK, Frits M, Cui J, et al. Diet and rheumatoid arthritis symptoms: survey results from a rheumatoid arthritis registry. Arthritis Care & Research 2017; 69(12):1920-1925.
12. McIntyre Little E, Grevich S, Huber JL, et al. Parental perception of dietary intervention in juvenile idiopathic arthritis. J Alt Complem Med 2019; 25(6):643-647.
13. Slater JJ and Mudryj AN. Self-perceived eating habits and food skills of Canadians. J Nutr Edu Beh 2016; 48(7):486-495.
14. Popkin BM, Adair LS, Ng SW. Global nutrition transition and the pandemic of obesity in developing countries.
15. Rizzello R, Spisni E, Giovanardi E, et al. Implications of the Westernized diet in the onset and progression of IBD. Nutrients 2019; 11(5):1033; https://doi.org/10.3390/nu11051033
16. Colapinto CK, Graham J and St-Pierre S. Trends and correlates of frequency of fruit and vegetable consumption, 2007 to 2014. Health Reports. 2018; 29(1):9-14.
17. Vatanparast H, Islam N, Prakash Patil R, et al. Snack consumption patterns among Canadians. Nutrients. 2019; 11:1152-1164.
18. Hosseini SH, Jones JM and Vatanparast H. Association between grain intake, nutrient intake, and diet quality of Canadians: evidence from the Canadian Community Health Survey-Nurtrition 2015. Nutrients. 2019; 11:1937-1952.
19. Urban H and Little CB. The role of fat and inflammation in the pathogenesis and management of osteoarthritis. Rheumatology (Oxford). 2018 Feb 9. doi: 10.1093/rheumatology/kex399. [Epub ahead of print].
20. Daien CI and Sellam J. Obesity and inflammatory arthritis: impact on occurrence, disease characteristics and therapeutic response. Rheumatic & Musculoskeletal Diseases Open 2015; 1(1):e000012. doi: 10.1136/rmdopen-2014-000012.
21. Liu Y, Hazlewood GS, Kaplan GG, et al. Impact of obesity on remission and disease activity in rheumatoid arthritis: a systematic review and meta-analysis. Arthritis Care & Research 2017; 69(2): 157-165.

22. Thomas S, Browne H, Mobasheri A, et al. What is the evidence for a role for diet and nutrition in osteoarthritis? Rheumatol 2018; 57: iv61-iv74.
23. Atwal K, Hubbard GP, Venter C, et al. The use of amino acid-based nutritional feeds is effective in the dietary management of pediatric eosinophilic oesophagitis. Immun Inflamm Dis 2019; 7(4): 292-303. doi: 10.1002/iid3.273.
24. Munkholm LP, Rasmussen D, Rønn B, et al. Elemental diet: a therapeutic approach in chronic inflammatory bowel disease. J Intern Med 1989; 225(5):325-31.
25. Badsha H. Role of diet in influencing rheumatoid arthritis disease activity. Open Rheumatol J 2018; 12: 19-28.
26. Semerano L, Chantal J, Aitisha O, et al. Nutrition and chronic inflammatory rheumatic disease. Joint Bone Spine 2017; 84: 547-552.
27. Alwarith J, Kahleova H, Rembert E, et al. Nutrition interventions in rheumatoid arthritis: the potential use of plant-based diets. A review. Frontiers Nutr 2019; 6(14): 1-11.
28. Otten J, Mellberg C, Ryberg M, et al. Strong and persistent effect of liver fat with a paleolithic diet during a two-year intervention. Intl J Oesity 2016; 40:747-753.
29. O'Neill B and Raggi P. The ketogenic diet: pros and cons. Atherosclerosis 2020; 292: 119-126.
30. Zubrzychki A, Cierpka-Kmiec K, Kmiec Z, et al. The role of low-calorie diets and intermittent fasting in the treatment of obesity and type-2 diabetes. J Physiol Pharmacol 2019; 69(5): 663-683.
31. Saeed N, Badeau B, Shannon C, et al. Evaluation of dietary approaches for the treatment of non-alcoholic fatty liver disease: a systematic review. Nutrients 2019; 11(12), 3064; https://doi.org/10.3390/nu11123064.
32. Lerner A and Matthias T. Rheumatoid arthritis-celiac disease relationship. Joints get that gut feeling. Autoimmunity Rev 2015; 14: 1038-1047.
33. Dahan S, Shor D, Comaneshter D, et al. All disease begins in the gut: celiac disease co-existence with SLE. Autoimmunity Rev 2016; 15: 848-853.
34. Conti V, Leone MC, Casato M, et al. High prevalence of gluten sensitivity in a cohort of patients with undifferentiated connective tissue disease. Eur Ann Allergy Clin Immunol 2015; 47(2): 54-57.
35. El-Chammas K and Danner E. Gluten-free diet in nonceliac disease. Nutr Clin Prac 2011; 26(3): 294-299.
36. Forsyth C, Kouvari M, D'Cunha NM, et al. The effects of the Mediterranean diet on rheumatoid arthritis prevention and treatment: a systematic review of human prospective. Rheumatol Intl 2018; 38: 737-747.
37. Petersson S, Philippou E, Rodomar C, et al. The Mediterranean diet, fish oil supplements and rheumatoid arthritis outcomes: evidence from clinical trials. Autoimmune Rev 2018; 17: 1105-1114.
38. Caso F, Navarini L, Carubi F, et al. Mediterranean diet and psoriatic arthritis activity: a multicenter cross-sectional study. Rheumatol Int 2019; Oct 11. [Epub ahead of print]
39. Ford AR, Siegel M, Bagel J, et al. Dietary recommendations for adults with psoriasis or psoriatic arthritis from the medical board of the national psoriasis foundation. JAMA Dermatol 2018; 154(8): 934-950.
40. Akbar U, Yang M, Kurian D, et al. Omega-3 fatty acids in rheumatic diseases. J Clin Rheumatol 2017; 23(6): 330-339.
41. Gioxari A, Kaliora AC, Marantidou F, et al. Intake of w-3 polyunsaturated fatty acids in patients with rheumatoid arthritis: a systematic review and meta-analysis. Nutrition 2018; 45: 114-124.
42. Li X, Bi X, Wang S, et al. Therapeutic potential of w-3 polyunsaturated fatty acids in human autoimmune diseases. Front Immunol 2019; 10:2241. doi: 10.3389/fimmu.2019.02241.
43. Bays HE. Safety considerations with omega-3 fatty acid therapy. American J Cardiol 2007; 99: 35C–43C.
44. Harrison SR, Li D, Jeffery LE, et al. Vitamin D, autoimmune disease and rheumatic arthritis. Calcified Tissue Intl 2020; 106:58-75.
45. Wessels I and Rink L. Micronutrients in autoimmune diseases: possible therapeutic benefits of zinc and vitamin D. J Nutr Biochem 2019; 77:108240. doi: 10.1016/j.jnutbio.2019.108240. [Epub ahead of print].
46. Yamamoto E and Jorgensen TN. Immunological effects of vitamin D and their relations to autoimmunity. J Autoimmunity 2019; 100:7-16.
47. Khanna S, Jaiswal KS and Gupta B. Managing rheumatoid arthritis with dietary interventions. Front Nutr 2017; 4: 52 doi: 10.3389/fnut.2017.00052.
48. Dahan S, Segal Y, Shoenfeld Y. Dietary factors in rheumatic autoimmune diseases: a recipe for therapy? Nature Rev Rheumatol 2017; 13: 348-358.
49. Bustamante MF, Agustin-Perez M, Cedola F, et al. Design of an anti-inflammatory diet (ITIS diet) for patients with rheumatoid arthritis. Contemp Clin Trials Commun 2020; 21;17:100524. doi: 10.1016/j.conctc.2020.100524. eCollection 2020 Mar.
50. Comee L, Taylor CA, Nahikian-Nelms M, et al. Dietary patterns and nutrient intake of individuals with rheumatoid arthritis and osteoarthritis in the United States. Nutrition 2019; 67-68:110533. doi: 10.1016/j.nut.2019.06.014. Epub 2019 Jun 28.
51. Malm K, Bremander A, Arvidsson B, et al. The influence of lifestyle habits on quality of life in patients with established rheumatoid arthritis-a constant balancing between ideality and reality. Int J Qual Stud Health Well-being 2016; 11:30534. doi: 10.3402/qhw.v11.30534.
52. Berube LT, Kiely M, Yazici Y, et al. Diet quality of individuals with rheumatoid arthritis using the healthy eating index (HEI)-2010 Nutr Health. 2017; 23(1):17-24.
53. Zmora N, Suez J and Elinav E. You are what you eat: diet, health and the gut microbiota. Nat Rev Gastroenterol Hepatol 2019; 16(1):35-56.

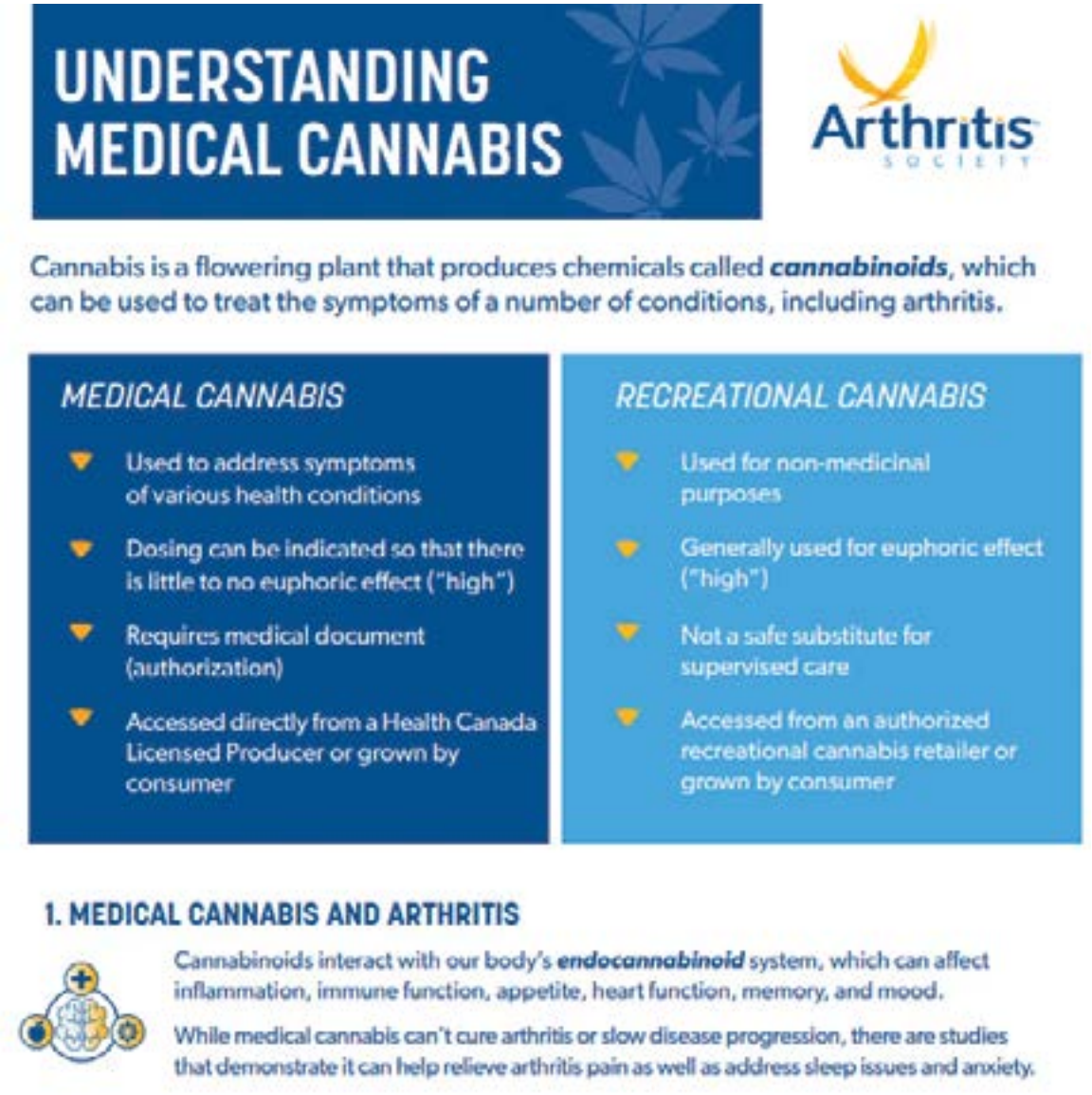
Medical Cannabis: New Patient Resources

Pain management remains one of the most common challenges that people with arthritis face. Many options, such as opioids or non-steroidal anti-inflammatory drugs (NSAIDs), have adverse side effects that make them ineffective or undesirable for long-term use managing symptoms of a chronic condition. This has contributed to growing interest in the use of medical cannabis to help manage pain and other arthritis symptoms.

If patients are asking you about their pain management options, or are curious about medical cannabis, the Arthritis Society's newly updated medical cannabis resources can be a great way to start an informed discussion.

The resources—found at *arthritis.ca/medicalcannabis*—were produced in consultation with rheumatologist Dr. Carolina Landolt-Marticorena, and feature content from noted pain researcher Dr. Jason MacDougall.

Incorporating video, infographics and text in an interactive experience, patients can explore the science behind the use of cannabis for medical purposes, potential benefits and risks, how to access the drug, and common questions like the difference between THC and CBD or the variety of delivery modes — including newly legal oils, extracts and edibles. For patients with more in-depth questions, a robust online learning module is also available from this page, or directly on our e-learning platform at *arthritis.ca/education*.



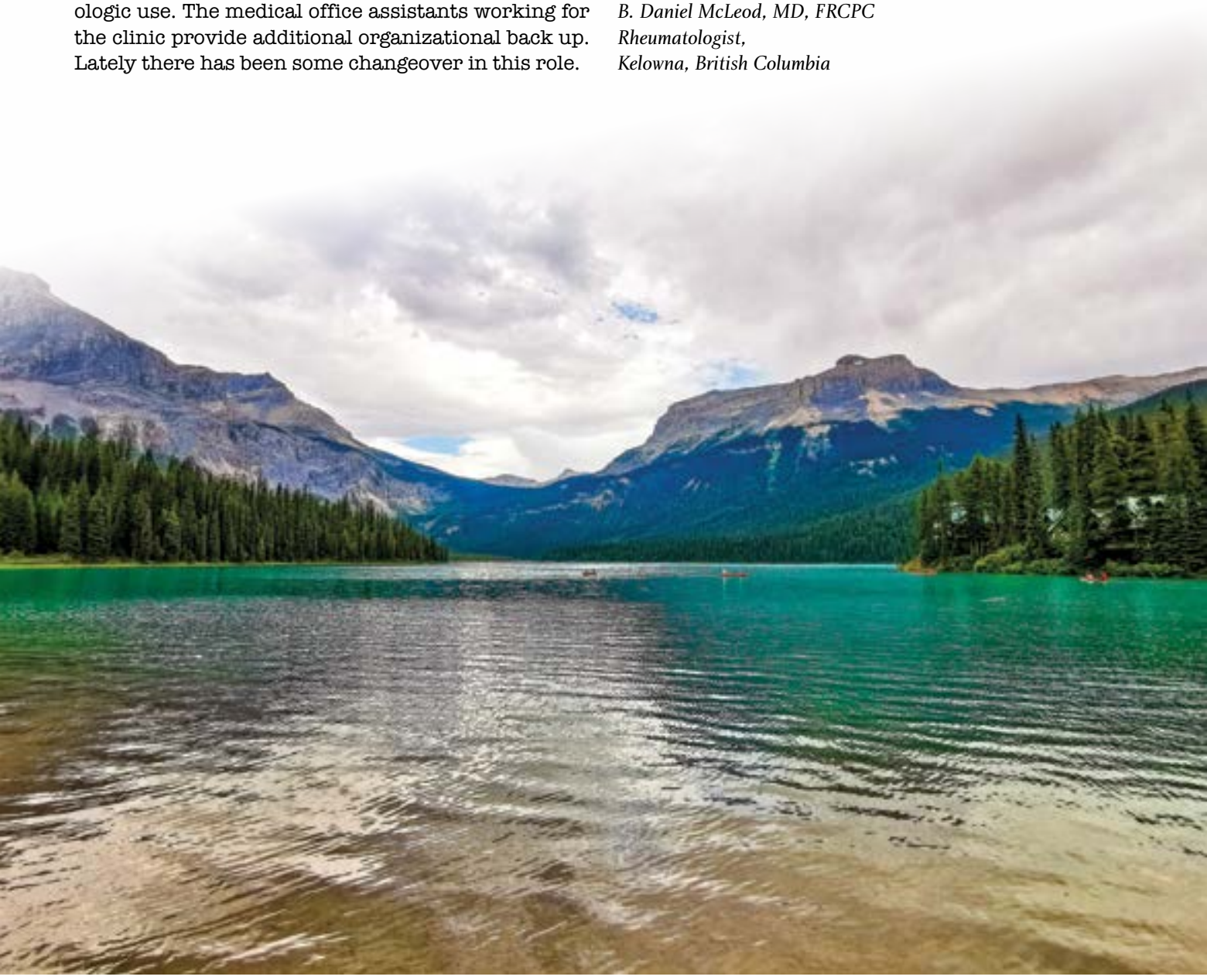
Update from the Yukon

By B. Daniel McLeod, MD, FRCPC

Rheumatology consulting services in the Yukon are provided by a visiting consultant allotted eight weeks of clinic time and reimbursement. The Territory provides clinic space in the Whitehorse General Hospital. A part-time clinic nurse is provided, and the current nurse Simone Cox deserves recognition for her dedication and efficiency. She provides excellent continuity of care and organization to the clinic. She carries out patient education, particularly for biologic use. The medical office assistants working for the clinic provide additional organizational back up. Lately there has been some changeover in this role.

We have access to standard imaging, MRI and CT. There is no nuclear medicine or bone densitometry. There is limited ultrasound access and interventional radiology. There are two full-time orthopedic surgeons. There is a visiting hand surgeon. There are visiting physiatry and neurology services, including electrophysiological testing. There is an excellent variety of clinical cases to see.

B. Daniel McLeod, MD, FRCPC
Rheumatologist,
Kelowna, British Columbia



Update from the Northwest Territories

By Martha Decker, MD, FRCPC

Healthcare delivery in rheumatology is evolving in Canada, and the North is no exception. The Northwest Territories (NWT) and Nunavut have seen several transitions in rheumatology care over the course of the last year.

In spring 2019, the new Stanton Territorial Hospital was opened in Yellowknife. The rheumatology clinic has transitioned to the expanded Ambulatory Care Centre in the new hospital. We continue to be well supported by a team, including nurses and administrators, who assist with coordinating the outreach clinics.

A major transition for Northern patients has occurred with Dr. Dalton Sholter retiring from the NWT portion of his practice. Dr. Sholter continues to maintain his rheumatology practice in Edmonton, Alberta. Dr. Sholter first went up to Yellowknife in July 1997, having just finished his rheumatology fellowship several weeks prior. He had taken over the practice from Dr. Sharon Le Clercq, who had been doing outreach clinics in the area for 10 years, and asked Dr. Sholter if he was willing to take on the challenge. Dr. Sholter says "She told me that I would see great pathology and function as a "true consultant." It seemed really cool and I was keen to go. I went for four days with the clinic booked exactly as she had done it before, 30 minutes for new patients and 15 minutes for follow ups, except they were all new to me. Plus, I had no idea how to navigate the system, but Dr. Le Clercq kept meticulous records and had the neatest handwriting (no computers were used back then). She took very good care of her patients so I felt like I had big shoes to fill."

Dr. Sholter provided consistent, high-quality rheumatology care to patients in the NWT and Nunavut for 22 years, holding clinics every three months without fail until his last clinic on July 15, 2019. I am in my first year of practice in rheumatology and completed my fellowship at the University of Alberta in June 2019. I held my first clinic in Yellowknife several weeks after finishing my fellowship, and have held clinics every three months since. There is a high burden of advanced rheumatic disease among Northern patients, who often live in resource-limited settings. Like Dr. Sholter, I have found it to be a challenging but highly rewarding experience. Dr. Sholter's patients are very well cared for and it's clear that the next generation of rheumatology trainees also have "big shoes to fill." I look forward to working with the Territorial Health Authority to expand the clinic, so that we can continue to provide timely and high-quality rheumatology care to patients in the North.

The new Stanton Territorial Hospital in January 2020.

Part of the team in the Stanton Ambulatory Care Centre. From left to right, Dr. Dalton Sholter, Tina Drew (Nursing, Urology), Pauline Sundberg (Clinic supervisor, retired), Tammy Connors (Administration, specialty clinics), Patricia (Nursing, ENT), Dr. Omar Ahmad (General Internal Medicine), Darlene Funk (ENT physician assistant).

Martha Decker, MD, FRCPC
Rheumatologist,
Lethbridge, Alberta

SIMPONI®

Proven efficacy.
Proven safety profile.

SIMPONI®, in combination with MTX, is indicated for reducing signs and symptoms and improving physical function in adult patients with moderately to severely active RA; Inhibiting the progression of structural damage in adult patients with moderately to severely active RA who had not previously been treated with MTX.

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.

PROVEN EFFICACY

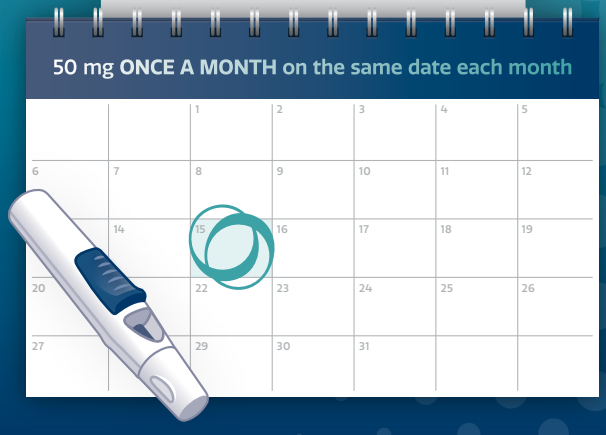
monthly Pr Simponi® golimumab

10+ YEARS EXPERIENCE

10+ YEARS
of Canadian experience behind us.

Supporting you and your patients in the years to come.

A SIMPLE Once a Month DOSING SCHEDULE



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.

Janssen Inc. | 19 Green Belt Drive | Toronto, ON | M3C 1L9
www.janssen.com/canada | CP-131909E

MEMBER OF INNOVATIVE MEDICINES CANADA

PAAB

Janssen | Pharmaceutical companies of Johnson & Johnson

XELJANZ: The first JAK inhibitor in RA, PsA and UC[1]*

PrXELJANZ®
(tofacitinib citrate)

RHEUMATOID ARTHRITIS

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.

PP-XEL-CAN-0480-EN