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CRAJ SCR

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EDITORIAL

Let Them Down Easy

By Philip A. Baer, MDCM, FRCPC, FACR

My patient of 26 years calls to let me know he needs a referral to a rheumatologist closer to home. Not an uncommon request these days, with virtual visits receding, and in-person visits requiring long commutes in post-pandemic traffic becoming the norm again. No problem: I keep a list of area rheumatologists just for this purpose. I choose a colleague, send the key information, and wait.

Two days later, I receive a fax back headlined "Not Accepting New Referrals." At first glance, this doesn't sound good: I had talked up the virtues of this rheumatologist, and now I must start over. However, closer inspection of the document makes me happier. While my selected colleague is not accepting consults, they have passed my request over to a new associate in their office. I'm totally fine with that.

There is an art to rejecting referrals. First, you must be comfortable with the fact that this is allowed, as long as it is done in a non-discriminatory fashion. You are perfectly free to limit the types of diseases you offer care for in an outpatient practice. That isn't the case if you are on-call to an emergency department or providing in-patient consultations. A few years ago, I was representing rheumatology in a provincial medical association health care sustainability working group, looking at improving the appropriateness of medical care. The idea of rejecting referrals was novel to many of the other specialists. I proposed a small fee for triaging referrals and providing alternatives for rejected referrals, but unfortunately, this idea has not yet been implemented.

You also must be cognizant of the supply-demand equation in your specialty. During the early pandemic, when referrals dried up, one couldn't be as choosy. In normal times, we all know there is a shortage of rheumatologists to service the demand for care, even in many urban areas. Read the "Stand Up and Be Counted" articles from the CRA if you want to review the evidence.[1]

I rarely have someone sitting in to observe my office, but I still remember having an American physician who worked in industry and was new to rheumatology come to visit, en route to a meeting we were both attending. Between patients, I was handling documents, one of which was a new referral. I declined the consultation, sending a note back with my reasons and alternative suggestions. My colleague was aghast, as he told me that I would never get another referral from that physician. I told him I doubted he was right, but I could live with the consequences. Sure enough, two hours later I received another referral from the same physician, which I accepted.

Offering options beyond a simple rejection is vital when triaging referrals. As a referring physician myself, I don't want referral rejections that simply inform me that the consultant I had selected does not perform a particular orthopedic procedure, or only deals with cosmetic dermatology. My patients and I are looking for solutions, not roadblocks. Similarly, when I cannot accept a referral, I don't want to leave the requesting physician in limbo or feeling lost. My plan is to reject quickly rather than leave someone hanging, and to provide concrete alternatives to advance the patient's care.

My rejected referral letter is my opus: clear, comprehensive, and tailored to the situation. I don't start with a negative headline, but with an acknowledgment of the referral, followed by specific reasons outlining why I cannot accept it. Then, I provide suggestions for alternative pathways for the patient, including links to relevant clinics, and the names, phone and fax numbers of other specialists who might be able to assist. The template is dynamic, with frequent additions keeping it relevant. For example, when I heard a colleague had developed an interest in fibromyalgia, I added their contact information to be included for relevant referrals in that domain.

I am also sensitive to the fact that long-established referral patterns may mean that the family doctor and I practice in proximity, but the patient may live far away from both of us. Directories of rheumatologists do exist, such as on the ORA website, but family physicians may not yet be in the habit of consulting them. I try to assist by suggesting rheumatologists who may be more convenient for the patient. After all, does it make sense for a patient to drive 90 minutes each way to my office, bypassing the offices of dozens of my colleagues, to see me? Environmentally, clinically, and in every other way, my answer is no.

Most recently, a patient was referred with a host of non-specific symptoms post-COVID infection. Comprehensive imaging, lab and serologic studies were all normal. I felt there was a low likelihood that the patient had

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Let Them Down Easy

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a defined rheumatic disease. I could accept the referral, have the patient wait months to see me, and confirm my immediate appraisal. Instead, I consulted Dr. Google and found an excellent directory of post-COVID resources and clinics on the website of the Ontario College of Family Physicians (OCFP)[2], including the following:

"On June 7, 2021, Unity Health Toronto launched a new Outpatient Post-COVID Condition Rehabilitation Program at Providence Healthcare. This program will support medically stable patients who are experiencing non-urgent post-COVID-19 symptoms through an inter-professional team that includes a physiatrist, an occupational therapist, physiotherapist, speech language pathologist, and social worker. Additional consultation services from other health disciplines such as a pharmacist or dietitian are available as needed, as well as access to medical specialty consultations."

That is far more than I could ever hope to provide in my solo office practice!

I always end my rejection letter with the phrase "Feel free to call me if you wish to discuss this matter further." Such calls are rare, but if someone takes the time and makes the effort, I am usually willing to reconsider my position.

It really helps to remember why triage is so important: it improves access for patients who can truly benefit from rheumatology care, while providing alternatives to languishing on a long wait list for those who can be redirected to more appropriate alternative resources.

Issues with referrals are highlighted in several recent articles I came across:

Dr. Alykhan Abdullah, an Ontario family physician (FP), writes about "A Day in a Life of a Family Physician", which sounds far worse than any day in my working life, and one of his many issues is "failed referrals to specialists without any guidance." As he doesn't refer patients to me, I can't help him directly, but maybe this editorial will help indirectly.[3]

Dr. Jabir Jassam, also an Ontario FP, points out in a Medical Post article "Do FPs cause delays in other specialists' wait time?" that "unnecessary referrals prolong the wait times of other doctors, but also the wait times of family doctors themselves because—besides the time consumed writing, attaching files and faxing the referrals—they may need to read all the incoming reports. In my opinion: The wait time for some specialists is very long for many reasons and family doctors are one of these reasons."[4]

Finally, an editorial in the July 2022 issue of *Arthritis Care & Research* highlights the value of clinical academic rheumatology practitioners in the American context. The authors recommend: "Screening of all outpatient rheumatology consults and scheduling of only patients with an inflammatory rheumatic disease in the university outpatient rheumatology clinic, assuring that patients most in need of rheumatologic care are seen in a timely manner and that more complicated cases are available for training fellows and residents. The university hospital administration recognizes the advantage of scheduling these patients who generate higher evaluation and management codes (in other words higher fees) and significantly more downstream revenue for the hospital compared to patients with noninflammatory musculoskeletal problems." Well, I am not triaging for financial reasons, but the theme resonates.[5]

Key learning: You can reject referrals but do it kindly and provide alternatives to the referring health care provider.

Philip A. Baer, MDCM, FRCPC, FACR
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Presidential Address

By Nigil Haroon, President,
Canadian Rheumatology Association (CRA)

Dr. Haroon with Dr. Felix Leung, ORA President at the 2023 ORA ASM in King City, ON.

Dear Colleagues,

Greetings!

I hope you are in the best of health and high spirits. As the President of the Canadian Rheumatology Association (CRA), I always look forward to different avenues to connect with the members of our esteemed organization. The *Journal of the Canadian Rheumatology Association (CRAJ)* is an excellent medium towards this end, and I thank the amazing team that has been leading this publication over the years, especially Philip and Jyoti, for this opportunity.

One of the key goals during my Presidency is membership engagement and, over the last year, I have had multiple opportunities to interact with our members from different parts of the country. I strongly believe that meeting you in your local environments helps develop a deeper understanding of the diverse cultures, perspectives, and challenges faced by our membership. This in turn feeds into the success of another major CRA strategic theme, fostering inclusivity, diversity, equity, and justice within our organizations. We are stronger together and I encourage you to invite your rheumatology colleagues to join the CRA if they are not already members. Our CEO Dr. Ahmad Zbib and I are keen to meet you in small gatherings and engage with local rheumatology communities. These interactions will help forge new connections, discover unique skill sets among our members, encourage knowledge sharing and build a more interconnected and inclusive organization, harnessing the full potential of our amazing membership. Please let us know if there are opportunities for the CRA to interact with and help you in any way. I would also encourage you to participate in leadership opportunities within the CRA. In addition to working with different committees, we are currently looking for two new board members. Based on the demographics and skills of the current board, adult rheumatologists, and those from smaller communities and/or within their first ten years of practice are encouraged to apply. For details on how to apply, please refer to my May 26th President's Update email or reach out to the CRA.

With the amazing CRA staff at the 2023 ASM in Quebec City.

At the 2023 Northwest Rheumatism Society (NWRS) meeting in Vancouver, B.C.

Our Annual Scientific Meeting (ASM) continues to serve as a remarkable platform for our members to gather, connect, and contribute to the collective growth of our field. It is an occasion that unites us in a shared passion for education, improving patient care, expanding our scientific understanding, and envisioning a brighter future for rheumatology. Thank you to all who were able to attend and contribute to the success of our 2023 ASM, virtually or in person in Quebec City. I sincerely thank the ASM committee who put together a meticulously curated program, esteemed speakers, and a diverse array of scientific sessions. The gala event was a night that we will cherish for a long time. Please mark your calendar for our 2024 ASM, which will be held in Winnipeg, Manitoba, from February 28 - March 2, 2024.

Please visit the CRA website (*rheum.ca*) and check out our incredible breadth of activities. Please send us a note if you would like to be involved in any initiatives. You can also listen to our highly rated Around the Rheum podcasts. Thank you to all who are supporting the CRA Foundation (CRAF). If you have not already done so, please visit the CRAF website. Under the leadership of our Chair, Dr. Vandana Ahluwalia, CRAF provides us with an opportunity to build a sizeable endowment that will help fund research, training and advocacy through grants, bursaries and other programs.

Thank you once again for the opportunity to be your president and I look forward to the next time we meet. Best wishes for a fantastic summer.

Nigil Haroon, MD, PhD, DM, FRCPC, MBA
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Head, Division of Rheumatology,
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Associate Professor of Medicine and Rheumatology,
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Senior Scientist, Schroeder Arthritis Institute
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Project Athena: Tackling EMR Inefficiencies with New Informatics Platform

The Canadian Rheumatology Association (CRA) Board has identified practice and electronic medical records (EMR) inefficiencies as a top priority for the CRA to address, based on a series of member consultations in 2022.

To tackle this issue, the CRA is working with Dr. Karim Keshavjee, an expert in digital health and clinical informatics, to identify the features of the next-generation pan-Canadian rheumatology informatics platform (code-named "Project Athena").

Streamlining clinical workflows will lead to more efficient use of technologies, reduce administrative burden, and enable better communication between clinicians and patients. The CRA recognizes the importance of optimizing the use of modern platforms for improving quality of care, increasing capacity for guideline implementation, and participation in disease registries.

To ensure that we fully understand the needs of our members and identify best practices, the CRA will be reaching out for member input on key streams of the project. These streams include EMR/office optimization, building on the work done to date to identify quality care indicators, identify common informatics needs for all the great disease registry work our members do, design dashboards and data standards, and explore opportunities for partnerships with other specialty organizations.

The CRA will continue to contact members who have expressed interest in providing input for this project. If members have any questions or would like to provide input on this project, please contact CEO Dr. Ahmad Zbib at *azbib@rheum.ca*, and the CRA will provide answers in a timely manner.

Canadian Innovators Awarded $200,000 at Arthritis Society Canada's 2023 Ideator Event

By Arthritis Society Canada

On April 20th, four Canadian innovators received the prestigious Arthritis Ideator Award™ from Arthritis Society Canada at its second annual pitch-style competition event held in Toronto. The Arthritis Ideator Awards™ recognizes the best innovations aimed at improving the lives of people living with arthritis.

"Arthritis is not well understood and there are so many myths about it," says Trish Barbato, president & CEO of Arthritis Society Canada. "The Arthritis Ideator Awards™ are part of our bold Innovation Strategy. We are excited to showcase innovations that will allow us to put a spotlight on this group of chronic, debilitating diseases, by supporting solutions to help the six million Canadians who manage these conditions daily."

To learn more about this year's four Award recipients—FirstHx, Heal Mary, Pillcheck and People's Choice Award winner Joints on Point – please visit **arthritis.ca/IdeatorAwards.**

As part of the Arthritis Ideator Awards™, the winning innovators receive access to experts from Arthritis Society Canada and the broader arthritis ecosystem including technology, research and corporate partners to help advance their work.

The Great Debate

By Volodko Bakowsky, MD, FRCPC, on behalf of Cory Baillie, MD, FRCPC; Louis Bessette, MD, MSc, FRCPC; Michelle Batthish, MD, MSc, FRCPC; and Anne MacLeod, PT, MPH, ACPAC

Be it resolved that Canadians with new inflammatory arthritis should have access to all therapeutic options at disease onset to induce remission.

The Great Debate team (from left to right): Anne MacLeod and Drs. Cory Baillie, Volodko Bakowsky (chair), Louis Bessette, and Michelle Batthish.

One of the nicest things about the CRA Annual Scientific Meeting once again returning to a live format was being able to share the stage with some of the greatest minds in Canadian rheumatologic care for the Great Debate. These eminent intellectuals were able to present their arguments in such an approachable fashion that even the chair (universally accepted as not a great mind) was able to follow along. The CRA faithful also witnessed the tallest (Dr. Bessette) and second tallest (Dr. Baillie) Canadian rheumatologists on stage together at the same time.

Dr. Cory Baillie and Anne MacLeod both spoke in favour of the motion. In the absence of any guidelines or evidence to defend their position, the affirmative side was forced to turn to smoke, mirrors and obfuscation. Among the pillars of their initial argument was a survey of 39 Canadian rheumatologists which found that 81% would prefer to be started on biologic monotherapy or biologic combination therapy by their rheumatologist if they themselves were diagnosed with moderate-to-severe rheumatoid arthritis (RA). The affirmative speakers also presented data about the prevalence of intolerance to methotrexate and other traditional disease-modifying anti-rheumatic drugs (DMARDs) in adults and children, the effectiveness of biologics on reducing disability, the cost savings of both biosimilars and biologic tapering making early biologic treatment more affordable, and the amount of general government waste which trivializes the costs of biologics for rheumatic disease patients.

Canadian data on access to care, in both adult and pediatric rheumatology, indicate system issues with meeting benchmarks created by the Wait Time Alliance in 2014. Research also confirms that wait times in certain urban areas, such as Toronto, are shorter than elsewhere in the province of Ontario. Recent studies concluded that there is a trend towards improvements in access to RA diagnosis and early treatment over time; however many gaps remain, including suboptimal DMARD dispensation. In this modern era of advanced therapeutic options, we still have issues with access to care and timely use of medications. So, should all Canadians with new inflammatory arthritis have access to all therapeutic options at disease onset . . . the answer was suggested to be a resounding yes.

Drs. Louis Bessette and Michelle Batthish spoke against the motion, and their side certainly benefited from an extensive body of information to support their argument. According to them, the current scientific evidence does not support the use of targeted synthetic/biologic disease-modifying antirheumatic drugs (ts/bDMARD) as first-line therapy in early inflammatory arthritis. In treat-to-target (T2T) studies, patients initially treated with conventional synthetic disease-modifying antirheumatic drugs (csDMARDs) have similar long-term clinical disease activity, functional capacity, and joint damage progression as the groups initially treated with a ts/bDMARD. Furthermore, starting with a biologic does not improve the chances of achieving drug-free remission and is not a cost-effective strategy. According to CATCH (Canadian early ArthriTis CoHort) data, more than 50% of RA patients are in remission after one year of using csDMARDs. Moreover, 75% of Canadian RA patients who started csDMARDs as first-line therapy do not require ts/bDMARDs to control their disease during the first five years of follow-up. Similarly, in the CAPRI (Canadian Alliance of Pediatric Rheumatology Investigators) JIA (juvenile idiopathic arthritis) registry, 81% of newly diagnosed JIA patients achieve clinically inactive disease and most are only on a csDMARD.

Safety needs to be considered in this argument as well. A systematic review revealed that the odds of developing a serious infection while on a biologic were 1.48 times greater than while on a csDMARD. In addition, there are no published guidelines that recommend the use of a ts/bDMARD as first-line therapy for csDMARD-naive patients. The scientific evidence shows that starting a csDMARD with a T2T strategy and adding a ts/bDMARD if necessary, the patient would have the same chance of achieving disease control without long-term functional impact as starting with a ts/bDMARD.

Sadly, all things come to an end (other than advanced therapy application forms), and it was time to vote. The winner was decided by an old-fashioned applausometer, with the "against" side (Drs. Bessette and Batthish) clearly crowned the winners. However, given the lopsided nature of the evidence (taking nothing away from Cory Baillie's phone-a-friend statistical analysis), the "for" team deserves a shout-out as well.

Among the cogent arguments were elements of humour sprinkled throughout, including the requisite poking fun at Carter Thorne. The Great Debate seeks to achieve a good balance between science and fun, and this year the debaters knocked it out of the park.

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RheumJeopardy! 2023

By Philip A. Baer, MDCM, FRCPC, FACR

Pictured, from left to right, Dr. Philip Baer, the host, and team captains, Dr. Vinod Chandran (East) and Dr. Raheem Kherani (West).

RheumJeopardy! has become a fixture at CRA Annual Scientific Meetings (ASMs), to the extent that the year it began antedates the time that most of the CRA staff have been working for the CRA. *RheumJeopardy!* returned as a plenary session at the 2023 CRA ASM for an eighth consecutive year according to my records. After two years in virtual format, the 2023 event was hybrid in nature, allowing both live and virtual attendees to answer the questions. Fortunately, seamless integration between the HOPIN meeting platform, the AV team from BBBlanc, and MKEM averted any possible technical glitches. I moderated from the Quebec City conference centre. After a West victory by 5,200 to 3,700 in the 2022 edition, Dr. Alison Clifford from Edmonton returned as Chair and scorekeeper. We maintained the traditional East versus West format, with Toronto the dividing line again this year, though to balance the attendees it was placed in the West camp! Our team captains were Dr. Vinod Chandran from Toronto and Dr. Raheem Kherani from Vancouver, both outgoing CRA committee chairs, and veterans of past *RheumJeopardy!* events. As in 2022, only the members of the team whose captain had selected a question voted on the answer, which had the effect of lowering the potential scores. The team captains selected the Final Jeopardy wagers and answered the Final Jeopardy question on their own.

The session drew a large audience of enthusiastic participants. The practice question related to the ChatGPT artificial intelligence program. The answer revealed that the program thought that only people with the first name "John" could possibly be top Canadian rheumatologists, including the semi-fictional Dr. John Pope and Dr. John Inman.

Ten questions were selected in the main game. They proved to be challenging, but our teams were more than up to the task. Potpourri and Sight Diagnoses were once again the most popular categories, and the 1,000-point row of questions was frequently selected. Questions picked related to the SURPASS and TARGET studies, CAR-T cell therapy for systemic lupus erythematosus (SLE), congenital malformations from mycophenolate mofetil (MMF), and the failure of curcumin as a therapy for rheumatoid arthritis (RA). Voters correctly identified the function of ARTHUR, the ARTHritis Ultrasound Robot. They also knew that the BIOBADASAR registry was based in Argentina, while the similar-sounding BIOBADASER registry originated in Spain. Stumpers included the "Dirty Dish" hypothesis of gout therapy, and the fact that rheumatologists scored highest for introversion of all medical specialties, according to a humorous article in the *Postgraduate Medical Journal* from the BMJ group.

At the end of the main Jeopardy round, the score favoured East with 3,600 over West with 2,000. Both captains maintained tradition and elected to wager everything on the Final Jeopardy question. The category was also familiar : "Famous Canadian Rheumatologists." The question focused on efforts by Canadian rheumatologists to train rheumatologists in an African country of 12 million people which had no rheumatologists at all, using a grant from the Royal College of Physicians and Surgeons of Canada. The shape of the country and the colours of its flag were provided as a hint.

The correct answer was Rwanda, with efforts there led by Dr. Carol Hitchon and Dr. Rosie Scuccimarri. Only the West captain answered correctly. That left West as the winning team with 4,000 versus East's score of 0. This means Dr. Raheem Kherani will likely chair *RheumJeopardy!* in 2024 in Winnipeg if the ASM Scientific Committee grants us a place on the agenda. I am already preparing a question bank if we are renewed for another season. Thanks to everyone who participated, and to Dr. Jane Purvis who tracked the questions we used in 2023 to ensure they do not reappear in future years.

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

The CRA's 2023 Distinguished Rheumatologist: Dr. Gilles Boire

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

The choice of rheumatology gradually became clearer during my core medicine residency. I had chosen medicine because I wanted to help people, but I also wanted to help improve patient care, if possible. At the time, rheumatology was a specialty with two common treatments (non-steroidal anti-inflammatory drugs [NSAIDs] and corticosteroids), with the occasional addition of hydroxychloroquine, gold salts and, rarely, cyclophosphamide. It was therefore essential to develop strong relationships with patients and to learn to listen to them to help them, if not to cure them.

It was also the time of the discovery of acquired immunodeficiency syndrome (AIDS). Clearly, we were so ignorant of how the immune system worked that there would soon be great advances in the field. Since rheumatological diseases obviously involved a disruption of the immune system, the future looked bright. Although I was born well before Generation Y, I had to consider that my wife was also a physician and that we already had two young daughters, so I needed a career with a predictable schedule. Rheumatology therefore offered the advantages of being relatively uncharted territory, but also of being less focused on hospitalized patients. But it was during my internship with Dr. Henri Ménard that things really clicked. The patients were suffering, and their doctors did not understand why. And then came Dr. Ménard who questioned, palpated, did some tests, and drew conclusions. The ability to make a diagnosis from seemingly unrelated elements appealed to me. Then Dr. Ménard and I prepared a first abstract that was submitted and accepted by the American College of Rheumatology (ACR). My passion for research was launched. And the advances in rheumatology and in research exceeded my wildest expectations.

Your major research interests include autoimmunity, in particular the Ro/hY RNA complex, improving first-line care of fragility fracture patients, and early prognostic classification of patients with recent onset inflammatory arthritis.

Can you tell us about the development of the Early Undifferentiated PolyArthritis (EUPA) cohort as well as the Biobank of Immune and Inflammatory Diseases and Disorders and the "University of Sherbrooke Registry of Advanced Therapies" that facilitate personalized approaches for the treatment of these patients?

My research career can be divided into three phases. The first phase was wet-laboratory oriented, focusing on my favorite autoantigen, the Ro ribonucleoproteins, targeted by anti-Ro (SS-A) antibodies. We studied antibodies and antigens in several ways: first with the tools I had learned during my postdoctoral fellowship at Yale University, and then with the help of colleagues in Sherbrooke. Some of our work from the 1990s is still cited regularly. Then, we crossed paths with Ms. Savoie. The discovery of anti-Sa (citrullinated vimentin) in the serum of this patient reoriented me towards clinical research, and in particular cohorts of patients, specifically with polyarthritis of recent onset (EUPA cohort). The principles underlying EUPA were clear: 1) without accurate and thorough phenotyping, biomarkers are useless; 2) long-term longitudinal follow-up is essential to properly define clinical outcomes; and 3) scientific knowledge evolves rapidly and in unpredictable directions. It is therefore crucial to have quality data matched to stored serialized biospecimens to allow for the study of new biomarkers, or the use of new analytical methods that we could not even dream of at the time of their collection. The EUPA patient specimens have now been analyzed by different "-omics" (genomics, microRNAmics, proteomics). Hence the third phase, the development of the Biobank of Immune and Inflammatory Diseases and Disorders, initially focused on the EUPA cohort. Thanks to recent legislative progress concerning clinical research, the Biobank is now dedicated to all aspects of rheumatology, from autoinflammation to autoimmunity, and from serum to synovial and salivary biopsies, including synovial fluid.

One of the most important conundrums in rheumatology is the heterogeneity of response to treatments. Our somewhat eccentric geographic location allows for prolonged follow-up of most of our patients. Moreover, the regional organization of care means that all the hospital administrative data of these patients can easily be combined with clinical information, leading to the development of our University of Sherbrooke Registry of Advanced Therapies (USRAT). We have linked our biobank with USRAT to better define the biological or psychosocial characteristics underlying treatment failure.

Dr. Gilles Boire receiving his award from CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Quebec City, which took place in February 2023.

In addition to running a busy clinic and assuming several administrative duties, you have supervised 20 graduate and postgraduate students as well as 27 rheumatology fellows, 5 of whom are still in training. What are your thoughts on teaching?

One of my greatest satisfactions during my career has been my involvement in teaching at all levels within the medical school. This included mentoring at the undergraduate level for general training of medical students, at the postdoctoral level teaching rheumatology basics to pediatric and core medical residents and training new rheumatologists, and at the postgraduate level training immunology and clinical scientists. Many of my former graduate students are now academic or industry researchers. Rheumatologists who graduated from the Sherbrooke program now represent nearly 20% of all rheumatologists in Quebec. I am pleased to have been able to facilitate their positive contribution to Quebec and Canada today.

Can you tell us about other adult cohorts that you have contributed to (CATCH; BIODAM) and pediatric (REACCH-Out; BBOP)?

From the very beginning, I had a high clinical interest in treating children with rheumatologic disease. I was initially responding to a local clinical need as there was no other rheumatologist available to treat children with arthritis. But it also allowed me to see how rudimentary the treatment of children was at the time. I quickly became interested in participating and contributing to pediatric research projects. I got to know some outstanding researchers (Ciaran Duffy, Jaime Guzman, Rae Yeung and Alan Rosenberg, among others) from whom I learned a great deal. These researchers have developed a world-class pediatric rheumatology research network that has truly improved the treatment of children with rheumatic diseases. In comparison, adult rheumatologists are disorganized and would greatly benefit from the pediatric networking experience.

As a result of the development of the EUPA cohort infrastructure, I was able to join other adult clinical research efforts, in particular the CATCH cohort led by Vivian Bykerk and the BIODAM project of Walter Maksymowych. Thanks to the existence of our EUPA cohort, we have been able to contribute significantly to these research projects. The results of these extremely productive collaborations have constituted a significant proportion of my publications.

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The CRA's 2023 Distinguished Investigator: Dr. Murray Baron

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

I have to say that the feelings associated with being awarded something like this are very mixed. This is such an enormous honour that, of course, it gives me a deep sense of satisfaction and pride that my work in research has been recognized. On the other hand, and I expect that others have had somewhat similar feelings, it is an award that I would never have sought on my own and it left me with a bit of a feeling that perhaps I don't really deserve this.

Nevertheless, I also thought of this award as perhaps more a recognition of my leadership of a group of very talented people whom I have worked with over the last 20 years. The Canadian Scleroderma Research Group began with a meeting at the Canadian Rheumatology Association (CRA) meeting in Quebec City 20 years ago. I cannot remember exactly all the attendees but many of the eventual rheumatologists who recruited patients and recorded data were there, including Sharon LeClercq, Janet Markland, Janet Pope, David Robinson, Doug Smith, Maysan Abu-Hakima, Peter Docherty, Elzbieta Kaminska, Niall Jones, Evelyn Sutton, Marie Hudson and Nadir Khalidi. We were joined in later years by Alena Ikic, Ariel Masetto, Genevieve Gyger, Maggie Larché and perhaps others I have inadvertently left out, for which I apologize. And, of course, Marv Fritzler, who did all our testing for antibodies, stored all our sera, and offered invaluable advice over many years.

And then there are the over 1,600 patients who donated their time, personal details, and biospecimens, without which this research could never have been done.

So, this wonderful award was something that I felt I accepted on behalf of a very large group.

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

When I did a rotating internship at the Jewish General Hospital in Montreal in 1972, the chief medical resident — and also a friend of mine — was Dr. Howard Stein who went into rheumatology and turned up on staff at St. Paul's Hospital in Vancouver when I was there in 1975 doing my internal medicine residency. I attended his clinics and did a 3-month rotation at G.F. Strong Rehabilitation Centre. I was impressed by both the clinical skills required in rheumatology and the academic aspects of the advances in the rheumatic diseases and decided that this would become my area of specialization.

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

What a loaded question! I think all investigators are driven by the excitement of creating new knowledge. For my research and that of my colleagues, the idea that you could create a database of patient information and suddenly be able to query all that data and come up with new information about a serious but rare disease was just so exciting. It was a "build it and they will come" situation, where questions we never even thought of when we created our registry just popped into our minds as we looked at the data.

In 1982, you created an inpatient rheumatic disease unit at the Jewish Rehabilitation Hospital for multidisciplinary care of patients. That unit closed about 20 years ago when biologic drugs became available for rheumatoid arthritis, vastly improving patients' health and well-being. Since then, research has become an important part of your contribution to medicine, and you created the Canadian Scleroderma Research Group (CSRG) in 2003. Can you tell us more about this research?

The CSRG research has been multi-pronged but mostly clinically based, although we have collaborated with several labs working on serum and skin biopsies. Initially, our work focused on function and quality of life issues facing our patients. We showed that our patients suffered very serious consequences of their disease which could be measured reliably. This opened the way to determine if function and quality of life could be improved by interventional trials. We have continued to focus on outcome measures of the disease. In collaboration with colleagues in Australia, we have developed a method to assess the accrual of organ damage over time and are now working with these same colleagues on a measure of disease activity. Our data have also been used in the development of a new endpoint, the Composite Response Index for Clinical Trials in Early Diffuse Cutaneous Systemic Sclerosis (CRISS), which is currently being used in drug trials in SSc and in the development of new classification criteria for SSs. Three of the four members of the core committee were Canadians, including myself. We are also currently working on a measure of the severity of cardiac involvement in SSc and have also looked at the reliability and validity of other outcome measures.

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

Dr. Murray Baron receiving his award from CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Quebec City, which took place in February 2023.

We are very interested in doing more work on the damage index we have created, and the new activity index under development. We have also launched a large project to try to better predict the course of lung disease in SSc, which will be essential to the efficient design of clinical trials of therapies for that condition, which is a major cause of morbidity and mortality in SSc. Part of this work has involved collecting hundreds of lung CT scans that have been performed across Canada on our patients over the last 20 years. We hope to be able to use artificial intelligence to read those scans to allow us to better understand the variables associated with the worsening of lung disease over time.

You have also been president of the Scleroderma Clinical Trials Consortium (SCTC) which represents most of the world's scleroderma researchers. You have transformed this group into a vibrant new organization with many working groups performing research that will improve the efficiency of scleroderma clinical trials. You are now an executive member of the organization and run two of the working groups. Additionally, you also chair a subcommittee that is working on a white paper for regulatory agencies, including the FDA, that will make recommendations about outcome measures for scleroderma therapeutic trials. What is the greatest professional and organizational challenge you have faced, and how did you address/overcome this challenge?
Participating in the activities of the SCTC has been one of the highlights of my time as a researcher. The organization has been funding projects that aim to improve the efficiency of clinical trials. If you cannot measure it well, you cannot study it. This could easily be the motto of the SCTC. The challenge has been raising the funds to support these research projects. I created an SCTC-PHARMA roundtable that has raised substantial money from pharmaceutical companies that has helped the SCTC support this kind of research, and I am very content that my input has been able to support that.

What have been the most rewarding aspects of going into the field of rheumatology and what have been some of the most challenging aspects?
Rewarding: Helping to improve the quality of life of our patients and to have been present during the transition from so-so drugs like gold injections to the very effective biologics. Frustrating: The slow advances in treating the non-inflammatory diseases like osteoarthritis. Those diseases make up a very high percentage of rheumatic diseases, and together account for the major proportion of the morbidity our patients suffer. Over the 40 years of my clinical practice, I do not feel we have made any major advances in the treatment of these conditions. Luckily, there are many highly qualified researchers in Canada and elsewhere working on osteoarthritis and, hopefully, that situation will improve.

What is your proudest accomplishment?
The creation of the CSRG and the collaboration with so many contributors across Canada and elsewhere.

What advice would you give to someone looking to pursue a career as an academic rheumatologist?
Do it! Canada is an excellent place to do this kind of work as we have an important tradition of collaboration not present in every country. Basically, it is important for young potential investigators to understand that research is fun and exciting. Creating knowledge is not what we are taught in medical school. There we learn to use knowledge. I can thus understand how difficult it is for a trainee to make the leap from many years of learning how to use knowledge to creating knowledge instead. Try it out and accept the challenge because the results are so rewarding!

What is your favourite book of all time?
I am just listening to "Demon Copperhead" by Barbara Kingsolver and it's terrific. Not sure I have a single favourite. I walk to work and listen to books on the way. At home, I do it the old-fashioned way — reading.

What is your favourite food or cuisine?
Anything my wife cooks. She is a terrific cook. I didn't have to say this just in case she reads this. It's true.

What is your dream vacation destination?
Somewhere the temperature is room temperature, the sky is clear every day and I can play golf while my wife plays tennis.

How many cups of coffee does it take to make a productive day?
None. But I do need a Pepsi Zero once a day, so I guess that covers my caffeine requirement.

Murray Baron, MD, FRCPC
Senior Investigator, Lady Davis Institute
Division of Rheumatology,
Jewish General Hospital
Past Director, Canadian Scleroderma Research Group
Professor of Medicine,
McGill University
Montreal, Quebec

The CRA's 2023 Emerging Investigator: Dr. Lihi Eder

You have a broad background in rheumatology with specific training and expertise in psoriatic arthritis, musculoskeletal ultrasound and cardiovascular diseases in rheumatic patients. You are Director of the Psoriatic Arthritis program at Women's College Hospital and co-Director of the Cardio-Rheumatology Program (University of Toronto), an interdisciplinary program that aims to improve the management of cardiovascular morbidities in rheumatic patients by developing novel models of care through research and educational activities. Can you tell us more about your research and its implications?

My research questions are triggered by questions that arise during my encounters with patients in the clinic. My main area of research is psoriatic arthritis (PsA), which is such a fascinating, heterogeneous disease with many unresolved issues. I combine clinical research using both large patient registries and population-based data with translational research using both imaging and laboratory biomarkers to improve our understanding of PsA. Specifically, my research on the transition from psoriasis to PsA aims to improve early diagnosis of PsA by developing new clinical prediction tools and employing targeted use of musculoskeletal ultrasound. I also use ultrasound to improve phenotyping of PsA by integrating imaging data with laboratory biomarker data. Using this combination, I aim to find ways to personalize the selection of advanced therapies.

Our cardio-rheumatology network, the first of its kind in Canada, involves a collaboration of rheumatologists and cardiologists. We aim to optimize the management of cardiovascular risk factors in patients with inflammatory rheumatic disease through early screening and the use of vascular imaging, such as coronary calcium score, to identify high-risk individuals. This allows the initiation of early therapies, such as statins, to reduce cardiovascular risk. We have seen more than 400 patients with rheumatic diseases since we opened the clinic in 2017 and approximately half of them required initiation or modification of medications following their visit to the clinic to reduce their cardiac risk. We also have a few anecdotal cases of patients who were found to have critical coronary artery blockages that were identified and successfully treated following their clinic visits. Overall, I am satisfied with the fact that my research contributes to the understanding of rheumatic diseases, and also influences the care of individual patients.

You were awarded the Canada Research Chair in Inflammatory Rheumatic Diseases (2021-2026) for studying barriers to equitable care in rheumatology, including the role of sex and gender as determinants of disease outcomes. Can you describe some of the most significant findings in this research area?

This is a recent area of research for me that stemmed from a study that I published as a PsA research fellow with Dr. Dafna Gladman. We found that female patients with PsA do worse than male patients considering their level of pain, physical function, and quality of life. This is despite the fact that male patients tend to develop more joint damage. More recently, we studied population-based data and showed that female patients with PsA, ankylosing spondylitis (AS) and rheumatoid arthritis (RA) require more visits to the rheumatologist before receiving a diagnosis of these conditions. In addition, I analyzed randomized clinical trial (RCT) data and found that female patients are less likely to achieve the minimal disease activity state in PsA compared to male patients. It is unclear what are the mechanisms underlying these differences in clinical features and response to treatment. I lead a Canadian Institute of Health Research (CIHR)- and Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA)-funded study with 40 sites across the world, which will attempt to tease out sex-related biological factors such as pharmacokinetics and immune factors from gender-related socio-cultural factors, such as pain reporting and coping mechanisms, in patients with PsA starting advanced therapies. We hope that by better understanding these sex and gender mechanisms, we can develop sex/gender-specific approaches to improve care of both men and women living with PsA.

Are there other areas of interest that you would like to investigate in the future?

I hope to study the role of obesity in PsA, as I believe it has a major influence on disease susceptibility, course and response to therapy. My group is conducting an RCT that studies the role of dietary modification as an adjunct therapy in PsA. I hope to explore more closely the use of behavioural and pharmacologic interventions to improve eating habits and lower weight as ways to manage PsA, especially in people who do not achieve optimal outcomes.

Dr. Lihi Eder receiving her award from CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Quebec City, which took place in February 2023.

Your research efforts have resulted in over 140 peer-reviewed publications in medical journals, book chapters and editorials. You are frequently invited to present the results of your studies in national and international conferences in the fields of rheumatology, dermatology and cardiology. You are an elected member of the GRAPPA steering committee and President of the Canadian Rheumatology Ultrasound Society. As a recognized expert in rheumatology, you received a New Investigator Award from the Arthritis Society (2016) and an Early Research Award from the Ontario Ministry of Research Innovation and Science (2018). What has been your proudest professional accomplishment to date?

I am proud of all of these awards and achievements; it is very hard to choose just one as they happened at different stages of my career and were all meaningful. They mostly remind me to pause, take a deep breath and recognize how very fortunate I am to have the opportunity to get paid for doing something that I enjoy so much.

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

My career path has been long and somewhat unplanned. As an international fellow who did not originally plan to become a scientist, I spent more than six years doing PhD and postdoc training. Moving with two babies to Toronto, going back to Israel, and then moving back to Toronto was also not easy, especially with all our extended family living on the other side of the globe. However, I do not regret any of the choices I made.

I have always liked travelling and being a scientist has given me the opportunity to visit many new places and meet people from different countries, many of whom became good friends. This is definitely one of the highlights of my job. I also enjoy the fact that I can effect change through my research. Studying clinical questions that arise during my encounters with patients and being able to provide answers to patients through my research as well as influence the field is a huge bonus.

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

It is great to receive such recognition from the CRA. This award means a lot to me since it comes from my peers, the Canadian rheumatology community. I feel very honoured.

For those wanting to pursue rheumatology and a career in research, what advice would you give them? Have you had key mentors who supported your career path? If yes, what were the key learnings you gained from them?

My best advice is to keep an open mind, explore different career options, and not be discouraged by the length of training needed to become a scientist. I had really good mentors who supported my career and continue to do so. A key piece of advice that I was given by one of my mentors is to always work with people who can teach you something that you don't know.

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

I would be a veterinarian. That was my childhood dream.

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

Sleeping in an extra hour in the morning.

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

"A Tale of Love and Darkness" by Amos Oz. A highly recommended Israeli novel.

What is your favourite food or cuisine?

I usually don't say no to any type of chocolate dessert.

What is your dream vacation destination?

Any place with warm weather, a sandy beach, and good food.

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

No more than two.

Lihi Eder, MD, PhD
Canada Research Chair in
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Associate Professor of Medicine, University of Toronto
Women's College Research Institute,
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The CRA's 2023 Emerging Teacher-Educator: Dr. Steven Thomson

Can you recall a teacher in your own past who inspired your direction into education?

I can think of two teachers. The first was my eighth-grade teacher, Mr. Ron Bloxam. He never accepted anything less than my best. He always wanted more but was very encouraging. He knew I wanted to go into medicine, and so referred to me back then as "the good doctor." The second was my grade 13 biology teacher, Mrs. Jeanette Denes. As part of a peer teaching experience, she allowed me to teach a grade 9 science class an entire unit with content I created, while I helped her teach the remainder of the semester. It was an incredible experience.

As a member of the University of Calgary faculty, you led the local implementation of Competency by Design for rheumatology. Most recently, you have taken on the role of Rheumatology Residency Program Director. Your teaching duties include weekly musculoskeletal (MSK) teaching sessions, multiple academic half days for different groups, as well as lectures for the medical school and directing the continuing medical eduction (CME) activities for the Division of Rheumatology in Calgary.

a) Can you tell us more about these projects and any others that are underway?

Way back, pre-pandemic, we were working on a plan to better teach rheumatologic emergencies. Those rare things that we don't often see but need to recognize right away. We had a three-part plan and content developed. It got sidelined by work from home and no in-person gatherings. I am hopeful we can resurrect that.

b) Nationally, you have joined the CRA education committee where you serve on the Continuing Professional Development sub-committee. You also recently started your own training in MSK ultrasound. Where do you see the future of medical education moving?

I think like most of the world, rheumatology education and medical education in general are going to move towards an on-demand approach. I foresee websites like Up-to-Date and other resources having a lot more video content. You will be able to log on and select a topic and see a lecture from one of the world's experts, or at least someone who is an excellent teacher in that field.

I hope that we see a rise in giving our students skills in effectively using learning resources, and how to manage their time to allow them to stay up to date on the medical information landscape that is growing at an exponential rate. The ability to learn, unlearn and relearn things will be increasingly important for new generations of physicians.

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

Given it is 2023, the first thing I did was check to make sure it wasn't spam . . . I was not expecting an award and everyone knows the pitfalls of phishing. Having done that, I thought how wonderful it was that someone thought I was contributing in a positive way. I began to wonder who would have nominated me. Then I thought about all the other excellent educators we have in this field and made sure that I'm making a list and checking it twice so that I can pay it forward in future years, so emerging educators beware!

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

I would say to be systematic. Be structured in your patient care, be structured in your learning. Set guidelines and failsafes for yourself. I'm not always at my best but, hopefully, I have enough structures in place that I can do a good job even on a substandard day.

As for teaching, just keep doing it. After my undergraduate time, I actually applied to teacher's college, and they turned me down. Then I tried applying for graduate school and they accepted me, which was particularly ironic since they then paid me to teach undergraduate classes. Be open to feedback and always try to improve.

If you weren't pursuing your interest in medical education as a career, what would you be doing?

I always wanted to be a Myth Buster. Those of a certain vintage will remember a show that ran on the Discovery Channel in the early 2000s. The idea of spending my days drea-

Dr. Steven Thomson receiving his award from CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Quebec City, which took place in February 2023.

ming up ideas, building them, testing them, and then often blowing them up sounds absolutely fabulous.

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

I think at this time, I would probably spend it learning/reading in the woods or walking in the woods. I enjoy the peace and find it restorative to be outside. Balance is good, but there is so much to do and learn.

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

The biggest volume of encyclopedias you can find. I can read and learn, use them for insulation on cold nights, start fires, and maybe ultimately make a paper boat (a la Myth Busters) to get off the island after reading the section on boat building.

What is your dream vacation destination?

I would like to see Italy. Perhaps one year in the future when the European Alliance of Associations for Rheumatology (EULAR) meeting is there, I'll get to go.

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

I can honestly say, I have never had a cup of coffee in my life. Love the smell, but tastes burnt to me.

Steven Thomson, MD, MSc, FRCPC
Clinical Assistant Professor, Division of Rheumatology
Director, Residency Program
Division of Rheumatology – Education
Director, CME Program, Cumming School of Medicine,
University of Calgary
Calgary, Alberta

The CRA Practice Reflection Award: Dr. Janet Roberts and Dr. Carrie Ye

GOLD

Janet Roberts, MD, FRCPC

Carrie Ye, MD, FRCPC

The use of immune checkpoint inhibitors (ICI) has steadily increased over the last decade and heralded a new era of cancer treatment, offering hope and significant survival benefit for many with advanced-stage malignancies. The interplay between autoimmunity and cancer has been magnified with the use of ICI through the development of off-target effects termed immune-related adverse events (irAE). Rheumatologists have now become an integral part of the oncology team, often called upon to diagnose and walk the fine line of managing these patients with immunosuppression. As rheumatologists, we are no strangers to managing rare conditions or navigating diagnostic uncertainty. However, the rapidly evolving nature of this field of medicine has made it challenging to keep abreast of the latest literature on this topic. Support of colleagues and the ability to discuss difficult cases, particularly with those who see large volumes of these patients across the world, is paramount in supporting Canadian rheumatologists who are faced with the challenges of managing these patients.

The Canadian Research Group of Rheumatology in Immuno-oncology (CanRIO), with members from nine academic sites across Canada, has been at the forefront of both research and educational initiatives in the management of rheumatic complications of cancer immunotherapy. Through the assistance of a CIORA grant we have developed the first online educational platform of its kind (*canrio.ca*), with the ultimate goal of improving care of cancer patients across Canada who develop rheumatic irAE or have pre-existing rheumatic disease, through collaboration, education, and research. As part of this educational initiative, we created five case-based learning modules on the topics of immune-related arthritis, myositis, vasculitis, sarcoid-like reactions, and the management of patients with pre-existing rheumatic diseases. The website also serves as the platform to register for bi-monthly case-based rounds which offer a unique opportunity for rheumatologists across Canada to meet with leading experts around the world to discuss challenging cases and ultimately learn from each other. We look forward to building upon the resources developed thus far to strive to meet the urgent need for education on this topic, and to ensure Canadian rheumatologists are optimally positioned to manage this patient population in concert with our oncology partners.

Janet Roberts, MD, FRCPC
Assistant Professor,
Division of Rheumatology,
Department of Medicine
Dalhousie University,
Halifax, Nova Scotia

Carrie Ye, MD, FRCPC
Clinical Assistant Professor,
University of Alberta
Edmonton, Alberta

Spotlight on the 2023 CRA Abstract Awards

BEST ABSTRACT ON SLE RESEARCH BY A TRAINEE – IAN WATSON AWARD

Sponsored by the Lupus Society of Alberta
Winner: Laura Whittall-Garcia, Toronto Western Hospital
Abstract Title: Neutrophil Extracellular Traps as a Biomarker to Predict Outcomes in Lupus Nephritis
Supervisors: Drs. Murray Urowitz and Zahi Touma

BEST ABSTRACT ON CLINICAL OR EPIDEMIOLOGY RESEARCH BY A TRAINEE – PHIL ROSEN AWARD

Sponsored by the Arthritis Society – Phil Rosen Memorial Award
Winner: Timothy Kwok, University of Toronto
Abstract Title: Adherence to Serum Urate Monitoring Guidelines Amongst Older Adults with Gout in Ontario, Canada: A Population-based Study
Supervisor: Dr. Jessica Widdifield

BEST ABSTRACT BY A RHEUMATOLOGY RESIDENT

Sponsored by the CRA
Winner: Mats Junek, McMaster University
Abstract Title: Characteristics of relapse of individuals with ANCA-associated vasculitis enrolled in the PEXIVAS trial
Supervisor: Dr. Michael Walsh

BEST ABSTRACT ON BASIC SCIENCE RESEARCH BY A TRAINEE

Sponsored by the CRA
Winner: Marie-Hélène Normand, Université de Montréal
Abstract Title: Vascular Injury Derived Exosomes Stimulate Lymphocyte Infiltration in the Kidney of Lupus Prone Mice
Supervisor: Dr. Mélanie Dieudé

BEST ABSTRACT BY A POST-GRADUATE RESEARCH TRAINEE

Sponsored by the CRA
Winner: Leah Flatman, McGill University
Abstract Title: Hospitalization with Infection in Offspring Exposed During Late Pregnancy to Tumour Necrosis Factor Inhibitors with High versus Low Placental Transfer Ability
Supervisors: Drs. Évelyne Vinet and Sasha Bernatsky

BEST ABSTRACT ON QUALITY CARE INITIATIVES IN RHEUMATOLOGY

Sponsored by the CRA
Winner: Amanda Steiman, University of Toronto
Abstract Title: "If you didn't chart it, you didn't do it:" Developing a template to address quality indicators in patients with childhood-onset systemic lupus erythematosus (cSLE) transitioning from pediatric to adult care

BEST ABSTRACT BY A MEDICAL STUDENT

Sponsored by the CRA
Winner: Shakeel Subdar, University of Toronto
Abstract Title: Preparing for a Shared-Care Model: What Proportion of Patients with Stable Rheumatoid Arthritis Could be Followed in Primary Care?
Supervisor: Dr. Claire Barber

BEST ABSTRACT BY AN UNDERGRADUATE STUDENT

Sponsored by the CRA
Winner: Jeremiah Tan, University of British Columbia
Abstract Title: Risk for Hospitalization, Intensive Care Unit Admission, and Mortality Among COVID-19 Patients Receiving Immunosuppressive Medications: A Population-Based SCOUT (underStanding COvid-19 in immUnosuppressed paTients) Study
Supervisor: Dr. J. Antonio Aviña-Zubieta

BEST ABSTRACT BY A RHEUMATOLOGY POST-GRADUATE RESEARCH TRAINEE

Sponsored by the CRA
Winner: Nicole Andersen, McGill University
Abstract Title: Cannabis Use in Inflammatory Arthritis: Characteristics and Comparisons Between Users and Non-Users
Supervisors: Drs. Deborah Da Costa and Annett Korner

BEST ABSTRACT ON RESEARCH BY YOUNG FACULTY

Sponsored by the CRA
Winner: Alexandra Legge, Dalhousie University
Abstract Title: Comparison of the Systemic Lupus International Collaborating Clinics Frailty Index (SLICC-FI) and the FRAIL Scale for Identifying Frailty Among Individuals Living With Systemic Lupus Erythematosus

BEST ABSTRACT ON SPONDYLOARTHRITIS RESEARCH AWARD

Sponsored by the Canadian Spondylitis Association
Winner: Patricia Remalante-Rayco, University of Toronto
Abstract Title: Does Concurrent Inflammatory Bowel Disease Alter the Profile of Axial Spondylarthritis?
Supervisors: Drs. Robert D. Inman and Nigil Haroon

Dunlop-Dottridge Lecture: The Evolution of JIA

By Rae S. M. Yeung, MD, PhD, FRCPC

The Great Debate is a long-standing highlight of the Canadian Rheumatology Association Annual Scientific Meeting. This year, the debate extended to the Dunlop-Dottridge Lecture, where the topic was the continuing evolution of classification and nomenclature of juvenile idiopathic arthritis (JIA). Good classifiers bring together similar patients in the clinic and for research, where appropriate comparisons are needed between studies and countries, to improve treatment and access to medications. Current classification systems for childhood arthritis are based mainly on clinical phenotype, with a move to incorporate more biology into future disease taxonomies. Features used to currently categorize patients include age (above and below 16 years) and site of inflammation (arthritis versus enthesitis). Basic laboratory findings include genetic underpinnings of disease (HLA-B27), innate versus adaptive arms of the immune system (systemic JIA versus non-systemic JIA), and presence or absence of autoantibodies (rheumatoid factor [RF]). Canada has a storied history in this debate, and the Lectureship showcased Canadian contributions to this journey.

The early descriptions of childhood arthritis were made in the late 1800s by Sir George Frederic Still. The 1970s introduced the great divide, with simultaneous but conflicting approaches to nomenclature from the different sides of the Atlantic. The juvenile rheumatoid arthritis (JRA) nomenclature originated from the precursor of the American College of Rheumatology (ACR), which was in contrast to the Juvenile Chronic Arthritis (JCA) nomenclature used by the European League Against Rheumatism (EULAR). The American JRA classification had 3 subgroups and used the number of affected joints as a cut-off to divide children into pauciarthritis (≤ 4 joints) and polyarthritis (≥ 5 joints) and those with systemic arthritis who had fever. The JCA nomenclature proposed by the Europeans included 6 subgroups, with an additional 3 subgroups corresponding to childhood forms of adult rheumatic disease — juvenile rheumatoid arthritis, juvenile psoriatic arthritis and juvenile ankylosing spondylitis. The International League Against Rheumatism (ILAR), brought the players together in 1997 to unify the nomenclature. Canadians played a prominent role in the efforts at consensus building, resulting in the current JIA terminology. The ILAR criteria stratify patients into seven mutually exclusive categories: systemic arthritis (sJIA), oligoarthritis, RF-negative polyarthritis, RF-positive polyarthritis, psoriatic arthritis, enthesitis-related arthritis, and undifferentiated arthritis, with an age boundary of 16 years between childhood and adult arthritis nomenclature.

Dr. Rae S. M. Yeung provided the Dunlop-Dottridge Lecture on the evolution of JIA at the CRA ASM in February 2023 in Quebec City.

The great debate continues today, with recent proposals by the Pediatric Rheumatology International Trials Organization (PRINTO) to develop a new classification schema. Four PRINTO JIA subgroups are defined: three with adult counterparts (systemic, RF-positive, and enthesitis/spondylitis-related JIA), and one unique to the pediatric population (early-onset antinuclear antibody-positive JIA). Two additional categories for unclassifiable patients are included: Other JIA and Unclassified JIA. Using a Canada-wide inception cohort of children with new onset JIA (ReACCH-OUT study), we evaluated the ILAR and PRINTO classification schemes and compared their alignment with each other. Unfortunately, the two classification systems resulted in significantly different groupings with only two exceptions — those with sJIA and RF+ polyarthritis. Of note, two-thirds of all patients with JIA were not able to be classified under the four PRINTO subgroups.

Advancements in genomics have provided the opportunity to integrate biology and clinical phenotype in classification. The dramatic increase in the number of data points has necessitated the use of machine learning and artificial intelligence approaches for pattern recognition, allowing big data to inform the classification system. Using a computational biology approach, we identified 5 unique subgroups of patients among children with JIA (excluding sJIA). The resulting patient taxonomy was able to resolve differences

between patient subgroups better when compared to current ILAR and PRINTO nomenclature. In most subgroups, the clinical and biologic measures of disease activity and inflammation were directly correlated. But importantly, in two subgroups, clinically well-looking children had extremely high levels of pro-inflammatory cytokines. These subgroups of children with subclinical disease activity had a worrisome disease trajectory, with increased disease activity at follow-up, pointing to the contribution of expanded biologic measures to improve the identification of children at high risk for poor outcomes.

Research networks have been formed across the globe to integrate biology into classification schemes towards this promise of precision medicine. The Canadian-led Understanding Childhood Arthritis Network (UCAN) was formed for this purpose, as were other research consortia around the globe. These groups together with others in the international pediatric rheumatology research community agreed to a set of principles for collaboration in childhood arthritis culminating in the 2016 "London Declaration" — recognizing collaborations as the norm, not the exception, when studying JIA. The future is now, for this perfect storm of opportunities to change the tone of the great classification debate.

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Senior Scientist and Staff Rheumatologist,
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Toronto, Ontario

AWARDS, APPOINTMENTS, ACCOLADES

Dr. Sean Hamilton – *CRA Master Award*

I am humbled to receive a 2023 CRA Master Award and wish to thank the CRA and my local rheumatology peers in Newfoundland and Labrador (NL) for their nomination. It is my assumption this award recognizes my clinical contribution to the people of NL, and my educational contribution to the medical students and postgraduate medical trainees of Memorial University of Newfoundland and Labrador.

I'll be retiring in June 2023 after thirty-six years in practice, and as I now pass the torch to my younger colleagues, the demographics dictate that there is much more to accomplish in rheumatic health care delivery in our province. The median age in NL in 1987 — the year I began practice — was 28 years, making us the youngest province in Canada, and as I leave in 2023, that median age is 48 — the oldest province in Canada. The total population is unchanged; the number of rheumatologists is the same.

I leave with confidence in the next generation, and locally I am witnessing strong leadership for the path forward.

To the Rheumatology Community, I wish you well.

Arthritis Health Professions Association (AHPA) 2023 Award Winners

Kristin Dillon and Anne MacLeod – *Extraordinary Service Award Co-winners*

This award recognizes the contributions an Arthritis Health Professions Association (AHPA) member has made in advancing the mission, vision, and goals of our organization. This year there are two awardees.

Kristin Dillon is an occupational therapist at Arthritis Society Canada where she works as a primary therapist and part-time clinical practice leader. Kristin joined the AHPA board in 2019, taking on the role of treasurer in 2020. This already complex role became even more so with the move to electronic banking, the addition of the Advanced Clinician Practitioner in Arthritis Care (ACPAC) Special Interest Group to our organization, and the increasingly important role of cybersecurity. In addition, while her term as treasurer ended in February 2022, she spent the remainder of the year providing considerable hands-on mentoring to the current treasurer while working conjointly with her on several special projects.

Anne MacLeod works as an Extended Role Practitioner in a variety of clinical settings including a shared care/collaborative practice with the sole rheumatologist in Thunder Bay, and Telehealth collaborative care clinics with pediatric rheumatologists from Sick Kids and the Children's Hospital at London Health Sciences Centre. Anne joined the AHPA board in 2019 as President-Elect, served two years as President, and in 2022 was the Past President. While too numerous to describe, her contributions include re-working the organizational structure of the board, shepherding the launch of the new AHPA website, and being the ever present go-to person for our professional and patient partners. This past year the board had five vacant positions and, as a result, Anne took on additional tasks related to Communications and Sponsorship & Marketing.

Noel Heath – *Lifetime Achievement Award*

This award honours an AHPA member who has made a significant contribution during their work career in the areas of clinical practice, research, education, academics and/or administration. This award is given to an individual who has demonstrated excellence through such characteristics as mentorship, initiative, quality, innovation, leadership, enthusiasm, and ongoing commitment to rheumatology.

As an ACPAC-trained occupational therapist, Noel has had the privilege of working in rheumatology for her entire 40-year career. During this time, she witnessed life-changing advances in treatment; learned from and mentored creative and caring colleagues; and was humbled by the grace and courage of the clients she served. She considers herself fortunate to work with a rheumatology team that values using ingenuity to deal with issues of access to care for a vast geographical area with limited resources.

Susan Bartlett – *Carolyn Thomas Award*

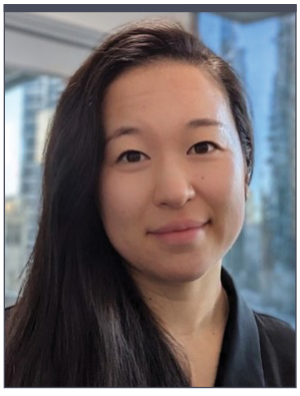
The Carolyn Thomas Award was established in honour of Carolyn Thomas, a founding member of the Arthritis Health Professions Association (AHPA) who supported research. It is given to the first author of the year's best scientific abstract. The recipient of this award will also be presented with an opportunity to present their work as a plenary presentation at the annual Canadian Rheumatology Association-AHPA Annual Scientific Meeting.

The recipient of the 2023 AHPA Carolyn Thomas Award is Susan Bartlett, PhD, for her work entitled "More than Half of Canadians with RA with a Lifetime History of Mood Disorders were Anxious or Depressed during the COVID-19 Pandemic." Dr. Bartlett is a clinical psychologist and Professor of Medicine at McGill University in the Divisions of Clinical Epidemiology, Rheumatology, and Respiratory Medicine. She is co-founder of the McGill Centre for Health Measurement and a senior researcher with the Research Institute of the McGill University Health Centre, Arthritis Research Canada and the Canadian Early Arthritis Cohort. Her studies focus on patient-centred research, measurement development, treatment adherence, and psychosocial factors that impact treatment outcomes. She is a member of the Association of Rheumatology Professionals Executive Committee and President-Elect of the National Institute of Health (NIH) Patient-Reported Outcomes Measurement Information System (PROMIS).

Karine Toupin-April – *Barbara Hanes Memorial Award*

The Barbara Hanes Memorial Award was established in honour of her work as an Occupational Therapy Director at the Arthritis Society, Ontario Division, and her contributions as a teacher and a contributing author to the rheumatology textbook "Physical Therapy in Arthritis". This award recognizes the best scientific abstract submitted by an occupational therapist.

The recipient of the 2023 AHPA Barbara Hanes Memorial Award is Karine Toupin-April, PhD, for her abstract entitled "Going Beyond Pain: Virtual Meetings and Survey to Expand the JIA Option Map with Other Symptoms and Functional Activities." Dr. Toupin-April is an Associate Professor in the School of Rehabilitation Sciences and with the Department of Pediatrics at the University of Ottawa and is affiliated with the Children's Hospital of Eastern Ontario Research Institute. Her research in pediatric and adult rheumatology includes developing patient-reported outcome measures (PROMs), clinical practice guidelines, patient decision support interventions and self-management tools. She is Chair of the AHPA Research Committee.



Ellen Wang – *Trainee Abstract Award*

The Trainee Abstract Award was established to recognize research being done by allied health professionals in summer studentships, graduate programs or post-doctoral fellowships. This award is given for the best scientific abstract submitted by a trainee.

The recipient of the 2023 AHPA Trainee Award is Ellen Wang for her abstract entitled "Inequities in Arthritis Care in Canada: The Black, Indigenous and Person of Colour (BIPOC) Experience". Ellen is a MPT/PhD student under the supervision of Dr. Linda Li at the University of British Columbia & Arthritis Research Canada. She is also the Programs Coordinator at Arthritis Consumer Experts, and a patient herself. Her research is at the intersection of health equity and patient engagement. In specific, her work aims to uncover how best to reach and meaningfully partner with diverse and underserved groups/communities in health research.

Joint Count Survey Results: Barriers to Incorporating Research into Practice

The Joint Count survey for the Summer 2023 issue of the *Journal of the Canadian Rheumatology Association (CRAJ)* focused on the barriers to incorporating research into practice. CRA members were asked to rank their most important potential barriers. A total of 63 surveys were completed out of a possible 568. Overall, the barriers chosen from a provided list of possibilities, ranked from most to least significant were: 1) time; 2) lack of access to new products/aids; 3) lack of knowledge of the most recent research; 4) uncertainty of the added benefit/risk of new research compared to standard of care; and 5) uncertainty about how the information applied to their practice.

In the comments, lack of funding and financial resources came up as barriers, along with lack of access to staff needed to undertake or implement research. One participant wrote that barriers consisted of the "financial cost of doing research instead of clinical work, and having available time to do research". Another comment cited "limited access to multiple team members needed to set up research effectively, (e.g., stats and analysis, methodology, funding, publication)".

It appears comments related to two different issues facing CRA members:

1. The difficulties of performing research activities while running a clinical practice.

2. The challenge of keeping up with research findings and deciding which are sufficiently proven to justify a change in therapeutic approach.

For any further feedback or questions regarding the survey, please contact Erin Stewart at *estewart@rheum.ca*.

Health Economic Evaluation of the Mandatory Switching Policy for Biosimilars in Patients with RA

By Nick Bansback, MSc, PhD

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

About the Study

The prices of biologics for rheumatoid arthritis (RA) have continued to increase over time and are one of the top expenditures for drugs across the Canadian healthcare system. It was hoped that biosimilars — effectively near-copies of biologics — would reduce prices, but their uptake has been low. This study, funded by CIORA, aimed to understand the effectiveness of new policies implemented in British Columbia (BC) (called the Biosimilars Initiative) to increase the uptake of biosimilars. We used administrative data from BC and payor-level data across Canada to see how the "new starts" policy, and later "mandatory switch" policy changed prescribing (in both policies, BC Pharmacare would only cover a biosimilar if one was available, unless there was a medical reason to provide coverage of the originator on an exceptional basis).

How Did the "New Starts" Policy Compare to the "Mandatory Switch" Policy?

Our analysis found that the "new starts" policy (whereby patients prescribed a new biologic where a biosimilar was available would only be covered for the biosimilar) was working, albeit very slowly. Since many patients remain on the same biologic for a long time, even after 3 years only approximately 30% of infliximab prescribing was for a biosimilar. However, the "mandatory switch" policy (whereby patients already using a biologic which had a biosimilar that was available had to switch to maintain coverage) increased the uptake to close to 90% within 6 months. A similar result was seen for etanercept.

How Did BC Compare to Other Provinces?

Of course, it was possible that other factors might have influenced the uptake of the biosimilars at this time, other than the policies themselves. To address this, we used payor-level data from across Canada to compare the uptake of biosimilars at this time. We found that the only increases in biosimilar use happened in BC during this time, giving us confidence that it was the policies that influenced these changes.

Implications

Our study has given other provinces and jurisdictions evidence that a "mandatory switch" policy will quickly transition patients to biosimilars. By giving market share to biosimilars, it will enable provinces to negotiate better prices, and save the healthcare system considerable costs — making the system more sustainable. We are continuing to review the longer-term data, and the impact of the switch for the adalimumab biosimilars.

Nick Bansback, MSc, PhD
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Vancouver, British Columbia

We would also like to acknowledge the other co-authors of this work: Alison McClean, Lucy Cheng, Fiona Clement, Mina Tadrous, Mark Harrison and Michael Law

References:

Biosimilars Initiative for health professionals. Available at *https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/prescribers/biosimilars-initiative-health-professionals*. Accessed June 11, 2023.

Our results papers:

McClean AR, Cheng L, Bansback N, Clement F, et al. Uptake and Spending on Biosimilar Infliximab and Etanercept After New Start and Switching Policies in Canada: An Interrupted Time Series Analysis. *Arthritis Care & Research*. 2023. In Press – available online.

McClean AR, Law MR, Harrison M, et al. Uptake of biosimilar drugs in Canada: analysis of provincial policies and usage data. *CMAJ*. 2022 Apr 19; 194(15):E556-60.

You are invited to submit abstracts for presentation during the 2024 CRA & AHPA Annual Scientific Meeting! The deadline for submissions is October 6, 2023. Details will be available at *asm.rheum.ca*.

AB

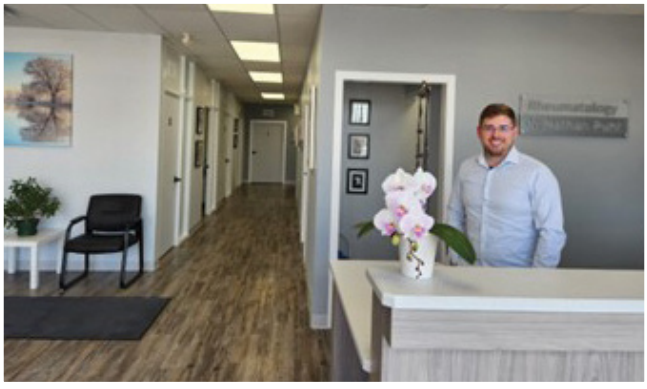
Updates from Lethbridge

By Nathan Puhl, MD, FRCPC

2023 brings a new clinic space, but now a solo practice, as Dr. Decker has relocated to Calgary. The clinic is expanding however, with the addition of nurse Erin, and likely a rheumatic-disease trained physiotherapist. Residents are always welcome, especially if interested in learning how to start a practice.

Lethbridge continues to be a great city, and we are excited to have a new conference centre opening and possibly international flights. There are many Canadians from Ontario and British Columbia relocating to southern Alberta as well, given more reasonable housing costs, a mild climate, and access to the Rocky Mountains. Referrals are welcome for any of your patients who might be moving, or if any rheumatologist wants a change of pace, there is plenty of ready space.

Nathan Puhl, MD, FRCPC
Rheumatologist,
Lethbridge, Alberta



Dr. Nathan Puhl at the new clinic space in Lethbridge.

News from Calgary

By May Choi, MD, MPH, FRCPC

Calgary has seen a wave of change over the last few years during COVID. Several rheumatology giants have departed, leaving behind big shoes to fill: Drs. Sharon LeClercq, Liam Martin, and Marvin Fritzler. We are very excited to be hosting a grand celebration in June 2023, dedicated to honouring their retirement and expressing our heartfelt gratitude for their many years of devoted service.

Rheumatology Division Admin Extraordinaire Ellen Lee (left), Past Division Chief Dr. Paul MacMullan (middle), New Interim Division Chief Dr. Gary Morris (right)

We welcomed a surge of enthusiastic young rheumatologists who have joined our forces in Calgary, including several from our own training program (Drs. Megan Barber, Tessa Campbell, Stuart Wiber, Eric Campbell, Hengameh Kheirkhah, Ali Shams, and Stephanie Kulhawy-Wibe) and across the country (Drs. Faranak Esmaeilbeigi, Martha Decker, Jenny Hong, Hafsah Al-Azem, Stephanie Garner, Britney Jones, and Jason Lee). The new generation

brings unique skillsets and experiences that perfectly complement our team.

There has also been a leadership change with Dr. Gary Morris taking over as Interim Division Chief for Adult Rheumatology from Dr. Paul MacMullan. Dr. Steven Thomson, who won the CRA's 2023 Emerging Teacher-Educator award, took over from Dr. Gary Morris as Program Director. We congratulate our colleagues on their new positions and wish them luck!

We are very excited that our family is growing and thankful for the road that has been paved for us by our mentors!

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Associate Professor,
Cumming School of Medicine
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Alberta Health Services
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Updates from Edmonton

By Stephanie Keeling, MD, FRCPC

Division of Rheumatology celebration for graduating rheumatology residents and the retirement of Dr. Joanne Homik (June 2022).

The faces of rheumatology in northern Alberta have changed considerably since "the end" of COVID in the greater Edmonton area. At the height of COVID, we welcomed and later said goodbye to Dr. Omid Niaki, a rheumatologist and dermatology expert in one person! While many of us initially only met him virtually, he became an integral part of the division, participating in teaching and seeing complex patients. Omid moved to the lower mainland for family reasons and will be missed, especially his experience managing complex patients, including those with VEXAS.

Over the past three years, we have welcomed several newly practicing rheumatologists including Drs. Mena Bishay, Larissa Petriw, Simran Jassar, Shivani Upadhyaya, and most recently Myat Nyo. This has been exciting and important, given the recent retirements of former divisional director Dr. Joanne Homik, as well as Drs. Alex Yan, Savi Sanaratne and Stephen Aaron. Our pediatric rheumatology colleagues said goodbye to Dr. Janet Ellsworth, and we all enjoyed her amazing grand rounds highlighting her pioneering work in pediatric rheumatology at the University of Alberta. Our pediatric rheumatology group has expanded despite the loss of Janet and more recently Dr. Tara McGrath, with the group now including Drs. Daniah Basodan, Dax Rumsey, Lillian Lim and Jeanine McColl.

Edmonton has always had an excellent network of collegial rheumatologists throughout the community and hospitals, strengthened by their passion and integrity. We have also celebrated the leadership of Dr. Jan Willem Cohen Tervaert, who recently completed his 5-year tenure as Divisional Director. We welcomed our new Division Director, Dr. Steven Katz, who recently completed his term as the General Internal Medicine Program Director at the University of Alberta. The rheumatologists of northern Alberta are prepared to take on the looming health care challenges facing Albertans, inspired by the legacy of our recently retired colleagues and the fresh hopes of our newest rheumatologists.

Stephanie Keeling, MD, MSc, FRCPC
Professor of Medicine,
University of Alberta
Edmonton, Alberta

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* Please see Product Monograph for complete dosing and administration information.

† The Arthritis Society Ease-of-Use commendation recognizes products that have been independently tested with people living with arthritis and is not intended as a general product endorsement. The Ease-of-Use logo indicates the ease of use only and does not endorse the therapeutic properties of the product.

References: 1. RINVOQ Product Monograph. AbbVie Corporation.
2. AbbVie Corporation. Data on file.

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References: 1. Leger. Reputation Survey. 2023: Ranking The Most Reputable Companies in Canada. **2.** Patient View. The corporate reputation of Pharma in 2021. The patient perspective—Canada edition. The views of 124 patient groups. Published June 2022. **3.** Fortune Magazine. FORTUNE World's Most Admired Companies 2022. https://fortune.com/company/pfizer/worlds-most-admired-companies/. **4.** Ethisphere. The 2023 World's Most Ethical Companies® Honoree List. https://worldsmostethicalcompanies.com/honorees/.

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