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The Journal of the Canadian Rheumatology Association

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EDITORIAL

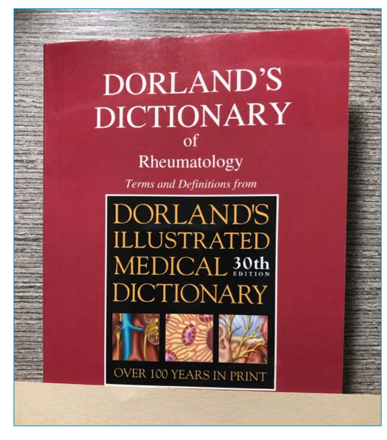
Progress in Rheumatology: How Far Have We Come?

By Philip A. Baer, MDCM, FRCPC, FACR

Twenty years ago, I attended a rheumatology conference, probably the American College of Rheumatology (ACR) meeting, and spent some time visiting various industry booths between sessions. Freebies were the norm in those days. Cleaning out some drawers at the office recently, I came across one of them: “Dorland’s Dictionary of Rheumatology.” I remembered giving it to my secretary to consult when typing letters and as a general reference. Maybe she used it, maybe not: it looked in mint condition and, at this point, its relevance was likely limited. But before consigning it to be recycled, I decided to inspect it to get a snapshot of how rheumatology looked to the authors in 2004.

The compendium was interesting both for what was included and what was not. The word “biologic” did not appear, though infliximab and etanercept had already been available for 5-6 years. “Apiotherapy” and “melissotherapy” were both included, as there had been some interest in bee venom therapy for rheumatoid arthritis (RA) at the time. “Chrysotherapy”, “aurotherapy” and “oleochrysotherapy” all reference gold treatment for RA, which was already in marked decline by 2004, but methotrexate does not appear. Page 1 included multiple terms I was unfamiliar with, including “acampsia” (rigidity or inflexibility of a part or of a joint), “acnemia” (atrophy of the calves of the legs), and “acrocinesis” (excessive motility; abnormal freedom of movement). The penultimate page covered “Volkmann’s subluxation” (a type of tuberculous arthritis) and “white tumour” (chronic tuberculous arthritis). In between I encountered a very large number of terms related to gout: “urarthritis”, “uarthritis”, “arthrolithiasis”, “anconagra”, ”omagra”, “cheiragra”, “pechyagra”, “gonagra”, and “podagra” (that latter one was familiar).

Did I recognize “anconitis” as inflammation of the elbow joint? No. “Arthroncus”, “arthrocele”, and “arthrophyma”, all meaning swelling of a joint? No. Eponyms were far more commonly listed than they would be now. We won’t miss having to remember the actual conditions represented by Albers-Schonberg, Albright, Bechterew, Marie-Strumpell, Poncet, Hench-Rosenberg and many others. Oddly, “Sjogren’s Syndrome”, which is a survivor, was not defined. The definition of “collagen disease” included not only what we now call SARDs (systemic autoimmune rheumatic diseases) but also RA, and was not to be confused with “collagen disorder”, which was not defined. Jack Cush includes “connective tissue disease” among the terms that belong in the Rheumatology Dead Word Cemetery[1], and we may as well bury “collagen vascular disorder” at the same time. Fortunately, he also interred SAARD (slow acting anti-rheumatic drug) which could easily be confused with the now accepted SARD.



I doubt “sacroiliac disease” was ever defined as “chronic tuberculous inflammation of the sacroiliac joint” but that’s what I found in this supposed reference book. Similarly, “seronegative RA” was defined as “any of various rare types of RA in which patients are seronegative for rheumatoid factor (RF).” A 25% frequency of having a negative RF in RA is hardly rare! Finally, "systemic lupus erythematosus (SLE), anti-nuclear antibody (ANA) negative" is not synonymous with antiphospholipid syndrome. In fact, the latest SLE criteria have defined ANA negative SLE out of existence.

Other terms are no longer politically correct, and really never were. “Dowager’s hump” stands out, as well as “housemaid’s knee” and “menopausal arthritis”. The word “senile” appears frequently, including “morbus coxae senilis” and “senile coxitis” (hip joint disease of aged people).

“Irritable joint” was defined as a joint subject to attacks of inflammation without discernable cause. I’m sure if I told a patient that was their diagnosis, I would have an irritable patient on my hands.

My 2004 dictionary was based on the larger Dorland’s Illustrated Medical Dictionary, 30th edition. According to *amazon.ca*, I can still buy the 33rd edition published in 2019 for only $65.85. That’s an easy decision based on my research: I’ll give it a pass.

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

Reference:
1. Cush Jack. Rheumatology Dead Word Cemetery. *RheumNow* 2019. Available at *rheumnow.com/blog/rheumatology-dead-word-cemetery-2019*. Accessed May 13, 2024.

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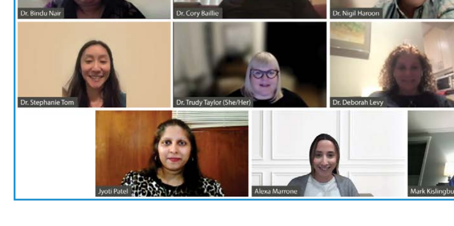

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Supporting Equitable Outcomes in Black Canadians and Persons with Diversity in Sexual Orientation, Gender Identity and Expression Living with Rheumatoid Arthritis: Project Summary

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

By Cheryl Barnabe, MD, FRCPC, MSc

The Canadian Rheumatology Association (CRA) Guidelines Committee has been progressive in their work to embed equity considerations throughout the GRADE Evidence-to-Decision process and to promote implementation practices geared to eliminating or minimizing arthritis care inequities. While data gathering for six different population groups experiencing inequities in arthritis care (rural/remote residents; Indigenous peoples; elderly persons with frailty; first-generation immigrant and refugee populations; persons of low socioeconomic status; women of reproductive age) had previously been completed, concerns specific to Black Canadians and those with diversity in sexual orientation, gender identity and expression had yet to be explored.

With funding from the Canadian Initiative for Outcomes in Rheumatology cAre (CIORA), we conducted interviews with persons from these communities to understand how their identity contributed to their understanding of rheumatoid arthritis (RA), preferences for treatment, and outcome goals. We also interviewed clinicians with expertise in the care of these populations to provide guidance on supportive practices.

For members of the Black Canadian population, we learned that healthcare access was influenced by financial resources, racism, exclusion, and discrimination. We became aware that cultural norms in seeking health care within the community exist, and there is varying awareness about RA and other forms of arthritis. The arthritis care journey was characterized by health system fragmentation, and difficulty connecting to arthritis care supports outside of physician care. When approaching treatment decisions, the legacy of oppression and history of medical experimentation on Black people, along with providers emphasizing biomedical approaches, were impacting uptake of recommendations. To counteract these realities, we need to practice differently, promoting holistic and cultural approaches in care plans, offering safe and flexible service models, and partnering with Black community organizations to promote knowledge about arthritis and to offer support mechanisms within the community.

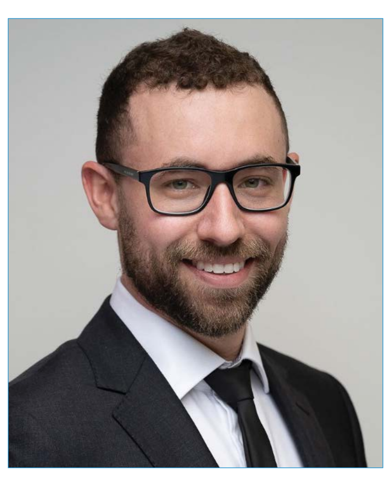
Persons diverse in sexual orientation, gender identity and expression experience stigmatization in society and in healthcare spaces, and face being denied healthcare outright based on their identity. For transgender persons, they may miss important health screening activities as these tend to be offered on the basis of biological sex, or have their labs misinterpreted if reference ranges are applied that do not align with their gender identity. It is important not to make assumptions about identity, and to use preferred names and pronouns, while also providing a safe and inclusive clinic environment. Rheumatologists are encouraged to work in partnership with the transgender medicine team to assess disease control and medication risks when the person is seeking gender-affirming hormonal treatment and surgeries.

You will continue to see these facilitators promoted in upcoming CRA Guidelines and can also learn more by taking the "Equity in Rheumatology Care" modules that were developed from this research. The program is free to CRA and AHPA members and eligible for Section 3 Credits. Check the weekly newsletters from the CRA to gain access to the program.

Cheryl Barnabe, MD, FRCPC, MSc
Professor, University of Calgary
Calgary, Alberta

CRA member exclusive! Are you passionate about advancing rheumatology research? Let the CRA support your cause! The CRA is here to champion your research endeavours with Letters of Support. Visit *rheum.ca/research/letters-of-support/* for more details.

Who's in the Rheum? Dr. Daniel Ennis, host of *Around the Rheum*



In this edition of *Who's in the Rheum?*, the Canadian Rheumatology Association (CRA) would like to introduce you to Dr. Daniel Ennis, host of the CRA's *Around the Rheum* podcast and a member of the Communications Committee. Dr. Ennis is a Clinical Assistant Professor at the University of British Columbia. He works as a general rheumatologist and vasculitis clinician at the Mary Pack Arthritis Centre in Vancouver. We're happy to share our interview with Dr. Ennis below!

What is a typical week in your practice?

My practice is primarily clinical, but I get to bounce between a few different roles. I have an outpatient general rheumatology practice that I share with my colleague and mentor Dr. Kam Shojania. I also run a vasculitis clinic alongside the brilliant Dr. Natasha Dehghan. I also am on-call at St. Paul's Hospital and Vancouver General Hospital. I really enjoy teaching trainees in each of these roles and love coming to work about 95% of the time.

What is the best thing to do in your community? (professional or recreational)?

Well, that's a tough one. Vancouver is full of outdoorsy people who head to the mountains on the weekend. So, I think the standard answer is hiking. However, my favourite thing to do in my community is bouldering or rock climbing. I got into it when I moved here for residency, but I've only been going consistently for a few years, and it is a lot of fun. It is a bit hard on the hands and feet. We will have to see if it gives me early onset osteoarthritis.

What's the last great TV show or movie you watched?

So glad you asked. I do love a good TV show. I've just finished the first season of "3 Body Problem" and "Fallout," which were both excellent. However, I've become obsessed with a show called "Taskmaster." It is a British panel comedy show where each of the guests is filmed doing mostly pointless tasks and they are judged on their performances. Now that I write it down, it does not sound particularly exciting. But it is incredible. Start with season 1. I guarantee you will like it. You're welcome.

What's it like being the host of the *Around the Rheum* podcast?

I was initially quite worried about hosting this podcast. Honestly, I am not a huge fan of public speaking. After getting over my initial jitters, it has been an absolute pleasure. I get to work with an outstanding production team including Dr. Dax Rumsey, Erin Stewart, and David McGuffin. They are incredibly supportive and patient with me. They make me sound quite a bit more competent as an interviewer than I actually am! I also have the privilege of interviewing (or co-hosting with) Dr. Janet Pope, who is a brilliant clinician and researcher. She is so delightful to spend time with. Being the host for *Around the Rheum* is an honour, but I still have "imposter syndrome" every time we turn the mic on to record. Hopefully, that will fade away after another 40 episodes or so.

What would you like to tell colleagues about *Around the Rheum*?

I think *Around the Rheum* is worth a listen. We have interviewed national and world leaders on a breadth of topics, and I have certainly learned a great deal from that process. Some of our guests are inspirational, some are brilliant scientists, some are clever problem-solvers, and all of them are caring people who are strong advocates for our patients. I think you will finish each episode feeling proud to be a part of such an incredible community.

Advancing Rheumatology Care: A Year of Progress for the Canadian Rheumatology Association Foundation

The first two years of The Canadian Rheumatology Association Foundation (CRAF) have been characterized by significant achievements, learnings and a deepening commitment to its vision of a future free from the burden of rheumatic diseases.

The recent Annual Scientific Meeting (ASM) marked another pivotal moment for the CRAF, as it provided the opportunity to further engage the rheumatology community. The enthusiastic reception and engagement from attendees underscored the relevance and importance of the foundation's mission.

In a testament to the support and commitment within our community, CRAF achieved 100% donor backing from both the Canadian Rheumatology Association (CRA) and CRAF Boards. This unified support has been instrumental in facilitating new initiatives and fostering collaboration.

We are currently expanding our solicitation strategy for CIORA to identify private foundations whose values align with the CRAF. This initiative is poised to help broaden the scope and reach of CRAF's initiatives, while facilitating greater collaboration and resource mobilization in the pursuit of improved care and outcomes for patients.

The CRAF Board recently embarked on a strategic development process, aligning its mission with a clear focus on fostering optimal care through research, training and advocacy. The CRAF's purpose is to "alleviate the burden of rheumatic disease on individuals, their community and society, while giving those who want to contribute the opportunity to do so."

The Foundation will continue to be guided by its vision, "Curing rheumatic diseases enabled by you", and its mission, "To create opportunities to support current and future rheumatology professionals to deliver the best care possible by funding research, training and advocacy."

Grounded in values of compassion, integrity, boldness and excellence, the foundation is poised to drive meaningful change in the field of rheumatology.

As CRAF moves forward in its mission to enhance rheumatology care, the importance of sponsors and donors cannot be overstated. Their support is crucial in sustaining the vital programs and initiatives which the foundation champions. From funding groundbreaking research to providing training opportunities for future rheumatology professionals, every contribution plays a pivotal role in advancing patient care and enabling innovation in the field. By partnering with CRAF as sponsors and donors, individuals and organizations have the opportunity to make a tangible difference in the lives of countless individuals affected by rheumatic diseases. Together, we can ensure that the momentum gained continues to propel us towards our shared goal of a future free from the burden of rheumatological conditions.

To learn more about how you can impact the important work of the CRAF, visit our website at *crafoundation.ca* or email us at *executivedirector@crafoundation.ca*.

Passing the Torch

"Hope is being able to see that there is light despite all of the darkness."
— Desmond Tutu

Dear CRA Members,

As my term as President of the Canadian Rheumatology Association (CRA) comes to a close, I am filled with gratitude and pride reflecting on the past two years. Serving as your President has been an incredible honour and privilege. I want to extend my heartfelt thanks to all our members who have generously volunteered their time and expertise, helping the CRA maintain its status as the trusted national voice for rheumatology in Canada. Your dedication and hard work are the cornerstones of our success.

The CRA's achievements are a collective effort. Our board, staff, and members, through their tireless work on committees and in various leadership roles, have been pivotal in advancing our mission. Together, we represent Canadian rheumatologists and promote excellence in arthritis and rheumatic disease care, education, and research. I am proud of the significant progress we have made across several key areas.

Over the past two years, we have seen remarkable advancements in membership engagement, equity, diversity, and inclusion (EDI), and financial independence. The establishment of the Canadian Rheumatology Association Foundation (CRAF) has been a significant milestone, providing a new avenue for supporting our community. We have launched innovative educational activities and enhanced the LEAP program to better serve our young members.

In addition, we have been proactive in addressing the environmental impact of our profession. The CRA was among the first organizations to raise awareness about the healthcare industry's significant carbon footprint. Following a series of informative seminars, we launched the Planetary Health Committee under the capable leadership of our Vice-President, Dr. Stephanie Tom. This initiative underscores our commitment to sustainable practices in healthcare.

As I step down, I am delighted to introduce Dr. Trudy Taylor as the new President of the CRA. Trudy's extensive experience with the CRA, including her recent role as a board member of the CRAF, makes her exceptionally well-suited to lead us through the new and complex challenges ahead. Her deep understanding of our organization and her visionary leadership will undoubtedly guide us to greater heights. It is my pleasure to pass the torch to such an incredible leader, and I am excited to continue serving the CRA as Past President.

I look forward to seeing you all at the next ASM in Calgary. Thank you once again for your unwavering support and dedication.

Warm regards,

Nigil Haroon
Outgoing President,
Canadian Rheumatology Association

"The purpose of human life is to serve, and to show compassion and the will to help others."
— Albert Schweitzer

Presidential Address

By Trudy Taylor, MD, FRCPC

Thank you, Nigil, for your leadership and commitment to the continued success and evolution of the Canadian Rheumatology Association (CRA) over the past two years. Your enthusiasm, creativity, and kindness have resulted in tremendous growth and engagement, which our members have enjoyed.

I entered my rheumatology training in Halifax in 2004 and have been a member of the CRA since that time. I was fortunate to have mentors who drew my attention to the value of CRA membership, not only for the valuable educational offerings, but also to help me make connections within this community of rheumatologists across our country. Over the years, I have enjoyed working with many of our members in one capacity or another. With the support of the CRA, I have also had the opportunity to develop my leadership skills as I took on more leadership roles within committees and eventually on the Board of Directors. This is my second stint on the Board of Directors, having served a six-year term earlier in my career.

After joining the board for the first time, one of my first revelations was that the CRA is its members. Before this realization, I thought of the CRA as an entity I belonged to that had established educational and operational offerings. I could not have been more wrong. The owners of the CRA are its members; we all have a role and a voice in developing the priorities of the CRA! I am fortunate to be a part of this vibrant, enthusiastic, and supportive community of rheumatology specialists nationwide, and I feel fortunate to have a voice in our organization.

During my term as CRA President, I hope to foster connections between Canada's provincial and regional rheumatology societies to help support advocacy work at the provincial level by sharing successes and experiences. I am also excited to continue to grow and learn in our commitment to equity, diversity, and inclusion (EDI). I thank our EDI Taskforce and consultant, Amorell Saunders N'Daw, for spearheading this work. We are starting to see the incorporation of the EDI lens in our day-to-day activities at the CRA, and I hope to foster more of this during my tenure and beyond! Finally, I am thrilled to support our new global health initiative, led by our incoming Vice President, Stephanie Tom. I am confident that with the support of our members and the tireless efforts of our CEO, Ahmad Zbib, along with our fantastic support staff, we will be able to meet these aspirations!

I look forward to serving this organization as President for the next two years. Thank you for putting your trust in me to take on this role.

From left to right: Dr. Trudy Taylor, the new CRA President, Dr. Nigil Haroon, the outgoing CRA President, and Dr. Ahmad Zbib, the CRA CEO.

Trudy Taylor, MD, FRCPC
President, Canadian Rheumatology Association
Associate Professor,
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Halifax, Nova Scotia

The Great Debate 2024

Be It Resolved That EMRs Save Time for Healthcare Providers & Improve Quality of Care

By Volodko Bakowsky, MD, FRCPC, on behalf of Tom Appleton, MD, PhD, FRCPC; Jill Hall, BScPharm, ACPR, PharmD; Steven Katz, MD, FRCPC; and Dax Rumsey, MD, MSc, FRCPC

One of the highlights of the CRA Annual Scientific Meeting is the Great Debate. The 2024 installment of the debate did not disappoint. The greatest minds in Canadian rheumatologic care once again engaged in an intellectual pugilistic slugfest. Mercy was seemingly nowhere to be found.

Jill Hall and Steven Katz argued in favour of the motion, while Dax Rumsey and Tom Appleton spoke vehemently against it.

"Team For" established early on that the teams were differentiated by geography, and that the East side had a wannabe westerner in its ranks, as Dr. Rumsey now works in Edmonton. They didn't stop there — next it was pointed out (with irony that silenced the crowd) that Dr. Appleton was named the Ontario Rheumatology Association (ORA) Rheumatologist of the Year in 2023, partly on the basis of his work with digital tools that integrate with EMRs. Ouch!

The Great Debate team (from left to right): Dax Rumsey, Tom Appleton, Volodko Bakowsky (chair), Jill Hall, and Steven Katz.

Arguments are briefly summarized below:

"Team For" noted that electronic medical records (EMRs) increase efficiency and offer improvement in various domains — prescriptions, templates, customized tools, improved legibility, faster communication and increased ease of tracking clinical changes over time. EMRs can be utilized to collect useful data that could lead to improved quality of care — for example by tracking wait times in response to system changes or innovations, as was demonstrated in Edmonton by Dr. Katz. Finally, the results of a CRA survey on EMRs was presented indicating that >70% of respondents were satisfied with their EMRs. Did that mean that the debate had already been won?

"Team Against" certainly didn't think so. The unwieldiness (yes, it's a word!) of many EMRs mandates an inordinate number of clicks and prolonged screentime, taking caregivers away from face-to-face care and contributing to burnout. EMR development is fraught with difficulty getting it right, as evidenced by the 1-billion-dollar Ontario eHealth scandal. Furthermore, EMRs that are poorly designed increase inefficiencies. EMRs also potentially result in loss of privacy — data breaches, cyberattacks, phishing and the risk that "Big Brother" will use them to collect data on caregiver performance to our own detriment. It was pointed out that the distinguished rheumatologists whom we all know and love all learned their craft at a time that preceded EMRs. Clearly, EMRs are unnecessary for the delivery of outstanding clinical care and academic productivity.

There were several lighter moments as well. Dr. Rumsey's children sang a heartbreaking ditty about the plight of the lumberjacks. Paper is made from trees and trees require lumberjacks! "Team Against" tried to drum up sympathy by having Dr. Appleton wear a neck collar due to EMR-induced muscle tension. Not to be outdone, "Team For" retaliated with a cover song from the movie Barbie, about the tragic future of a no-longer-needed pen.

Alas, debates must always end, and there must always be a winning team. This year the "For" side dominated the vote and were crowned winners for 2024.

Volodko Bakowsky, MD, FRCPC
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RheumJeopardy! 2024

By Philip A. Baer, MDCM, FRCPC, FACR

RheumJeopardy! returned as a plenary session at the 2024 CRA Annual Scientific Meeting (ASM) in Winnipeg for the ninth consecutive year, now ensconced in the final timeslot before the Friday night gala. The 2024 event was again hybrid in nature, allowing both live and virtual attendees to answer the questions. Seamless integration between the PheedLoopGo! meeting app, and the teams from BBBlanc and MKEM prevented any technical issues. I moderated from the state-of-the-art Winnipeg conference centre. After a West victory by 4,000 to 0 in the 2023 edition, the winning West captain of 2023, Dr. Raheem Kherani from Vancouver, fulfilled the roles of Chair and scorekeeper. We maintained the traditional East versus West format, with Mississauga the dividing line this year, placing those from Western University in the West as per their name. Our team captains were Dr. Timothy Kwok, a rheumatology fellow from Toronto, and Dr. Herman Tam, a pediatric rheumatologist from Vancouver, both members of the CRA ASM Program Committee. Only the members of the team whose captain had selected a question voted on the answer. The team captains selected the Final Jeopardy wagers and answered the Final Jeopardy question on their own.

The session again drew a large in-person audience of enthusiastic participants, including rheumatologists, trainees, allied health professionals and industry and patient attendees. The practice question related to the 2023 Oxford University Press Word of the Year, "Rizz". The audience correctly figured out that "rizz" is a shortened form of the word charisma, and not frizzy, risotto or terrazzo.

Fourteen questions were selected in the main game. Categories included Pediatric Rheumatology (designed before I knew that a pediatric rheumatologist would be one of the team captains), Guidelines, Old Drugs/New Tricks, Sight Diagnoses, Potpourri, and a special category honouring the 50th anniversary of the *Journal of Rheumatology*. Questions were designed to be challenging, but the two teams managed well, answering almost every question correctly and generating high scores. The $800 and $1,000 rows of questions were the most frequently chosen. Questions selected included those related to the DADA2 syndrome, myositis-specific antibodies, hypermobility syndrome, new Assessment of SpondyloArthritis International Society-European Alliance of Associations for Rheumatology (ASAS-EULAR) Spondyloarthritis (SpA) guidelines, brepocitinib and exhausted T cells. Voters correctly identified apremilast as potentially useful to treat alcohol use disorder, but not metformin to reduce the risk of joint replacement in diabetics with osteoarthritis. The CRA's newest board member, Dr. Mary Purcell, received

Dr. Philip Baer, host of *RheumJeopardy!* 2024, pictured with Dr. Timothy Kwok (Team Captain of the East), Dr. Herman Tam (Team Captain of the West) and Dr. Raheem Kherani (Chair of this year's event).

a shoutout as the winner of the 2023 ACR Image Competition Grand Prize for her case of systemic light chain amyloidosis. Participants also knew that the lower extremity counterpart of "mechanic's hands" is referred to as "hiker's feet", and that the panda sign is an imaging feature seen in sarcoidosis.

At the end of the main Jeopardy round, the score favoured East with 6,000 over West with 5,200. The Final Jeopardy category was the traditional "Famous Canadian Rheumatologists". The question focused on which two Canadians were recognized as Great Women in Rheumatology by Jack Cush on RheumNow in 2023. The choices included various combinations of Drs. Dafna Gladman, Janet Pope, Claire Bombardier and Gillian Hawker. The correct answer was the duo of Drs. Gladman and Bombardier. The answer was accompanied by an inspirational quotation from Dr. Tuhina Neogi, a Toronto-trained rheumatologist now practicing in Boston, on the value of having female mentors, such as Drs. Gladman, Bombardier and Hawker, during her training.

Both team captains answered correctly. Team East wagered everything, while Team West wagered 33%. That left East as the winning team with 12,000 versus West's score of 6,916. This means Dr. Tim Kwok will likely chair *RheumJeopardy!* in 2025 in Calgary if the ASM Scientific Committee grants us a place on the agenda for a tenth year. I am already preparing a question bank if we are renewed for another season. Thanks to everyone who participated, the anonymous photographers who sent me photos for this article, and everyone who posted, reposted and tweeted about *RheumJeopardy!* on X and LinkedIn. Special thanks as well to Dr. Marinka Twilt, the ASM Program Committee chair, who tracked the questions we used in 2024 to ensure they do not reappear in future years.

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The CRA's 2024 Distinguished Teacher-Educator: Dr. Nicole Johnson

Where do you think your passion for medical education stemmed from?

I grew up with parents who prioritized post-secondary education and lifelong learning. My father's motto was "No education is wasted education." I have this motto top of mind whenever I face any knowledge gap, hence I would approach this new learning enthusiastically. I have been able to share this motto and enthusiasm with my learners. In my early medical education journey, I was given the responsibility of chief resident. This was well before there was the now discreet role of the "resident as a teacher", and I felt that teaching was a key component of the chief resident role. I would develop teaching modules for the medical students, and fellow pediatric and off-service trainees. Following my mini-teaching, didactic, bedside teaching sessions, I would see their progress and increased ability to contribute to patient care. This would inspire me to continue in medical education.

Of course, having great medical educators around me throughout training and my work experiences continues to motivate me to contribute as a medical educator. It brings me joy to see my students and sometimes my patients choose a medical path similar to mine and even more satisfaction to have them surpass me in their success.

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

I have had many educators who have influenced me in some way, and I feel blessed to have so many mentors. I feel I have teachers around me every day. Certainly, my first teachers were my parents and family elders who taught me life skills and values like compassion, empathy, and integrity. They began my journey of life-long learning. In my formative years, I had teachers and fellow students in elementary and primary school who taught me about the value of community and cultural humility as I constantly encountered so many nationalities and cultures growing up in the Caribbean, South Pacific, Africa, and Canada.

In pediatrics, I had early guidance from the clerkship director, who was a strong student advocate. She taught me the value of creating an inclusive learning environment to make it conducive for students to learn, and one that influenced the patient care they could provide and support for the medical team. This did not mean she did not have high expectations for the students' performance, but rather she made it possible for them to learn and potentially excel in her environment.

In rheumatology, my training at SickKids was inspirational. I first met the team as an elective pediatric resident. I immediately felt the wisdom around me. I was impressed by their strong clinical skills and their ability to lead care in the hospital with complex cases. They provided clinical leadership in the field internationally, as well as through education and research. Every day in the clinic was a learning moment, whether at the bedside or one on one in the clinic or in preparing for a conference presentation with the personalized guidance that was given. Some of the things I took away from this experience were the value of a thoughtful history and physical examination, and of teamwork to move the department forward. The other lessons were the importance of reading around each case. By going back to the literature, you see if there are any advances to support your patient, and this also helps to develop clinical questions to fuel new research in the field.

In Calgary, my colleagues have also helped to shape me in rheumatology. There, it was about learning to collaboratively build a program from small beginnings to a successful clinical, educational, and research program. From my educational mentors in Calgary, I learned the value of continuous program improvements. My students also bring the excitement of new learnings with the questions they ask. By observing them I pick up new clinical pearls for myself. Finally, my patients teach me every day as I understand the privilege given to me of being able to walk their medical journeys with them.

You have received many awards for teaching and education including the 2023 Department of Pediatrics CARE award for Education. Moreover, many of your Canadian Rheumatology Association (CRA) summer students have been inspired to pursue rheumatology as a career. As a respected teacher-educator, what would your advice be to prospective and early career rheumatologists?

I tell all my trainees, whether they plan to pursue rheumatology or not, that the rheumatology experience will teach them effective communication, astute physical exa-

Dr. Nicole Johnson receiving her award from outgoing CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Winnipeg, which took place in February 2024.

mination skills, as well as sharp investigation interpretation acumen. Given our diseases may affect the whole body at once or over time, I explain to trainees that they will learn to gather lots of data and must learn how to process all this information to find the unifying diagnosis. These skills are transferable to any discipline in medicine and will enhance their skills as a clinician. I remind them that the rheumatologist often plays the detective role in medicine. We must be comfortable with uncertainty at times and make decisions sometimes without a clear diagnosis to save a life. The rheumatologist may come into difficult life-threatening situations while needing to support patients at some of the most critical times in their lives. The rheumatologist may become the quarterback in the field to advocate and direct therapy to support multiple colleagues from different disciplines simultaneously. To do this work effectively, they have to learn collaborative skills early to create a support system around themselves. I remind them that the chronicity of rheumatology diseases can be the blessing and the challenge of the diseases we look after, but we can walk the journey with our patients providing opportunities to improve quality of life and provide hope. The field is changing rapidly as our immunology knowledge improves and our therapies expand. For early career rheumatologists, I share my experience of having a national and international rheumatology community that embraces each other professionally and personally so that they understand they are joining a large family.

You have conducted several media appearances advocating for children and youth with rheumatic diseases and have provided pediatric rheumatology presentations for national and international medical associations. For 10 years, you have directed pediatric rheumatology electives for the University of Calgary. You were also a Royal College of Physicians and Surgeons of Canada Pediatric Rheumatology examiner. What's more, you are the Evaluation Coordinator for Pediatric Clerkship for the Cumming School of Medicine (CSM) and a member of the Student Academic Review Committee for the CSM. You now have a new position as Associate Director for MD admissions for the CSM. Given your extensive work in medical education, where do you see the future of medical education moving?

I have always been a proponent for observed assessments of learners, so I embrace competency-based learning. By observing the learner, you can see first hand their strengths and areas needing improvement. Competency-based learning also pushes preceptors to be more thoughtful in our feedback process to give specific constructive feedback to our learners. It also asks us to tailor to the specific needs of the learner, which will empower each learner to become the best they can be. My hope for the future is that we are nimble as preceptors to meet the diverse needs of learners. Also important to me is the movement of medicine to be a more inclusive community. We need a more inclusive curriculum in medicine that does not emphasize the white male as the norm and understands that patients come in all shapes and forms.

I would like to see principles of structural competence be taught more universally. Rather than teaching about social determinants of health as a consequence of an individual's lifestyle choices, we need to move towards understanding how the upstream barriers and systemic factors lead to a patient's health behaviours. By doing so, we are more able to see solutions to the healthcare challenges thus overcoming any sense of futility for improving our patients' health status. In addition, I would like to see us train physicians from diverse backgrounds, so our medical community reflects the same diversity as the patients we serve. This diversity is not just about increasing the ability of those underrepresented in medicine to serve in the profession, but to recognize the value they bring to the table in elevating the knowledge of those around them including staff, colleagues and patients and raising the bar for all of us in the quality of health care we provide.

As we build on the diversity of our medical community, we need to simultaneously address the barriers and discrimination felt by our healthcare providers and patients from diverse backgrounds. Many within our community understand this fundamentally but are struggling with how to make these changes. It will take individual and organizational changes to bring about a more inclusive society. The first step will be the acknowledgment that change is needed, then education and empowerment of each and everyone to make these incremental steps towards addressing bias in recruitment and assessment of learners and staff. Within our spheres of influence, we can ask

questions about who is not at the table for decision-making and how decisions may affect those not represented as decision-makers. We have to redefine what professionalism in the profession means to include cultural humility and anti-discrimination as fundamental principles, along with all the other qualities we admire and place value on in physicians. Our new generation of learners are grasping these concepts, and we need to also embrace these principles. These incremental changes will have a great impact in changing our medical culture, where we all benefit from a sense of belonging and strengthen our capacity to provide quality care to our diverse patient population.

In addition to your advocacy for children and youth with rheumatic diseases, you have also been engaged in anti-Black racism advocacy work. You hold the positions of Co-Curriculum Lead for Post Graduate Medical Education for Racial Equity in Healthcare at the CSM; Chair for the Diversity and Inclusion Task Force for the Canadian Rheumatology Association; and Board Executive and Physician Lead for the medical student mentor program for the Black Physicians' Association of Alberta. Furthermore, your contributions to inspiring women and girls in Science, Technology, Engineering, and Mathematics has been recognized by the Calgary Black Achievement Award for STEM from the Calgary Black Chambers in 2021. In 2023, you received the inaugural award for Mentorship from the Black Physicians of Canada. Why was getting involved in advocacy with regard to anti-Black racism and women in STEM so important to you?

Supporting women and girls in STEM is truly about paying it forward for me. My family, including my grandparents and parents, were advocates for girls having the same opportunities in education as boys at a time when it was not customary to advocate for females. I was encouraged to explore all my interests and gained an early love of the sciences. I realized it came from early exposure and a supportive environment. I hope to provide that exposure and encouragement to women who may not have had the same support that I received. I also feel we do not discuss the history of women in medicine and STEM enough to ensure that female pioneers are understood and celebrated. If young females do not see role models in the field it may not occur to them that they may have a role in STEM careers, so I cherish being a role model for other female learners.

My enthusiasm for anti-Black racism in medical education comes from my own lived experience. Throughout my education there were many instances of racial discrimination in my training that have shaped me. Without great mentors and supporters, I could have faltered along the way after these various discriminatory experiences. I learned how to address microaggressions, knowing how to advocate for myself, but not all racialized learners have learned these resilience techniques. Indeed, we should reach a point where microaggressions and discrimination are not commonplace or accepted aspects of our medical culture, but until then we need to work and bring awareness and strategies to eliminate discrimination in medicine, not just for our trainees, but for all working in healthcare and, importantly, for our patients. Canada has declared racism as a social determinant of health and, as such, we are obligated to address it for the greater health of our people.[1,2,3]

What is your proudest accomplishment?

From a professional perspective, the Canadian Rheumatology Association Distinguished Teacher-Educator Award was a definite highlight for me. Since being a fellow in rheumatology I have looked up to the educators who have received this award previously. I was truly speechless when I heard I was the 2024 awardee. Most of my work has been in undergraduate medicine and not specifically focused on rheumatology or through a residency training program, so it was a surprise to know my work reached the radar of the rheumatology family.

From a personal perspective, I cherish my family and friends and appreciate being known as the glue that keeps everyone together.

What are some of your other passions outside of rheumatology and medical education? What would you be doing if you had not pursued rheumatology?

I love travelling and connecting with friends and family around the world. I would say it also is a passion to get out of the cold and hit a tropical destination when I can.

What is your favourite food or cuisine?

I enjoy all types of cuisine having grown up around the world.

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

That is a hard one for me, as there are so many places where I have friends and family. However, with that plane ticket, I would head back to the Fiji Islands. I stay connected with classmates from the '80s and would love to see them again and experience the diversity of culture there.

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Spotlight on the 2024 CRA Abstract Award Winners

IAN WATSON AWARD *for the Best Abstract on SLE Research by a Trainee*

Sponsored by the Lupus Society of Alberta
Winner: Eugene Krustev, University of Calgary
Abstract Title: Autoantibodies Against Myxovirus Resistance Protein 1 Are Associated with Myositis and Interstitial Lung Disease in Systemic Lupus Erythematosus
Supervisor: Dr. May Choi

PHIL ROSEN AWARD *for the Best Abstract on Clinical or Epidemiology Research by a Trainee*

Sponsored by the Arthritis Society – Phil Rosen Memorial Award
Winner: Derin Karacabeyli, University of British Columbia
Abstract Title: Incidence of Autoimmune Rheumatic Diseases Following Exposure to Dipeptidyl Peptidase-4 Inhibitors, Glucagon-Like Peptide-1 Receptor Agonists, or Sodium-Glucose Cotransporter-2 Inhibitors: A Population-Based Study
Supervisor: Dr. Juan Antonio Aviña-Zubieta

BEST ABSTRACT *by a Rheumatology Resident*

Sponsored by the CRA
Winner: Shane Cameron, University of Manitoba
Abstract Title: Reduced Statin Use in Patients with Autoimmune Myopathies and Systemic Lupus Erythematosus Compared to Rheumatoid Arthritis and Non-Inflammatory Diseases
Supervisor: Dr. Annaliese Tisseverasinghe

BEST ABSTRACT *on Basic Science Research by a Trainee*

Sponsored by the CRA
Winner: Kaien Gu, University of Manitoba
Abstract Title: Novel Gene Expression Analysis Documents Significant Differences in Osteoarthritis Cartilage Based on the Presence of Mutations in ALDH1A2
Supervisors: Drs. Peter Lipsky and Amrie Grammer

BEST ABSTRACT *by a Post-Graduate Research Trainee*

Sponsored by the CRA
Winner: Zoha Faheem, University of Toronto
Abstract Title: Investigating the Role of Interferon in Promoting Flares of SLE at a Single Cell Level
Supervisor: Dr. Joan Wither

BEST ABSTRACT *on Quality Care Initiatives in Rheumatology*

Sponsored by the CRA
Winner: Jean-Charles Mourot, Université de Montréal
Abstract Title: New Canadian Fast-Track Ultrasound Clinic by Rheumatologists for Diagnosis of Giant Cell Arteritis: Are Temporal Artery Biopsies a Story from the Past?
Supervisor: Dr. Nicolas Richard

BEST ABSTRACT *by a Medical Student*

Sponsored by the CRA
Winner: Angel Gao, Queen's University
Abstract Title: Sex-Related Differences in Participation and Trial Outcomes in Axial Spondyloarthritis Randomized Clinical Trials: A Systematic Literature Review and Meta-Analysis
Supervisor: Dr. Lihi Eder

BEST ABSTRACT *by an Undergraduate Student*

Sponsored by the CRA
Winner: Nicholas Chan, University of Toronto
Abstract Title: Applying Similarity Network Fusion to Identify Patient Clusters for People with Systemic Inflammatory Disease
Supervisor: Dr. Linda Hiraki

BEST ABSTRACT *by a Rheumatology Post-Graduate Research Trainee*

Sponsored by the CRA
Winner: Carolina Munoz-Grajales, University of Toronto
Abstract Title: Elevated Serum Levels of S100A8/A9 Discriminate Systemic Lupus Erythematosus Patients with Cognitive Impairment from Patients Without Impairment
Supervisor: Dr. Zahi Touma

BEST ABSTRACT *on Research by Young Faculty*

Sponsored by the CRA
Winner: Lauren King, University of Toronto
Abstract Title: Validation of Clinical Criteria to Diagnose Knee Osteoarthritis

BEST ABSTRACT *on Pediatric Research by Young Faculty*

Sponsored by the CRA
Winner: Ruud Verstegen, University of Toronto
Abstract Title: Therapeutic Drug Monitoring of Rituximab to Predict Early B-Cell Repopulation in Children

BEST ABSTRACT *on Spondyloarthritis Research*

Sponsored by the Canadian Spondylitis Association
Winner: Fadi Kharouf, University of Toronto
Abstract Title: Tuft Resorption in Patients with Psoriatic Arthritis
Supervisors: Drs. Dafna Gladman and Vinod Chandran

You are invited to submit abstracts for presentation during the 2024 CRA & AHPA Annual Scientific Meeting! The deadline for submissions is October 4, 2024. Details will be available at asm.rheum.ca.

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* May not be available in Quebec.

The CRA's 2024 Emerging Teacher-Educator: Dr. Pari Basharat

What or who inspired you to become involved in medical education?

I was definitely inspired by my teachers and mentors along the way. Teachers have always played a very important role in my life. Even as far back as elementary school, I still remember educators who went out of their way to nurture the spark they saw in their students. In medical school, I was most inspired by staff who seemed to genuinely enjoy the work that they did, and who sincerely shared their knowledge with enthusiasm and creativity. Part of what has always attracted me to medicine is the many roles we fulfill, teacher and educator being one of them. It has always been the path of medicine that I wanted to explore, as I think one of our most important roles is passing on knowledge and inspiring those who follow us, who will become the future leaders and educators of tomorrow. And we learn so much from our students along the way, too. We are, in fact, lifelong students ourselves! In medicine, there is always something new to learn.

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

My first teachers in life, for all things, and on so many levels, were my parents. They are definitely a constant source of inspiration. I have learned from their intellectual curiosity, work ethic and patience. My dad loves problem solving and helping out others. My mom has an outstanding way of connecting on an intellectual and emotional way with people, during her time working and in leadership positions, but also just in life in general!

In elementary school, I had a wonderful educator who took the time to get to really know each student and help them hone and further their knowledge and skills and celebrate their uniqueness. I remember her taking the time to support us in student government, and her spending time with me practicing public speaking for example. Later on in life, I was privileged to be part of her medical team as a physician caring for her during a time of illness. It was truly a full-circle moment!

What do you believe are the qualities of a good educator? Moreover, how do these apply to you?

A good educator really needs to be empathetic and in tune with their learners. As doctors, I believe most of us are inherently empathetic — it is what drew us to this profession. Being empathetic with a learner means really spending the time to see where they are coming from. What are their goals? Challenges? How does one as an educator uniquely connect to and inspire their student? This means being creative and innovative as well.

You have a special interest in inflammatory myopathies and have completed a fellowship in Inflammatory Myopathies at Johns Hopkins University. You currently conduct subspecialty clinics in this area, which is one of the highlights of the rheumatology resident program at Western. You also participate in research in this area, have mentored residents in research projects in myopathies, and lecture on this topic at residency courses and conferences. Can you tell us more about your research and findings?

The exciting thing about myositis is that there is so much more to learn about this group of diseases. There are many opportunities for collaborative research in this field. I am lucky to be connected with international myositis research groups. But working with interested residents is great, too. At the local level, I worked with residents on looking at interstitial lung disease patterns and treatments based on myositis antibody profiles, for instance. I recently became a part of the Myositis International Health and Research Collaborative Alliance and I look forward to working with this organization in the future.

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

I was very honoured to learn I received this award. I have learned so much from my teachers and educators along my educational and professional journey, so to be given this award really meant a lot to me!

You are currently Curriculum Coordinator for the Internal Medicine (IM) Program at the Department of Medicine at

Dr. Pari Basharat receiving her award from outgoing CRA President Dr. Nigil Haroon at the CRA Annual Scientific Meeting in Winnipeg, which took place in February 2024.

Schulich. Moreover, you are a member of the IM Residency Training Committee (RTC), a member of the Post Graduate Medical Education (PGME) Committee at Schulich as well as a member of the PGME Policy Subcommittee. As a respected teacher-educator, what would your advice be to a prospective rheumatologist?

My advice would be to choose something that really excites and motivates you, and if you already have an interest in rheumatology, that's a great sign because it means you have discovered this specialty that is full of fascinating pathology and developments. Many people don't realize how stimulating a specialty rheumatology is until they are exposed to it; it is a black box for many, so you are already at an advantage! I would say always approach your clinics with a sense of curiosity and creativity. Learn from those around you, especially in the first few years of your practice. Expose yourself to collaborations with others in the field, and with clinicians in other specialties. You never know where inspiration will come from and what future projects could lie ahead. Never stop asking questions and learning, and I would highly recommend being involved in education. It is an area that will keep you constantly inspired, it is highly fulfilling and you will learn a lot from your learners.

Do you have any advice for those who mentor trainees in rheumatology?

I would say mentoring is a great way to keep the passion alive for our specialty. Sometimes we become jaded with the everyday grind, and many times we forget how far we have come and even the great innovative things we have done in our profession. Mentoring is a way to remind ourselves what drew us to this specialty in the first place. It keeps our sense of wonder and curiosity alive, since we are exposed to and inspired by those we are mentoring. It is a constant positive reminder of why we chose this path in life.

What are some of your other passions outside of rheumatology and medical education?

I am an avid creative writer, and really enjoy writing poetry and prose. Some of my poems have been published in medical journals and recently in an anthology book about the history of the stethoscope. It is a great way to unwind and be reflective. I also enjoy gardening, spending time in nature, and interior decorating.

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

"Pride and Prejudice" by Jane Austen. It never gets old and is very layered and provides a very interesting social commentary.

What is your favourite food or cuisine?

I love Persian food. It is a great example of a varied cuisine that is not spicy or overwhelming, but bursting with flavour and with many options for everyone to choose from and to enjoy.

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

I would go to Istanbul. It is a city filled with history, culture, and beautiful arts and cuisine. The people there are lovely too.

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

I actually do not drink coffee! I have never cared for the taste of it, and it makes me feel too jittery. I prefer a soothing hot mug of decaffeinated tea. I know I am definitely an anomaly when it comes to physicians in this respect!

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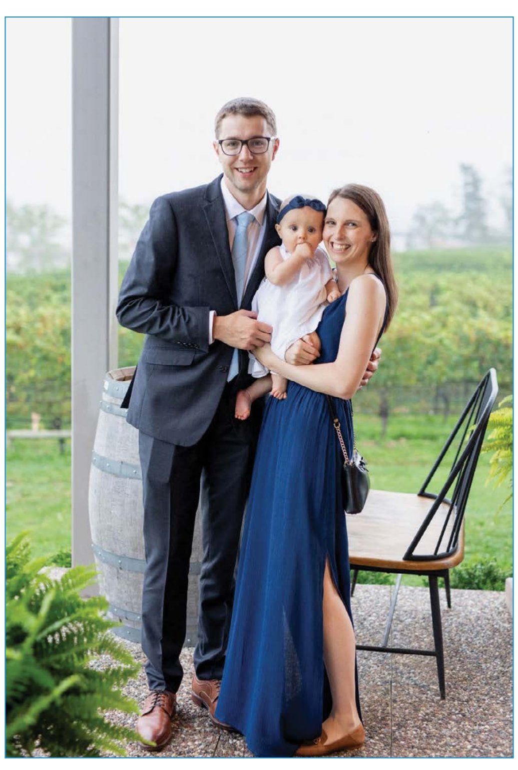
Patient Perspective: Molly Dushnicky

I can't tell you much about my initial diagnosis of polyarticular juvenile idiopathic arthritis. That's because I was only 18 months old when I was diagnosed. My mom tells me the same story I have now heard so many times from my own patients — I had started walking, and then I stopped; it was hard to bend my knees to get me into my sleepers; I was such a happy baby, and then, I just wasn't.

My name is Molly, I am 33 years old, and I have been living with arthritis for the majority of my life. I am also currently in my final year of a pediatric rheumatology fellowship at the Hospital for Sick Children in Toronto, and I cannot wait to continue a career as a pediatric rheumatologist and be able to give back to a community that has given me so much.



Dr. Molly Dushnicky with her husband, Tim Wright, and daughter, Charlie.

As I am sitting here writing this article, I am reflecting on my life with arthritis and the challenges I have faced. Growing up with a chronic disease and being constantly told to slow down and take it easy drove me to be even more active. I never took it easy. I grew up playing sports, pushing myself to keep up with all the other kids, and always wanting to participate in literally everything. Even if I was in pain, I always wanted to keep going. In that sense, I'm grateful for my arthritis; I'm a stronger person because of it. Now, I am an active soccer player, curler, and skier. There are still many days where my arthritis doesn't allow me to do the things I want to do, but for the most part, I can, and I'm always grateful for that.

It has exhausted me — despite all my knowledge of the disease now, I continue to have hope that one day I might come off medication, that one day I would not have to think about all of this anymore. It's hard to not have hope, even if all my medical training tells me that at this point, I'll likely always have to deal with my arthritis. When I was younger, I would have disease-free periods, where I was able to come off all medications. Then I would have a flare. Every time that I've needed to restart medication, to increase or change my medication, to go for another joint injection, it's emotional and tiring. I sit here now as a budding pediatric rheumatologist, constantly having conversations with families about changing treatment plans, and all I can say is, I get it.

Let's take a moment to talk about something — none of the medications we prescribe are particularly fun to take. I've been on most of our standard gamut of therapy at some point, from non-steroidal anti-inflammatory drugs (NSAIDs) and steroids, to all of the conventional disease-modifying anti-rheumatic drugs (DMARDs), to an assortment of biologics. I can't think of a single one that I've enjoyed being on. Some of them just taste terrible, and some, like methotrexate, have tiring side effects that interfere with the high-level functioning I need to continue my career goals. Finally, weekly or biweekly injections — not fun, it's as simple as that.

It has frustrated me. The world of pediatric rheumatology has come a long way in the last three decades. Growing up, if I told someone I had arthritis, I would quickly get told that "arthritis was for old people". The medications available to treat my arthritis 30 years ago were limited, and I have damage from joints that just wouldn't respond to those medications. I encountered barriers in sports, in school, and at work, because my illness isn't always "visible". When I am at my most frustrated, I think about the progress we as a rheumatology community have made. Our knowledge and awareness of rheumatic diseases in children is constantly growing, thanks to so many amazing patient advocates and charitable organizations. The treatments for rheumatic disease have improved so much, and the number of children who now experience joint damage is much lower than when I was young. There is still so much room for improvement, but it's important to reflect on how far we have come.

Most importantly, my arthritis has motivated me. When I was young, I used to wish on stars that my arthritis (back then I called it "my-thritis") would go away forever. Now, I don't have to wish. As a physician and researcher, I work with other patients just like me regularly and help

Snowboarding at Mont Tremblant, Quebec.

Dr. Molly Dushnicky and her daughter, Charlie.

improve their disease activity. I participate in local, national, and global research aimed at improving outcomes in pediatric patients with rheumatic disease. Through my experience, I have a unique perspective on areas for improvement. For example, I grew up in Thunder Bay, Ontario — a city with no pediatric rheumatology care, a 14-hour drive from the closest centre in Ontario. I am thankful to have had an amazing adult rheumatologist provide most of my care when I was growing up, but that was a unique scenario, and today, most adult rheumatologists in Northern and rural communities simply don't have the capacity to care for pediatric patients. Although the pediatric rheumatology community continues to try to improve access to care, with outreach clinics and telemedicine care, to be frank, the care these patients receive just isn't the same as someone who lives in downtown Toronto. I have recently been involved in work with the CRA highlighting that there are geographical barriers to accessing care across the country. More recently, I've become a member of the Ontario Rheumatology Association (ORA) Northern Ontario Committee, with a personal goal to improve access to pediatric rheumatology care for all Northern patients through my career.

Further, I know the importance of a strong transition to adult care. Although I didn't undergo a standard transition to adult care, when I was in my early twenties I left Northern Ontario for graduate school, moving away from home for the first time. My lifelong rheumatologist referred me to a rheumatologist in my new city. Shortly after my move, I continued my routine bloodwork like the good, independent patient I was trying to be. The following week, I received a call from my new rheumatologist's office instructing me to stop my methotrexate because I was neutropenic. I asked if I had an appointment and was told to be patient and that I was on the waitlist. Months went by and I stayed off my methotrexate because no one told me otherwise. I still had no appointment. Then I started to flare. I continued to call to try to obtain an appointment, but was told the same canned line that I was "on a waitlist" despite trying to communicate that I was flaring. I was 22 years old, living in a new city alone, and unable to get dressed or brush my hair in the morning, with no rheumatology follow-up in sight. Eventually, I spoke to my previous rheumatologist back home, who told me to restart methotrexate and go for more frequent bloodwork for now. I was lucky to be able to maintain that connection easily. Mine is just one of countless stories of the struggles of young adults during this transition. Now, I aim to improve healthcare transition in pediatric rheumatology and, to date, have been involved in several transition-to-adult-care projects and initiatives, including building transition toolkits, helping establish transition readiness assessments, and publishing multiple articles in this field. I love what I do every day, and I am so grateful to have the opportunity to change more lives than just my own.

To all my rheumatology colleagues out there, I'm here to remind you that whether your patients and families are frustrated, exhausted, challenged, or motivated, we need to be here to support them. Dealing with chronic disease can be a roller-coaster ride, and it's our job to help patients with both the challenges and the successes of their disease and do all that we can to help each of them achieve their dreams.

Molly Dushnicky, MD, MSc, FRCPC
Pediatric Rheumatology Fellow, Hospital for Sick Children, Toronto, Ontario

Summary of the New Physician Services Agreement in Manitoba

By Konstantin Jilkine, MD, FRCPC

Greetings from Manitoba! It was a pleasure to see so many colleagues attend the first-ever "President's Choice No Name Band" concert at the Annual Scientific Meeting (ASM) hosted in Winnipeg earlier this year! Hopefully, this sparks a trend of the Prairies hosting. I will note, for the formal record, that it was warmer in Winnipeg than in Quebec that week. Although may I suggest a week earlier to experience Festival du Voyageur next time?

Last fall, Doctors Manitoba and the Province ratified a new Physician Services Agreement (PSA) and I was asked to share our progress. One of the biggest challenges in Manitoba is that our patients come from a large rural, northern, and remote (without road access) catchment area and we also see patients from northwestern Ontario, Nunavut, and a slice of eastern Saskatchewan facilitated through interprovincial agreements. As chair of the Rheumatology Working Group, keeping this in mind, I advocated to maintain parity between virtual and in-person care and to improve our remuneration to be more competitive.

I am pleased to report this PSA represents an additional $268 million (of which rheumatology billings probably comprise a rounding error) over four years with initial focused fee adjustments; 2% across-the-board increases in years 2/3/4; and a retention bonus to all physicians. Most changes are not specific to rheumatology, but my colleagues and I now benefit from the following:

- A focused ~6% bump in our most used follow-up fee when billed by a rheumatologist
- A new "continuing care by medical specialists" fee offering an approximately 30% increase per follow-up visit for specific ICD codes (modelled after Ontario; although with notable gaps to address)
- A new modest per-visit fee for community practices aimed at overhead support
- An ~11% increase in the on-call stipend
- A new 15% complexity premium for inpatient billings
- Two new fees for giving out/calling to get phone advice (a huge gap previously, given the documentation time required and medicolegal risk)
- Virtual care fees were not decreased where an existing provider-patient relationship exists (and decreased significantly otherwise). In practice the new continuing care premium above doesn't apply so in-person care is now remunerated higher.

"President's Choice No Name Band".
Lawyers from a certain large retailer have been trying to identify these dastardly trademark infringers.

- A new virtual visit premium of 2.5%/12%/17.5% for rural, northern, and remote patients, respectively
- The alternatively funded academic agreement is now defined as a dollar amount per full-time rheumatologist rather than a set amount to be divided and diluted with recruitment
- The Ongomiizwin Health Services daily specialist rate for northern and remote travel clinics was increased by 10%!

Hopefully, this is helpful in your own provincial negotiations. It's worth noting we don't have any nurse, trainee, advanced care practitioner, or ultrasound fees. There is a tendency for nonphysicians to look across the board at similarly named fees and say "close enough", but the nuances in billing practices, modifiers, and contracts vary the actual remuneration significantly. Thus, I'd like to sincerely thank colleagues who were willing to discuss details so that we could push back.

Finally, I would like to welcome Dr. Juanita Romero-Diaz and Dr. Sonal Mehra to our province and thank Dr. Ramandip Singh for his hard work and successful training of multiple fellows during his term as program director through COVID.

Konstantin Jilkine, MD, FRCPC
Assistant Professor of Medicine, Rady Faculty Health Sciences
University of Manitoba
Medical Advisor, Ongomiizwin Health Services
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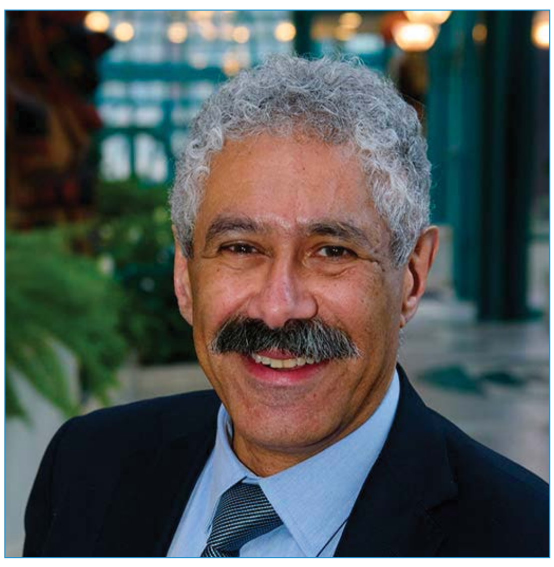
Dunlop-Dottridge Lectureship: The Impact of RA on First Nations People, and How We Can Work with Communities to Detect and Prevent It

By Hani El-Gabalawy, MD, FRCPC, FCAHS

It was truly an honour and a privilege for me to be selected to present the prestigious Dunlop-Dottridge Lecture at the 2024 Canadian Rheumatology Association Annual Scientific Meeting. This was made even more meaningful for me by having the meeting, for the first time, in my home city of Winnipeg. The title of the lecture was "What is the Impact of RA on First Nations People, and How We Can Work with Communities to Detect and Prevent it". In addition to the lecture itself, the presentation was complemented by a highly productive workshop focused on rheumatoid arthritis (RA) prevention. The following summary of the contents of the Dunlop-Dottridge lecture is from the abstract of the article on the lectureship, as published in the May 2024 issue of the *Journal of Rheumatology*.



Abstract

RA is prevalent in many Indigenous North American First Nations (FN) and tends to be seropositive, familial, and disabling, as well as associated with highly unfavourable outcomes such as early mortality. The risk of developing RA is based on a perfect storm of gene-environment interactions underpinning this risk. The gene-environment interactions include a high frequency of shared epitope encoding HLA alleles, particularly *HLA-DRB1*1402*, in the background population, and prevalent predisposing environmental factors such as smoking and periodontal disease. Together, these provide a compelling rationale for an RA prevention agenda in FN communities.

For the past twenty years, our research team has worked in partnership with several FN communities to prospectively follow the first-degree relatives of FN patients with RA, with the aim of better understanding the preclinical stages of RA in this population. We have focused on specific features of the anti-citrullinated protein antibodies (ACPA) and other proteomic biomarkers as predictors of future development of RA. These studies have now led us to consider interventions having a favourable risk-benefit ratio if applied at a stage prior to a hypothetical "point of no return," when the autoimmunity potentially becomes irreversible. Based on a supportive mouse model and available human studies of curcumin, omega-3, and vitamin D supplements, we are undertaking studies where we screen communities using dried blood spot technology adapted for the detection of ACPA, and then enrol ACPA-positive individuals in studies that use a combination of these supplements. These studies are guided by shared decision-making principles.

Hani El-Gabalawy, MD, FRCPC, FCAHS
Professor of Medicine and Immunology
University of Manitoba
Winnipeg, Manitoba

AWARDS, APPOINTMENTS, AND ACCOLADES

Dr. Philip Baer – *Life Membership in the Ontario Medical Association*

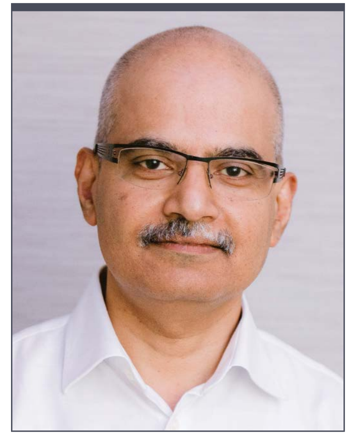
Dr. Philip Baer has been granted Life Membership in the Ontario Medical Association (OMA) in recognition of his outstanding contribution to the work of the Association, the medical profession and medical science or common good in Ontario. Dr. Baer is the Chair of the OMA Section on Rheumatology and a member of the OMA Awards and Recognition Committee. He has served as a Delegate to OMA Council and received the OMA Section Service Award in 2012.

Dr. Gilles Boire – *CRA Master Award**

It is a great honour to receive a 2024 CRA Master Award, and I wish to thank my rheumatology peers.

After thirty-five years in practice and basic and translational research, I am in the process of retiring. I remain Adjunct Professor at the University of Sherbrooke, to contribute to some of the ongoing research initiatives. I transferred my long-term patients to younger colleagues, but I still evaluate new children's referrals, as there will be a hiatus of a few months before a recruit takes over this clientele, bringing the Division to 11 rheumatologists.

To the Rheumatology Community, I wish you well.

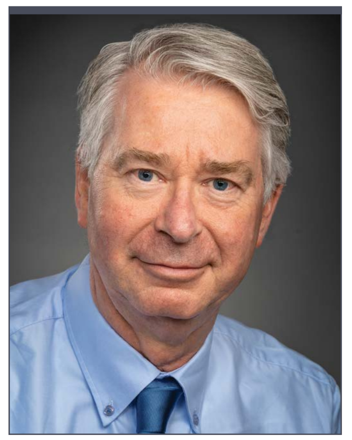


Dr. Vinod Chandran – *Appointed as Vice President, GRAPPA*

Dr. Vinod Chandran, a rheumatologist and Associate Professor of medicine at the University of Toronto, was appointed as the co-vice president of the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) and will commence his three-year term after the GRAPPA annual meeting on July12-13, 2024. GRAPPA is a global not-for-profit professional organization that aims to promote patient care, education, and research in psoriatic disease, including cutaneous and arthritic manifestations as well as comorbidities. Members include rheumatologists, dermatologists, people with lived experience with psoriatic disease, methodologists, and representatives of the biopharmaceutical industry. During his term, Vinod intends to provide leadership to enhance global research and educational collaborations to make GRAPPA truly representative of all stakeholders in the care of patients with psoriasis and psoriatic arthritis.

AWARDS, APPOINTMENTS, AND ACCOLADES

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



Dr. Jan Willem Cohen Tervaert – *CRA Master Award**

I am humbled to receive a 2024 CRA Master Award.

Thanks to the CRA, my University of Alberta colleagues, and my patients with either ANCA-associated vasculitis or with breast or mesh implants that developed Autoimmune/inflammatory Syndrome Induced by Adjuvants (ASIA).

My journey as a clinician-scientist started in 1984. What a joy it was that in 1986/1987 our group discovered antibodies to myeloperoxidase (MPO-ANCA) and to proteinase 3 (PR3-ANCA) in patients with vasculitis. In 2017, I started together with Dr. Mo Osman a translational lab at our university, where our work focuses on fatigue in rheumatic diseases.

Dr. Bianca Lang – *CRA Master Award**

I am honoured to receive a 2024 CRA Master Award, and grateful to my colleagues for their nomination.

In turn, I would like to recognize my mentors from Sick Kids: Ron Laxer, Earl Silverman, and the late Abe Shore. These wonderful individuals inspired me to become a pediatric rheumatologist 35 years ago, when there were none in the Atlantic provinces. They prepared me to establish our programme at the IWK.

I'm really encouraged to see the very active involvement of pediatric rheumatologists in the various initiatives of the CRA. Reflecting, I recall the fruitful collaboration with my adult rheumatology colleagues (notably Carter Thorne, Arthur Bookman, and Michel Zummer) that laid the groundwork for this. Together, we developed a compelling proposal for the establishment of a Pediatric Rheumatology Section (now termed Committee) within the CRA. It's clear that including pediatric rheumatology in the CRA has been a significant achievement for both rheumatology and patients across Canada.

Enormous strides have been made in the care of children with rheumatic diseases over the course of my career. However, there is still a lot to do, and I'm excited about the strides we'll collectively make in care, education, and research.

Dr. Jane Purvis – *OMA Section Service Award*

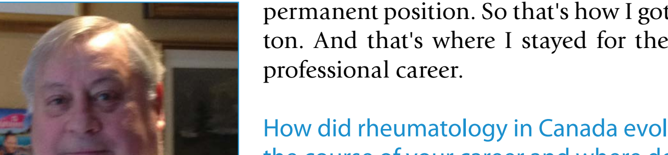
Dr. Jane Purvis has received the 2023 Ontario Medical Association (OMA) Section of Rheumatology Service Award in recognition of outstanding leadership abilities toward shaping the future of medicine. Dr. Purvis has held various roles at the OMA, including Section of Rheumatology Vice Chair, and has worked with the Ontario government on improving access to advanced therapeutics, vaccines for immunocompromised patients, getting anti-CCP antibodies and ANCA paid for through the provincial lab system, and the recent introduction of biosimilars to the province. Dr. Purvis is continuing to represent rheumatologists at the provincial level.

*The designation of Master is conferred on CRA members, age 65 or older by December 31st of the year in which they are nominated, who have excelled in one or more of the following ways:

1. outstanding service to patients;
2. outstanding administrative service (e.g. involvement in a provincial college, the Royal College of Physicians and Surgeons of Canada, provincial or national medical association, provincial rheumatology association or the Canadian Rheumatology Association);
3. excellence in rheumatology teaching and education;
4. excellence in rheumatology research.

Canadian Heroes in Rheumatology: An Interview with Dr. Paul Davis

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



My interest in rheumatology started even before I went to medical school. I worked as a lab technician at the Canadian Red Cross Memorial Hospital in Taplow, England. This was Britain's premier clinical and research institute in arthritis, under the direction of Professor Eric Bywaters and Dr. Barbara Ansell at the time.

One of the jobs that I had as a lab technician was to set up the erythrocyte sedimentation rates (ESR) and the rheumatoid factor (RF) and LE (lupus erythematosus) cell test preparations for patients with rheumatic diseases. I became fascinated by the conditions that these tests were being used for, and that piqued my interest in rheumatology, which lasted obviously for the rest of my career.

From where did your passion and interest in rheumatology stem?

I was lucky enough throughout my training to have exposure to other subspecialties. At one stage, I was even being persuaded to become an orthopedic surgeon, which fortunately I didn't do. But, throughout my career, I found so many of the specialties fascinating. But each time I gravitated back to rheumatology. I think one of the reasons was that clinical immunology and its application in disease processes was rapidly evolving at that stage. So, this was a unique opportunity to combine my interest in clinical immunology with clinical disease as we see it in rheumatology.

Can you tell us about your journey from being a medical student in England to establishing yourself as a rheumatologist in Edmonton, Alberta?

Well, when I left Taplow as a lab technician, I went to the University of Bristol where I obtained my medical degree; but through my undergraduate training, I maintained my relationship with the Research Institute in Taplow, working there during the longer vacations. Subsequently, when I graduated, I spent a short period of time working there as a medical resident. After that, I spent 3 years of training in general internal medicine and then landed a position at the Royal Postgraduate Medical School in the Hammersmith Hospital in London, England, again under the directorship of Professor Eric Bywaters and Dr. Graham Hughes. This was an opportunity for me to reinvigorate, if you like, my interest in rheumatology.

Subsequently, I became a Fellow at the University of Bristol and Bath where I worked in the Bath Mineral Hospital for rheumatic diseases, and throughout that period of time, my enthusiasm for rheumatology persisted and indeed increased.

In 1974, I had the opportunity of attending the Pan American Congress of Rheumatology which was held in Toronto. There I met Dr. Tony Russell who I had worked with previously in Taplow, and he told me that they were recruiting for a rheumatologist at the University of Alberta in Edmonton. So, in 1975 I took a year's sabbatical from my position at the University of Bristol. I went to Edmonton for a year and never looked back. Fortunately, I wanted to stay. Fortunately, they were prepared to offer me a permanent position. So that's how I got to Edmonton. And that's where I stayed for the rest of my professional career.

How did rheumatology in Canada evolve over the course of your career and where do you see it heading now?

I think the changes over the years have related to, firstly, a greater understanding of the pathogenesis and the clinical manifestations of rheumatic diseases, and, secondly, our understanding of the pathophysiology has allowed us to become more focused on specific therapies. As an example, when I first went into rheumatology, the treatment for rheumatoid arthritis used high doses of aspirin, other anti-inflammatory medications, occasionally antimalarials, and if you were really bad, gold injectables. If you ask the trainees now, they would laugh at you with this antiquated treatment regime. I think the definition of the different subsets of rheumatic diseases, our understanding of the pathophysiology, and our ability to develop targeted therapies, particularly biologics, have significantly changed the treatment for patients with rheumatic diseases.

You were President of the Canadian Rheumatology Association from 1990-1992 and led the successful process of making the CRA independent of the Royal College. Can you tell us more about why you became involved with the CRA and why making the CRA independent of the Royal College was so important?

I think there were a number of factors that came into play around about the same time. Certainly, the CRA was important, but it wasn't relevant to many practicing rheumatologists, particularly those in the community. When I first joined the CRA, it was really more like an elite club for those people who were working in the academic rheumatic disease units. So, its relevance to community rheumatologists was lacking.

What happened was that the Royal College, mainly due to external pressure, decided that it was important that physicians should be able to demonstrate their continuing commitment to professional development beyond just obtaining their medical degree or some specialty diplomas.

The CRA was one of the first subspecialties to actually participate in the Royal College of Physicians and Surgeons of Canada's Maintenance of Competence program. This program, as you probably know, has developed into the Maintenance of Certification program which is now part of everyday physicians' lives. I think the CRA can have a pat on the back for actually taking the initiative to be part of the development of that program, which was, I must say, a little stressful and was actually at times quite controversial.

So, the spin-off from that was that it was inherent on the CRA to try and develop educational programs that were relevant to rheumatologists to allow them to fulfill the requirements of the Maintenance of Competence/Maintenance of Certification program. We couldn't do that in the existing structure; therefore, it became important for the CRA to take the initiative to develop educational programming that was relevant to all rheumatologists

(academic or community-based) so that they could fulfill these requirements. And again, it was something of a bold step; it wasn't universally accepted originally. But we've continued with it, and of course, it's now continued for many years. But in fact, we established a program, and the basic structure we established then is still being used in the programming today.

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

I think there are a number of issues which face rheumatologists. But they're not unique to rheumatology. I think they probably are relevant to all practicing physicians, whether they're specialists or family doctors. I think the first thing in rheumatology is making sure that we maintain a good lifestyle balance between work and the home. There has been a massive change in terms of manpower. We have a large number, in fact, probably even now a majority of practicing rheumatologists who are women. And we need to respect their needs to balance clinical practice with their home life. I think to some extent that applies also to males in clinical practice. We need to ensure that this balance is maintained because I think maintenance of that balance is reflected in the quality of care that we give to our patients.

I think the second thing is that we need to ensure that we make maximum use of the time that we spend in the office. It's become increasingly apparent to me that physicians are spending huge amounts of time dealing with paperwork, bureaucracy, and this is unremunerated time, but more importantly, this is time that is being taken away from devoting ourselves to patient care. We need to ensure that when we're in the office, we're actually doing what we're specifically trained for, not bogged down by bureaucracy.

And finally, I think it's important to ensure that when we're in the office we are seeing the patients that we are specifically trained to diagnose and treat. There is increasing evidence now that an early diagnosis and early treatment leads to very positive outcomes. We must ensure through whatever mechanism, whether it be through screening processes or some other mechanism, that we get to give priority to those patients that we are particularly trained to treat, which would be patients with inflammatory arthritis and connective tissue diseases. Those are the patients that we can do the most for, and those are the people that we must give priority to; they should not be sitting on a waiting list for 6 months, 9 months, or a year.

What are your proudest accomplishments to date?

It's a difficult question because one doesn't like to blow one's own trumpet. But I actually in reflection, do think I've accomplished something, certainly in my time on the CRA Executive and as CRA President. I think I did significantly influence the development of the CRA, changed its focus, and helped to develop it into what it has become today.

I'm particularly proud of the fact that I, along with Bonnie Thorne of the Arthritis Society (now known as Arthrits Society Canada), co-organized Arthritis 2000. This was a one-off free-standing meeting involving all stakeholders in the rheumatology community. It was held in Ottawa. We had a huge attendance. It was very well received, and as a result of that, there are many other initiatives that evolved from that initial start, which persist today.

I must say I'm also quite proud of the fact that along with John Esdaile, we started the Western Alliance for Rheumatology. This was started off as a one-off meeting. We didn't expect it to go beyond just one meeting. In a couple of weeks, we'll be celebrating our 21st anniversary, and that is a local, regional meeting that has become hugely popular and has been quite a good focus for local rheumatologists, but also for supporting local trainees who subsequently go into rheumatology as a long-time career.

What do you enjoy most about being retired? What have been some of your other passions outside of rheumatology?

Well, although I don't have the chance to do it as much as I used to, travel has always been a passion, and I've been very, very lucky in that over the years, I've had the opportunity to travel both professionally and for personal reasons. I had the opportunity to practice in Zimbabwe and in Kenya, and, I've always had and continue to have a huge love of Africa. I'm not quite sure if I will ever get back there, but certainly that would be on my bucket list. I'm a huge fan of rugby, so I played rugby until I was I think, 40, and I continue to follow International rugby with a passion. And I guess, finally, I'm a collector. I collect toy soldiers, toy trains, English stamps, and I'm very proud of my Canadian art collection, which I enjoy every day.

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

Arthritis Society Canada Invests to Stop Osteoarthritis in Its Infancy

Arthritis Society SOCIETY CANADA

Arthritis Society Canada is partnering with the University of Alberta to scale a revolutionary project to quickly and affordably diagnose and treat developmental dysplasia of the hip (DDH) in infancy.

The Newborn Arthritis Prevention Screening (NAPS) project is led by Dr. Jacob Jaremko, a pediatric musculoskeletal radiologist at the University of Alberta. This digital health innovation uses artificial intelligence (AI) and 3D imaging to capture images of babies' hips, comparing them to thousands of previously-recorded scans to determine — within seconds — if an abnormality exists. These portable devices, currently piloted in places like rural Alberta, can be operated by trained professionals already in communities.

Up to 40 percent of hip osteoarthritis is associated with DDH. Yet DDH that is diagnosed early in infancy can be successfully treated by wearing a soft brace — sparing newborns a lifetime of pain and discomfort.

Arthritis Society Canada is supporting the project's expansion, fundraising with an organizational goal of $5 million and seeking an additional $5 million in funding opportunities from government. This collaborative approach has the potential to save the healthcare system millions of dollars while reducing future cases of osteoarthritis due to undiagnosed and untreated DDH.

Survey Results: Planetary Health

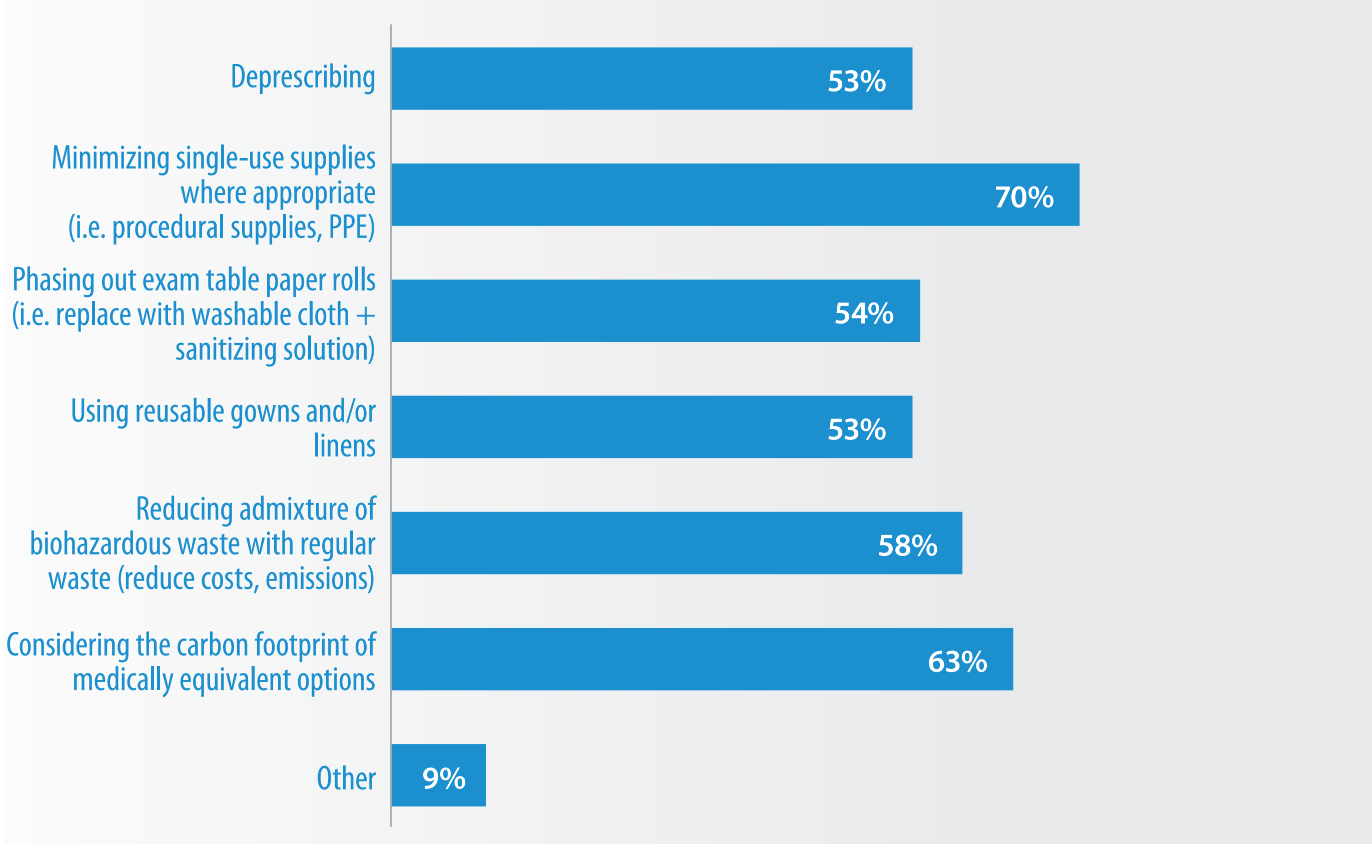
This edition's Joint Count survey focused on Planetary Health and CRA members' perspectives on this topic within the context of the healthcare sector. There were 68 surveys completed, equating to a response rate of 12%.

The first question asked, "Do you think physicians have an influential role to help reduce the carbon footprint of the healthcare sector?" More than half of respondents (56%) replied affirmatively, followed by 35% responding "maybe" and 9% saying "no".

The second query asked about what sorts of actions are taken at the places where rheumatologists work. The most common action appeared to be reusing gowns and/or linens (60%), followed by properly sorting biohazardous vs. non-hazardous waste to reduce biohazardous waste volumes (biohazardous waste requires incineration which has a much higher carbon footprint and disposal costs) (35%).

Some changes to reduce the carbon footprint of rheumatology practices would definitely require physician involvement. The next query asked what actions rheumatologists would be interested in taking. The responses are summarized in the Chart below. However, a couple of those surveyed commented that, while all of these actions would be ideal, there has to be hospital support as these changes cannot be made on one's own.

Chart 1. Some changes to reduce the carbon footprint of rheumatology practices would require the rheumatologist's involvement. Would you be interested in the following:



When asked about what they would be interested in learning more about regarding this topic, approximately 85% of survey respondents would be interested in learning more about how to reduce their carbon footprint and save costs in their medical practices. About half said they would be interested in learning more about the environmental impacts on human health and medical practices, as well as how to influence their hospitals and organizations to reduce emissions.

The Planetary Health Task Force is evaluating these results and is working on building resources for CRA members. For any questions or feedback, please reach out to *info@rheum.ca*.

REGIONAL NEWS

News from the McGill Division of Rheumatology, Montreal

By Arielle Mendel, MD, MSc, FRCPC; and Laeora Berkson, MD, MHPE, FRCPC

Hello from McGill Adult Rheumatology!
We practice across the McGill University Health Centre, the Jewish General Hospital (JGH), and St. Mary's Hospital, providing general and subspecialized rheumatology care, with research that aligns with our clinical programs.

We are training 6 enthusiastic rheumatology residents, and will be welcoming a scleroderma-myositis fellow to the JGH.

Two recruits are completing post-doctoral fellowships, Dr. Alexandra Ladouceur (irAEs), and Dr. Thaisa Cotton (scleroderma, cell therapies). We welcome Dr. Nader Toban to the MUHC (Lachine Hospital), and wish Dr. Murray Baron, Dr. John Di Battista (PhD) and Dr. Carol Yeadon well on their pathways to retirement.

During this past academic year, Dr. Leclair obtained her PhD (Karolinska Institute), Dr. Elizabeth Hazel received her Masters in Management (McGill), and Dr. Évelyne Vinet was honoured with the Department of Medicine Mid-Career Research Award. Dr. Hazel became Director of the MUHC Division of Rheumatology, and we thank Dr. Christian Pineau for his many years in this position. Many thanks to our dedicated team!

Members of the McGill Division at the Laurentian Conference of Rheumatology, May 2024: from left to right, Genevieve Gyger, Elizabeth Hazel, Olga Tsyruk (med student), Reem Farhat (grad student), Valérie Leclair, Marie Hudson, Christian Pineau, Matthew Dabarno (resident), Évelyne Vinet, Leah Flatman (grad student), Michael Catarino (resident), Caitlyn Kanters (resident), Rayleigh Chan (resident), Michele Stanciu (resident), and Nader Toban.

The Adult Rheumatology Department at CHU of Québec – Université Laval is Undergoing a Complete Overhaul

By Laëtitia Michou, MD, PhD

- Our dear colleagues, Dr. Charlotte Grondin and Dr. Claude Marcoux, have taken a well-deserved retirement.
- We have recruited six new rheumatologists with highly specialized expertise in systemic autoimmune rheumatic diseases (SARD), vasculitis, inflammatory arthritis, and patient education.
- Dr. Sonia Lagacé now runs our adult rheumatology residency program.
- We are actively seeking a new career researcher-clinician to join our team.

News from the Pediatric Rheumatology Team at CHU of Québec – Université Laval

By Julie Couture, MD, FRCPC

Pediatric rheumatology in Quebec City continues to grow! Last August, we were delighted to welcome Dr. Justine Turmel-Roy to our team. The fact that we are now four pediatric rheumatologists means we can devote more time to our respective projects: setting up a joint rheumatology, immunology, and genetics clinic; pediatric musculoskeletal ultrasound and the development of a pediatric lupus patient registry; and the upcoming pediatric pain clinic! We continue our involvement in pre-clinical teaching, and teaching of medical students and residents at Laval University, and in our research collaboration.

Our motivated team continues to ensure excellence in care for children in the Quebec City area and throughout the East of Quebec!

The Pediatric Rheumatology Team at the CHU Québec–Université Laval, pictured from left to right: Dr. Julie Couture, Dr. Anne-Laure Chetaille, Dr. Justine Turmel-Roy and Dr. Jean-Philippe Proulx-Gauthier.

BIMZELX® NOW HAS INDICATIONS IN:[1]
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- **axSpA** (axial spondyloarthritis, including ankylosing spondylitis and non-radiographic axial spondyloarthritis)

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- active psoriatic arthritis. BIMZELX can be used alone or in combination with a conventional non-biologic disease-modifying antirheumatic drug (cDMARD) (e.g., methotrexate)
- active ankylosing spondylitis who have responded inadequately or are intolerant to conventional therapy
- active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) who have responded inadequately or are intolerant to nonsteroidal anti-inflammatory drugs (NSAIDs)

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For more information:
Please consult the Product Monograph at ucb-canada.ca/en/bimzelx 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 1-866-709-8444.

* Comparative clinical significance is unknown.

1. BIMZELX Product Monograph. UCB Canada Inc. March 11, 2024. **2.** Data on file, UCB Canada Inc.

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CIMZIA (certolizumab pegol) in combination with MTX is indicated for:

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- reducing signs and symptoms and inhibiting the progression of structural damage as assessed by X-ray, in adult patients with moderately to severely active PsA who have failed one or more DMARDs.

CIMZIA is indicated for:

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- reducing signs and symptoms in adult patients with active AS who have had an inadequate response to conventional therapy.
- the treatment of adults with severe active nr-axSpA 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.
- the treatment of adult patients with moderate to severe PsO who are candidates for systemic therapy.

* Comparative clinical significance unknown.
† Clinical significance unknown.
CRP: C-reactive protein; DMARDs: disease-modifying anti-rheumatic drugs; MRI: magnetic resonance imaging; MTX: methotrexate; NSAIDs: nonsteroidal anti-inflammatory drugs; TNF: tumor necrosis factor alpha.

Consult the product monograph at https://health-products.canada.ca/dpd-bdpp/index-eng.jsp for important information about:

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- Conditions of clinical use, adverse reactions, drug interactions and dosing instructions

The product monograph is also available through Medical Information Services at 1-866-709-8444.

1. CIMZIA® Product Monograph. UCB Canada Inc. November 13, 2019. **2.** Health Canada Notice of Compliance Database. Available at https://health-products.canada.ca/noc-ac/search-recherche.o;jsessionid=C19864F3D26560FC593BFC094A8B0CD1?lang=en. Accessed October 13, 2022.

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