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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Spotlight on:

CRA Committee and Regional Association Reports

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

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Please Don't Let Me Be Misunderstood[1]

By Philip A. Baer, MDCM, FRCPC, FACR

After six years away, I recently returned to a prior role as Chair of the Section on Rheumatology at the Ontario Medical Association. Much has happened during that time, including a pandemic, high inflation, and increases in administrative burden and physician burnout. However, some things never change: as physicians, we are always confronting our single payer, the provincial Ministry of Health, in an effort to maintain and improve the healthcare system, including funding rheumatology services at a reasonable level.

For several years, we have been advocating for a new fee code as an add-on to visits that involve initiating or switching of a biologic (biologic disease modifying antirheumatic drug [bDMARD]) or oral small molecule advanced therapy (targeted synthetic [ts]DMARD). Unfortunately, the bilateral medical association/Ministry of Health committee has consistently indicated it does not support our proposal, stating that "the elements described for this new code are already compensated with existing visit codes. The committee lacks evidence of the provision of care which is not already compensated."

The committee apparently feels that the components of these advanced therapy initiation/switching visits are analogous to standard follow-up visits. Anyone who understands the front lines of rheumatology care must be shaking their head in disbelief. A patient with rheumatoid arthritis who is doing well and coming in for a scheduled every six months follow-up visit is very different from a patient whose disease activity is not controlled, and thus may require the initiation or switching of an advanced therapy.

What is our rationale? When a patient is stable, we might schedule a visit length of 15-20 minutes, whilst knowing that some patients will require longer. This time is absolutely filled with a targeted history, a physical examination including joint counts, the determination of composite disease activity measures incorporating patient questionnaires, review of interim lab work and imaging, and ultimately decisions about future care and appointments. For a well-controlled patient, the visit conclusion may consist of simply refilling their medications, or we might attempt to taper their therapy. On the occasional day when the visit is uncomplicated, there may even be time to deal with all the disease comorbidities rheumatologists feel increasingly responsible for managing, including mood disorders, cardiovascular risk factors, bone health, and immunizations, among others. The patient-facing activities might be completed during the actual appointment time, though it is not uncommon to have to finish documentation tasks after the patient leaves, and sometimes at the end of the day after the office has been completed.

In contrast, we may be faced with a patient who is flaring, potentially requiring the initiation or switching of an advanced therapeutic. The patient may have made an impromptu appointment because of a flare. Many of these patients have to be added at the end of an office or during a lunch break. Alternatively, the patient may not be doing well, but may not recognize that they need a change in therapy. For such a patient who feels that their symptoms are in a "patient acceptable symptom state", the rheumatologist will have work to do to convince them that a change in therapy is needed to prevent joint damage, deformity, disability, and premature mortality.

The time required for these visits is far greater than that normally allotted to a follow-up visit. This puts the physician behind for the rest of the day and adds to the pressure felt in the office. Furthermore, once a decision is made to initiate or switch an advanced therapy in a patient with rheumatoid arthritis, we have more than 20 choices of therapies, counting originator and biosimilar drugs. The decision on which therapy to use is nuanced, and adequate time is required to consider individual patient factors and preferences, employing shared decision-making as much as possible. The patient could take a pill, receive an injection therapy or an infusion therapy. Patient support programs are often involved, requiring enrollment through a lengthy form. As well, all of these therapies remain expensive, ranging from $5,000-$20,000 per year, with public and private payers often demanding additional forms to be filled out for special authorization. Naturally, all of these tasks demand extra time after the visit. Not infrequently, after we mutually decide on a therapy with a patient, we later find out that the patient's insurance does not cover that therapy first-line due to tiering (a major issue with private payers whose criteria are not transparent). This engenders further currently unremunerated work.

Our non-rheumatologist colleagues have told us that they cannot understand how a biologic initiation or switching visit can be equated to a standard follow-up visit. In addition, before starting an advanced therapy, there is a biologic safety checklist which must be completed. Patients may require immunization updates, attention to other risk factors, and informed consent regarding potential adverse events must be documented.

Continued on page 5

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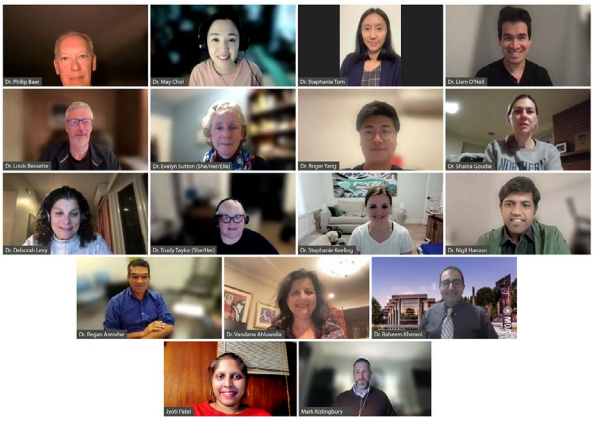

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Please Don't Let Me Be Misunderstood[1]

(continued from page 3)

We are trying to get some traction by analogy to inpatient visit codes. In the past in Ontario, there was a single billing code for all internal medicine inpatient visits for the first five weeks of a patient's admission to hospital. Eventually, it was recognized that there was greater intensity associated with visits on the first day in hospital, the second day in hospital, and the last day in hospital when a patient is discharged. New codes have been added for these days, with a higher value than the standard daily visit fee. This is the same discrepancy that we face when we conduct a biologic initiation/switching visit versus a standard follow-up visit, and we think this should be recognized in the fee schedule.

What is a rheumatologist? Judging from some of the referrals we receive, and the blank look of many lay people when hearing the term "rheumatologist," we are certainly one of the most misunderstood specialties. We need to reassure payers that our intentions are good, and that with proper funding there is no limit to what we can achieve in helping our patients obtain better outcomes. Maybe then rheumatology can be restored to its former status as "the happiest specialty."[2,3]

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

Selected References:
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3. James R. O'Dell, MD. The Happiest Specialty: Rheumatology Is #1! July 2012. Available at *www.the-rheumatologist.org/article/the-happiest-specialty-rheumatology-is-1/*. Accessed November 12, 2024.

Arthritis Society Canada and Creative Destruction Lab Announce Four Innovators Poised to Advance Arthritis Innovations

Ahead of World Arthritis Day on October 12th, Arthritis Society Canada, in partnership with Creative Destruction Lab (CDL), announced four arthritis-focused companies selected to join CDL's world-class program for massively scalable, seed-stage, science- and technology-based companies. They will spend the next nine months developing and bringing their innovations to market to improve the quality of life of people living with arthritis.

The selected innovators are:

1. **Canurta Therapeutics** – a biotechnology company addressing unmet needs in neurodegenerative diseases, including ALS, dementia, rheumatoid and juvenile arthritis, by developing rare botanical drugs.
2. **Interface Biosciences** – using a novel discovery platform that integrates artificial intelligence to develop therapies for autoimmune diseases, including rheumatoid arthritis and cancer.
3. **SereNeuro Therapeutics** – spearheading non-opioid pain therapies for long-term pain relief, using advanced cell and gene therapy for chronic pain, including applications for juvenile arthritis and other types of arthritis.
4. **A new company** (yet to be public) – advancing precision therapeutics targeting the root causes of inflammation in antibody-mediated diseases like rheumatoid and psoriatic arthritis.

These companies, along with 15 other seed-stage ventures, will gain mentorship and resources to launch their innovations. In Spring 2025, Arthritis Society Canada and CDL will celebrate their contributions to the future of arthritis care at an inaugural showcase event.

Learn more about Arthritis Society Canada's leadership in driving innovative solutions at *arthritis.ca*.

Project Athena Update: AI Scribes

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The Canadian Rheumatology Association's (CRA) Project Athena team has been working hard to address the inefficiencies of electronic medical records (EMR) and improve the burden on our members.

The CRA is pleased to announce that rheumatology-optimized AI scribes will soon be offered to members at a discounted rate! AI scribes are a new technology that helps physicians document their encounters without having to type, as the AI scribe transcribes and structures the encounter note.

The CRA, with the guidance of the Informatics Task Force, has vetted and negotiated with two AI scribe vendors for a significant discount, Heidi Health and Scribeberry. Both vendors' technologies are compliant with federal and provincial privacy legislation.

In addition to a discount, these scribes have begun and will continue to optimize their offerings with a rheumatology focus, including templates for rheumatology encounters and disease activity scores. We are also looking into adding a homunculus.

Over the past year, the Informatics Task Force has researched and tested many AI scribes to narrow the options down to the top two.

"Using AI scribes has transformed my practice," says Dr. Vandana Ahluwalia, Informatics Task Force co-chair. "I'm able to focus on the patient's clinical status as opposed to focusing on the computer. The burden of documentation has been eased, as the note is done at the end of each visit, letting me finish the day with a smile!"

Informatics Task Force co-chair Dr. Tommy Gerschman says AI scribes may take some patience and time to get used to, but he highly recommends giving them a try.

"Getting this to work for you takes some configuration, but with rheumatology-focused templates we have tried to make this process as simple as possible," says Dr. Gerschman. "Utilizing an AI scribe has made a positive difference in my administrative work, and I think everyone can benefit from the reduced cognitive burden associated with clinical documentation that AI scribes help provide. The technology will only become better."

Stay tuned for communications from the CRA regarding the two AI scribe offerings. Each scribe comes with a one-month free trial period so members can trial which platform they prefer.

In more Project Athena news, the Digital Quality Improvement Subcommittee has created a "CRA Guide for Developing and Endorsing Quality Measures". This guide has been approved by the CRA Board of Directors and will be available to members.

If you have any questions regarding Project Athena and the ongoing work on EMRs, please contact the CRA at *info@rheum.ca*.

Invest in the Future of Rheumatology: Education and Innovation

As members of the Canadian Rheumatology Association (CRA), you play a vital role in advancing the care and treatment of patients living with rheumatic diseases. The Canadian Rheumatology Association Foundation (CRAF) is proud to partner with you in this mission, supporting critical programs in research, education and advocacy.

The **CRA Education Bursary Program** supports the next generation of rheumatologists. This program provides bursaries to medical students and rheumatology trainees, enabling them to attend the CRA Annual Scientific Meeting (ASM) and Residents' Pre-course. Your donations are directly investing in the education and growth of future leaders in our field, ensuring that patients continue to receive cutting-edge care. These bursaries play a vital role in inspiring many trainees, equipping them with the knowledge and skills to excel in clinical practice and research. Thank you to MitogenDx for establishing the inaugural ASM Resident Registration Bursary for 2025.

The **Summer Studentship Program** sparks interest in the field by providing hands-on clinical or research experience with CRA members. By supporting this program, you are nurturing future rheumatologists and researchers, ensuring that our field remains dynamic and innovative. Many of today's rheumatologists were introduced to the specialty through this initiative.

The **Canadian Initiative for Outcomes in Rheumatology cAre (CIORA)** funds academic and clinical research projects focused on improving outcomes for patients with rheumatic diseases. These projects cover a wide range of critical areas, including optimizing care systems, improving access to rheumatology services and developing innovative treatment approaches. Your support of CIORA advances groundbreaking research that directly benefits patient care.

We are excited by the success of our **Matching Gift Campaigns**, where lead donors, such as Dr. Vandana Ahluwalia, Seema Sharma and Peter Simpson have pledged to match donations to the CRAF up to a predetermined amount. This means donations will go further to support both immediate needs and long-term goals. Whether you are passionate about supporting research into rheumatic diseases or advocating for better care systems, the Matching Gift Campaign allows you to maximize the value of your gift. To learn more about running a similar campaign in your office, contact Chonée Dennis at *cdennis@thedennisgroup.ca*.

CRAF is committed to building a sustainable organization that will drive innovation in rheumatology. We invite you to join us in our mission to alleviate the burden of rheumatic diseases across Canada and make a lasting impact on patient care and the field of rheumatology.

Visit *crafoundation.ca* to learn more about these opportunities and how you can make a difference. Your generosity today will help shape the future of rheumatology for generations to come.

News from the ASM Program Committee

By Marinka Twilt, MD, MScE, PhD

The Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM) Program Committee looks forward to seeing you all at the 2025 CRA Annual Scientific Meeting, this coming February 26 - March 1, 2025. We are looking forward to reconnecting with colleagues and friends in Calgary!

We will celebrate the 79th anniversary of the CRA. This year's meeting theme, "Ascending to New Heights: Peaks of Innovation in Rheumatology", will focus on new innovations and evidence to assist in shared decision making for our patients with rare diseases. We will once again provide unparalleled educational and networking opportunities, centered on a program that will deliver innovative leading-edge science, interactive programming, and insights from Canadian and international experts.

In addition to the Distinguished Investigator lecture, the ASM will feature three keynote addresses: Dr. Muhammad Mamdani from the University of Toronto will present his lecture titled, "Applied Artificial Intelligence in Medicine: Moving from Hype to Reality"; Dr. Micheal Ombrello from the National Institutes of Health (NIH), USA, will discuss "Still's Disease and AOSD Across the Age Spectrum"; and the CRA's own Dr. Dafna Gladman will present the 2025 Dunlop-Dottridge Lecture, "The Road to a New Horizon in Psoriatic Arthritis."

This year's ASM schedule will change slightly from last year; it will start earlier on Wednesday at 1:30 pm with core educational content featured from Wednesday to Friday evening (Wednesday morning prior to the start of the ASM and Saturday morning will be reserved for small group meetings). The meeting will commence on the afternoon of Wednesday February 26th, 2025, with the Year in Review and will end Friday, February 28th, 2024, with the gala dinner and awards ceremony. Each day will offer a full day of educational programming, with adequate time for networking. This year we have expanded the Year in Review presentation to include Pediatrics, in addition to Clinical and Basic Science highlights. Additionally, we are excited to introduce new Abstract Workshops that will feature top abstracts — your opportunity to engage directly with cutting-edge research and participate in lively discussions with leading experts.

The meeting will of course feature all the compelling content you have come to expect from the CRA ASM. We will have poster sessions and poster tours for trainees and investigators to showcase their research activities; State-of-the-Art, paired specialty and crowd-sourced workshops; satellite symposia; as well as favourites such as Mysterious Cases and Clinical Pearls, Controversies in Rheumatology, the Year in Review, *RheumJeopardy* and the Great Debate! This year's debate topic is "Be it Resolved that MSK Point of Care (POC) Ultrasound (US) Should be a mandatory Component of the Rheumatology Curricula". Opportunities to celebrate our award-winning colleagues will be featured throughout the meeting. Satellite meetings include the Residents' Pre-Course and CRA RheumReview Course.

We welcome all CRA and AHPA members, as well as other colleagues within the rheumatology community from across Canada and around the world. We look forward to seeing you all in Calgary and celebrating all our achievements together in February 2025.

Marinka Twilt, MD, MScE, PhD
Pediatric Rheumatologist,
Clinician Scientist,
Alberta Children's Hospital
Professor, Department of Pediatrics,
Cumming School of Medicine,
University of Calgary
Calgary, Alberta

Dr. Dafna Gladman

Dr. Muhammad Mamdani

Dr. Micheal Ombrello

Abstract Review Committee Update

By Mohammed Osman, MD, PhD, FRCPC

Dear Colleagues,

The abstracts have been submitted, and the Canadian Rheumatology Association (CRA) Abstract Review Committee has been working hard, reading and scoring the abstracts, ably supported by Virginia Hopkins (Manager, Innovation & Research). The committee aims to select the abstracts worthy of poster or podium presentations at the 79th CRA Annual Scientific Meeting (ASM). We are excited to see you all in Calgary!

This year, we received 216 abstract submissions. Each abstract will be scored by three reviewers, and the best in each category are chosen based on the average score. The chair will break any tie for a spot on the podium presentations, abstract workshops, and in-person poster tours. Many thanks to all our reviewers for their help and commitment!

There will be in-person podium presentations, poster tours and abstract workshops during which the top-ranked abstracts will be presented. The abstract workshops are new this year and will consist of a main abstract as a mini state-of-the-art lecture followed by three or four mini abstract presentations relevant to the main topic presented in the same session. We will also adjudicate the top five abstracts in each award category during the scheduled abstract workshop, podium, poster tour or poster session for the following awards:

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

We look forward to seeing you all during the in-person 2025 CRA ASM!

Sincerely,

Mohammed Osman, MD, PhD, FRCPC
Chair, CRA Abstract Review Committee
Consultant Rheumatologist and Immunologist
Associate Professor, Department of Medicine
University of Alberta
Edmonton, Alberta

Pediatrics Committee News

By Nadia Luca, MD, FRCPC, MSc

The Canadian Rheumatology Association (CRA) Pediatrics Committee is a diverse and active group of 95 pediatric rheumatologists, trainees and researchers from across Canada. The Pediatrics Executive oversees the work of several subcommittees including Human Resources, Education, and a number of working groups. In February 2024, Dr. Nadia Luca began her two-year term as Chair and Dr. Bobbi Berard stepped into the role of Past-Chair. We welcomed Dr. Lillian Lim to serve as Vice-Chair and CRA board liaison, Dr. Audrea Chen as Secretary and Dr. Mercedes Chan as member-at-large.

The Pediatric subcommittees have been very busy over the last twelve months, offering a variety of educational opportunities in addition to producing manuscripts and guidance materials.

Here is a summary of some of the important work they have completed over the past year:

Drs. Mercedes Chan and Evelyn Rozenblyum at the Canadian Paediatric Society meeting in Vancouver (June 2024).

- The Canadian Autoinflammatory Case Rounds (CANaC) Steering Committee offered two presentations for pediatric members with interactive case presentations by CRA members Drs. Rebeka Stevenson and Marinka Twilt, and invited guests Dr. Jenny Garkaby (immunologist) and Dr. Ashish Marwaha (geneticist).
- The Education Subcommittee offered two accredited National Grand Rounds webinars: "'Hip tips' to avoid the 'cold shoulder' – sport medicine conditions not to miss!" by Drs. Kristin Houghton and Claire Leblanc and "What to Consider After Methotrexate and Mycophenolate Treatment in Localized Scleroderma: Biologics and JAK Inhibitors" by Drs. Kathryn Torok and Suzanne Li.
- Drs. Evelyn Rozenblyum and Mercedes Chan gave a talk on non-articular joint pain and pain syndromes at the Canadian Paediatric Society meeting in Vancouver in June 2024 (see photo).
- The Human Resources subcommittee presented their qualitative study describing models of pediatric rheumatology care across Canada, led by Dr. Molly Dushnicky, as an abstract at the CRA Annual Scientific Meeting (ASM) in Winnipeg. Key themes of importance in care processes include: geographical barriers to care; the value of advanced clinician practitioners in arthritis care (ACPACs); community rheumatologists helping improve access to care; shortages and inconsistencies nationally in allied health resources including social work support and physiotherapists and occupational therapists knowledgeable about rheumatology care; and virtual care. Identification of these themes will lead to future advocacy efforts to improve equity and access to care for pediatric rheumatology patients across Canada.
- The Pediatrics Committee collaborated with the Human Resources Committee to deliver a physician coaching program to CRA members led by ICF-Certified Coach Dr. Kate Baldwin. The themes for these group sessions included: 1) Core values and meaning in work; 2) Self-compassion; and 3) Boundary setting. At completion of the program, 100% of participants indicated they had made (or planned to make) changes to work and/or life habits based on topics discussed in coaching sessions.

Nadia Luca, MD, FRCPC, MSc
Chair, CRA Pediatrics Committee
Associate Professor of Pediatrics,
University of Ottawa
Chief, Division of Dermatology and Rheumatology,
Children's Hospital of Eastern Ontario
Ottawa, Ontario

Update from the CRA Therapeutics Committee

By Alison Kydd, MD, PhD, FRCPC

The Canadian Rheumatology Association (CRA) Therapeutics Committee has been busy over the past year. We have many new members and have been working on new position statements and initiatives for the CRA. Some of the highlights over the past year include the following:

- Ongoing work on several different drug shortage issues along with the External Relations Committee
- Implementation of a review process for Canada's Drug Agency clinician input applications for submission by the CRA with the completion of several CADTH reviews by Canada's Drug Agency
- Development of a Therapeutics Access review summary to provide the basis for advocacy for medication access in different jurisdictions
- Position statement on phosphodiesterase type 5 (PDE5) inhibitors for the treatment of severe Raynaud's phenomenon
- Position statement on biologic access
- Updated position statement on the safety of hydroxychloroquine in the treatment of rheumatic diseases

Monitoring drug shortages and advocating for CRA members and their patients are always our top priorities. We will continue to respond to emerging issues on behalf of our members through position statements.

This work is only possible through the dedication of our volunteer committee members, who are all very busy with their numerous other roles. I would particularly like to thank my new Vice-Chair, Dr. Cathy Flanagan, who will bring her expertise in therapeutics to our committee. We have had several new members join our committee who are highly committed and efficient. I am always impressed with our committee members' timely responses and expert guidance. Finally, our work would not be possible without Sarah Webster, a CRA staff member, who is critical to our ongoing functioning.

Alison Kydd, MD, PhD, FRCPC
Chair, CRA Therapeutics Committee
Clinical Associate Professor, Rheumatology
University of British Columbia
Nanaimo, British Columbia

News from the Education Committee

By Beth Hazel, OLY, MDCM, FRCPC, MM

In 2024, the Canadian Rheumatology Association (CRA) Education Committee's major focus has been on starting the process of restructuring in order to further enhance collaboration between committees. We are striving to ensure that the CRA educational offerings respond to our members' needs, both perceived and unperceived, and provide educational opportunities in different formats and throughout the year. We are working on offering a full slate of educational events without redundancy in content. Our goal is to support educational initiatives that will help steer potential, trainee, and current members towards engagement with the CRA as their premier education resource.

Members of the CRA Education Committee at the 2024 ASM. From left to right (top row): Steven Thomson, Nicole Johnson, Cristina Moran-Toro, Liane Heale, Marie Clements-Baker, Trudy Taylor, Elizabeth Hazel, and Megan Himmel; (bottom row): Claire LeBlanc, Raheem Kherani, Ahmad Zbib, Claire McGowan, and Lori Albert.

Our first step has been to review resident programming. While the CRA offers a wide array of resident programs and events, this has historically been facilitated by three different groups, the Residents' Pre-Course and National Rheumatology Resident's Curriculum (NRRC) Program Committees and the National Written Rheumatology In-Training Exam (NWRITE) Sub-Committee. This year we have improved collaboration between the groups to better align goals and enhance the coordination of resident offerings, and have made some significant changes to programming including the following:

- NWRITE exam is now administered online
- Residents' Pre-Course Day 1 will be moved to January 2025 (earlier scheduling)
- National virtual Objective Structured Clinical Examination (OSCE) will be moved to April 2025 (between written & oral exams)
- Fall resident event will be a social event exclusively prior to Canada Night and the spring resident event has been discontinued

To assist with content planning, this year we have also sought feedback from program directors regarding their required training experiences. Going forward, we plan to amalgamate all resident programming groups into a single program committee (new name forthcoming) so that we may optimize content planning, scheduling and operational efficiencies to provide a comprehensive and cohesive curriculum.

Our other sub-committees have continued with exciting projects. The Undergraduate Sub-Committee is working on developing educational resources for rheumatology educators, medical students, and pediatrics/internal medicine residents. The Postgraduate Sub-Committee continues to review and populate residency training resources in our CRA portal. They are reaching their goals regarding the development of a national immunology curriculum, through a multidisciplinary national collaborative process. The Continuing Professional Development (CPD) Sub-Committee continues to be engaged in many internal and external accreditation requests and the CRA LEAdership Program (LEAP) welcomed a new cohort to the 2024-2026 program.

The Education Committee is proud to support medical education initiatives throughout the career of a rheumatologist. We are committed to answering our members' educational needs and are looking at ways beyond the traditional needs assessment to better identify high yield education projects and offerings. Our goal is to support educational initiatives that will help steer potential, trainee, and current members towards engagement with the CRA, as their premier education resource.

Elizabeth M. Hazel, OLY, MDCM, FRCPC, MM
Chair, CRA Education Committee
Division Director, Rheumatology,
McGill University Health Centre
Assistant Dean, PGME, CBME
Associate Professor of Medicine,
Division of Rheumatology, McGill University
Montreal, Quebec

Highlights of the Year from the Equity, Diversity and Inclusion Task Force

By Nicole Johnson, MD, FRCPC

The Equity, Diversity and Inclusion (EDI) Task Force continues to work with the Canadian Rheumatology Association (CRA) CEO and Board to enhance inclusivity within the CRA.

This year we have begun meetings with our committee chairs to identify areas of collaboration between the committees and the Task Force to incorporate EDI into our daily work. We have seen the positive impact of these conversations, with EDI principles interwoven into the scientific program of the Annual Scientific Meeting (ASM) and planning contracts for the annual meeting. With the support of our EDI consultant Amorell Saunders N'Daw, the review of the employee handbook from an EDI lens has been completed and recommendations are in the implementation stage. At the last annual scientific meeting, the Task Force presented an engaging workshop on "Cross-Cultural Communication: Embracing the Diversity of your Rheumatology Patients."

Members of the CRA EDI Task Force (from left to right): Amorell Saunders N'Daw, Dr. Susan Humphrey-Murto, Dr. Alan Zhou, Dr. Nicole Johnson, and Erin Stewart.

The CRA EDI Special Project, sponsored through an unrestricted grant from Pfizer Canada, has produced three webinar series on healthcare inequities in rheumatology. The first of our engaging speakers was Dr. Grace Wright, President of the Association of Women in Rheumatology (AWIR), introducing principles of EDI in rheumatology. The second speaker was Dr. Lynden (Lindsay) Crowshoe, a Blackfoot primary care physician and researcher, who spoke on health equity action for Indigenous, First Nations and Inuit communities. The third speaker, Dr. Katherine Smart, a pediatrician in Whitehorse and a past-president of the Canadian Medical Association, addressed health equity considerations for rural and remote communities. The recordings of these presentations are still accessible through the members' portal of the CRA website and are accredited for MOC credits. There will be infographics developed for knowledge translation on the actionable steps from these webinars.

The EDI Special Project collaborated with Dr. Cheryl Barnabe and her CIORA research team to facilitate French translation of a free online educational resource on health equity in rheumatology, which has been launched on the University of Calgary website, *ecme.ucalgary.ca/programs/equity-in-rheumatology-care/*. CRA members and Arthritis Health Professions Association (AHPA) members have exclusive access for which the login information is accessible in the members' portal of the CRA.

At this year's Annual Scientific Meeting keep an eye out for the inaugural award for Best Abstract on Equity, Diversity and Inclusion. The award will highlight the abstract's relevance to equity, diversity and inclusion, inclusive study design and diverse representation in study populations, evidence of cultural humility and impact on equity.

Our next steps for the Task force will be to continue enhancing our advisory role to the CEO and board. The Equity Corner in the President's newsletter will continue to highlight EDI activity and resources. A report of the Task Force's progress has been produced for the CRA CEO and board to review. We will survey the CRA membership on their views on future desired EDI action for the organization, and move us towards an EDI road map for the future.

Nicole Johnson, MD, FRCPC
Pediatric Rheumatologist, Clinical Associate Professor, University of Calgary
Chair, Equity, Diversity and Inclusion Task Force, CRA
Calgary, Alberta

Engaging Young People with Arthritis in Physical Activity: Harnessing the Power of a Social Media-Based Intervention

By Sabrina Cavallo, O.T., Ph.D.

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

Over the last ten years our team has been investigating the patterns of physical activity and related determinants among young people living with juvenile idiopathic arthritis (JIA). Based on our earlier findings, it was apparent that the intensity and frequency levels of physical activity for persons living with JIA were below those recommended by national guidelines and were consistently lower compared to peers without arthritis. Contextual barriers to engagement in regular physical activity included limited access to activities tailored to their specific needs; lack of knowledge about the long-term impact on their health; lack of social support; and out-of-pocket expenses for registration and travel for community-based activities. The benefits of taking part in an active lifestyle are numerous and well documented. However, for many living with JIA, opportunities remain limited and resources scarce. Considering this, our team decided to explore other means of delivering the knowledge and the support needed to promote physical activity among this group.

Preliminary acceptability data highlighted the pertinence of a social media-based intervention that is interactive, informative, accessible and esthetically appealing to help promote active behaviour. Encouraged to pursue the development of our proposed intervention, JIActiv, we turned our attention to testing its usability. With funding from the Canadian Initiative for Outcomes in Rheumatology cAre (CIORA), we conducted semi-structured interviews with young people living with JIA to garner information on their level of satisfaction with the proposed intervention, as well as its ease of use. We also interviewed rehabilitation professionals to explore the implementation of JIActiv in clinical settings.

For young people, we learned that participating in a social media-based intervention like JIActiv was influenced by the quality of the content, user-friendly navigation, appealing visual design, a well-structured intervention, as well as peer interactions and the chance to learn through group-based activities. The quality and the credibility of the information was essential to program adherence. Social support and guidance from peers, family members and health care professionals were important motivators to participation. Using a preferred social media site, in this case Instagram, facilitated user performance, as features were known to participants.

For rehabilitation professionals, JIActiv was compatible with clinical treatment goals aimed at promoting and empowering young people with JIA and might be of aid during the transition from pediatric to adult care. Furthermore, the interactive nature and accessibility of the intervention were appealing to professionals, as they recognised the potential impact on health outcomes. Nonetheless, successful implementation of such an intervention is dependent on institutional resources (time and material), as well as professionals' workload and ease with digital resources.

Social media-based interventions, such as JIActiv, may offer supplementary resources to complement clinical care provision, as well as new avenues for delivering knowledge and support to promote health in JIA.

Sabrina Cavallo, O.T., Ph.D.
Associate Professor, School of Rehabilitation
Faculty of Medicine, University of Montreal
Montreal, Quebec

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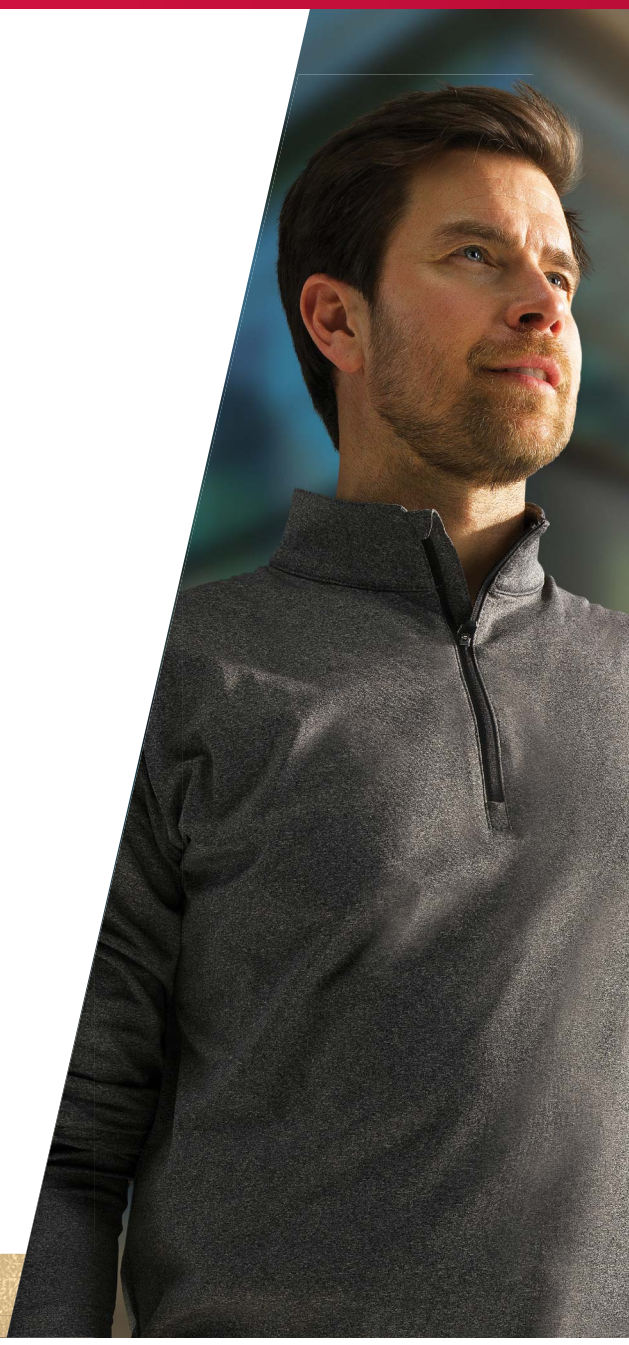

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B.C. Society of Rheumatologists (BCSR) – Update from the Pacific

By Jason Kur, MD, FRCPC

2024 was a year for growth and change in British Columbia (BC) Rheumatology. Our society continues to build momentum and lead system change.

As it stands, we are nearing 100 practicing rheumatologists in the province. This number is still not enough to meet the demands of the population, but a significant improvement from the 54 rheumatologists (32 full-time equivalents) that were documented in 2010. Like many specialities, we struggle with disparities in access to rheumatology care based on geography. However, there has been support and innovation from the University of British Columbia (UBC) Division of Rheumatology. Rheumatology trainees will now experience rotations in either Nanaimo or Kelowna, in a renewed effort to expose more trainees to different regions of the province and practice environments, not to mention different beaches and skiing.

Politically, BC has been a hotbed of activity. In October we had a nailbiter provincial election that seems to have returned the NDP government to office pending recounts. Why is this important? The Doctors of BC is beginning to renegotiate the Physician Master Agreement, with messaging directed to a renewed focus on specialist issues. After the implementation of the longitudinal family practice payment model, specialist sentiment for change is on the rise; access to specialty care and specialist issues must be a major focus of negotiations and system change.

BC rheumatology has been an early adopter of specialty change. After a 14-year journey starting in 2010, when we applied for disparity funding for a nursing team model of care, a complex time-based fee code, and our immunosuppressant review tool, the BCSR was elated to report that the provisional status of our fee codes has been removed. After years of painstaking monitoring and review, these codes have been incorporated into the general fee guide. This gives rheumatologists more certainty in their practice decisions and also aids with reciprocal billing for patients from the Yukon and Alberta, many of whom seek specialty care in BC due to geographic proximity.

From left to right: Drs. James Yeung, Raheem Kherani, Annie Colwill, Kam Shojania and Mo Bardi.

In addition to the annual Western Alliance of Rheumatology meeting hosted in Kelowna in spring, the 19th annual British Columbia Rheumatology Invitational Education Series (BRIESE) conference took place in September in Vancouver. We had another successful year with enriched learnings from Dr. Atul Deodhar (Oregon), Dr. Sarah Hansen (UBC), Dr. Angela Hu (UBC), and Dr. Hani El-Gabalawy (Manitoba). The conference also included an ultrasound program and the return of an allied health component for nurses.

At the BRIESE gala, we took the opportunity to praise some of our finest with the Annual BCSR/UBC Award presentations. The Innovation Award was jointly awarded to Dr. Raheem B. Kherani and Dr. James Yeung. Drs. Kherani and Yeung have been integral in the creation and support of a fracture liaison service at Richmond General Hospital (one of the few such programs in BC). They have been vocal members of the BC Coalition of Osteoporosis Physicians that has been organizing to improve access to osteoporosis care and treatment. In a short time, they have had a large impact both locally and provincially on these cross-specialty initiatives. Dr. Mo Bardi was awarded the UBC BCSR Teaching Award for outstanding contributions to the medical training program. Dr. Bardi has been an early Canadian leader in rheumatology ultrasound and has been eagerly transmitting that knowledge to the next waves of learners. Finally, Dr. Kam Shojania received the Advocacy Award. His work as a BC rheumatologist leader has been unparalleled and has included time as Program Director, UBC Rheumatology Division Head, and as an advocate for specialist clinics, including the joint rheumatology/dermatology DART clinic at St Paul's Hospital. Our rheumatology community has greatly benefited from his inclusive vision.

Once again, in this time of reflection, we want to honour the contributions of other pillars of the BC rheumatology community who retired recently. Dr. Jackie Stewart of Penticton and Dr. Nancy Hudson from Kamloops are recent retirees. They both have skillfully cared for patients in the BC Interior, and their impact on care will be hard to replicate.

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

News from the ORA

By Deborah Levy, MD, MS, FRCPC

Rheumatologists, ACPACs, and ASC representatives at the Northern Ontario Committee meeting in Thunder Bay in October 2024.

Greetings from the Ontario Rheumatology Association (ORA)! I am pleased to report that we remain an active and engaged organization, with multiple successes over the past year. As a pediatric rheumatologist, I appreciate that every family member has a role in the health of the (affected) child. Likewise, engagement of the entire ORA family, including the Executive, Board of Directors, Committee Chairs and all ORA members, fuels the success of our initiatives and events. Together we are committed to improving rheumatology care across Ontario as well as nationally through our important partnerships.

A few highlights:

The Annual Scientific Meeting (ASM) at the Kingbridge Centre just north of Toronto in May 2024 was a great success, with the highest attendance on record. We held a well-received Resident's Day and Objective Structured Clinical Examination (OSCE) event, followed by our state-of-the art meeting featuring international speakers including Dr. Désirée van der Heijde, Dr. Robert Landewé and Dr. Jeff Sparks, alongside Dr. Janet Pope and several "local", yet internationally renowned rheumatologists. We are already looking forward to the 2025 ASM scheduled for May 23-25. This is open to all rheumatologists, so please mark your calendars. Details will be available in the new year.

The Informatics Committee, chaired by Dr. Tom Appleton, continues to make exciting progress. RheumView™, the ORA's digital health solution, has launched and many Ontario rheumatologists are onboarded and using this intuitive interface every day in their offices. RheumView™ is fully designed, developed, owned, and supported by the ORA. Early adopters have been impressed by the ease of use, allowing both improved efficiency for individual patient care, and the ability to visualize their performance on important quality indicators in their practice and compare it to the wider provincial cohort. Ongoing development will allow wider implementation in community-based rheumatology practices, in addition to integrations across different platforms.

We continue to build relationships with the Ontario Ministry of Health and with private payers. Dr. Jane Purvis and the Government Affairs Committee have frequent communications with the government and our members regarding issues such as the biosimilar transition, public funding of specialized laboratory testing (e.g. anti-CCP, ANCA, myositis antibodies), unifying reimbursement criteria, and ensuring that we minimize the administrative burden of fulfilling complex criteria for recently funded biologics.

The Northern Ontario Committee, chaired by Dr. Sahil Koppikar, Chandra Farrer and new co-chair Dr. Kamran Shaikh, has seen the completion of training of two (of several planned) Advanced Clinician Practitioners in Arthritis Care (ACPACs). A recent successful meeting of rheumatology, ACPAC and Arthritis Society of Canada participants took place in Thunder Bay. This was an opportunity to develop a plan for further expansion of the pediatric and adult rheumatology models of care in this large, underserviced area. Ongoing work with the Ontario government has provided support for the necessary training and implementation of the model in Thunder Bay and other regional hubs in northern Ontario.

The Early Rheumatologists of Ontario (ERO) committee continues to host innovative virtual workshops and interactive sessions for all ORA members. Turnout has been impressive at sessions covering important topics such as Financial Wellness, Parental Leave, Employment Law 101, and Productivity and Efficiency. The committee is already planning new and timely offerings for 2025.

I certainly can't write a summary without mentioning the Pediatric Committee, a new and active group that has taken on a province-wide collaborative project. Together, the four academic pediatric rheumatology centers (London, Hamilton, Toronto, and Ottawa) will merge data to characterize current access to care measures in Ontario. They will identify several quality indicators including timely assessment by a pediatric rheumatologist.

These are just a sampling of our new and ongoing initiatives. Importantly, all of these events and projects would not be possible without the countless volunteer hours of our dedicated leadership team and ORA members. I am also incredibly grateful for our fantastic Executive Director Sandy Kennedy for her dedication to ensuring our ongoing success.

All the best for the coming year!

Deborah Levy, MD, MS, FRCPC
President, ORA
Pediatric Rheumatologist
Toronto, Ontario

From ARMS to SOAR 1984-2024!

By Evelyn D. Sutton, MD, FRCPC

Drs. Ken McCarthy and Jamie Henderson, founding members, flank Dr. Hani El-Gabalawy who joined in 1985.

On January 16, 1984, Dr. Jack Woodbury sent a letter to the "Atlantic Province Rheumatologists" summarizing the "ten written replies to the questions which I had put to you. In addition, John and Edith Verrier Jones have replied orally." The replies indicated "a unanimous opinion that meetings of the group be held." He then summarized feedback about venue, content, invited speakers, whether spouses should be invited or not, and who should organize the meeting. "Eight people thought that I should organize the first meeting, one thought that my wife should help me, and three felt that a small committee should do the organizing." (I will refrain from making a comment about the suggestion that Jack's wife should help!)

And so, it began. Jack organized the first meeting in Halifax. The constitution of the Society was discussed and adopted, an executive was elected and it was agreed that the 1985 meeting be in Saint John, New Brunswick (NB), and in 1986 in St. John's, Newfoundland (Nfld). The group (Drs. Tom Edgett, Moncton, NB, David Hawkins, St. John's, Nfld, Edith Jones, John Verrier Jones, Siraj Ahmed, Jack Woodbury, and Joanne Marsh of Halifax, NS, Virender Khanna and Henrik Tonning, of Saint John, NB, and Jamie Henderson, Fredericton) agreed on the objectives of the society:

1. To improve the care of patients with rheumatic diseases
2. To share information concerning facilities, procedures and personnel available in the Atlantic Provinces of Canada
3. To provide opportunities to participate jointly in medical investigations
4. To provide a forum for scientific exchange
5. To provide opportunities for discussion of mutual problems and shared educational programmes
6. To become a voice speaking for rheumatology on behalf of the Atlantic Community

Forty years later, the current members of the Society of Atlantic Rheumatologists (SOAR) are very grateful to the founders. The meeting has stayed true to its objectives. Some changes have occurred: families, not just spouses are invited, hospital meeting rooms gave way to hotel conference rooms, and two guest speakers are invited to present. Instead of the meeting running all day Saturday, the medical education is now split over Saturday and Sunday mornings, leaving time for golf competition or other recreational activities on Saturday afternoon. Saturday evening continues to be reserved for the group to dine together.

A veritable Who's Who of rheumatology greats have accepted invitations to share their knowledge and time at SOAR, starting with Dr. Watson Buchanan as the inaugural invitee. This year, two rising stars in Canadian rheumatology, Drs. Tom Appleton and Hugues Allard-Chamard, were our guests, and we were delighted that former SOAR members traveled the country to join us — Drs. Dianne Mosher from Calgary and Hani El-Gabalawy from Winnipeg.

ARMS? The original name proposed was **A**tlantic **R**heumatology **M**usculoskeletal **S**ociety. I think we all will agree that SOAR is more appropriate, although the homonym "sore" is what many hear, which arguably is also apt given the nature of rheumatic diseases!

Evelyn D. Sutton, MD, FRCPC
Associate Dean Undergraduate Medicine
Professor of Medicine, Dalhousie University
Halifax, Nova Scotia

AMRQ in Negotiations: Strengthening Rheumatology in Quebec and Preparing for the Future of Specialized Care

By Hugues Allard-Chamard, MD, PhD, FRCPC

The *Association des médecins rhumatologues du Québec (AMRQ)* and the *Fédération des médecins spécialistes du Québec (FMSQ)* are now entering a crucial phase of negotiations with provincial authorities, including discussions regarding fees for rheumatologists. Our goal is to ensure that the government commits to providing the necessary technical platforms to enable rheumatologists to realize their full potential and deliver quality care to our patients. In addition, we are pressing for the introduction of an arbitration clause to negotiate working conditions in the event of a conflict, ensuring fair and transparent processes for our members.

These negotiations, though complex, represent a decisive step towards improving the quality of rheumatology care in Quebec. We remain confident that our collective efforts will lead to significant results for the rheumatology community.

Following our annual meeting, we are pleased to announce that Dr. Josiane Bourré-Tessier has been awarded the AMRQ Merit Scholarship in recognition of her outstanding contributions to rheumatology. This distinction underscores Dr. Bourré-Tessier's commitment to advancing our discipline.

We are also pleased to inform you that the AMRQ now has a dynamic new Board of Directors, ready to work enthusiastically to meet current challenges and promote the advancement of our specialty. The Board will focus on improving access to care, promoting collaboration between professionals, and advancing research.

As we look back, I would like to express my sincere gratitude to Dr. Frédéric Morin, our outgoing president, for his outstanding leadership and unwavering dedication to the AMRQ. Under his leadership, we have established a solid foundation to face the challenges and seize the opportunities ahead.

As we look ahead, we are confident that many of the projects initiated will come to life during my term in office. The AMRQ looks forward to the support and collaboration of its members as we strive to improve rheumatology care across Quebec. Together, we can make significant progress in our mission to provide the highest quality of care.

Hugues Allard-Chamard, MD, PhD, FRCPC
President, AMRQ

Joint Count Survey Results: How Do We Like To Learn?

By Beth Hazel, OLY, MDCM, FRCPC, MM

The mandate of the Education Committee at the Canadian Rheumatology Association (CRA) is to respond to the continuing professional development needs of our members. The COVID pandemic helped to expose all of us to virtual learning opportunities, and we were curious about how this has changed our members' preferences about learning.

Our Joint Count survey was answered by 71 CRA members. University-based rheumatologists were overrepresented at 52%, but all career stages were well represented. We asked respondents to rank their three preferred methods of learning. In-person conferences were preferred by almost 75%. Case-based discussions, rounds, and reading journals and textbooks were the next most popular at 39%, 35% and 35%, respectively.

Interestingly, more than half of respondents did not feel that their preferences had changed since the COVID pandemic, but members commented that they were more open to online options and that they saw advantages to virtual learning including saving time and money. A few comments reflected a feeling that it seems more difficult to prioritize learning activities due to a busier and more stressful work/life balance.

Indeed, members do value the networking and social interactions that in-person learning activities offer. See you all in Calgary, at the CRA ASM!

Elizabeth M. Hazel, OLY, MDCM, FRCPC, MM
Chair, CRA Education Committee
Division Director, Rheumatology,
McGill University Health Centre
Assistant Dean, PGME, CBME
Associate Professor of Medicine,
Division of Rheumatology, McGill University
Montreal, Quebec

The Mini-Practice Audit Model (mPAM): A Practical Guide to Analyzing and Applying the Data

By Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE; Elizabeth M. Wooster, M.Ed, PhD(c); and Douglas L. Wooster, MD, FRCSC, FACS, DFSVS, FSVU, RVT, RPVI

"I remember at the 2020 CRA Annual Scientific Meeting (ASM) in Victoria, just before the pandemic, we were all together and some of us went to the workshop on mini-Practice Audit Models (mPAM)," remarked Dr. AKI Joint, a rheumatologist member of the Canadian Rheumatology Association (CRA). I have data from my first analysis. It seemed easy then, but with so much that has gone on since the pandemic ended, I think I need a reminder. Maybe I'll need to contact the CRA staff at *info@rheum.ca* to ask how I can get into the Member Portal to view the workshop slides from that specific workshop."

The cycle of audit, analysis, education/intervention, application, re-audit and re-application used in the mPAM can be used for personal improvement or in a group strategy. Let us go back to the example with the 2018 systemic lupus erythematosus (SLE) Guidelines and cardiovascular risk assessment (Box 1).

Figure 1 outlines the process of the mPAM cycle to collect the first and subsequent sets of data. By using a 1-5 Likert scale, we can assess our answers to the questions with 10-15 charts for the audit.

Following the initial audit (Figure 2), we can reflect and review opportunities for improvement. The grey cells show that there are opportunities to improve (scores below 3 out of 5) in diabetes, dyslipidemia and obesity identification.

In addition to educational resources in these clinical areas and understanding the reasons to refer the patient back to the primary care provider for cardiovascular risk factor management, we can take the opportunity to review resources in documentation and record keeping *(www.cmpa-acpm.ca/en/education-events/good-practices/physician-patient/documen-*

Box 1.

CV risk assessment from SLE Guidelines

For adults with SLE, we recommend that indicators of obesity, smoking, arterial hypertension, diabetes, and dyslipidemia be measured upon diagnosis of SLE, be reassessed periodically according to current recommendations in the general population, and be used to inform the CV risk assessment.

Figure 1.

mPAM Quality Improvement Cycle

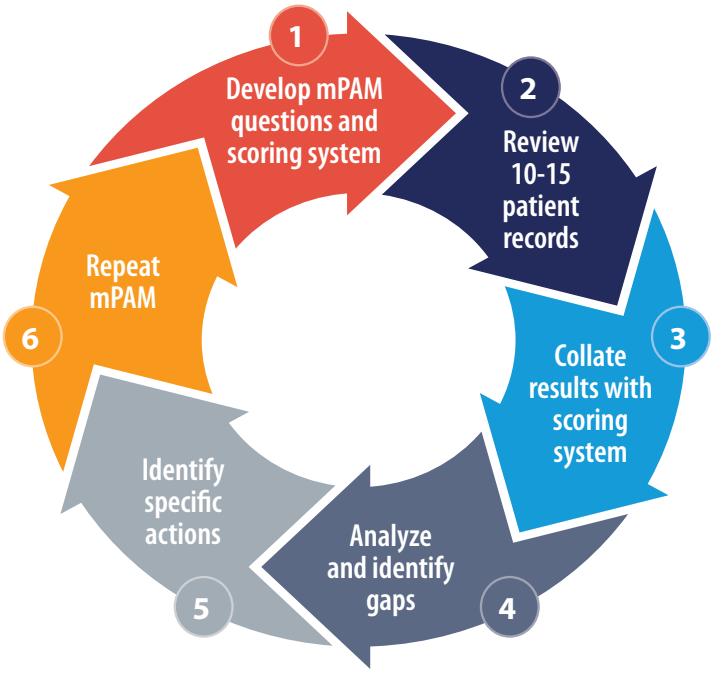

Figure 2.

mPAM Risk Factors for Patients with SLE Followed for at Least One Year

	Upon diagnosis	At start of therapy	Year 2
Obesity	3.7	2.9	2.8
Smoking	4.2	4	3.6
Hypertension	3.4	4.6	3
Diabetes	2.8	3.2	4
Dyslipidemia	1.9	2.6	4.1

Gaps are those identified by the grey cells. These cells represent the results that fall below the designated cutoff of 60% or 3 out of 5 on a Likert scale. These gaps should be addressed with educational and system interventions within the individual's practice.

Figure 3.

mPAM Risk Factors for Patients with SLE Followed for at Least One Year (re-audit)

	Upon diagnosis	At start of therapy	Year 2
Obesity	3.4	3.0	3.2
Diabetes	3.2	3.6	4.1
Dyslipidemia	2.4	2.8	3.2

Areas reviewed in re-audit include areas where there were opportunities to improve. The grey cells show continued areas for improvement.

tation-and-record-keeping and *www.cmpa-acpm.ca/en/education-events/teaching-resources/physician-patient/documentation--principles-of-medical-record-keeping)*. The mPAM highlights that if we did not document this information, it did not happen.

In three to six months, we can re-audit (Figure 3) and review the areas that need improvement. By carrying out these re-audits, we can continue to enhance our practice and expand to look at other areas that may benefit from this type of positive impact.

"The mPAM is practical and possible for me to do…" says Dr. AKI Joint. "I continue to apply these changes I have learned by my focused re-audits and continue to improve my patient care (and receive MOC Section 3 credits)."

The authors' full affiliations are available online at craj.ca.

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Patient-Doctor Perspective
A Journey of Dedication, Resilience and Triumph

By Muhammad Asim Khan, MD, FRCP, MACP, MACR

I was born in 1944 into an educated middle-class family. However, only three years later, we were forced to relinquish the life we once knew, uprooted from our ancestral lands, never to return. The loss was further deepened by the death of my toddler brother from gastroenteritis. The persistent plight of an ever-increasing number of dispossessed, desperate, and defenseless refugees, mirroring my own fate and faith, continues to weigh heavily on my heart.[1]

I have suffered from ankylosing spondylitis (AS) since the age of 12, with a diagnosis delayed by six years. Initially, I was under the care of an orthopedist who suspected tuberculosis and treated me with triple therapy: isoniazid, para-aminosalicylic acid, and streptomycin, the antibiotic, which I self-injected intramuscularly every day for a year. When no clinical benefits were observed, he administered intravenous injections of honey, imported from West Germany. That also did not help but it made me ever so sweet, as that honey must still be running in my veins.[1]

I aspired to excel in my studies and obtained admission to the nation's oldest and premier medical college at age 16, and ranked first in both anatomy and physiology in the initial examination two years after admission.[1] During the start of my clinical rotations, I discussed my symptoms with my professor, who correctly diagnosed my illness and prescribed phenylbutazone, which proved to be very effective.

I graduated in 1965 at 21 years of age, and in September of that year my country was attacked by a neighbouring nation. I voluntarily enlisted in the Army Medical Corps, driven by my zeal to serve the nation that had accepted me as a three-year-old refugee and invested in my education. In my eagerness to serve, I did not reveal my illness.

In 1967, I left the army as a Captain and flew to England for postgraduate training. Two years later, I moved to the United States, where I have had a very fulfilling academic career as a rheumatologist, despite facing many health challenges. I have undergone bilateral total hip arthroplasties and three subsequent surgical revisions. Unfortunately, the very last revision was a disaster, leaving me reliant on a walker and an almost three-inch thick sole on my left shoe.

More than four decades ago, I suffered a neck fracture that failed to heal despite five months of immobilization with a halo device screwed into my skull and attached to a vest encircling my chest. When this method proved unsuccessful, surgical fusion was performed, but I had to continue wearing the halo and the vest for an additional three months. I continued to care for my patients for all of those eight months. Just imagine driving to work and trying to sleep at night leaning back on a chair with that hardware around your head! One day, a new patient came to see me. After our initial handshake, his face turned pale. I immediately had him lie down on the examination table. Once he felt better, he started laughing and said, "Doc, I had been hurting and waiting to see you for two weeks, but with one look at you all my pains are gone!"

I had developed hypertension and coronary artery disease at an early age, and in 1998, I underwent coronary angioplasty with stent placement. The associated anticoagulant therapy caused painless hematuria that led to the discovery of a renal-cell carcinoma for which I underwent radical nephrectomy, and subsequently faced the added uncertainty that a cancer patient has to live with.

More than a decade ago, I was diagnosed with hypothyroidism secondary to pituitary macroadenoma. I consulted several renowned neurosurgeons, but they were reluctant to perform the surgery because of the total immobility of my neck. Determined to proceed, I finally convinced one of them to take the surgical risk by suggesting a pre-operative tracheostomy for intubation to facilitate general anesthesia and provide easier trans-nasopharyngeal access. The surgery was successful although I now require pituitary hormones replacement. Additionally, I have chosen to keep the tracheostomy tube to facilitate any future emergency intubation.

My medical challenges have since expanded to include tophaceous gout, asthma, and severe obstructive sleep apnea, which necessitates the use of a BiPAP ma-

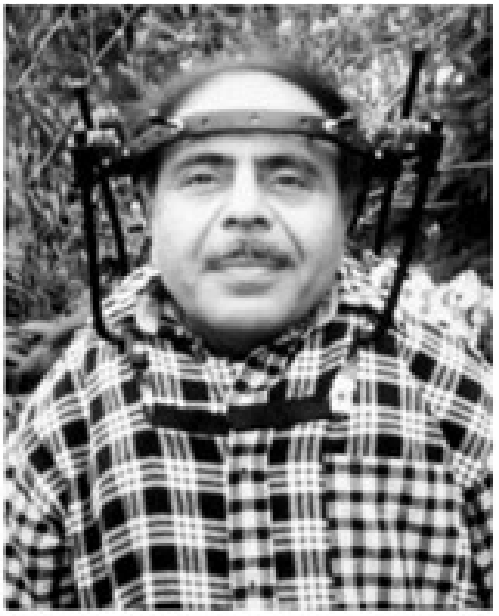


Figure 1. My picture wearing a halo screwed into my skull was taken in 1983. I have republished it with the permission of Blackwell Publishing from *MA Khan. Spondyloarthropathies,. In: Hunder G, ed. Atlas of Rheumatology, Oxford, UK, Blackwell Science; 1998:5.1-24*.

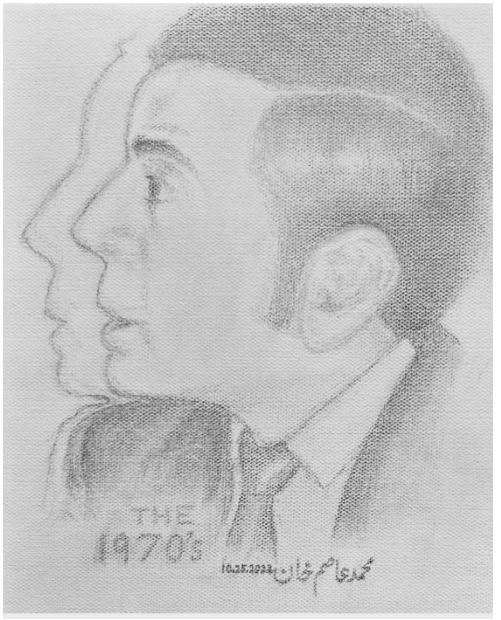


Figure 2.
My self portrait drawn with carbon pencils; this is how I looked presenting my scientific abstract at the Annual Scientific meeting of the ARA (now called ACR) in the early 1970s. Please note the long sideburns that were fashionable in those days.

chine to sleep. I also wear a cardiac pacemaker. On June 7, 2022, I walked into a hospital at 7:30 am using my three-wheeled walker and walked out at 7:30 pm the same day with a new aortic valve, without any visible stitches on my body. And two months ago, I underwent a successful coronary artery angioplasty with stent placement in the left anterior descending artery. This "bionic man" is therefore deeply grateful to the Almighty and modern medicine for keeping him going.

I have enjoyed every bit of my life, with all its humor, hardships, hurdles, and dramatic moments that could even appeal to the Hollywood movie moguls.[2] I extend my heartfelt gratitude to my family for their unending support.

References:
1. Khan MA. What a life lived despite adversity!. *The Kemcolian*. 2023; 36 (Spring/Summer): 35-36.
2. Khan MA: Patient-doctor. *Ann Intern Med*. 2000; 133: 233-235.

Muhammad Asim Khan, MD, FRCP, MACP, MACR
Professor Emeritus of Medicine,
Case Western Reserve University
Cleveland, Ohio

Figure 3.
My artistic self-portrait that has been published (Khan MA. My self-portrait. *Clin Rheumatol*. 2001; 20:1-2.)

Updates from the U of T Division of Rheumatology

By Heather McDonald-Blumer, MD, FRCPC, MSc (HPTE)

The Division of Rheumatology at the University of Toronto has undergone some major changes over the last few years. It has long been said "There is nothing permanent, except change." We are proof of this.

Dr. Murray Urowitz retired from having been a pillar of the division, a highly recognized teacher and a world-renowned lupus researcher. Dr. Urowitz led the Toronto Lupus Program for more than 50 years. Murray's legacy is honoured through the Dr. Murray B. Urowitz Chair in Lupus Research, with Dr. Zahi Touma being the inaugural recipient. Zahi is now the Director of the lupus program, continuing to combine optimal lupus care with an articulate research agenda. Zahi and the team are ably supported by our newest recruit at Toronto Western Hospital, Dr. Laura Whittall Garcia, a new Clinician Investigator.

Dr. Simon Carette has also retired recently. A true renaissance man when it comes to rheumatology, Simon was a beloved teacher, an insightful investigator — collaborator and a skilled administrator across varying time points in his career. His expertise in vasculitis is missed, most notably by his colleague, Dr. Christian Pagnoux, who runs our vasculitis program at Mount Sinai Hospital (the workload is overwhelming). Dr. Medha Soowamber is a newly appointed Clinician Teacher, with additional expertise in vasculitis, and focuses on our giant cell arteritis (GCA) rapid access program. Dr. Megan Himmel, as a Clinician Teacher at Toronto Western, took over Dr. Carette's general rheumatology practice and now provides exemplary care for patients with vasculitis at the Western, rounding out the divisional expertise in this niche.

Drs. Edward Keystone and Claire Bombardier retired in 2022, leaving a large hole. Their legacies in the field of rheumatoid arthritis (RA) cannot be overstated. A Chair has been posted at the University of Toronto to recruit a worthy candidate to support and grow our RA program and to maintain their legacies.

Dr. Rachel Shupak and Dr. Louise Perlin have retired from St. Michael's Hospital. Their presence is missed by their patients, colleagues and, perhaps most of all, by our trainees. Rachel and Louise were superb teachers and educators of the highest magnitude. While their clinical practises have been absorbed by many, the wisdom they brought to rheumatology and the passion they infused into their craft remains aspirational for trainees and other faculty alike.

Dr. Dafna Gladman retired from clinical practice at the end of 2024 and was duly celebrated. Dafna, like her friend and colleague Murray Urowitz, has left a huge footprint in the world of lupus. Dafna is equally recognized as an expert in psoriatic arthritis clinical care and research. While Dafna will continue her research activities, Dr. Vinod Chandran, who was recruited over a decade ago to work with Dafna, now leads the Psoriatic Arthritis Program. Recently, our division was fortunate to recruit Dr. Denis Poddubnyy from Germany. Denis is an internationally recognized investigator with expertise in imaging within the spondyloarthropathies.

Dr. Mary Bell has announced her retirement starting July 2025. Mary has been a pillar of clinical care and patient-focused research during her career as a Clinician Investigator at Sunnybrook Health Sciences Centre. She has mentored the team at Sunnybrook in an exemplary manner and has extended her wisdom across our division, supporting many faculty members and learners as they worked to define their career goals and pathways. While their clinical work will have a different focus, Sunnybrook has just welcomed Dr. Timothy Kwok as a Clinician Investigator, following in Dr. Bell's footsteps.

So many changes across the University of Toronto, Division of Rheumatology . . . While we wish all our senior rheumatologists the very best in their new endeavours, we will miss them tremendously. Indeed, "change is the law of life. And those who look only to the past or present are certain to miss the future" (John F. Kennedy). Our division is grateful to all of those who have shaped our past and set the stage for success going forward. We are so fortunate that we have been able to welcome new colleagues to help maintain our divisional commitment to excellence in patient care, teaching, and research.

Heather McDonald-Blumer, MD, FRCPC, MSc (HPTE)
Division Director, Rheumatology
Faculty Lead, Curriculum, PGME
University of Toronto
Toronto, Ontario

Updates from CanRIO

By Shahin Jamal, MD, FRCPC, MSc

The CanRIO group at their most recent meeting in Toronto in May 2024.

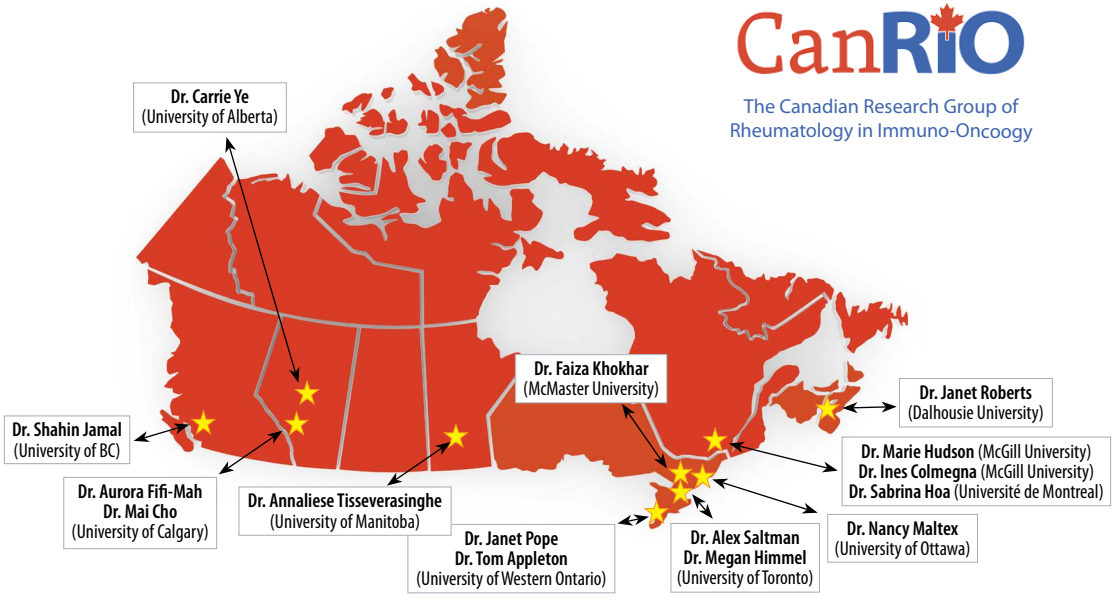
The Canadian Research Group of Rheumatology in Immuno-Oncology (CanRIO) is a network of rheumatologists and scientists from across Canada (see map) with an interest in improving the care of patients with rheumatic immune-related adverse effects (Rh-irAE) associated with cancer immunotherapy and patients with pre-existing rheumatic diseases (PRD) who are being considered for or receiving treatment with immunotherapy for cancer.

The idea to establish a Canadian collaboration in immuno-oncology was introduced in 2018. We had our inaugural meeting in 2018 where we defined our name, logo, objectives, mission, network and authorship agreements. Since then, CanRIO has become a globally recognized leader in patient care, research, education and advocacy for patients with Rh-irAE and those with PRD requiring cancer immunotherapy.

As we celebrate our five-year anniversary, we would like to reflect on our accomplishments and review our goals for the future. Since our inception, members of CanRIO have completed and published a national needs assessment and multiple review articles, which have guided our research agenda. We have established a national prospective cohort with clinical and biological data from over 300 patients and a national retrospective cohort with over 500 patients. The data from these two cohorts have been used to describe emerging rheumatic irAEs, and to evaluate the impact of patient and treatment factors on autoimmune and cancer outcomes.

In 2020, with the support of a CIORA grant, a website (*www.canrio.ca*) was created with interactive learning modules, clinician and patient resources, and a platform for connecting with the global community. Through the website, CanRIO has commenced successful quarterly international case rounds, attended by clinicians and researchers from around the world. In collaboration with the CRA Guidelines Committee, we have been actively working on a set of clinical practice guidelines, with a focus on management of immunotherapy in the context of PRD, de-novo inflammatory arthritis, de-novo myositis and de-novo sarcoid-like reactions. In 2023, CanRIO was awarded a second CIORA grant to conduct a proof-of-concept clinical trial evaluating adalimumab induction for de-novo inflammatory arthritis which is currently underway.

Looking to the future, we hope to continue our leadership role in this emerging area, both nationally and globally. We are collaborating with the Spanish Rheumatology Association to add 20 sites from Spain, and harmonizing data collection with sites in the USA, France, Germany and Australia. We would like to acknowledge the ongoing support we have received from the ARC, CRA, CIORA, our multiple industry partners, collaborators, colleagues and patients. Please continue referring patients to CanRIO sites. We would not be where we are without our entire community.



References available online at *craj.ca*.

Shahin Jamal, MD, FRCPC, MSc
Clinical Professor of Medicine, University of British Columbia
Clinician Investigator, Arthritis Research Canada
Co-Director, CanRIO Network
Vancouver, British Columbia

Tribute to Dr. Salman Anwar

By Nadil Zeiadin, MD CM, FRCPC

The sudden and tragic loss of Dr. Salman Anwar has left an indelible mark on everyone who knew him. A young and talented rheumatologist, Salman completed his training in Internal Medicine at the University of Saskatchewan and his fellowship in Rheumatology at the University of Manitoba. He then joined the rheumatology group in Newmarket in 2022. In a short span, he left a profound legacy marked by compassionate care and a commitment to his patients that few could match.

Salman was driven by an unwavering dedication to his work and approached each day with purpose and passion. His patients knew him not only as a skilled physician but as a kind-hearted individual who genuinely cared about their well-being. He took the time to understand each of them, forging deep, meaningful relationships and often went beyond what was expected. He was one of the first rheumatologists to join the Centre of Arthritis Excellence (CARE), playing a key role in establishing multidisciplinary models of care. He participated keenly in educational workshops for patients and was deeply involved in the educational development of both residents and staff. Driven by a desire to serving patients in underserved communities, Salman collaborated with local partners to provide clinics in Sudbury on a regular basis.

Beyond his clinical skills, Salman was an exemplary team member who proved to be a true friend to his colleagues. He was always there when needed, ready to lend a helping hand, whether it was during a challenging case or in the small, day-to-day tasks that kept the team running smoothly. His presence brought a sense of camaraderie and stability; he lifted others with his optimism and jovial demeanour. Salman's willingness to step in during difficult times was not just a testament to his character but also to the depth of his commitment to those around him. He was, in every sense, the friend that everyone could count on.

Yet above all, Salman's heart belonged to his family. His wife, Noor, and young son, Sammi, were his greatest joys, and he held an unwavering devotion to them. Salman cherished every moment with his family, balancing his demanding work with a steadfast commitment to being a loving husband and father. He was also deeply connected to his parents and extended family, showing a profound respect for the values they instilled in him and carrying them forward in his own life. Salman's faith and principles guided him daily, as did his belief in social justice and doing the right thing, even when it was difficult. His kindness and integrity were rooted in his conviction that compassion and fairness were the cornerstones of a life well lived.

Salman's life, though cut short, remains a powerful reminder of the impact one person can have. His devotion to medicine and the care he provided will live on in the memories of his patients and colleagues, who were fortunate enough to know him. His loss leaves a void that will not be filled, yet his spirit and kindness will continue to inspire those who knew him to carry on his legacy of compassion, dedication, and friendship.

Nadil Zeiadin, MD CM, FRCPC
Rheumatology – Southlake Regional Health Centre
Newmarket, Ontario

NS

News from Nova Scotia

By Trudy Taylor, MD, FRCPC

Greetings from beautiful Nova Scotia! We have been busy as ever in our small province and are making headway on improving access to rheumatology care. We now have four rheumatologists practicing outside of the Halifax area: Dr. Julie Mongeau in Truro, Dr. Juris Lazovskis in Cape Breton, and Drs. Diane Wilson and Zach Shaffelburg in Lunenburg. When I reached out to our community colleagues for any news to contribute to this update, I received this lovely reply from Juris (pictured on the right):

Community Rheumatology in NS:

I think that much of what we do can be related to what we are expected to do for the community. Health care system aside, it depends on us how we hear those needs. "I hear" or "audio" in Latin can be expressed as an acronym AUDIO:
Assuming responsibility and acceptance; we may see patients who need acknowledgement, assurance, or who have arthralgias or even orthopedic issues;
Uncovering with ultrasound; this has allowed us to "unhide" the under the skin structures. We all have experience in MSK US and we may use it daily;
Discussion and, sometimes, simultaneous Dictation with Dragon and prescribing drugs and filling out applications through EMRs in the presence of the patient increases efficiency;
Inquiring about immunizations and inhalations helps with motivation to live a healthier life;
Optimizing waiting list (by catching arthritis early) and optimizing use of time by "AI" (algorithm implementation), to avoid going through hundreds of messages at the end of the day.

In addition to our community colleagues, we've had a few changes in the Halifax region: In January, Volodko Bakowsky completed his term as Division Head after 7.5 years expertly leading the charge. I have taken over his role on an interim basis, wondering how I can fill these tremendously large shoes! We've also had a new addition to the Nova Scotia rheumatology family, Jack, who is the son of our rheumatology trainee Mary Purcell (pictured below with Jack and her husband Hamid).

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

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BIMZELX is indicated for the treatment of adult patients with:[1]
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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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- Pregnant or nursing women
- Women of childbearing potential

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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  - **Rheumatoid arthritis (RA) – 2009; Psoriatic arthritis (PsA) – 2014; Ankylosing spondylitis (AS) – 2014; Plaque psoriasis (PsO) – 2018; and Non-radiographic axial spondyloarthritis (nr-axSpA) - 2019**[1,2]

CIMZIA (certolizumab pegol) in combination with MTX is indicated for:
- reducing signs and symptoms, including major clinical response, and reducing the progression of joint damage as assessed by X-ray, in adult patients with moderately to severely active RA.

CIMZIA alone or in combination with MTX is indicated for:
- 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:
- reducing signs and symptoms in adult patients with moderately to severely active RA who do not tolerate MTX.
- 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.

Consult the product monograph at https://health-products.canada.ca/dpd-bdpp/index-eng.jsp for important information about:
- Contraindications in active tuberculosis or other severe infections such as sepsis, abscesses and opportunistic infections; and moderate to severe heart failure (NYHA Class III/IV)
- The most serious warnings and precautions regarding serious infections and malignancy
- Other relevant warnings and precautions regarding worsening congestive heart failure and new onset CHF; hepatitis B virus reactivation; hematological reactions; neurologic reactions; use in combination with other biologic medicines; monitoring for patients in surgery and those being switched to another biologic DMARD; hypersensitivity symptoms; latex sensitivity; formation of autoantibodies; administration of live or live-attenuated vaccines; use in patients with severe immunosuppression; possible erroneously elevated activated partial thromboplastin time (aPTT) assay results in patients without coagulation abnormalities; women of childbearing potential; pregnancy and breastfeeding; caution in infants exposed in utero; caution in geriatric patients
- 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.

* 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.

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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