# 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!

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# **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!

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# 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

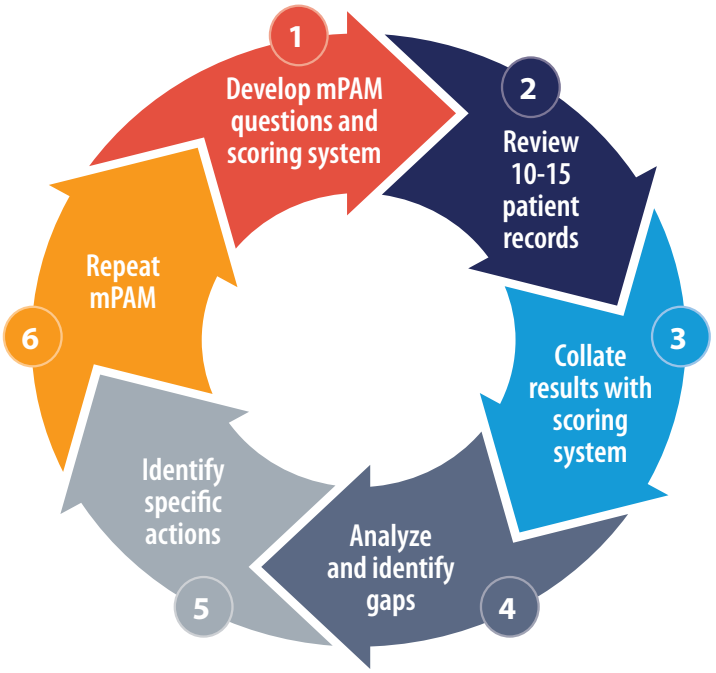

Figure 2.

## 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-

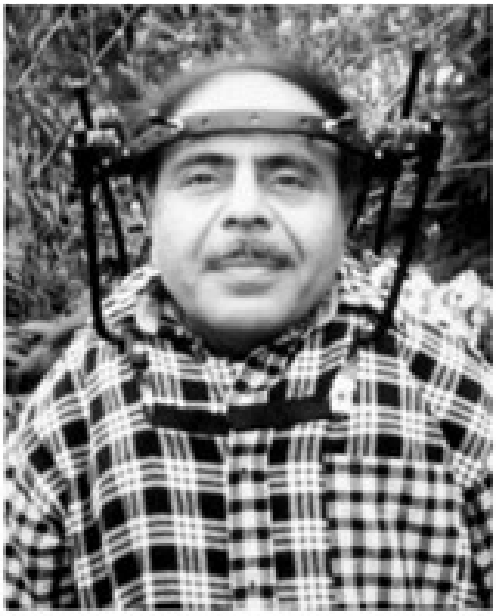

**Figure 1.** My picture wearing a halo screwed into my skull was taken in 1983. I have republished it with the permission of Blackwell Publishing from *MA Khan. Spondyloarthropathies,. In: Hunder G, ed. Atlas of Rheumatology, Oxford, UK, Blackwell Science; 1998:5.1-24*.

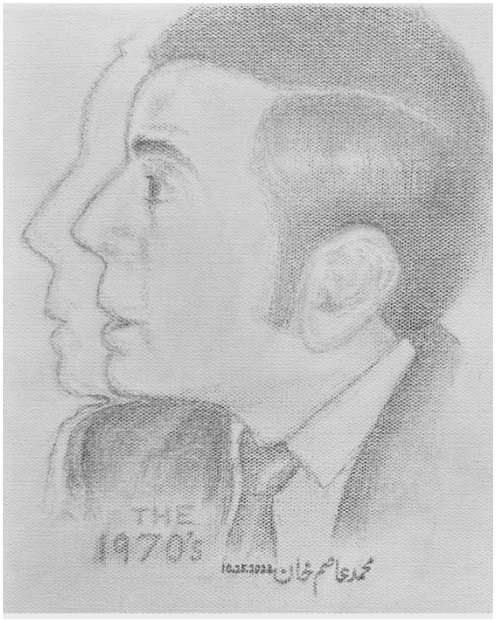


**Figure 2.**
My self portrait drawn with carbon pencils; this is how I looked presenting my scientific abstract at the Annual Scientific meeting of the ARA (now called ACR) in the early 1970s. Please note the long sideburns that were fashionable in those days.

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.

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**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.

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# Updates from CanRIO

By Shahin Jamal, MD, FRCPC, MSc

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

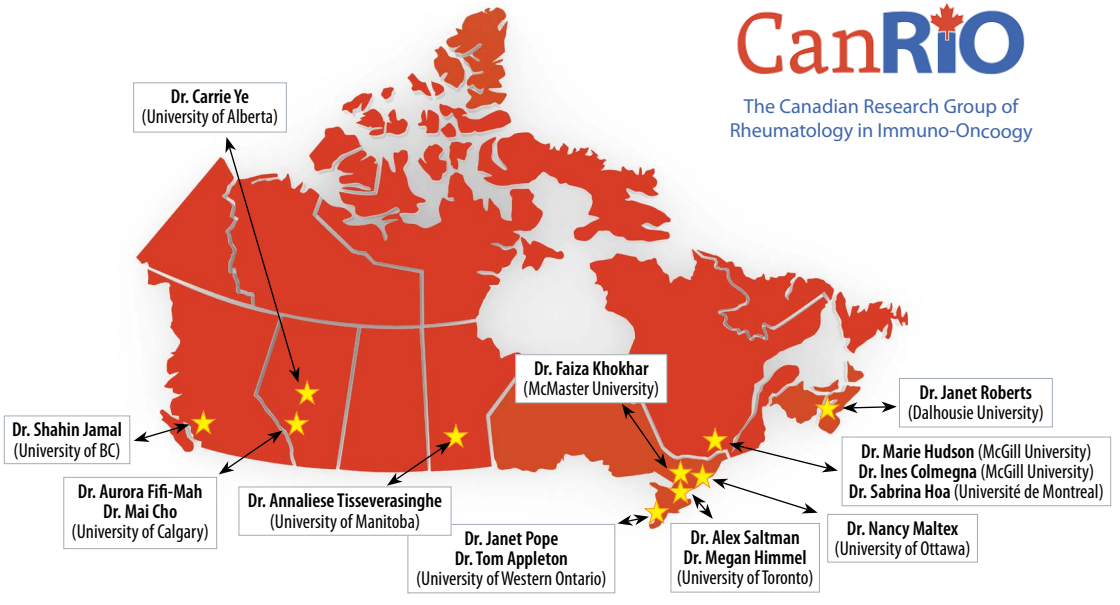
The Canadian Research Group of Rheumatology in Immuno-Oncology (CanRIO) is a network of rheumatologists and scientists from across Canada (see map) with an interest in improving the care of patients with rheumatic immune-related adverse effects (Rh-irAE) associated with cancer immunotherapy and patients 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*.

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# 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*

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# 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:
**A**ssuming responsibility and acceptance; we may see patients who need acknowledgement, assurance, or who have arthralgias or even orthopedic issues;
**U**ncovering 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;
**D**iscussion and, sometimes, simultaneous Dictation with Dragon and prescribing drugs and filling out applications through EMRs in the presence of the patient increases efficiency;
**I**nquiring about immunizations and inhalations helps with motivation to live a healthier life;
**O**ptimizing 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
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**BIMZELX® NOW HAS INDICATIONS IN:[1]**
- **PsA** (psoriatic arthritis)
- **axSpA** (axial spondyloarthritis, including ankylosing spondylitis and non-radiographic axial spondyloarthritis)

# AN OPPORTUNITY TO CHALLENGE PSA AND AXSPA WITH BIMZELX

BIMZELX is indicated for the treatment of adult patients with:[1]
- moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- 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)

## THE **FIRST AND ONLY** IL-17A AND IL-17F INHIBITOR*[1,2]

**Conditions of clinical use:**
BIMZELX is not authorized for use in pediatrics (<18 years of age).

**Relevant warnings and precautions:**
- Inflammatory bowel disease
- Serious hypersensitivity reactions
- Vaccinations
- Infections, including tuberculosis
- 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.

Inspired by patients. Driven by science.

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Pr Bimzelx® (bimekizumab)


## Consider CIMZIA®

- An anti-TNF with a molecular structure that does not contain a fragment crystallizable (Fc) region, which is normally present in a complete antibody[1]*
- Over 14 years of clinical experience combined across all indications in:†
  - **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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Pr cimzia® (certolizumab pegol)


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For more information, visit PfizerFlex.ca

* May not be available in Quebec.

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