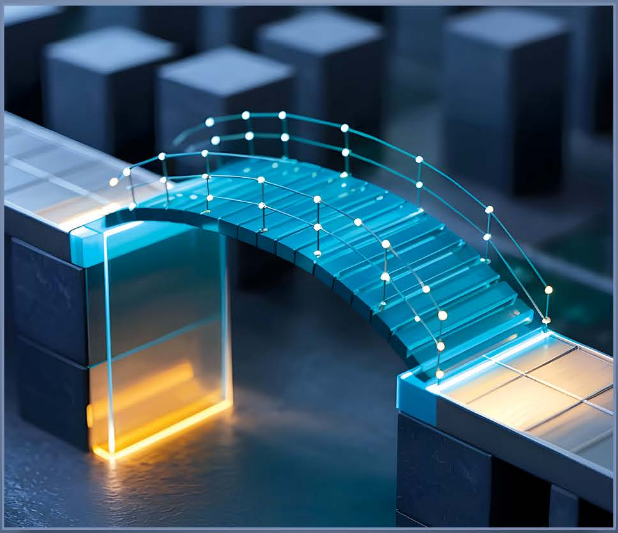
Fall 2025, Volume 35, Number 3

CRA SCR

The Journal of the Canadian Rheumatology Association



Spotlight on: Transitions in Rheumatology

Editorial
Awards

What's the CRA/CRAF Doing For You?
Sustainable Health Care: An Implementation Guide for Rheumatology
Rally for Rheumatology

News from CIORA
Multicriteria Decision Analysis with 1000Minds for Developing Scleroderma Renal Crisis Classification Criteria

Northern (High)lights
Not Just a Hand-Off: Rethinking Transition in Rheumatology
Pediatric-to-Adult Care in Rheumatology
Transition of Care in Rheumatology: A Long and Winding Road to Achieving Successful Transition of Care
A Continental Shift: My Transition to Rheumatology in Canada
Transatlantic Transition: A Rheumatologist's Perspective on Practicing in Canada

In memoriam
Tribute to Dr. Siraj Ahmad

Joint Communiqué
Arthritis: The Silent Drain on Canada's Economy
Patient Perspective: Christine Sperling
CRA/CanRIO Living Guidelines for the Management of Baseline Immunosuppression in Individuals with Pre-existing Rheumatic Diseases Initiating Immune Checkpoint Inhibitors: A Summary and Reflection

Awards, Appointments, and Accolades
Interview with the CRA's 2025 Distinguished Teacher-Educator: Dr. Dana Jerome

Clinical Tips
Sarcoidosis for the Rheumatologist: Advanced and Atypical Cases

Joint Count
Joint Count Survey Results: Quality and Innovation

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

All Fab’ fragment

CIMZIA® - a **PEGylated** antibody fragment - is the only anti-TNFα that does not contain an Fc region, normally present in a complete antibody.*

Over 15 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://www.ucbcanada.com/en/cimzia 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.
CHF: congestive heart failure; CRP: C-reactive protein; DMARDs: disease-modifying anti-rheumatic drugs; Fc: Fragment-crystallizable; MRI: magnetic resonance imaging; MTX: methotrexate; NSAIDs: nonsteroidal anti-inflammatory drugs; NYHA: New York Heart Association; PEG: polyethylene glycol; TNFα: tumour 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/?lang=eng. Accessed January 9, 2025.

CA-CZ-2500021E

REVIEWED BY PAAB

cimzia®
(certolizumab pegol)

EDITORIAL

Awards

By Philip A. Baer, MDCM, FRCPC, FACR

"When we give cheerfully and accept gratefully, everyone is blessed."
-Maya Angelou

In the past year, I have had the pleasure to nominate a colleague, Dr. Dana Jerome, for two rheumatology awards and seen her win both, as the 2025 CRA Distinguished Teacher-Educator and the 2025 Ontario Rheumatology Association Rheumatologist of the Year (ROTY). As I told Dana when I presented her with the ORA award, her success has everything to do with the qualities she has demonstrated throughout her exemplary career and very little to do with any prowess I may have as a nominator.

Interestingly, I have been involved in the awards and recognition processes at the CRA, the ORA and the Ontario Medical Association (OMA). At the CRA, I was appointed to the Nominations Committee when Carter Thorne was the chair. I attended my first meeting on short notice. As it immediately preceded a dinner continuing medical education (CME) event I was attending, I took the audio call (pre-ZOOM) in a service closet at the restaurant. The quality of my participation improved thereafter, and I was pleased to champion the creation of the CRA Master Award during my time on the committee. The CRA now boasts 3 Distinguished and 2 Early Career Awards, a new for 2026 CRA Leadership Impact award, as well as the CRA Master and Practice Reflection Awards. Some may worry that having more awards dilutes the value ascribed to them, but with so many members deserving to be recognized, I would argue that there are never enough awards to go around for those who have earned consideration for them.

At the ORA, I have served on the Nominations Committee as a Past-President for several years. In addition to our ROTY award, we now have an Early Career Rheumatologist Award and several ORA Distinguished Member Awards given out annually. The more, the better.

The OMA has the greatest number of awards and award categories. Amidst the tumult of the pandemic and all of the issues facing provincial health care systems, I noticed in 2023 that the OMA had not handed out any of its usual awards. Our then OMA President Andrew Park was advertising that any member could book a 15-minute online video "Conversation with Andrew", so I booked one and brought up the absence of awards. Soon after, The OMA Awards and Recognition Committee was reestablished, and I was successful in my application to become a committee member. We have been very busy revitalizing and consolidating the awards under a modernized framework, trying to increase engagement, honour winners in a personalized manner, and increase transparency and objectivity in selecting our winners.

It is not an easy process. If awards come with a monetary prize or offer recipients an exemption from paying annual association fees, the financial cost can be significant, and the number of awards of this type may need to be restricted. If association membership is not mandatory, we can find that worthy nominees are not members and, therefore, may be ineligible to be prize recipients. Conferring an award also engenders some reputational risk for the organization, as controversies involving several Order of Canada recipients have demonstrated. It is becoming more common to scan social media to ensure that the values of the award winners align with those of the organization. The public records of the relevant medical regulatory colleges may also be checked — anyone can have complaints registered about clinical issues, but those alleging problematic behaviours are more contentious. Medical politics can be heated, and where one draws the line between fervent advocacy and unreasonable criticism of the organization is often debated at award decision meetings.

Even with an expansion of award offerings, there are many peers we may wish to recognize for their day-to-day work improving the lives of patients, assisting their colleagues in the health professions, and fostering health system change. Informal recognition, through laudatory emails, mentions in organizational newsletters, or "Recognize a Colleague" systems are all important tools in combatting burnout and making people feel valued. The Ontario medical regulator (CPSO) home page offers the option to "compliment a physician"; one hopes it is used occasionally, rather than the link to complain about a physician on the same page.

There remains work to do as well to improve gender equity in awards. A 2024 letter in *Annals of Rheumatic Diseases*[1] highlighted the function of professional awards "in recognising exemplary individuals who uphold the values and objectives cherished by award-granting institutions… Under certain conditions, awards can galvanise motivation and amplify performance." The authors then analyzed

Continued on page 5

CRAJ EDITORIAL BOARD

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

EDITOR-IN-CHIEF

Philip A. Baer, MDCM, FRCPC, FACR
Chair, Section of Rheumatology,
Ontario Medical Association
Toronto, Ontario

CRA EXECUTIVE

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

Stephanie Tom, MD, FRCPC
Vice-President,
Canadian Rheumatology Association
Division Head of Rheumatology,
Trillium Health Partners
Mississauga, Ontario

Nigil Haroon, MD, PhD, DM, FRCPC
Past-President,
Canadian Rheumatology Association
Co-Director, Spondylitis Program,
University Health Network (UHN)
Clinician Scientist, UHN
Scientist, Krembil Research Institute
Associate Professor,
University of Toronto
Toronto, Ontario

MEMBERS

Vandana Ahluwalia, MD, FRCPC
Former Corporate Chief of Rheumatology,
William Osler Health System
Brampton, Ontario

Regan Arendse, FRCP, PhD
Clinical Assistant Professor,
Division of Rheumatology
University of Saskatchewan
Saskatoon, Saskatchewan

Louis Bessette, MD, MSc, FRCPC
Associate Professor,
Université Laval
Rheumatologist,
Centre hospitalier universitaire de Québec
Québec City, Quebec

May Y. Choi, MD, MPH, FRCPC
Associate Professor,
Cumming School of Medicine
University of Calgary and
Alberta Health Services
Calgary, Alberta

Shaina Goudie, MD, MA, FRCPC
Clinical Assistant Professor of Medicine
Memorial University
Newfoundland and Labrador

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

Raheem B. Kherani, MD, FRCPC, MHPE
Program Director and
Clinical Associate Professor,
Division of Rheumatology,
Department of Medicine,
University of British Columbia
Clinician Investigator,
Arthritis Research Canada
Vancouver, British Columbia

Deborah Levy, MD, MS, FRCPC
Associate Professor,
University of Toronto,
Team Investigator,
Child Health Evaluative
Sciences Research Institute
Toronto, Ontario

Liam O'Neil, MD, FRCPC, MHSc
Assistant Professor
University of Manitoba
Winnipeg, Manitoba

Evelyn Sutton, MD, FRCPC, FACP
Associate Dean,
Undergraduate
Medical Education
Professor of Medicine,
Dalhousie University
Halifax, Nova Scotia

Roger Yang, MD, FRCPC
Clinical Assistant Professor,
Co-Director of Vasculitis Clinic,
Clinician associated with
RC-HMR, Hôpital Maisonneuve-Rosemont
Faculty of Medicine,
Université de Montréal
Montreal, Quebec

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

PUBLISHING STAFF

Mark Kislingbury
Executive Editor

Jyoti Patel
Managing Editor

Catherine de Grandmont
Senior Medical Editor
(French)

Virginie Desautels
Junior Editor
(French)

Donna Graham
Production Manager

Dan Oldfield
Design Director

Mark Kislingbury
Publisher

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

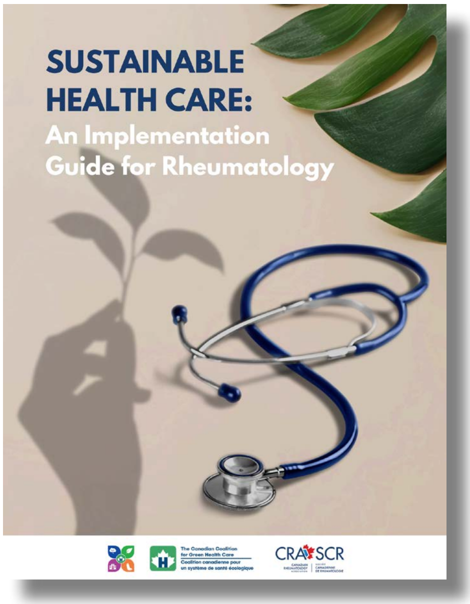
Copyright©2025 STA HealthCare Communications Inc. All rights reserved. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION is published by STA Communications Inc. in Pointe Claire, Quebec. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means (electronic, mechanical, photocopying, recording or otherwise) without the prior written permission of the publisher. Published every three months. Publication Mail Registration No. 40063348. Postage paid at Saint-Laurent, Quebec. Date of Publication: November 2025.

The opinions expressed herein are those of the editors and authors and do not necessarily reflect the views of STA Communications or the Canadian Rheumatology Association. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION selects authors who are knowledgeable in their fields. THE JOURNAL OF THE CANADIAN RHEUMATOLOGY ASSOCIATION does not guarantee the expertise of any author in a particular field, nor is it responsible for any statements by such authors. Physicians should take into account the patient's individual condition and consult officially approved product monographs before making any diagnosis or treatment, or following any procedure based on suggestions made in this document.

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

Sustainable Health Care: An Implementation Guide for Rheumatology

CRA SCR
CANADIAN RHEUMATOLOGY ASSOCIATION | SOCIÉTÉ CANADIENNE DE RHUMATOLOGIE



SUSTAINABLE HEALTH CARE:
An Implementation Guide for Rheumatology

The Canadian Rheumatology Association (CRA) is proud to present the new planetary health toolkit for rheumatology. ***Sustainable Health Care: An Implementation Guide for Rheumatology*** is designed to spread awareness and help rheumatology professionals incorporate planetary health principles into their practice spaces.

Building on work done by the Ontario Rheumatology Association (ORA), which created the world's first rheumatology sustainability toolkit, the CRA Planetary Health Taskforce developed a bilingual toolkit to be shared more widely among the national rheumatology community for feedback and ideas.

"We created an easy-to-use guide and it's all about promoting high value patient care, which typically results in cost savings to clinics and also has a positive environmental impact," says CRA Vice-President Dr. Stephanie Tom, Chair of the Planetary Health Task Force.

Toolkit Highlights

Awareness: Learn about the health impacts caused by the changing climate, and how to mitigate them.
Practical Steps: Detailed guidance on how to make your practice more sustainable.
Bilingual Resource: Available in both English and French to cater to the national rheumatology community.
Collaborative Effort: Developed with input from leading experts in rheumatology and sustainability.

Thank you to the CRA Planetary Health Task Force members, Drs. Stephanie Tom (Chair), Philip Baer, Claire Barber, Sasha Bernatsky, Molly Dushnicky, Beth Hazel and Fergus To.

The Planetary Health Task Force looks forward to engaging and supporting members in greening their workspaces. If you have any questions, feedback, or ideas, please email *info@rheum.ca*.

View the toolkit here:

Awards

Continued from page 3

data on recipients of rheumatology awards from six major international bodies between 1972 and 2023, including ACR and EULAR. The CRA was not included. The ACR gave out two-thirds of all awards. EULAR had the highest gender parity with 31% female recipients. The gender gap has narrowed considerably, with only 11.6% female winners pre-1990 versus 36.2% since 2021. Recommendations included diversifying selection committees of award-granting institutions, advertising awards more widely, and enhancing transparency in the award nomination and selection processes. From my vantage point, these changes are well underway at the OMA, ORA and CRA.

Reference:
1. Roy D, Andreoli L, Ovseiko PV, et al. *Ann Rheum Dis.* 2024;83:958–959. doi:10.1136/ard-2024-225670

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

WHAT'S THE CRAF DOING FOR YOU?

Rally for Rheumatology

This September, rheumatologists across Canada launched a new tradition rooted in collective action and a shared commitment to the future of patient care. The inaugural "Rally for Rheumatology", led by the Canadian Rheumatology Association Foundation (CRAF), invited rheumatologists to match patient donations during Arthritis Awareness Month, doubling their impact in support of research, education, and patient care.

By encouraging rheumatologists to match patient donations, and doubling their collective impact, the campaign sparked national conversation around the importance of sustained investment in rheumatology research and education to improve patient care. "Rally for Rheumatology" saw participation from rheumatologists across Canada, generating momentum across provinces and practices. The funds raised will support CRAF's core mission: funding Canadian-led research, supporting education, and strengthening care for people living with rheumatic diseases.

CRAF's Executive Director, Dr. Ahmad Zbib, emphasized the impact of this early momentum and the deeper purpose behind the campaign: "We've made great progress with treatments for many rheumatic diseases, but we still don't have cures. For some conditions, good treatment options are still out of reach. That's why research is so important, as it gives us the chance to change outcomes. Our goal is to build a strong endowment so we can keep supporting research now and into the future."

He also expressed deep gratitude to everyone who took part in the rally: "We're truly thankful to the rheumatologists and patients who stepped up this year. We're excited about what the campaign can help to accomplish in the years ahead."

Dr. Trudy Taylor, CRA President and a participating rheumatologist in Halifax, reflected, "This campaign provided a new opportunity to work together with patients for the future of rheumatology care, and together we can make a real impact."

With plans already underway for 2026, "Rally for Rheumatology" is set to become a new anchor in CRAF's efforts to engage the profession and the public in shaping what comes next.

NOTE: To build off of the momentum and success the campaign has achieved to date, the CRAF extended the deadline to participate until December 31, 2025! Join the Rally and visit ***crafoundation.akaraisin.com/ui/rallyforrheum2025.***

NEWS FROM CIORA

Multicriteria Decision Analysis with 1000Minds for Developing Scleroderma Renal Crisis Classification Criteria

The Scleroderma Clinical Trials Consortium Scleroderma Renal Crisis Working Group was created to develop and validate classification criteria for scleroderma renal crisis (SRC). In accordance with recommendations for rheumatic disease classification criteria development, we designed a multi-phase expert- and data-driven study. In phase 1, we performed a scoping review to generate items to define SRC.[1] In phase 2, we undertook item reduction using consensus techniques (3-round online Delphi exercise and Nominal group discussion) to generate a core set of items to define SRC.[2]

We secured CIORA funding in 2023 to conduct phase 3 of the study (Principal Investigators: Marie Hudson, Sindhu Johnson and Christopher Denton). The aim was to refine and weight the core set items. Thirty-one case vignettes reflecting the broad range of SRC were submitted by 8 experts from around the world. A first-ranking exercise was performed by an independent panel of 14 experts (see photo below) to capture individual preferences for item importance. The same experts then met in person for a 1.5-day meeting. Items were discussed individually, and a framework and glossary were finalized. Experts discussed the need for 1) entry criteria; 2) exclusion criteria; and 3) sufficient (or absolute) criteria for inclusion. A multi-criteria decision analysis (MCDA) exercise was then conducted to determine the relative weighting of each item using 1000Minds software. The panel was presented with paired scenarios comparing items and asking them to select the option they believed had a higher probability of being classified as SRC. The distribution of choices on each scenario was presented to the group. Where there was no agreement, the reasons for disagreement were discussed. Consensus was considered achieved when all experts indicated agreement or could accept the majority decision. Through iterative discrete pair-wise choices, the decision analytic software was able to assign relative weights to the items.

Finally, the results of the first-ranking and MCDA exercises were analyzed to produce a continuous measure of the relative probability that a case could be characterized as SRC, and a provisional threshold score above which a case could be definitely classified as SRC.

CIORA ICORA

CANADIAN INITIATIVE FOR
OUTCOMES IN
RHEUMATOLOGY CARE

INITIATIVE CANADIENNE POUR
DES RESULTATS EN
SOINS RHUMATOLOGIQUES

We have now undertaken the 4th and final phase of the project. We are collecting a large international cohort of SRC cases and controls to 1) refine the weights and threshold score in a new derivation cohort, and 2) test the sensitivity and specificity of the final criteria in an independent validation cohort. We expect to produce the first expert- and data-driven classification criteria for SRC. This work will provide a robust framework for future projects to tackle substantial unmet clinical needs for SRC.

References:

1. Hoa S, Stern EP, Denton CP, Hudson M, Scleroderma Clinical Trials Consortium Scleroderma Renal Crisis Working Group Investigators of the Scleroderma Clinical Trials Consortium Scleroderma Renal Crisis Working G. Towards developing criteria for scleroderma renal crisis: A scoping review. *Autoimmun Rev.* 2017;16(4):407-15.
2. Butler EA, Baron M, Fogo AB, Frech T, Ghossein C, Hachulla E, et al. Generation of a core set of items to develop classification criteria for Scleroderma renal crisis using consensus methodology. *Arthritis Rheumatol.* 2019;71(6):964-71.

Members of the MCDA panel: Dr. Robyn Domsic (USA), Dr. Laura Ross (Australia), Dr. Virginia Steen (USA), Dr. Benjamin Chaigne (France), Dr. Tracy Frech (USA), Dr. Andrea Low (Singapore), Melanie Baniña (study coordinator), Dr. Edward Stern (UK), Alison Hendry (moderator), Kristina Clark (UK), Falguni Desai (patient partner), Dr. Madelon Vonk (Netherlands), Dr. Tatiana Rodriguez (Mexico), Dr. Marie Hudson (Canada), Dr. Patricia Carreira (Spain) and Dr. Lee Shapiro (USA). Absent: Swati Mehta (USA).

Not Just a Hand-Off: Rethinking Transition in Rheumatology

By Michelle Batthish, MD, MSc, FRCPC; and Karen Beattie, PhD

The period of transition from pediatric to adult care is critical for youth with rheumatic diseases. Far from being a single hand off, transition is best understood as a process that includes preparation in pediatric care, the transfer itself, and the period of adjustment within adult care. At each stage, youth face risks of care disruption, adverse health outcomes, and psychosocial strain. This transition coincides with the timing of critical brain development and maturation and significant life changes, including commencing post-secondary school, moving away from home and changes in social environments. It's critical to understand that this period of high vulnerability puts youth with rheumatic disease at risk of poor health management and outcomes.


Dr. Michelle Batthish


Dr. Karen Beattie

Preparing for Transfer: Transition Readiness

Preparation is the cornerstone of successful transition. Yet evidence suggests that many youth feel ill-equipped to manage their health independently when they leave pediatric care.[1] Assessing transition readiness, whether formally[2] or informally, is important in determining how competent and confident youth are managing medications, scheduling and attending appointments, and navigating health systems. Notably, readiness must be assessed on an individual basis given the variability in skills within youth of similar ages.[3,4] Involving parents/caregivers in discussions about independence and self-management skills is important given that their perceptions of readiness may be different from the youth.[5]

To support both youth and their parents/caregivers in preparation for transition, co-designed resources are valuable to support skill-building and self-management.[6] Allied health professionals can play important roles in supporting the readiness of youth for the expectations of the adult healthcare setting.

The Point of Transfer: Preventing Loss to Follow-Up

Even with careful preparation, the transfer itself often represents the most vulnerable point in the continuum of care. Studies consistently show that a significant proportion of youth disengage from care after leaving pediatrics, with reported rates up to 50% loss to follow-up within two years.[7] For patients with rheumatic diseases, potential serious consequences include flares, irreversible damage, and poor long-term outcomes. The role of transition coaches or peer navigators may help provide individualized support to address practical challenges (such as system navigation) and emotional barriers (such as anxiety about new providers). A much lower loss to follow-up rate (~20%) was recently reported in a clinical setting where youth regularly met with their pediatric and adult rheumatologists together, and where the youth regularly discussed their self-management skills and set goals for improvement.[8]

After Transfer: Adjustment and Mental Health

Challenges associated with transition extend well beyond the first adult appointment and are compounded by the

PARENT/CAREGIVER REFERENCE GUIDE

Transition to Adult Care

need to manage a lifelong condition within a new and often fragmented health system. It is no surprise that these youth experience significant mental health burdens during this period, as shown by the prevalence of anxiety, depression, and social isolation in this population.[9-11] These rates tend to be higher than in peers without a chronic disease. These insights point to the need to integrate aspects of psychosocial and mental health support into routine care. Adult rheumatology teams must be attentive not only to disease activity but also to the emotional well-being of young adults adapting to new routines and responsibilities.

Moving the Field Forward

Transition research has evolved from problem description to intervention testing. Building on readiness assessments, toolkits, and pilot coaching models, next steps include scaling interventions, embedding resources for mental health supports, and implementing policy-level accountability for successful transitions.[12,13] Importantly, responsibility for transition cannot rest solely with pediatric providers. As a process, transition continues to progress into adulthood, and adult rheumatology practices need to meet the developmental needs of these young adults. Ensuring adult providers are well-resourced to provide this level of care is critical for continuity of care and long-term disease control.

Conclusion

Transition is not an event but a process spanning preparation, transfer, and post-transfer adjustment. Each stage presents risks, but also opportunities for intervention. Through research on readiness, development of the Transition Toolkit, documentation of loss to follow-up, pilot studies of coaching, and evaluation of mental health outcomes, we are building a stronger evidence base for transition care. As rheumatologists, we must work together across pediatric and adult systems to ensure youth are not lost in transition but supported to thrive into adulthood.

Michelle Batthish, MD, MSc, FRCPC
Pediatric Rheumatologist,
Physician Lead, Ambulatory Care,
McMaster Children's Hospital
Associate Professor, Pediatrics, McMaster University
Scientist, CanChild Centre for Disability Research
Subplatform lead, Transition to Adult Care, RareKids-CAN

Karen Beattie, PhD
Professor (Assistant),
Department of Medicine
McMaster University

References:

1. Sabbagh S, Ronis T, White PH. Pediatric rheumatology: addressing the transition to adult-orientated health care. *Open Access Rheumatol.* 2018;10:83-95.
2. Yi T, Hu Y, Xia L, et al. Instruments to Assess Transition Readiness Among Adolescents With Chronic Disease: A COSMIN Systematic Review of Measurement Properties. *Child Care Health Dev.* 2025;51:e70017.
3. Ma C, Dushnicky M, Talaat H, et al. Self-Reported Transition Readiness of Adolescent Patients with Rheumatic Disease: Do the Parents Agree? *J Pediatr.* 2022;247:155-9.
4. McColl J, Semalulu T, Beattie KA, et al. Transition Readiness in Adolescents With Juvenile Idiopathic Arthritis and Childhood-Onset Systemic Lupus Erythematosus. *ACR Open Rheumatol.* 2021;3:260-5.
5. Dushnicky MJ, Fine C, Cellucci T, et al. Mind the Gap: A Longitudinal Analysis of the Experiences of Adolescents and Parents in a Rheumatology Transition Clinic. *J Clin Rheumatol.* 2023;29:235-9.
6. Dushnicky MJ, Scott J, McCauley, D, et al. Transition us together: development of a parent-centered toolkit to support adolescents with rheumatic disease transition to adult care. *J Trans Med.* 2022;3.
7. Hazel E, Zhang X, Duffy CM, et al. High rates of unsuccessful transfer to adult care among young adults with juvenile idiopathic arthritis. *Pediatr Rheumatol Online J.* 2010;8:2.
8. Heera S, Sholdice M, Herrington J, et al. Lost in Transition: Examining Loss to Follow-up in JIA and cSLE. *J Clin Rheumatol.* 2025.
9. Palman J, McDonagh JE. Young Minds: Mental Health and Transitional Care in Adolescent and Young Adult Rheumatology. *Open Access Rheumatol.* 2020;12:309-21.
10. Siddiq S, Ainsworth JS, Pain CE, et al. Involving young people in research investigating comorbidity associated with childhood-onset rheumatic disease: perspectives of a series of focus groups. *BMC Rheumatol.* 2025;9:40.
11. Beaudoin K, Lo J, Mewhinney E, et al. Silent Struggles: Uncovering Mental Health Burdens in Adolescents with Inflammatory Bowel Disease and Juvenile Idiopathic Arthritis-A Retrospective Chart Review. *Children (Basel).* 2025;12.
12. Marani HFJ, Tabatabavakili S, Bollegala N. Systematic narrative review of pediatric-to-adult care transition models for youth with pediatric-onset chronic conditions. *Children and Youth Services Review.* 2020;118.
13. Society for Adolescent Health and Medicine. Transition to Adulthood for Youth With Chronic Conditions and Special Health Care Needs. *J Adolesc Health.* 2020;66:631-4.

Pediatric-to-Adult Care in Rheumatology

By Angela How, MD, FRCPC

The definition of successful transition of care for youth consists of the development of the skills to manage one's own healthcare and to avoid irreversible disease-related damage. Transfer of care is the act of moving from pediatric care to adult care.

Before the early 2000s, pediatric-to-adult care transition was underdeveloped, despite the fact that 90% of children with chronic health issues survive into adulthood.[1] In 2010, the Montreal Children's Hospital reported that 52% of patients with juvenile idiopathic arthritis (JIA) did not transfer successfully to adult care[2] despite the fact that 50% of JIA patients still had active disease at the time of transfer.[1] Poor transition increases the risk for morbidity, mental health challenges, suboptimal vocational outcomes, etc.

Adolescents face physical and psychosocial developmental challenges as they transition to independence, often hindered by excessive parental involvement. Successful transition can be supported by appropriate healthcare beyond the pediatric setting.

Over the past twenty years, increasing awareness of these challenges led to the development of guides to improve successful transitioning. Got Transition[3] and The American College of Rheumatology Transition Toolkit[4] provide foundational and best practices curricula. Despite this, a survey of US adult rheumatologists in 2018 found that 45% were never trained in transition practices, only 56% felt comfortable caring for former pediatric patients, and 37% did not have a plan for transitioning young adults into their practices.[5]

British Columbia is a leader in transition services in rheumatology. Pilot transition programs for young adults with spondyloarthritis and autoimmune diseases were offered in1988! In 1993, Dr. David Cabral, a pediatric rheumatologist, and Dr. Stephanie Ensworth, an adult rheumatologist, combined these clinics and included patients with other inflammatory diseases such as JIA into the Young Adults with Rheumatic Diseases (YARD) clinic. This was located in the Mary Pack Arthritis Centre and was supported by the Arthritis Society. Dr. Angela How took over as the adult rheumatologist in 1998. There are now four pediatric and three adult rheumatologists associated with the YARD clinic.

The YARD clinic model is shared care with pediatric and adult rheumatologists and fellows, a nurse coordinator, a social worker, an occupational therapist, a physiotherapist, and clerical staff. Timely access to mental health services, vocational and sexual counselling, and a network of youth-friendly adult specialists (*e.g.*, ophthalmology, orthopedics, nephrology, etc.) is also provided.

The clinic promotes independence, acquisition of disease and treatment knowledge, and readiness for transfer.[6]

The determinants of readiness to transition include the patient having:

1. Adequate knowledge of the disease, with their treatment choices being balanced and informed
2. Skills to negotiate the healthcare system and manage their health needs
3. An independent adult relationship with the health care system
4. A family doctor and the ability to advocate for themselves regarding their health

The average time of transfer to adult care is around 20-21 years of age. If the patient is not ready by age 22, the feeling is that more time in the YARD clinic is unlikely to be helpful.[6]

Transfer to an adult rheumatologist can be more challenging if the young adult lives in a remote or rural area, moves for education, or plans to travel to other parts of Canada and beyond. This takes extra planning and time. The patient needs to be coached on what steps to take if a health complication occurs.

In a 2018 survey of 46 youth being seen in the YARD clinic, 76% completed the questionnaire. Some of the results were as follows:

1. 95% were satisfied with the care they received
2. 75% liked not having their parents attending their clinic visits except for transport when necessary. They felt this encouraged them to take more responsibility for their health.
3. 25% requested more information on drug and alcohol use and mental and sexual health services

In answers to open-ended questions, the top positive aspects of our transitional clinic were:

1. Friendly and welcoming staff
2. Continuity from pediatric care
3. Availability of a nurse to contact outside clinic hours

Negative aspects included the following:

1. The need to travel to a centralized clinic which, for some patients, required flights from more remote areas of BC
2. Long wait times in the clinic on occasion

Data from a 2025 YARD survey are still being processed. Here are some positive comments to open-ended questions:

1. "The team speaks to me about my disease and medication in a way that I can easily understand."
2. "Since coming to the clinic I have found it easier to take my medications and to stay on treatment."
3. "I like that my parents are not in the room at clinic visits."
4. "I feel confident to see an adult rheumatologist."

There were also a few negative comments:

1. "I fear I will give up on 'self-support' and need more lessons to keep track of the disease (sic)"
2. "I prefer to see the same doctor at every visit."
3. "The time I spend in the waiting room is too long."

We plan further follow-up studies to track these young adults as they transition to exclusively adult care, made easier as the three adult rheumatologists in the YARD clinic have accepted the majority of transfers from YARD.

I have included one other reference that is an excellent review of the transition and transfer process.[8]

Angela How, MD, FRCPC
Young Adult Rheumatic Diseases clinic,
Vancouver Coastal Health
Vancouver, British Columbia

References:

1. Transitions in Rheumatic Disease: Pediatric to Adult Care. *Pediatr Clin North Am.* 2018 Aug;65(4):867-883.
2. High Rates of Unsuccessful Transfer to Adult Care Among Young Adults With Juvenile Idiopathic Arthritis. *Pediatr Rheumatol Online J.* 2010 Jan 11:8:2.
3. Got Transition®. Available at *www.gottransition.org.* Accessed October 8, 2025.
4. Pediatric to Adult Rheumatology Care Transition. Available at *www.rheumatology.org/Practice-Quality/Pediatric-Adult-Rheumology-Care-Transition.* Accessed October 8, 2025.
5. US Adult Rheumatologists' Perspectives on the Transition Process for Young Adults With Rheumatic Conditions. *Arthritis Care Res (Hoboken).* 2020 Mar;72(3):432-440.
6. D. Cabral. Transition Management. In. Gay K, Davidson I, eds. Occupational and Physical Therapy For Children with Rheumatic Diseases – A Clinical Handbook. 1st ed. Taylor & Francis; 2008.
7. Jessa J, Avery G, Taylor G, et al. Patient Satisfaction in a Rheumatology Transition Clinic: The Young Adults with Rheumatic Diseases Clinic in British Columbia. Poster presented at CRA; February 26-29, 2020; Victoria BC.
8. Sadun RE, Mind the Gap: Improving Care in Pediatric-to-Adult Transition Through Education. *Rheum Dis Clin North Am.* 2020 Feb;46(1):103-118.

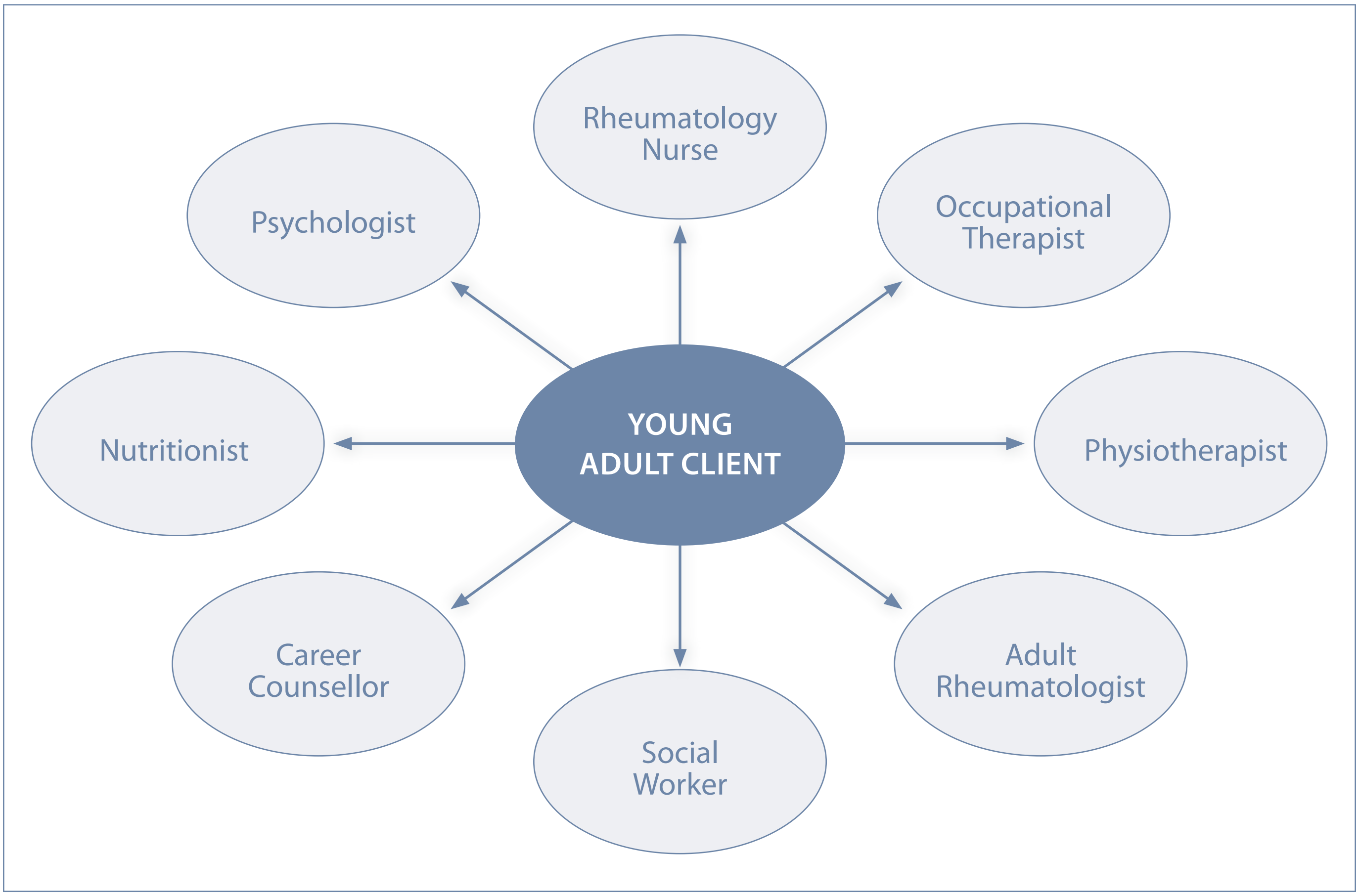
Transition of Care in Rheumatology: A Long and Winding Road to Achieving Successful Transition of Care

By Beth Hazel, OLY, MDCM, FRCPC, MM

After completing a fellowship in adolescent medicine and issues of Transition in Young Adults with Rheumatic Diseases (YARD) at the University of British Columbia (UBC), McGill and *Université de Montreal*, I brought my expertise back to McGill. My fellowship research project examined young rheumatology patients who graduated from the Montreal Children's Hospital and were transferred to adult rheumatologists in the McGill network. The study demonstrated that over half of these patients were not receiving the necessary care they needed because they could not navigate the transition period to an adult hospital. Many were lost to follow up despite having severe systemic diseases and ended up in emergency rooms with flares of their diseases and accumulated irreversible damage.

After identifying that this patient population requires special treatment and guidance in order to integrate themselves into the adult healthcare system, we embarked on designing a better transition experience for these young adults. The YARD clinic was opened in 2007 at the Montreal General Hospital (MGH) where over 250 patients are now followed annually. This clinic allows for more flexible appointment scheduling and patients have the support of our rheumatology nurse. The goal of the YARD clinic is to give young adults agency and autonomy through understanding their diseases, and the medications and non-medical approaches to managing their symptoms.

Despite the rapid growth of the YARD clinic, we soon realized its limitations. Unlike at the Children's Hospital, my patients had very limited access to occupational therapy, physical therapy, social work and psychology services. After exploring many different avenues, we helped to create a specialized multi-disciplinary program at the Constance-Lethbridge Rehabilitation Centre. We worked together with other healthcare teams and realized that there are common issues in the transition of care for young adults with chronic diseases, and we were able to leverage some of those services. We created a program that both evaluates the young adult's preparedness for transition to adult care and helps them to achieve greater independence in their daily activities, by providing them the tools to navigate school, work, leisure, home, and family life.



This program was successful, but only a minority of eligible patients were accessing it. Therefore, in 2016, I collaborated with my colleagues in pediatric rheumatology to change the way that we transition patients from the Montreal Children's to the adult clinic at the Montreal General Hospital (MGH). All eligible 17-year-olds are first seen at a transition clinic at the Constance Lethbridge Centre, which is attended by myself, the Children's Hospital rheumatology nurse, the Centre's program coordinator, physiotherapist and social worker as well as the patient's parent(s). The focus of this clinic is on the non-medical aspects of the patient's care, and the team gets a good idea of each teenager's limitations and goals. The team develops an individualized treatment plan for each young adult (See Figure 1). A few months later, we complete the transfer of care with the patient's first medical visit at the MGH.

The initial feedback from patients and parents was very positive. We noticed improved physical function, medication compliance and disease outcomes for those young adults who had taken advantage of the resources. But many of our clientele did not see the necessity of the rehabilitation program, especially if their arthritis was under control.

In 2023, we modified the program and added a career counsellor to our team. She meets with every client and assists them in planning their studies and careers. Both parents and patients have commented on the importance of addressing this important facet of their lives.

In 2024, we repeated the study on the transition process, and our rate of success climbed to almost 90%. It truly takes a village to support youth with chronic diseases. I am incredibly lucky to have a wonderful team.

References:
1. Hazel E, Zhang X, Duffy CM, et al. *Pediatr Rheumatol Online J.* 2010 Jan 11:8:2. doi: 10.1186/1546-0096-8-2.
2. Hazel E, Azar C, Mendel A. *J Rheumatol.* July 2025; 52 (Suppl 2): 62; DOI: https://doi.org/10.3899/jrheum.2025-0314.38

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

A Continental Shift: My Transition to Rheumatology in Canada

By Denis Poddubnyy, MD, PhD

Exactly one year ago today (at the time of this writing), I landed at Toronto Pearson Airport with two suitcases and a heart full of cautious optimism. Everything I packed was—at the time—deemed essential for launching my new Canadian life, at least in summer. Warm clothes followed in a few boxes and arrived safely just in time for the first snow.

What led to that arrival was nearly a year of relentless bureaucratic procedures, enough to challenge even the most determined academic. When I finally confirmed, "Yes, I'm willing to come," I was promptly met with a PDF full of mysterious abbreviations: CPSO, CMPA, RCPSC, OHIP… It read more like a codebook than a welcome guide. The well-meaning administrative contact seemed to assume that rheumatologists in Germany work under the same rules as those in Ontario—and that the CPSO is, perhaps, a global licensing powerhouse.

Among the many surprises was the requirement for a "Certificate of Good Standing." At first, I had no idea what that even meant, let alone where to get one. Was this a moral evaluation? A personality test? A letter from my mother? Fortunately, after a few frantic phone calls and the usual round of confusing German bureaucracy, I learned that the local health authority in Berlin issues such certificates for people trying to leave the country (a suspiciously specific service). Thankfully, I was still in good standing—at least in the eyes of the office clerk—and got it without delay.

That was just the beginning.

You know the saying: the neighbour's grass is always greener. Back in Germany, when I told colleagues that I was moving to Canada, many reacted with envy. Canada, in the German imagination, occupies an almost utopian place: stunning nature, a relaxed yet sophisticated culture, North American opportunity paired with European safety. To them, I was heading toward a dreamland.

Imagine my surprise when I got to Canada and encountered the exact opposite reaction: "You left Germany . . . why?" Many Canadians seemed baffled that someone would willingly trade a life in a "safe, stable European country" for. . . Toronto? To them, Germany was a land of opera houses, bike lanes, and health insurance that doesn't require a glossary.

Still, I quickly fell in love with Toronto. One of my favourite aspects of living here is the lake—which honestly looks more like a sea. I had missed having water nearby in Berlin, and the wide, endless horizon of the lake gives the city a certain peacefulness that's hard to describe. What impressed me even more, however, was the city's true multicultural spirit. It genuinely doesn't matter where you're from, what your skin colour is, or what accent you speak with. People here care far more about what's in your head than where your passport is from. That's something I sadly can't always say about rather conservative Germany.

And the kindness—wow. The level of politeness and warmth is visible everywhere: in clinics, stores, hallways, and elevators. But I must admit, it seems to end abruptly the moment someone gets behind the wheel. It's as if entering a car triggers a transformation: the gentle, smiling pedestrian instantly becomes an impatient, honking speed machine. Perhaps this is Canada's version of Dr. Jekyll and Mr. Hyde.

Fortunately, this kind and multicultural environment greeted me at the hospital as well. Starting work wasn't as difficult as one might expect—medicine is still medicine. Diseases are mostly the same on both sides of the Atlantic, and 20 years of experience in internal medicine, rheumatology, and infectious diseases helped ease the transition. I found the Canadian healthcare system overall to be fair. Unlike Germany, where the two-tier system privileges the privately insured minority with shorter wait times and broader (though not always evidence-based) access to therapies, Canada's single-payer model may involve delays, but it levels the playing field—and also protects physicians. Once a treatment is approved, no one questions the prescription. In Germany, rheumatologists often live under the shadow of insurance audits, with the ever-present risk of being asked to pay back the cost of biologics used "off-label," regardless of outcome or patient benefit.

Another big shift: my role in inpatient care. In Germany, I was always the most responsible physician. Here, I'm a consultant. This can work well—especially when rheumatology is clearly the main issue—but in complex cases like macrophage activation syndrome or overlapping infections, the communication can be more challenging.

I now work in an academic clinical practice, trying to balance my three lives as clinician, teacher, and scientist. What I deeply appreciate here is that these roles are recognized as distinct and worthy of dedicated time. Despite being busy, I've found space to think conceptually, to develop ideas, and to start new projects. The university setting around me is both supportive and inspiring—something I hope continues to motivate me not only during this transition, but for many years to come.

Denis Poddubnyy, MD, FRCPC
Professor of Medicine,
Division of Rheumatology, Department of Medicine
Temerty Faculty of Medicine
University of Toronto
Senior Scientist,
Director of Advanced Imaging Studies for
Rheumatic Diseases Program
Co-director of Gladman Krembil Psoriatic Arthritis Program,
Schroeder Arthritis Institute
Krembil Research Institute
University Health Network
Toronto, Canada

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

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)

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. November 27, 2024. **2.** Data on file, UCB Canada Inc.

ucb Inspired by **patients.**
Driven by **science.**

REVIEWED BY PAAB

Pr Bimzelx®
(bimekizumab)

All Fab’ fragment

CIMZIA® - a **PEGylated** antibody fragment - is the only anti-TNFα that does not contain an Fc region, normally present in a complete antibody.*

Over 15 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.

* Comparative clinical significance unknown.
† Clinical significance unknown.
CHF: congestive heart failure; CRP: C-reactive protein; DMARDs: disease-modifying anti-rheumatic drugs; Fc: Fragment-crystallizable; MRI: magnetic resonance imaging; MTX: methotrexate; NSAIDs: nonsteroidal anti-inflammatory drugs; NYHA: New York Heart Association; PEG: polyethylene glycol; TNFα: tumour necrosis factor alpha

Consult the product monograph at https://www.ucbcanada.com/en/cimzia 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.

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/?lang=eng. Accessed January 9, 2025.

CA-CZ-2500021E

REVIEWED BY PAAB

cimzia®
(certolizumab pegol)

Transatlantic Transition: A Rheumatologist's Perspective on Practicing in Canada

By Priyanka Chandratre, BSc (Hons), MBBch, PhD, FRCP (UK)

Why Canada?

That is a question I have been asked many times as a newly appointed staff rheumatologist and clinician investigator at The Ottawa Hospital (TOH) over the past two years. Writing this deeply personal reflection has given me an opportunity to look back on that decision from many perspectives.

When our family decided to move to Canada from the UK, our friends, relatives, and colleagues were intrigued. I am a clinical and academic rheumatologist trained in the UK, having completed my medical education at Cardiff Medical School, followed by 12 years of general internal medicine and rheumatology specialty training (including a PhD) at several teaching hospitals in England. I was fortunate to progress through training without breaks in employment. My husband, a UK-trained family physician, transitioned from surgical training to family medicine during the Modernising Medical Careers (MMC) upheaval—a period well remembered by my generation of doctors. We had both secured stable consultant and GP partner positions and had finally settled in the same city, bought our dream home, and envisioned long, fulfilling careers within the historically admired British National Health Service (NHS), supported by extended family and good schools for our two young children.

So why leave mid-career—uprooting our family, leaving loved ones, and giving up a thriving NHS and private practice? On paper, it may seem illogical. Yet lived experience rarely fits neatly on paper. We left the UK in search of a more fulfilling professional life—one where we felt valued, appreciated, and heard. We longed for autonomy to make decisions based on our patients' clinical needs, and for a work routine that allowed us to fulfill responsibilities beyond medicine. While the NHS was founded on the principle of equality — "to universalize the best"—its current state has left many clinicians and patients disillusioned. The challenges are not unique: an aging population and workforce shortages strain many healthcare systems. But the personal frustration of being managed by non-clinical administrators out of touch with clinical realities, coupled with inadequate infrastructure (limited office space, "hot desking," scarce administrative support, lack of efficient electronic medical record systems and minimal trainee assistance), made meaningful change feel impossible. Bureaucracy often hindered innovation—such as establishing multispecialty clinics, protecting research time, or centralizing care. These realities ultimately motivated us to take a leap of faith.

What began as a curious email to the Canadian Rheumatology Association became a life-changing journey—one I am profoundly grateful for. I was connected with a UK-trained rheumatologist who had previously relocated to Canada and guided me through the process of obtaining an academic registration to practice as a rheumatologist in Ottawa. My current Division of Rheumatology at TOH has been extraordinarily welcoming and supportive, making this professional and personal transition far smoother than I could have imagined.

Clinical medicine is remarkably similar in Canada and the UK, and the rheumatology practice guidelines are largely aligned—particularly regarding biologic therapies. However, there are notable differences. A dedicated biologic coordinator and patient support programs for accessing high-cost biologic drugs are unique here, and allow patients to access these medications relatively quickly as well as additional services such as vaccinations, dietitian services and pre-biologic screening. I now work within a publicly funded fee-for-service model, which incentivizes clinical work, rewards efficiency, and, in my view, enhances patient access and care. The Ontario Health Insurance Plan (OHIP) covers core medical services for residents, but allied health services and many medications depend on private or age/income-based coverage. Navigating "limited use codes" and variable insurance formularies remains a work in progress. Despite these nuances, the advantages of practicing rheumatology at TOH far outweigh the inconveniences. I am grateful for a dedicated office, an efficient administrative assistant, and an inspiring, collaborative team of medical colleagues and trainees. Canadian rheumatology specialty training, though shorter than in the UK, is intensive and well-structured. While service provision dominates a large proportion of UK training time, Canadian programs emphasize focused clinical learning and decision-making.

The respect afforded to physicians in Canada is another notable difference. While multidisciplinary teamwork is the future of healthcare, strong medical leadership remains vital for quality and safety. In the NHS, that sense of medical leadership—and with it, professional morale—is eroding. In Canada, physicians are appreciated and appropriately recognized for their expertise and accountability. From an academic standpoint, although competitive, opportunities abound. There is consistent institutional encouragement to apply for internal and external research funding—from TOH's Department of Medicine, affiliated universities, academic medical organizations, and national grant bodies.

Ultimately, everything comes back to our patients—the reason we do what we do. Hearing comments such as "We're so glad you're here" or "We hope you will stay despite the harsh winters" truly warms my heart. It reflects a culture of gratitude and mutual respect that is refreshing and deeply motivating. As a family, we have embraced the relaxed, outdoors-oriented lifestyle Ottawa offers. My husband is content in his family medicine career, and our children proudly call Canada home. Not every leap of faith guarantees success—but this one has brought personal growth, professional satisfaction, and a renewed sense of purpose for which we will always be grateful.

Priyanka Chandratre, BSc (Hons), MBBch, PhD, FRCP (UK)
Staff Rheumatologist and Assistant Professor,
The Ottawa Hospital, Riverside Campus
The Ottawa Hospital Research Institute (OHRI)
and University of Ottawa
Ottawa, Ontario

The CRA's 2025 Distinguished Teacher-Educator: Dr. Dana Jerome

What do you believe are the qualities of a good educator? How do these apply to you?

I think a good teacher/educator is someone who takes the time to make the teaching interactions worthwhile for each student. I think that creating an environment where the trainees feel that they can ask questions, that no question is "too basic", is very important for learning. It is hard for trainees not to feel "imposter syndrome" and this can make them hesitant to ask for help or guidance. I think breaking down these barriers is vital to creating a successful learning environment.

You are a Clinician Teacher and Associate Professor of Medicine at the University of Toronto (UofT) and Division Head of Rheumatology at Women's College Hospital. You completed your medical school and Internal Medicine residency at University of Western Ontario, your rheumatology subspecialty training at the University of Ottawa and a Master of Health Professional Education at the Ontario Institute for Studies in Education, UofT. You have been a passionate contributor to rheumatology education at the University of Toronto, where you have been the Program Director of the Adult Rheumatology Training program for the last 8 years.

a) From where do you think your passion for medical education stemmed?

Wow—that is a good question. I think first and foremost I enjoy people and I enjoy rheumatology. I think that being able to share my love for rheumatology is a great joy. It is like wanting someone to share in a good meal or a piece of music you love. Sharing it is always better than enjoying it on your own. I also think that working in an environment where I am surrounded by smart, ambitious and energetic young trainees is energizing for me. Students can sometimes think of things in a different way; this can challenge the ways we have always done things and make me think harder and learn every day.

b) How has medical education changed over the course of your career?

This is also a really big question. I think medical education has changed as our world has changed and as patients and our health care system have changed. When I was a medical student, we found our information in the library, not the Internet; we didn't have smart phones to access any bit of information at any time. How education is delivered in the current context must be different. I think we have to work harder to make sure there is a deep understanding of the material. A quick answer is available in seconds with an AI overview on a Google search. However, I think it is imperative to have a deeper understanding of why we recommend things, what the nuances are between certain choices we make in medical care and how we can apply this knowledge in patient-specific ways. Achieving these educational outcomes will be a challenge and our teaching methods will likely change over time.

There are also very concrete ways that medical education and assessments have changed. We have moved to a competency-based evaluation model where the goal is to look for mastery of a skill rather than just exposure to a skill and time-based measurement of training. I think this is still evolving and we have yet to measure the success of this initiative. Ultimately, this is likely to be tweaked and modified in order to achieve the intended purpose.

You have also been active with leadership positions in educational initiatives provincially with the Ontario Rheumatology Association (ORA) and nationally with the CRA, including practice Objective Structured Clinical Examinations (OSCEs), resident education courses and the National Written Rheumatology In-training Exam (NWRITE). You have been a member of the Royal College Specialty Committee in Rheumatology for the past 8 years and have just taken on the role of Committee Chair.

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

I have been very fortunate to have had opportunities to work in so many realms of rheumatology education. Although working with students is always a highlight, I have to say that working on provincial and national projects has also been a real pleasure. It's allowed me to get to know rheumatology colleagues

Dr. Dana Jerome receiving her award from CRA President Dr. Trudy Taylor at the CRA Annual Scientific Meeting in Calgary, which took place in February 2025.

from across the country. This has been a highlight because we have a country full of amazing, super-smart, inspiring rheumatologists who are some of the best people you could know. Being able to work with these colleagues has really made work better and more enjoyable. Getting to know and understand all the great work going on across the country is inspiring. I am always in awe and wish I had half as much energy as many of these amazing colleagues.

I think a challenge for so many of us is trying to feel like we have a proper balance. There are always competing demands of work and family, not to mention personal time. I don't think I have overcome this challenge, but I have managed it as best I could over the years. What I understand now that my kids are a bit older (and I'm in the first few weeks of being an empty-nester) is that what your family needs from you changes quickly and it's hard to keep up. My family knows that for the important things I will be there for them in an instant and that nothing is more important. However, they also know that being a doctor has its own demands, and I think that seeing me do my doctor job, having patients and other work colleagues depend on me, is also a way of "showing up" for my family in that I am demonstrating the importance of committing to something, and having an impact in my work and my community. I hope they grow up to have the good fortune of being able to have this, too.

Can you recall a teacher in your own past who inspired you and directed your own course into education?

There are so many teachers I had who inspired me over the years. Some date back to my high school teachers, like my history teacher who taught with such enthusiasm that it was easy to love the subject matter. He was a perfect example of how telling stories can help make the material relatable and memorable. I think medicine, like history, lends itself well to the power of story telling. I often think of Mr. Thomas when I am preparing a presentation and wonder what story I can tell to help emphasize my point. Within medicine/rheumatology, Dr. Janet Pope in London, Ontario, where I trained in Internal Medicine was definitely someone who made me feel that rheumatology was a fit for me. She had a unique balance of giving 100% attention to her patients, 100% to her students and 100% to her family. I know this math doesn't add up but watching her make this work was truly inspiring. I did my rheumatology training in Ottawa and there, Dr. Doug Smith helped me decide on a career in education as I could see how fulfilling he found his academic career and as a trainee I know how much I appreciated his help and guidance.

You are a strong believer in the power of the rheumatology community. You have worked to build a culture of collegiality, mutual respect and support for all the organizations in which you have had the privilege of working. Your educational philosophy centers around the learning environment/culture, and role modelling. You firmly believe that trainees thrive and learn best when they feel safe, and when they are supported. You have worked hard to create learning environments where these goals can be achieved.

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

I think the most important thing is to do what you love. Medicine and rheumatology are special because there are so many ways to make it your own. I think the worst thing is to try to fit a mould of what you think others expect of you. Your career in medicine/education is long, and the most important thing is that you do what you love and, in doing this, you will inspire

The CRA's 2025 Distinguished Teacher-Educator: Dr. Dana Jerome

Continued from page 21

others, even without trying to do so. I recognize however that, in any career, you can't do what you love 100% of the time and there will be hard times or hurdles you must cross, even when not "loving" the process. This is still okay if it gets you to a place that makes you happy in the long run. I think an equally important thing is to recognize that you're a part of something bigger, and that helping others will also, in the end, help you too. So, listen, go the extra mile, offer to help, even when it isn't the most convenient for you, and these efforts will make your career better and more fulfilling.

If you weren't a rheumatologist/teacher-educator, what other career path might you have chosen?

It is funny that you ask this question. As Program Director, on the first day of orientation for our new trainees, I have asked each of them this question for many years. It is a way of getting to know them in a non-medicine context and I am always surprised at how interesting people are.

My answer for this question is always the same. I always tell trainees that in another life I would be an event planner where I got to organize large, elaborate and, of course, glamorous events. Alternatively, I would put my creativity to use as a floral designer and hopefully have lots of leftover flowers to take home!

You have 3 children. What lessons have you learned as a professional educator that translate well to the task of raising children, and vice versa?

Yes, I have three children, a daughter who is 19 and twin boys who are 18. I am still the same person who is a teacher/educator and a mom. One of the things I love about teaching is that I can bring home stories of things that happened or interactions that occurred with trainees and we talk about it at the dinner table. This invariably ends with a discussion about how everyone might have handled a certain situation. I hope that my kids learn from this and understand why decisions are made from a "teacher" point of view. I don't think of myself as "mom" to my trainees but I do understand that so many things may influence how a trainee presents on a specific day or how they perform on a certain test. I think perhaps that being a mom reminds me to remember the "person" behind the student and how important it is to understand and get to know trainees and to be there for them.

What are some of your other passions outside of rheumatology?

Not surprising based on my answers to previous questions, I enjoy cooking, entertaining and flower arranging.

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

Only one book is hard. An easy reading guilty pleasure is the Louise Penny Inspector Gamache series set in rural Quebec. I like stories that remind us of the goodness in people. There are so many good ones!

What is your favourite food or cuisine?

My recent obsession of the last few years has been Mediterranean food. I am a huge fan of chef Yotam Ottolenghi. I have tried most of his restaurants in London and have all of his cookbooks which are some of my favourites.

You are offered a plane ticket to anywhere in the world. Where would you like to go?

My children will tell you that the place I want to go to the most is the Galapagos Islands to see the Blue Footed Booby and other species which are unique and endangered. Machu Picchu and Buenos Aires are also high on the list.

Dana Jerome, MD, MEd, FRCPC
Chair, CRA Human Resources Committee
Program Director, Rheumatology Training Program
Assistant Professor of Medicine,
University of Toronto
Toronto, Ontario

JOINT COMMUNIQUÉ

Arthritis: The Silent Drain on Canada's Economy

A new white paper from Arthritis Society Canada and Leger Healthcare, titled Arthritis: The Silent Drain on Canada's Economy, reveals the profound and often overlooked economic burden of arthritis. Despite being the number one cause of disability in the country, only 4% of Canadians recognize arthritis as such. The condition costs an estimated $33 billion annually in lost productivity and healthcare expenditures—and with the prevalence expected to rise from 6 million today to 9 million by 2045, the strain will only intensify.

Among respondents with arthritis in the workforce, 85% reported that the disease has affected or will affect their ability to work. Yet only 24% have received workplace accommodations, and 65% feel their employers do not provide sufficient support. Notably, one-third of Canadians with arthritis are diagnosed before age 45, underscoring the disease's impact during prime working years.

"Canadians are feeling the squeeze of today's economy—rising costs, tariffs, and global uncertainty. Those forces are beyond our control. But one challenge we can address is arthritis," said Trish Barbato, President and CEO of Arthritis Society Canada.

The paper calls for greater investment in research, stronger workplace supports and increased public awareness to close the perception gap.

For full findings, visit *arthritis.ca/news*.

Sarcoidosis for the Rheumatologist: Advanced and Atypical Cases

By Na'ama Avitzur, MD, FRCPC; and Daniel Vis, MD, FRCPC

Sarcoidosis is a systemic granulomatous disease of unknown origin that can affect almost any organ. Due to the inflammatory and multisystem nature of the disease, sarcoidosis is relevant to the practice of rheumatology and warrants consideration in the differential diagnosis of a variety of presentations.

CTD/Sarcoidosis Overlap

Connective tissue disease (CTD) may exist concomitantly with sarcoidosis, and therefore clinicians must be vigilant when patients present with new or changing signs and symptoms that may not be entirely attributable to their primary condition. In these scenarios, CTD diagnosis more commonly precedes diagnosis of sarcoidosis, but the reverse order is also well-described.[1] The most common CTD diagnoses concomitant with sarcoidosis are scleroderma, systemic lupus erythematosus, and rheumatoid arthritis. Patients are more likely to be female and have sarcoidosis characterized by skin or pulmonary organ involvement.[1] The possible drivers of this relationship are unknown, but it is hypothesized that in those with CTD preceding sarcoidosis, the underlying CTD may drive granulomatous inflammation leading to sarcoidosis.

Drug-Induced Sarcoidosis

Rheumatologists may also encounter sarcoidosis due to drug reactions. Drug-induced sarcoidosis has been reported to be caused by a variety of medications including interferons, anti-retroviral therapies, immune checkpoint inhibitors, and anti-tumour necrosis factor (TNF) medications, with the immune checkpoint inhibitors and anti-TNF medications being of particular interest recently.[2] Case series or case reports have been published describing sarcoid-like granulomatosis developing in patients prescribed etanercept, adalimumab, and infliximab, among others.[3-5] This association is seemingly counterintuitive due to the well described use of anti-TNF therapy for refractory sarcoidosis.[6] The reactions can affect any organ, resulting in pulmonary, skin, renal, or ocular sarcoidosis. Discontinuation of the offending anti-TNF medication is typically sufficient for resolution of the reaction, although time to remission can vary from 1-12 months.[7] Glucocorticoids may be used to treat patients with significant organ dysfunction or symptoms. Attempts to re-trial a different anti-TNF agent are usually well tolerated, although failed re-trial cases have been reported.[8]

Immune-checkpoint inhibitors (ICI) have been associated with pulmonary and cutaneous sarcoidosis-like reactions.[9] These medications include nivolumab, ipilimumab, and pembrolizumab, with occurrence of drug-induced sarcoidosis reactions ranging from 2-20%.[10] Treatment recommendations vary among clinical practice guidelines, with low quality recommendations to continue ICI in asymptomatic cases, with addition of low dose glucocorticoids if patients are symptomatic. Importantly, all guidelines recommend biopsying concerning lesions, in order to distinguish sarcoidosis from tumour progression.[9]

Advanced Therapies

The sarcoid granuloma is thought to form due to an abnormal cell-mediated immune response of CD4+ T cells. The initial trigger of this reaction is the presentation of an unidentified antigen by antigen-presenting cells, such as macrophages or dendritic cells, to T cells.[11] In refractory cases of sarcoidosis, advanced therapies seek to directly target these pathways.

Infliximab is an antibody targeting TNF-alpha and is generally the preferred third-line agent in refractory patients. Clinical trial data have shown improvements in lung function, quality of life, and 6-minute walk test.[11,12] Patients with ongoing evidence of inflammation or pulmonary disease are more likely to respond favourably.[13] Adalimumab is an antibody that also targets TNF-alpha. There is some evidence for improvements in refractory pulmonary sarcoidosis with adalimumab following infliximab failure.[14] Additionally, it has shown benefit in uveitis, cardiac, or cutaneous sarcoidosis.[15-17] Adalimumab is less immunogenic and carries less risk of severe allergic reactions, but infliximab tends to have a higher response rate.[11]

Other TNF inhibitors are considered less effective than infliximab and adalimumab, specifically golimumab or etanercept. These medications are felt to be ineffective due to their primary action being targeted towards soluble as opposed to membrane-bound TNF.[11] Additionally, etanercept appears to be most strongly associated with the development of paradoxical drug-induced sarcoid-like granulomatosis reactions compared to the other anti-TNF medications.

Interestingly, while sarcoid is a predominantly T-cell-mediated disease, there may be a potential role for B-cell directed therapy such as rituximab in refractory cases. Small case series and one trial have shown mild but non-sustained improvements in forced vital capacity and 6-minute walk test.[18]

Tocilizumab, an IL-6 inhibitor, has demonstrated improvements in symptoms and lung function when used as a fourth-line agent in patients who are refractory to anti-TNF therapy. Patients in this case series had a treatment response despite failure of one or more prior anti-TNF agents, a promising result for a refractory treatment population.[19] Tofacitinib is a janus kinase (JAK) inhibitor, which is an orally available small molecule that acts on numerous pro-inflammatory cytokines involved in sarcoid granuloma formation.[20] Various cytokines associated with sarcoidosis signal through the JAK-STAT pathway. Therefore, JAK inhibitors are exciting therapies that may prove beneficial in sarcoidosis. Tofacitinib has been demonstrated to improve refractory cutaneous and pulmonary sarcoidosis in a small ten patient case series.[21]

Conclusion

In summary, sarcoidosis is a complex disease that may be encountered by the rheumatologist in various clinical scenarios. The diagnosis of drug-induced sarcoidosis or concomitant sarcoidosis with CTD requires keen clinical suspicion and knowledge of these uncommon complications. Treatment options for advanced cases are expanding, providing patients more effective options than have previously existed.

Na'ama Avitzur, MD, FRCPC
Division of Respirology, Department of Medicine
University of British Columbia,
Vancouver, British Columbia

Daniel Vis, MD, FRCPC
Division of Respirology, Department of Medicine,
University of Calgary,
Calgary, Alberta

References:

1. Judson MA, Shapiro L, Freitas S, et al. Concomitant sarcoidosis and a connective tissue disease: review of the clinical findings and postulations concerning their association. *Respir Med.* 2013;107(9):1453-1459.
2. Chopra A, Nautiyal A, Kalkanis A, et al. Drug-Induced Sarcoidosis-Like Reactions. *Chest.* 2018;154(3):664-677.
3. Theunssens X, Bricman L, Dierckx S, et al. Anti-TNF Induced Sarcoidosis-Like Disease in Rheumatoid Arthritis Patients: Review Cases from the RA UCLouvain Brussels Cohort. *Rheumatol Ther.* 2022;9(2):763-770.
4. Sobolewska B, Baglivo E, Edwards AO, et al. Drug-induced Sarcoid Uveitis with Biologics. *Ocul Immunol Inflamm.* 2022;30(4):907-914.
5. Bewley AP, Maleki S. Systemic sarcoidosis reactions as a result of tumour necrosis factor-alpha treatment for patients with psoriasis. *Clin Exp Dermatol.* 2021;46(8):1548-1550.
6. Baughman RP, Valeyre D, Korsten P, et al. ERS clinical practice guidelines on treatment of sarcoidosis. *Eur Respir J.* 2021;58(6).
7. Daien CI, Monnier A, Claudepierre P, et al. Sarcoid-like granulomatosis in patients treated with tumor necrosis factor blockers: 10 cases. *Rheumatology (Oxford).* 2009;48(8):883-886.
8. van der Stoep D, Braunstahl GJ, van Zeben J, et al. Sarcoidosis during anti-tumor necrosis factor-alpha therapy: no relapse after rechallenge. *J Rheumatol.* 2009;36(12):2847-2848.
9. Donkor KN, Jang H, Sail R. A Systematic Review of Clinical Practice Guidelines for Managing Pulmonary Toxicities Caused by Immune Checkpoint Inhibitors: Quality of Treatment Recommendations and Differences in Management Strategies Between Guidelines. *Clin Med Insights Oncol.* 2023;17:11795549231203153.
10. Chorti E, Kanaki T, Zimmer L, et al. Drug-induced sarcoidosis-like reaction in adjuvant immunotherapy: Increased rate and mimicker of metastasis. *Eur J Cancer.* 2020;131:18-26.
11. Obi ON, Lower EE, Baughman RP. Biologic and advanced immunomodulating therapeutic options for sarcoidosis: a clinical update. *Expert Rev Clin Pharmacol.* 2021;14(2):179-210.
12. Rossman MD, Newman LS, Baughman RP, et al. A double-blinded, randomized, placebo-controlled trial of infliximab in subjects with active pulmonary sarcoidosis. *Sarcoidosis Vasc Diffuse Lung Dis.* 2006;23(3):201-208.
13. Vorselaars AD, Crommelin HA, Deneer VH, et al. Effectiveness of infliximab in refractory FDG PET-positive sarcoidosis. *Eur Respir J.* 2015;46(1):175-185.
14. Crommelin HA, van der Burg LM, Vorselaars AD, et al. Efficacy of adalimumab in sarcoidosis patients who developed intolerance to infliximab. *Respir Med.* 2016;115:72-77.
15. Pariser RJ, Paul J, Hirano S, et al. A double-blind, randomized, placebo-controlled trial of adalimumab in the treatment of cutaneous sarcoidosis. *J Am Acad Dermatol.* 2013;68(5):765-773.
16. Erckens RJ, Mostard RL, Wijnen PA, et al. Adalimumab successful in sarcoidosis patients with refractory chronic non-infectious uveitis. *Graefes Arch Clin Exp Ophthalmol.* 2012;250(5):713-720.
17. Rosenthal DG, Parwani P, Murray TO, et al. Long-Term Corticosteroid-Sparing Immunosuppression for Cardiac Sarcoidosis. *J Am Heart Assoc.* 2019;8(18):e010952.
18. Sweiss NJ, Lower EE, Mirsaeidi M, et al. Rituximab in the treatment of refractory pulmonary sarcoidosis. *Eur Respir J.* 2014;43(5):1525-1528.
19. Sharp M, Donnelly SC, Moller DR. Tocilizumab in sarcoidosis patients failing steroid sparing therapies and anti-TNF agents. *Respir Med X.* 2019;1.
20. Kisseleva T, Bhattacharya S, Braunstein J, et al. Signaling through the JAK/STAT pathway, recent advances and future challenges. *Gene.* 2002;285(1-2):1-24.
21. Damsky W, Wang A, Kim DJ, et al. Inhibition of type 1 immunity with tofacitinib is associated with marked improvement in longstanding sarcoidosis. *Nat Commun.* 2022;13(1):3140.

Patient Perspective: Christine Sperling

At the age of 19, I experienced debilitating joint pain, severe fatigue, an unexplained rash, and a critically low platelet count. After several months of uncertainty, I was diagnosed with systemic lupus erythematous (lupus) in the 1980s. At that time, information about this complex autoimmune condition was limited, and as a young woman in my first year of university, I had many unanswered questions. I wondered how lupus would affect my education, career aspirations, relationships, and overall quality of life. Sometime later, I was also diagnosed with antiphospholipid syndrome (APS) and immune thrombocytopenia (ITP).

Over the years, I have experienced a wide range of symptoms, from mild flares to life-threatening complications requiring hospitalizations, surgeries, blood transfusions, and ongoing treatments. These experiences have significantly shaped my daily life and long-term decisions about my career and personal life. Although I faced high-risk pregnancies and complications related to this, I was fortunate to have two healthy children. Despite the many challenges of living with lupus, becoming a mother has been the most rewarding and fulfilling part of my life. My family has continually been a source of strength, joy, and purpose, even during the most difficult times in my health journey.

Recognizing the importance of understanding my condition, I actively sought to educate myself about lupus, its treatment options, and emerging research. This led me to participate in various research projects as a patient, which eventually opened the door to a more formal role. About five years ago, I was invited to join a research team as a patient partner. Since then, I have had the privilege of contributing my lived experience to inform and support the development of meaningful, patient-centered research. I am also a member of the Canadian Venous Thromboembolism Research Network (CanVECTOR) Patient Partner Council, which focuses on research related to venous thromboembolism (VTE).

Living with lupus has had a profound impact on my life. As both a patient and a patient partner, I aim to share perspectives on symptoms, treatment, and access to information. Through my collaboration with researchers, I am helping to ensure that research is more reflective of patient realities and supports better awareness, education, and outcomes for individuals living with lupus.

I am thankful to the incredible researchers who have engaged me as a patient partner and recognized the value of my lived experience in informing study design, improving relevance, and helping to guide research that improves outcomes for those living with lupus.

Ultimately, my goal is to contribute to research in a way that advances care and improves the lives of those affected by this challenging disease.

Christine Sperling
Patient Partner in Medical Research
Calgary, Alberta

Christine Sperling pictured here with her children, Natasha and Sasha.

CRA/CanRIO Living Guidelines for the Management of Baseline Immunosuppression in Individuals with Pre-existing Rheumatic Diseases Initiating Immune Checkpoint Inhibitors: A Summary and Reflection

By Shahin Jamal, MD, FRCPC, MSc; and Carrie Ye, MD, FRCPC, MPH

Immune checkpoint inhibitors (ICIs) have revolutionized cancer treatment and outcomes by facilitating chronic activation of the immune system to target and destroy cancer cells. They are being used for multiple different types of cancers, and in different ways including for curative intent, palliative intent and as adjuvant therapy. In the US, patients with cancer eligible for ICI treatment increased from 1.54% in 2011 to 43.68% in 2018.[1] With the growing use of ICI (sometimes in combination with other ICI, chemotherapy, targeted therapies, hormone therapies, cancer vaccines, and other emerging therapies) and the aging population, ICI use is predicted to continue expanding in the coming years. The downside of chronic immune activation is the development of off-target inflammatory reactions, called immune-related adverse events (irAE), which can impact any body system.

Patients with pre-existing rheumatic diseases (PRD) were largely excluded from clinical trials studying ICI in cancer. Regardless, it is widely accepted that our patients with PRD should be offered ICI, if indicated, for their cancer. Our role as rheumatologists is to work with the oncologist, patient and other health care providers to optimize cancer outcomes in the safest way possible.[2] In clinical practice, patients with PRD have unique challenges including higher risk of developing de novo irAE, risk of flare of their underlying rheumatic diseases, and management of their baseline immunosuppression to optimize cancer outcomes without a flare in their underlying disease.

There are currently no clinical trials or other guidelines to help guide clinicians on best practices to manage rheumatic disease in patients who are being treated with ICI for their cancer. To this end, the Canadian Rheumatology Association (CRA) and Canadian Research Group of Rheumatologists in Immuno-Oncology (CanRIO) collaborated to develop living guidelines on optimal management of baseline immunosuppression in patients with PRD who are initiating ICI. The multidisciplinary panel (see photo) included clinical rheumatology experts from across Canada, along with an oncologist, methodologist and patient partner. The guidelines are divided into two parts, with part 1 focusing on patients with pre-existing inflammatory arthritis (including rheumatoid arthritis, polymyalgia rheumatica, psoriatic arthritis, and seronegative spondyloarthropathy) and part 2 focusing on patients with pre-existing systemic autoimmune rheumatic diseases (including systemic sclerosis, systemic lupus erythematosus, Sjogren's disease, myositis, sarcoidosis, vasculitis and Behcet's disease).[3,4] General good practice statements and specific statements regarding management of baseline immunosuppression by disease are summarized in the tables which accompany the published articles. In general, we recommended de-escalating baseline immunosuppression for those with pre-existing inflammatory arthritis, while recommending continuing the same level of immunosuppression for those with pre-existing systemic autoimmune rheumatic diseases, although nuances exist for each specific PRD. These guidelines have been made available as open access for wide distribution and use. As they are living guidelines, we will be able to update them as research evolves.

The development of these living guidelines has been a collaborative and rewarding experience, with a steep learning curve for us all. We would like to acknowledge the support of the CRA Guidelines Committee, especially Jordi Pardo and Glen Hazlewood, and our patient partner, Dirk Velthuizen, who provided invaluable insights. We hope that these guidelines will be useful for clinical care and advocacy and as a platform for further research.

Panel Members at the End of Two Days of Discussion and Voting:
Top row (from left to right): Alexandra Ladouceur, Marie Hudson, Faiza Khokhar, Janet Roberts, and Aurore Fifi-Mah.
Second row: Dirk Velthuizen, Carrie Ye, Nancy Maltez, Megan Himmel, and Shahin Jamal.
Third row: Roko Nikolic, Jordi Pardo, Janet Pope, Ines Colmegna, and Alexandra Saltman.
Bottom row: Sabrina Hoa, May Choi, and Lourdes Gonzalez Arreola.

CRA/CanRIO are working on two further guidelines, focusing on ICI-induced inflammatory arthritis and ICI-induced myositis, so stay tuned.

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

Carrie Ye, MD, FRCPC, MPH
Associate Professor, University of Alberta
Department of Medicine
Faculty of Medicine & Dentistry
Edmonton, Alberta

References:
1. Haslam A, Prasad V. Estimation of the Percentage of US Patients With Cancer Who Are Eligible for and Respond to Checkpoint Inhibitor Immunotherapy Drugs. *JAMA Netw Open.* 2019;2(5):e192535.
2. Kostine M, Finckh A, Bingham CO, et al. EULAR points to consider for the diagnosis and management of rheumatic immune-related adverse events due to cancer immunotherapy with checkpoint inhibitors. *Ann Rheum Dis.* 2021;80(1):36-48.
3. Ye C, Nikolic RPA, Choi M, et al. Canadian Rheumatology Association/Canadian Research Group of Rheumatology in Immuno-Oncology Living Guidelines for Baseline Immunosuppression in Individuals With Preexisting Rheumatic Diseases Initiating Immune Checkpoint Inhibitors. Part 1: Preexisting Inflammatory Arthritides. *J Rheumatol.* 2025.
4. Ye C, Nikolic RPA, Choi M, et al. Canadian Rheumatology Association/Canadian Research Group of Rheumatology in Immuno-Oncology Living Guidelines for Baseline Immunosuppression in Individuals With Preexisting Rheumatic Diseases Initiating Immune Checkpoint Inhibitors. Part 2: Preexisting Systemic Autoimmune Rheumatic Diseases. *J Rheumatol.* 2025.

Joint Count Survey Results: Quality and Innovation

This edition's Joint Count survey focused on asking CRA members their perspectives on quality and innovation. A total of 65 survey responses were submitted.

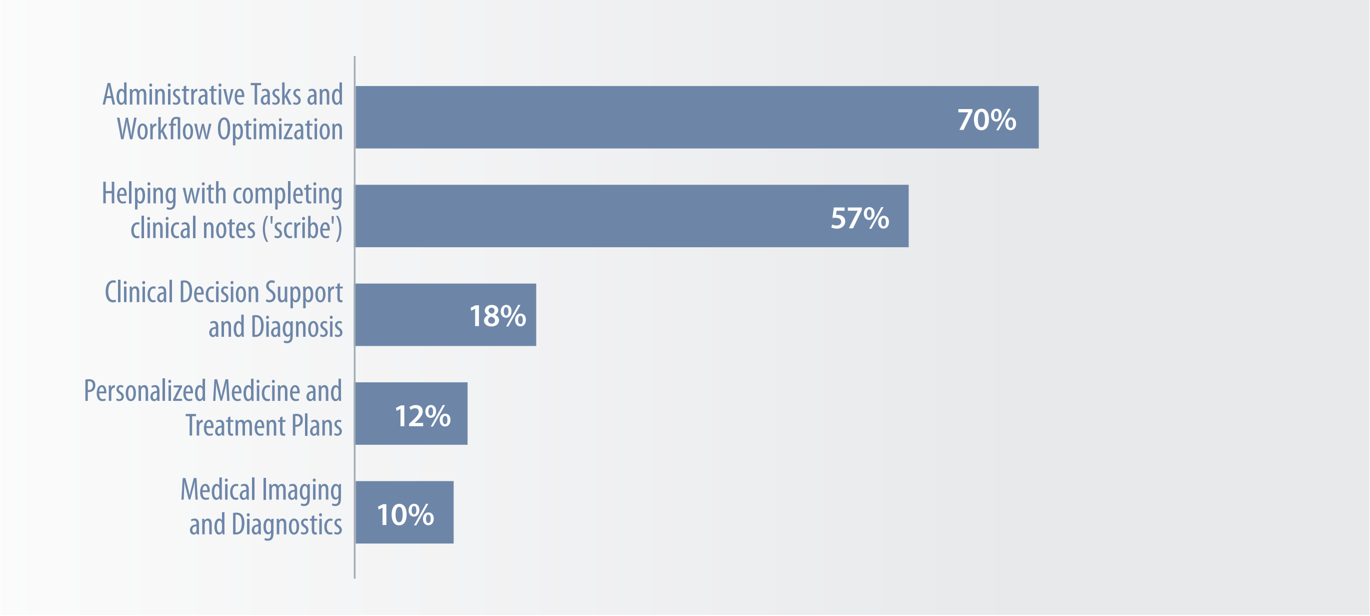
The first question regarding burnout asked "As a physician, which areas do you find most contribute to burnout in your clinical work? (Pick top two areas.)" More than 60% of respondents selected "administrative tasks such as prescriptions, reviewing results, insurance/government forms" followed by 37% choosing "completing clinical notes" and 30% indicating "patient phone calls/queries outside of clinic appointment."

The second query asked "As a physician, which areas are you most interested to learn about when it comes to artificial intelligence (AI) to improve your clinical work? (Select top two areas.)" The top response at approximately 70% was "administrative tasks and workflow optimization" followed by about 57% saying "helping with completing clinical notes ('scribe')." Refer to Figure 1 for a full breakdown of responses.

General comments and concerns pertained to limitations of using AI at institutions or hospitals, as they may not allow its use, as well as individual physician confidence and trust in AI accessing patient information. Another comment related to government insurance forms: "Insurance/government forms are taxing because they take time to fill out, but also because of arbitrary 'rules' that limit access to patient care."

The CRA Quality and Innovation Committee is evaluating these results. For any questions or feedback, please reach out to ***info@rheum.ca***.

Figure 1. As a physician, which areas are you most interested to learn about when it comes to artificial intelligence (AI) to improve your clinical work? (Select top two areas.)



IN MEMORIAM

Tribute to Dr. Siraj Ahmad (1939-2025)

By Evelyn Sutton, MD, FRCPC, FACP; and Volodko Bakowsky, MD, FRCPC

Dr. Siraj Ahmad with his wife Munawar and daughter Zareen at his retirement celebration in 2008.

Dr. Siraj Ahmad passed away peacefully at home in Halifax in October 2025.

Born and educated in Peshawar, Pakistan, Dr. Ahmad completed his secondary education at Islamia College before entering Khyber Medical College, where he was a proud member of the institution's first graduating class in 1960. His pursuit of medical excellence took him abroad to the United States, where he completed an internship at Albany Medical College in 1963, followed by a residency in Internal Medicine at St. Vincent's Charity Hospital in Cleveland, Ohio.

In 1967 he joined Dalhousie University to begin a fellowship in rheumatology, where he formed a lifelong friendship with Dr. Jack Woodbury, whose mentorship helped shape his career. Through Dr. Woodbury's support, Dr. Ahmad studied for several months with Dr. Eric Bywaters in Taplow, England — an experience that further deepened his expertise and passion for rheumatology.

Following his training, Dr. Ahmad had a long and successful career as a rheumatologist, splitting his time between his bustling outpatient private practice and a faculty position at Dalhousie University with hospital-based responsibilities. He was a recipient of the Brian M. Chandler Lifetime Achievement Award in Medical Education.

Following his retirement in 2008, he worked toward strengthening Khyber Medical College in Peshawar through collaboration with Dalhousie University.

Beyond medicine, Dr. Ahmad was devoted to his faith, family, and community. Together with his beloved wife, Munawar, he was instrumental in establishing the first mosque in the Halifax region — a lasting contribution that continues to serve as a place of worship and gathering for generations. A man of quiet faith, Dr. Ahmad led by example rather than words, embodying humility, integrity, and compassion in every aspect of his life. He took immense pride in his children, son Kamran, daughter Sabeena and daughter Zareen, who followed in her father's footsteps to become a rheumatologist in Toronto.

Dr. Ahmad will be remembered for his pioneering spirit, his dedication to patients and students, and his gentle, steadfast presence in the community. His legacy endures through his family, his faith, and the many lives he touched.

Evelyn Sutton, MD, FRCPC, FACP
Professor of Medicine, Division of Rheumatology
Department of Medicine, Dalhousie University
Halifax, Nova Scotia

Volodko Bakowsky, MD, FRCPC
Associate Professor, Division of Rheumatology,
Department of Medicine, Dalhousie University
Halifax, Nova Scotia

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)

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. November 27, 2024. **2.** Data on file, UCB Canada Inc.

ucb Inspired by **patients.**
Driven by **science.**

REVIEWED BY PAAB

PrBimzelx®
(bimekizumab)