Winter 2025, Volume 35, Number 4

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Spotlight on:
CRA Committee and Regional Association Reports

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

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]

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

A alone or in combination with MTX is indicated for:
cing signs and symptoms and inhibiting the progression of structural age as assessed by X-ray, in adult patients with moderately to severely e PsA who have failed one or more DMARDs.

A is indicated for:
cing signs and symptoms in adult patients with moderately to severely e RA who do not tolerate MTX.

cing signs and symptoms in adult patients with active AS who have had an equate response to conventional therapy.

reatment of adults with severe active nr-axSpA with objective signs of mmation as indicated by elevated CRP and/or MRI evidence who have had adequate response to, or are intolerant to NSAIDs.

reatment of adult patients with moderate to severe PsO who are candidates ystemic therapy.

arative clinical significance unknown.
l significance unknown.
ngestive heart failure; CRP: C-reactive protein; DMARDs: disease-modifying anti-rheumatic c: Fragment-crystallizable; MRI: magnetic resonance imaging; MTX: methotrexate; NSAIDs: idal anti-inflammatory drugs; NYHA: New York Heart Association; PEG: polyethylene glycol; mour 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.

IA® Product Monograph. UCB Canada Inc. November 13, 2019.
h 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

Teamwork

By Philip A. Baer, MDCM, FRCPC, FACR

"The strength of the team is each individual member. The strength of each member is the team."

- Phil Jackson

I am writing this after having just watched our beloved Toronto Blue Jays lose Game 7 of the World Series. A heartbreaking moment for fans of Canada's team, but what a team they were: everyone pulling for each other, greater than the sum of their parts…

We have teams in government, business, science, medicine and, of course, in rheumatology, but are they functioning to their highest potential? If not, where might we be going wrong and how can we improve?

One error is to focus on the apex member of a team, while forgetting about all the supporting members. No F1 driver wins a race by themselves. Tennis players always acknowledge their team in their victory speeches. Novak Djokovic, nearing the end of his career, now requires a team of 10 to prepare for his matches.[1]

The recent movie "Mickey 17" dramatizes the fate of team members who are viewed as non-core or expendable. Mickey is literally an "Expendable", performing dangerous and deadly tasks, and being recreated as a new Mickey with a higher number every time he is killed.

While Mickey's story is science fiction, we must recognize that many people labour unrecognized while being vital to a team's success. Hospital cleaners come to mind. What is more vital to a hospital's mission than asepsis, antisepsis and infection control?

According to the World Health Organization, cleaners "are the first line of defense against health care-associated infections, and support efforts to reduce antimicrobial resistance."[2] Research shows that appropriate staffing levels and rigorous infection control practices are key to maintaining good hygiene in health care settings, which may be compromised by misdirected cost-cutting efforts.

Women also have historically been overlooked and undervalued in teams. My thanks to Dr. Janet Pope for pointing this out in a previous *CRAJ* article.[3] She reviewed the Matilda effect, referring to the denial of the contributions of women scientists in research. Famous examples include the contributions of Lise Meitner to the understanding of nuclear fission, Rosalind Franklin to the decoding of the structure of DNA, and Esther Lederberg for her work on replica plating and antibiotic resistance. None of them received the Nobel prizes awarded for these discoveries.[4] The problem persists: According to one U.S. study, "although overt gender discrimination generally continues to decline in American society", "women continue to be disadvantaged with respect to the receipt of scientific awards and prizes, particularly for research."[5] This gender imbalance has been noted in rheumatology awards as well.[6]

As a devotee of movies, I found another illuminating case while watching "Joy", which revolves around the development of in vitro fertilization and the birth of the first "test-tube" baby, Louise Joy Brown. Eventually, Robert Edwards received the Nobel prize and his collaborator Patrick Steptoe was recognized for the work, but the embryologist Jean Purdy was excluded from most accounts of the discovery.[7]

What is the future of rheumatology? Team-based care of course. Google's AI tool provided this overview:

> Team-based care in rheumatology involves a group of different healthcare professionals working together to manage a patient's complex condition. This approach uses the complementary skills of various specialists like rheumatologists, nurses, physical and occupational therapists, and others to provide more comprehensive care. Key benefits include better access, improved communication, and more thorough patient visits that address a wider range of concerns, leading to higher patient satisfaction and potentially better outcomes.
>
> **What it is**
>
> - Interdisciplinary collaboration: Rheumatologists work with a team of other health professionals to manage a patient's needs comprehensively.
> - "One-stop shop": This model often aims to have multiple providers in one location, making it easier for patients to access different types of care and reducing travel burdens.
> - Patient-centered approach: It emphasizes a partnership where patients have a voice in their treatment decisions and are empowered through education and support.

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.

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

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.

Teamwork

Continued from page 3

How it works

- Team composition: The team can include rheumatologists, nurses, physical therapists, occupational therapists, pharmacists, psychologists, dietitians, and social workers, among others.
- Shared responsibilities: Team members use their unique skills to cover different aspects of care, such as managing medication side effects, addressing physical mobility, providing mental health support, and helping with self-management strategies.
- Structured appointments: It can allow for longer, more comprehensive appointments where all of a patient's concerns are addressed in one visit.
- Regular check-ins: Patients may have more frequent follow-ups, including with team members other than the rheumatologist, to monitor their condition and ensure treatment adherence.

Benefits

- Improved access: Especially beneficial for rural or remote patients who may have difficulty traveling to see a rheumatologist.
- Better patient outcomes: Comprehensive care can lead to a better understanding of the disease, improved adherence to treatment, and more effective management.
- Higher patient satisfaction: Patients feel more confident and engaged in their care because they receive a more complete and supportive experience.
- Enhanced communication: The team approach improves communication between providers and makes it easier for patients to get answers to their questions.

Challenges

- Implementation hurdles: Challenges can include the need for shared workspaces and electronic medical records, competitive compensation, and training for staff on team-based models.
- Cultural shift: Requires a collaborative team mindset, adaptability, and trust among team members.
- Patient experience: For some patients, longer visits with multiple providers might feel overwhelming.

I was also referred to information on the core principles of effective team-based care from the National Academy of Medicine,[8] and to a recent article in the *Journal of Rheumatology*. The latter was an abstract presented at the 2025 CRA ASM, reviewing the Centre of Arthritis Excellence (CArE), Ontario's only provincially funded community team-based model of rheumatology care. The authors concluded that their study "has provided insights into the critical components and contextual factors that contribute to successful delivery of interdisciplinary team-based rheumatology care. The findings will support the adoption, spread and scale of effective team-based models, aiming to improve the quality of care for individuals with RMDs".[9]

That is a goal we can all support.

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

References:

1. Djokovic on 'nasty fall': 'The real impact I will feel tomorrow. Available at *https://www.atptour.com/en/news/djokovic-wimbledon-2025-qf-reaction*. Accessed November 30, 2025.
2. Environmental cleaning and infection prevention and control in health care facilities in low- and middle-income countries. World Health Organization (WHO). Available at *https://www.who.int/publications/i/item/9789240051065*. Accessed November 30, 2025.
3. Glass Ceilings, Implicit Bias, Imposter Syndrome and the Matilda Effect. CRAJ. Available at *http://www.craj.ca/archives/2021/English/Fall/pdf/CRAJ_Fall_2021_Janet_Pope.pdf*.Accessed November 30, 2025.
4. The Matilda Effect: How Women Are Becoming Invisible in Science. Available at *https://www.lostwomenofscience.org/news-events/the-matilda-effect-how-women-are-becoming-invisible-in-science*. Accessed November 30, 2025.
5. Lincoln AE, Pincus S, Koster, JB. The Matilda effect in science: Awards and prizes in the US, 1990s and 2000s. *Social Studies of Science*. 2012;42(2):307–320. doi:10.1177/0306312711435830. PMID 22849001.
6. Roy D, Andreoli L, Ovseiko PV, et al. Gender equity in global rheumatology awards. *Ann Rheum Dis*. 2024;83:958–959.
7. Joy review – warm and intensely English portrayal of the birth of IVF. Available at *https://www.theguardian.com/film/2024/oct/15/joy-review-ivf-bill-nighy-james-norton*. Accessed November 30, 2025.
8. Core Principles & Values of Effective Team-Based Health Care. Available at *https://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf*. Accessed November 30, 2025.
9. King L, Daphne T, Zeenat L, et al. Elucidating the Program Theory of a Successful Interdisciplinary Team-Based Model of Rheumatology Care: An Implementation Science Exploratory Case Study. *The Journal of Rheumatology*. July 2025, 52 (Suppl 2) 101; DOI: https://doi.org/10.3899/jrheum.2025-0314.117.

CRA AI Scribes Peer Support Program Overview

In Fall 2025, the Canadian Rheumatology Association (CRA) launched the CRA AI Scribes Peer Support Program, a limited-time initiative designed to support members interested in integrating AI scribes into their clinical workflows.

This peer-led program helped CRA members explore and optimize the use of Scribeberry and Heidi Health, two leading AI scribe platforms which had partnered with the CRA. Through one-on-one mentorship, participants received personalized guidance from experienced CRA mentors who had successfully adopted these tools.

Thanks to our mentors, the program was well received, with strong participation from CRA members across the country. Feedback highlighted the value of peer-to-peer learning and of the practical support offered during the integration process.

While the peer support program is no longer active, the CRA continues to partner with AI scribe vendors Scribeberry and Heidi Health to offer additional value to CRA members.

AI scribe offerings for CRA Members include the following:

- Exclusive AI scribe discounts
- Extended 4-week FREE trials
- Rheumatology-optimized solutions
- Collaboration between scribe vendors and CRA

Take advantage of the CRA's AI scribe partnerships today and start your free trials!

Learn more
https://rheum.ca/resources/ai-scribes/

Do you have any suggestions or comments? Connect with the CRA at *info@rheum.ca.*

Advancing Community-Driven Research: Introducing the CRAF Community Research Fund

The Canadian Rheumatology Association Foundation (CRAF) is pleased to introduce the CRAF Community Research Fund, a new initiative designed to empower community-based rheumatologists to lead innovative research that enhances patient care and advances the field of rheumatology.

This new program provides community rheumatologists with a streamlined pathway to manage research funding obtained from an industry partner. The CRAF will oversee and administer the funding at a lower administrative cost than usual institutional rates, maximizing the research budget by minimizing overhead, so more funding goes directly to research efforts.

This program recognizes that meaningful research does not occur only in large academic centres. Across the country, community rheumatologists are identifying trends, challenges, and opportunities in real time, particularly those that directly affect access, quality of care, and patient outcomes. The Community Research Fund provides practical support to turn these insights into action.

Eligible projects must align with CRAF's mission to improve patient care and advance scientific knowledge in rheumatology. Proposals should include clear and measurable outcomes and be led by a CRA member serving as Principal Investigator or site lead.

The administrative structure includes a 15% fee, with an additional incentive for CRA members who champion matched-giving initiatives such as Rally for Rheumatology. Those members will be eligible to have 3% of their administrative fee reinvested in the same project or a future research initiative, further strengthening community-driven innovation.

By reducing barriers and supporting community leadership, the CRAF Community Research Fund encourages more rheumatologists to participate in research, more ideas to reach the implementation stage, and more discoveries to benefit patients.

This initiative reflects CRAF's commitment to supporting excellence in rheumatology education while ensuring that promising ideas, wherever they originate, can help shape the future of care in Canada.

CANADIAN RHEUMATOLOGY ASSOCIATION FOUNDATION
FONDATION DE LA SOCIÉTÉ CANADIENNE DE RHUMATOLOGIE

CRA members interested in applying can complete the online submission form and are invited to contact Virginia Hopkins (*vhopkins@rheum.ca*) with questions or for support.

Visit the website page to learn more and apply today.

https://crafoundation.ca/researchers/community-research-fund/

News from the ASM Program Committee

By Marinka Twilt, MD, MScE, PhD

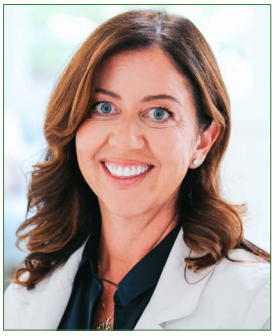
The Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM) Program Committee looks forward to seeing you all at the 2026 CRA ASM, this coming April 16th-19th, 2026. We are looking forward to reconnecting with colleagues and friends in Halifax!

We will celebrate the 80th anniversary of the CRA ASM. This year's meeting theme, Shifting Tides: Embracing Change in Rheumatology, will focus on shifting paradigms and evidence to assist the understanding of our diseases in order to improve care for our patients with rare diseases. We will once again provide unparalleled educational and networking opportunities, centered on a program that will deliver innovative leading-edge science, interactive programming, and insights from Canadian and international experts.

In addition to the Distinguished Investigator lecture, which will be delivered by awardee Dr. Cheryl Barnabe, the ASM will feature three keynote addresses: Dr. Elizabeth Volkmann from the University of California will present her lecture titled, "Holistic Approaches to Autoimmunity"; Dr. Michael Ombrello from the National Institute of Health (NIH), USA, will discuss "Still's Disease and AOSD Across the Age Spectrum"; and Dr. Lisa Christopher-Stine from the Johns Hopkins Myositis Center will present the 2025 Dunlop-Dottridge Lecture, "Myositis."

Dr. Michael Ombrello

Dr. Lisa Christopher-Stine



Dr. Elizabeth Volkmann

This year's ASM schedule will change slightly from last year; it will start on Thursday at 1:30 pm with core educational content featured from Thursday to Saturday (Thursday morning prior to start of the ASM and Sunday morning will be reserved for small group meetings). The meeting will commence the afternoon of Thursday April 16th, 2026, with the Year in Review and will end Saturday, April 19th, 2026, with the gala dinner and awards ceremony. Each day will offer a full day of educational programming, with adequate time for networking. This year we have a new session called "Tough-to-Treat" where the speakers will highlight definitions, management, existing knowledge gaps and the importance of a multidisciplinary approach through a case-based structure. In addition to the top abstract sessions introduced last year, we will introduce a new abstract workshop on "translational research"—your opportunity to engage directly with cutting-edge research and participate in lively discussions with leading experts.

The meeting will of course feature all of the compelling content you have come to expect from the CRA ASM. We will have poster sessions and poster tours for trainees and investigators to showcase their research activities; State-of-the-Art, paired specialty and crowd-sourced workshops; satellite symposia; as well as favourites such as Mysterious Cases and Clinical Pearls, Controversies in Rheumatology, the Year in Review, RheumJeopardy and the Great Debate! This year's debate topic is "Be it Resolved that Medications Should be Tapered in Patients with Inflammatory Arthritis." Opportunities to celebrate our award-winning colleagues will be featured throughout the meeting. The Residents' Pre-Course will again be delivered over two days, one virtual afternoon in January and one in person on Thursday April 16th (in the morning) before the CRA ASM.

We welcome all CRA and AHPA members, as well as other colleagues within the rheumatology community from across Canada and around the world. We look forward to seeing you all in Halifax and celebrating all our achievements together in April 2026.

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

Abstract Review Committee Update

By Mohammed Osman, MD, PhD, FRCPC

Dear Colleagues,

The abstracts have been submitted, and the CRA Abstract Review Committee has been working hard, reading and scoring the abstracts, ably supported by Virginia Hopkins (Manager, Innovation & Research). The committee aims to select the abstracts most worthy of poster or podium presentations at the 80th CRA Annual Scientific Meeting (ASM). We are excited to see you all in Halifax!

This year, we received 282 abstract submissions. Each abstract will be scored by three reviewers, and the best in each category are chosen based on the average score. The chair will break any tie for a spot on the podium presentations and in-person poster tours. Many thanks to all our reviewers for their help and commitment!

The ASM will feature in-person poster tours, poster sessions, and an exciting new **Translational Science Abstract Workshop** which, along with the other Abstract Workshops and Podium presentations, will showcase the exciting work our community is performing! During these sessions, we will adjudicate the top five abstracts in each award category:

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

We look forward to celebrating these achievements and connecting with you during the in-person CRA ASM in Halifax!

Sincerely,

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

News from the Therapeutics Committee

By Alison Kydd, MD, PhD, FRCPC

The CRA Therapeutics Committee has been busy over the past year. Some of the highlights include the following:

- Preparation of numerous reviews for Canada's Drug Agency (CDA) for submission by the CRA
- Development of a Therapeutics Access review summary to provide the basis for advocacy for medication access in different jurisdictions
- Position statements on vaccinations in patients with rheumatic diseases, hydroxychloroquine monitoring guidance for optical coherence tomography, access to targeted agents for rheumatoid arthritis, and JAK inhibitors for juvenile idiopathic arthritis (JIA) in collaboration with the Paediatric Committee
- Submission of feedback on a consultation call for advice on a national bulk purchasing strategy

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

This work is only possible through the dedication of our volunteer committee members, who are all very busy with their numerous other roles. Our committee is involved, enthusiastic and a pleasure to work with. As always, I am impressed with our committee members' timely responses and expert guidance. Our work would not be possible without Sarah Webster, a dedicated CRA staff member, who is critical to our ongoing functioning.

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

Delivering Timely, Evidence-based Support for People with Arthritis

Arthritis Society Canada is dedicated to supporting the six million people in Canada living with arthritis by providing free, evidence-based programs and resources that promote effective arthritis management and improved quality of life. Through a national ecosystem of information, education, and support services, the organization helps people make informed decisions about their health and navigate the daily challenges of arthritis with confidence.

Arthritis Management Tools and Resources

Arthritis Society Canada offers an extensive library of credible, up-to-date information on arthritis types, treatments, symptom management, physical activity, mental health, and strategies for daily living. These resources are accessible anytime at *arthritis.ca*, ensuring nationwide access to trusted guidance.

Arthritis Connections

Arthritis Connections provides moderated online peer support groups where people can share experiences, exchange strategies, and find community with others who understand the realities of arthritis. The program fosters connection, resilience, and shared support. Visit *arthritis.ca/connections* for more information.

Arthritis Line

The Arthritis Line is a national information service offering personalized support from trained professionals. Individuals can receive guidance on arthritis management, treatment considerations, community resources, and day-to-day concerns by calling 1-800-321-1433 (select option 2) or emailing *info@arthritis.ca*.

Arthritis Talks

Arthritis Talks is a national webinar series featuring leading clinicians, researchers, and experts who share evidence-based insights on pain management, joint health, emerging therapies, and more. Participants can register for upcoming webinars or access past recordings at *arthritis.ca/talks*.

To learn more about Arthritis Society Canada's programs and resources, please visit *arthritis.ca*.

Arthritis™ SOCIETY CANADA

Pediatrics Committee Update

By Nadia Luca, MD, FRCPC, MSc

The CRA Pediatrics Committee is a diverse and active group of 95 pediatric rheumatologists, trainees and researchers from across Canada. The Pediatrics Executive oversees the work of several subcommittees including Human Resources, Education, and many working groups. The Pediatrics Executive currently consists of: Dr. Nadia Luca (Chair), Dr. Lillian Lim (Vice-Chair and CRA board liaison), Dr. Audrea Chen (Secretary), Dr. Bobbi Berard (Past-Chair), and Dr. Mercedes Chan (Member-at-Large). Starting in November 2025, we will welcome a pediatric rheumatology trainee representative, Dr. Daphne Cheung.

Members of the CRA Pediatrics Committee at the CRA ASM in Calgary (February 2025).

The Pediatrics Committee members have been very busy over the last twelve months, offering a variety of educational opportunities in addition to producing manuscripts and guidance materials. Here is a summary of some of the important work they have completed over the past year:

- The Canadian Autoinflammatory Case Rounds (CANaC) Steering Committee offered two presentations for pediatric members: "A Year in Review for SAIDs" (Presented by Dr. Erkan Demirkaya) and "Spectrum of Behcet's: Beyond the Basics" (Presented by Drs. Lori Tucker and Dilan Dissanayake).
- The Education Subcommittee offered two accredited National Grand Rounds webinars: "Planetary Health" (presented by Dr. Stephanie Tom) and "Changing Rheums: A Day in the Life of a Young Adult with a Rheumatic Disease, reviewing the new CRA Transition Clinical Practice Guidelines" (presented by Drs. Nadia Luca, Elizabeth Stringer, Ms. Julie Herrington and Ms. Emma Linsley).
- Drs. Evelyn Rozenblyum and Piya Lahiry gave a workshop at the Canadian Pediatric Society Meeting in Quebec City entitled: "Bugs, drugs and joints: Everything you ever wanted to know about infectious arthritis but were too afraid to ask!"
- The HR Subcommittee published their qualitative study describing models of pediatric rheumatology care across Canada, led by Drs. Molly Dushnicky, Jennifer Lee and Deb Levy - "Pediatric Rheumatology Care in the Canadian Context: A Qualitative Analysis of Care Providers" (DOI: 10.3899/jrheum.2024-0965)
- The newly developed Transition Clinical Practice Guidelines were presented in a workshop at the CRA ASM by Natasha Trehan, Julie Herrington, Dr. Nadia Luca and Dr. Elizabeth Stringer.

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

Education Committee Update

By Beth Hazel, OLY, MDCM, FRCPC, MM

This past year the CRA Education Committee has continued to strengthen its commitment to positioning the CRA as the leading provider of rheumatology resources and continuing professional education for our members. We remain committed to proactively addressing their evolving educational needs. In 2025, our key focus areas included optimizing program structures, advancing our processes for assessing and responding to member learning needs, and leadership succession planning.

To better inform program and activity planning, the annual needs assessment was conducted at an earlier time point in the year. This adjustment provided sufficient time to interpret, share, and apply the findings to upcoming initiatives, while also enabling the committee to expand its overarching process for overseeing and coordinating educational priorities. To facilitate this, a new tool was introduced to help streamline educational content delivery, maximize topic breadth, and reduce redundancy across CRA programs. Beginning next year, committees and planning groups will use the new topic matrix tool to guide all educational planning initiatives and ensure alignment with prioritized learning needs.

To capture unperceived learning needs more effectively, the committee launched quarterly pulse surveys. These short, targeted questionnaires are disseminated to members to explore alternative channels for assessing continuing professional development (CPD) needs. The pulse surveys complement the annual needs assessment, enabling a more responsive approach to identifying emerging educational gaps.

This year marked a major advancement in resident programming with the formal consolidation of resident program committees and sub-committees into RheumAcademy, the new overarching framework responsible for delivering a cohesive resident curriculum through the Resident Pre-Course, National Written Rheumatology In-Training Exam (NWRITE) and Objective Structured Clinical Examination (OSCE) sub-committees. The CRA continues its standing commitment to assessment-driven learning, with the NWRITE, long established with adult programs, and the inaugural pediatric pNWRITE which was successfully launched this year. Since 2021, the CRA has also supported a national virtual OSCE, building on years of in-person delivery at the National Rheumatology Residents Weekend (NRRW).

The CPD Sub-Committee continued to review both internal and external programs, ensuring high standards of educational quality and accreditation consistency. The Postgraduate Sub-Committee remained committed in their development of rheumatology resources, including the development of a National Immunology Curriculum for Rheumatology learners and educators, reflecting the CRA's commitment to core training enhancements. The CRA LEAdership Program (LEAP) delivered a combination of virtual and in-person programming for the current two-year cohort of future rheumatology leaders.

The Annual Scientific Meeting (ASM) remains a cornerstone event for the CRA; the Education Committee continues to contribute to the scientific planning content and support presenter programs at the conference. The committee remains involved in cross-committee collaboration, oversees the Practice Reflection Award program, and recently supported the Mini-Practice Audit Model (mPAM) pilot program.

Finally, in 2025, the committee was delighted to welcome Medha Soowamber as vice-chair, bringing valuable leadership to support long-term succession planning and ensure continuity.

The Education Committee remains committed to delivering relevant, high quality, and coordinated educational opportunities throughout all stages of a rheumatologist's career. We will evolve our approaches to ensure CRA's educational offerings remain responsive, inclusive, and aligned with our members' professional development needs.

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

Equity, Diversity and Inclusion Task Force Update

By Nicole Johnson, MD, FRCPC

Amorell Saunders N'Daw continues to engage with the Canadian Rheumatology Association's Equity, Diversity and Inclusion (EDI) Task Force as an advisor and shared her thoughts on the collaboration: "I've worked with many organizations and committees and I have to say that the members of the CRA EDI Task Force bring a passion of purpose and commitment to promoting inclusive and equitable practices that is truly impressive in intent and execution."

This summer, the EDI Task Force launched an inclusivity scan to gain deeper insight into how CRA members perceive the organization's EDI initiatives.

Members were invited to participate in focus groups or complete a survey. Three focus groups were held between July and September, bringing together a total of 11 participants. These sessions provided valuable feedback on the CRA's EDI efforts, with participants offering thoughtful reflections and encouraging remarks about the organization's commitment and progress. If you are still interested in providing your input through the survey, please reach out to *estewart@rheum.ca*.

The final report from the inclusivity scan will be completed once all survey responses are received and analyzed. This will occur after the publication deadline for this article. Once we have our finalized results, look for an update in the future!

Interested in Joining the EDI Task Force?

The EDI Task Force is actively seeking new members. Current members share how the experience has impacted them:

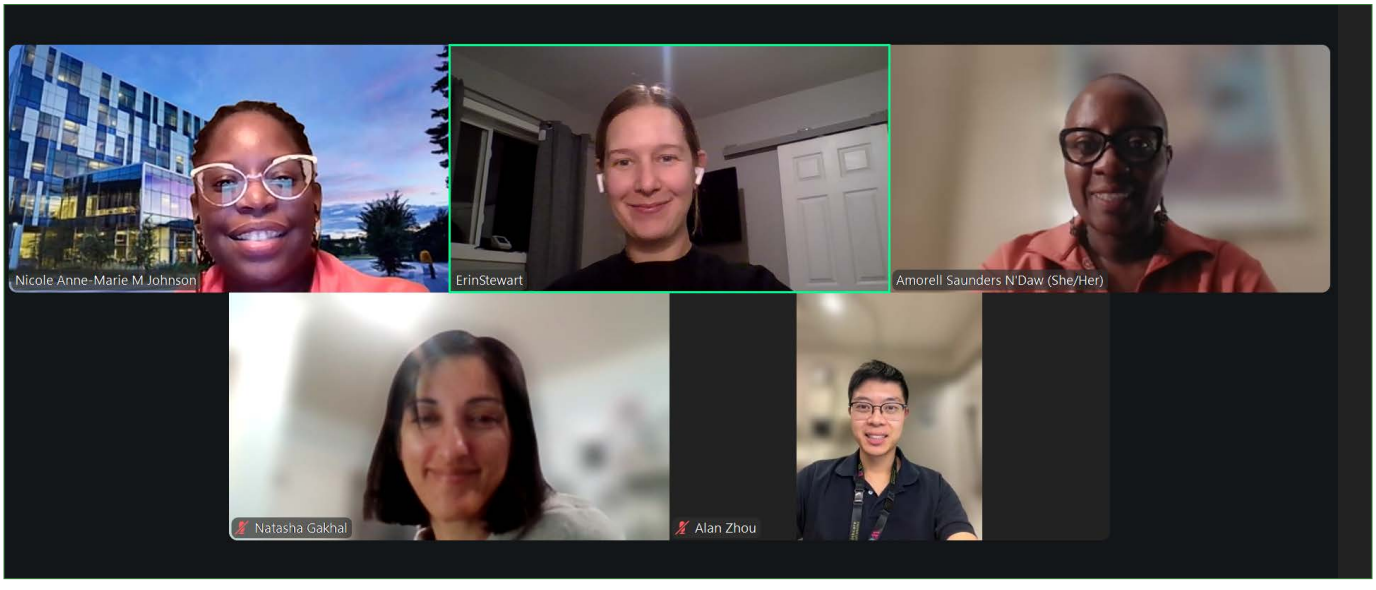
"I joined the EDI Committee to deepen my understanding of equity, diversity, and inclusion and to learn from colleagues with diverse perspectives. Through this work, I have grown as an advocate and applied these insights to help improve the CRA's culture, member experience, and ultimately the care we provide to patients." – Dr. Natasha Gakhal.

"It has been humbling to see the members of the CRA EDI Task Force come together to tackle the challenging but important work of advancing equity and inclusivity in our organization. I feel fortunate to work alongside such dedicated colleagues and am grateful to be a part of this effort." – Dr. Alan Zhou.

"Being part of the EDI task force has enriched my understanding of others, fostering personal growth, compassion, and better communication." – Dr. Manisha Mulgund.

If you're interested in contributing to this important work, please email *info@rheum.ca* to learn more or express your interest.

Nicole Johnson, MD, FRCPC
Pediatric Rheumatologist, Clinical Associate Professor, University of Calgary
Chair, EDI Task Force, CRA
Calgary, Alberta



Members of the CRA EDI Task Force at a recent virtual meeting.

CRA SCR

2026 ANNUAL SCIENTIFIC MEETING

2026 ASSEMBLÉE SCIENTIFIQUE ANNUELLE

APRIL 16-19 • HALIFAX, NS • 16-19 AVRIL

CRA ANNUAL SCIENTIFIC MEETING

APRIL 16 – 19, 2026

asm.rheum.ca

Registration Opens Dec. 1, 2025 | IN PERSON

New dates, same great conference!

Join us for the 2026 CRA Annual Scientific Meeting, hosted IN PERSON in Halifax, Thursday to Sunday, April 16 – 19, 2026!

Exceptional education, innovative science, interactive programming, and **networking** with Canada's largest rheumatology community.

This year's theme, **Shifting Tides: Embracing Change in Rheumatology,** encourages delegates to embrace new perspectives, challenge old assumptions, and shape the future of rheumatologic care—together.

Learn more and register at **asm.rheum.ca**

Registration deadline: Mar. 20, 2026

VIRTUAL | VIRTUELLE

RheumReview

Learn more

Feb. 20, 2026

Registration opens Nov. 14, 2025

Refresh your knowledge with a high-yield educational program on clinically relevant topics! **CRA RheumReview: Canadian Clinical Updates** is a full-day virtual event offering rheumatologists practical, evidence-based updates on hot topics in rheumatology.

Registration deadline: Jan. 30, 2026

Advancing Excellence and Supporting Members Through Innovation: An Update from the Quality and Innovation Committee

By Amanda Steiman, MD, MSc, FRCPC

The Quality and Innovation Committee (QIC)—formerly known as the Quality Care Committee—has undergone a thoughtful evolution this year to better reflect its dual focus: advancing quality of care and supporting innovative approaches to optimize practice and physician well-being. The committee remains committed to its ongoing collaboration with Choosing Wisely, under the leadership of Dr. Arielle Mendel, ensuring continued alignment with evidence-based, high-value care in rheumatology. This year, in addition to continued focus on cultivation/adaptation of existing rheumatology indicators, there were also efforts made to build awareness of Choosing Wisely statements of other subspeciality groups, germane to the practice of rheumatology.

A key initiative of the QIC this year is the launch of the CRA Innovation Lab, designed to help members enhance practice efficiency, improve workflow, and ultimately strengthen patient care. The Innovation Lab embraces a collaborative model—all teach, all learn—where members share tools, strategies, and models of care that are working effectively across the country.

The 2025 National Physician Health Survey was recently published by the Canadian Medical Association, which revealed that physician burnout remains high at 46%. Key findings of the survey highlighted the important contribution of administrative burden, with the majority of physicians spending more than a full further workday (10.4 hours) per week on their electronic medical records (EMRs) outside of their clinical time. It is with this challenge in mind that we launched the Innovation Lab series.

The inaugural session, held on October 15th, 2025, titled "Burnout and Efficiency: You Are Not the Problem," featured Drs. Diane Lacaille, Mamta Gautam, and Anand Doobay. Together, they facilitated a compelling discussion on the multifactorial contributors to burnout and explored actionable strategies for fostering resilience and system-level change. Participants also examined "pockets of positive deviance"—innovative practices within our community that improve both care delivery and professional satisfaction.

Future initiatives will address workflow optimization, the use of artificial intelligence (AI) and human scribes, and leveraging EMR data to advance quality indicators and collaborative learning. The QIC looks forward to ongoing engagement with CRA members through these initiatives, as together we continue to drive innovation, enhance quality, and support the well-being of our rheumatology community.

Amanda Steiman, MD, MSc, FRCPC
Associate Professor, University of Toronto
Staff Rheumatologist, Division of Rheumatology,
Mount Sinai Hospital/University Health Network
Rebecca MacDonald Centre for Arthritis &
Autoimmune Disease
Toronto, Ontario

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.

Inspired by patients. Driven by science.

REVIEWED BY PAAB

Pr Bimzelx® (bimekizumab)

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.

† 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)

Update from the ORA

By Deborah Levy, MD, FRCPC

On behalf of the Ontario Rheumatology Association (ORA), please accept a warm greeting! The *CRAJ* is a great forum to share our successes with colleagues, and to reflect upon the achievements over the past year. I am fortunate to work with a committed executive, board and committee chairs and members, all of whom have fuelled the success of our initiatives and events. Together we are committed to improving rheumatology care across Ontario as well as nationally through our important partnerships.

A few highlights:

The Annual Scientific Meeting (ASM) with the theme of "Strength in Collaboration, Innovation in Practice" was held at the Kingbridge Centre this past May and was a great success, once again surpassing our prior attendance records. Our state-of-the-art meeting featured renowned Canadian and international speakers including Dr. Mandy Nikpour, Dr. Victoria Werth, Dr. Elizabeth Stringer, Dr. Maja Djikic, Dr. Tom Appleton, Dr. Mats Junek and Dr. Janet Pope, alongside several other highly respected "local" rheumatologists. Feedback and reviews from attendees including rheumatologists, allied health and industry partners were uniformly excellent. We are already looking forward to the 2026 ASM scheduled for May 22nd-24th at the same location. This meeting is open to rheumatologists across the country, so please mark your calendars. Details will be available in the new year.

The Informatics Committee, chaired by Dr. Tom Appleton, is set to release RheumViewPLUS™ this Fall. The new launch will include a powerful integrated AI Assistant known as ROXI (Rheumatology Optimized eXpert Intelligence). ROXI takes AI in the rheumatology practice to a new level. In addition to the capabilities of a regular AI Scribe and Note Generator, ROXI offers the never-before-seen capability of a Charting Agent that extracts key information from a transcript and immediately enters it as structured data in the chart. ROXI also offers an integrated AI-assisted Rheumatology Consultant that supports AI chat consultations. ROXI combines the power of AI, rheumatology expertise and RheumView™. We are excited to make this tool available to our members!

The Government Affairs Committee, chaired by Dr. Jane Purvis, continues to meet regularly with the Ministry to ensure that Ontario rheumatologists and their patients are well served by government programs. Goals include streamlining paperwork for prescribers and reducing wait times for patients needing medications. The committee is also active in advocating for a General Practitioner-focused practice designation in Primary Care Rheumatology. This has involved collaboration with the OMA Section of Rheumatology, allied health professionals and testimonials from patients.

Dr. Dana Jerome was presented with the ORA Rheumatologist of the Year Award by Dr. Philip Baer.

The RheumOpportunities committee, chaired by Dr. Faiza Khokar, held its inaugural "Rheum to Discover" event on September 27th, 2025, hosted at McMaster University. This event welcomed 35 first- and second-year medical students from the seven Ontario medical schools to a day-long introduction to rheumatology event. It began with an inspirational talk by Dr. Simon Carette, and included hands-on workshops, interactive learning sessions, and Q&A panels with adult and pediatric rheuma-

Dr. Catherine Ivory was presented with the Early Career Rheumatologist Award by Dr. Deborah Levy.

tologists representing the different career stages as well as work environments. Feedback has been enthusiastically positive, and we are looking forward to establishing this annual ORA event in our calendars. With this early introduction, we expect a strong future for the Ontario rheumatology workforce.

The Northern Ontario Committee, chaired by Dr. Kamran Shaikh, has been working hard in its goal to improve equitable access to rheumatological care in northern communities. A pilot project that began in 2022 in Thunder Bay demonstrated successful results, leading to its expansion across other hubs in northern Ontario. The committee also created a Clinical Pearls document around care provision for Indigenous populations. This resource was disseminated to the ORA membership and is also available on our website.

Dr. Jonathan Park and Dr. Jennifer Lee co-chair our Pediatric Committee. They have been working on a province-wide quality improvement initiative aimed at assessing and enhancing access to care for patients newly diagnosed with Juvenile Idiopathic Arthritis (JIA) in Ontario. The four academic pediatric rheumatology centres (London, Hamilton, Toronto, and Ottawa) are evaluating current access-to-care metrics—specifically whether children diagnosed with JIA are assessed promptly by a pediatric rheumatologist, while identifying existing gaps in care. We look forward to seeing these results at the next CRA ASM.

At the ORA board, we thank Dr. Dana Cohen for her service in completing her term, and welcome Dr. Andrew Chow as a new board member. The Executive will continue its momentum without any changes until after the 2026 ASM, and I am looking forward to a membership engagement event in Ottawa in January 2026. Special thanks to Dr. Sahil Koppikar on completing his term as Chair of the Northern Ontario Committee, and for his innumerable hours dedicated to establishing government funding for the new Models of Care. A warm welcome to Dr. Gemma Cramarossa who has taken on co-chair responsibilities for the Early Rheumatologists of Ontario (ERO) committee.

Congratulations are also extended to our 2025 ORA Award Winners, given out at our ASM. Dr. Dana Jerome was awarded the ORA Rheumatologist of the Year, Dr. Catherine Ivory was given the Early Career Rheumatologist Award, and Dr. Michael Sugai and Dr. Lynn Hamilton received the Distinguished Members Award. Each award was well-deserved and deeply appreciated.

The ORA has multiple other exciting initiatives underway. All of these events and initiatives would not be possible without the countless volunteer hours of our dedicated leadership team and ORA members. We are also incredibly grateful for our fantastic Executive Director, Sandy Kennedy, for her dedication to ensuring our ongoing success.

All the best for the coming year.

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

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

By Jason Kur, MD, FRCPC

Political Climate

The healthcare landscape in British Columbia (BC) has shifted significantly over the past year. Although the NDP government remains in office, it now faces a much tighter fiscal environment. Funding shortfalls and shrinking budgets have affected many areas of healthcare across the province. As a result, negotiations related to specialist waitlist management have stalled, and the expansion of specialist team care programs has slowed. Despite these challenges, there have been a few positive developments worth highlighting.

Dr. John Esdaile and distinguished lecturer Dr. Neda Amiri.

Corridors of Care

Dr. Brent Ohata is collaborating with the "Provincial Pathways Program" to establish "Corridors of Care." Pathways is an online resource that provides physicians and their teams with quick access to accurate referral information, including current wait times and specialists' areas of expertise. The "Corridors of Care" initiative aims to improve access to rheumatology in remote BC communities by connecting them through Pathways to rheumatologists with shorter wait times.

Complex Care Codes

For over a decade, BC rheumatologists have been able to use a time-based complex consult code to support patients with multisystem diseases. This code recognizes the additional time and planning required for these complex initial consultations. Following a successful disparity award in 2020, the BC Society of Rheumatologists (BCSR) is now preparing to introduce two new complex follow-up codes; one time-based and the other focused on multi-organ disease. These are now close to implementation.

The purpose of these new codes is multifaceted. A key goal is to help address gender pay disparities in rheumatology. Studies show that female physicians often spend more time with complex patients yet earn less for the same hours worked. These new codes are a small but important step toward recognizing that additional effort.

In addition, the multi-organ disease follow-up code is intended to support sub-specialty rheumatology clinics, where physicians manage particularly complex patients and often face financial limitations. Together, these new billing codes are designed to strengthen care for BC's most vulnerable patients.

Recruitment and Retention

Many regions in BC continue to struggle with shortages of specialist physicians. Reports of emergency department closures in small communities and hospital-based specialist resignations are becoming increasingly common. In community rheumatology, significant service gaps persist, particularly in Northern BC and parts of the Interior, such as Kamloops. In contrast, Vancouver and Victoria currently have adequate rheumatology coverage.

This year, BC hosted two major rheumatology meetings:

- The Western Alliance of Rheumatology (WAR) meeting in Kelowna (May)
- The 20th annual BC Rheumatology Invitational Educational Series (BRIESE) Conference in Vancouver (November)

WAR had great representation from across the West, including a large contingent from Saskatchewan this year. The BRIESE Conference was also another great success, featuring insightful presentations from: Dr. Neda Amiri (UBC), Dr. Jonathan Chan (UBC), Dr. Ann Clarke (University of Calgary), Dr. Narsis Daftarian (Arthritis Research Canada), and Dr. Anisha Dua (Northwestern University School of Medicine).

Honouring Our Colleagues

As we reflect on the year, we also wish to recognize a member of the BC rheumatology community who has recently retired.

Dr. Jolanda Cibere has made immeasurable contributions to UBC Rheumatology and Arthritis Research Canada. She has been a leader in osteoarthritis care and a champion for both excellence in research and compassionate teaching. Many of us have benefited greatly from her dedication and expertise.

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

Attendees at the Western Alliance of Rheumatology Meeting in Kelowna, BC, May 2025.

The AMRQ: A Year of Consolidation and Momentum for the Future

By Hugues Allard-Chamard, MD, PhD, FRCPC

The *Association des médecins rhumatologues du Québec (AMRQ)*, in collaboration with the *Fédération des médecins spécialistes du Québec (FMSQ)*, has seen negotiations with provincial authorities intensify in recent months. Despite significant ministerial changes that are currently slowing down negotiations, we hope for a swift resolution to the crucial issues related to the organization of care and remuneration for our approximately 160 Quebec rheumatologists, as well as access to the technical platforms necessary for optimal practice. We are also advocating for the inclusion of an arbitration clause to regulate working conditions in the event of a dispute, thereby ensuring fair and transparent processes for our members in the future and avoiding a repeat of the current negotiation stalemate with the next administration.

In order to modernize our practice, this year we launched a strategic initiative to evaluate the integration of ultrasound into our clinical practice. This project aims to fully recognize its diagnostic and therapeutic value and to ensure fair and appropriate remuneration.

In addition, our pilot project with the *Institut de la pertinence des actes médicaux (IPAM)*, aimed at supporting medical practice in rheumatology, will continue its activities for the coming year pending renewal by the provincial government. Three sites are now fully operational, and we are confident that we will be able to continue rolling out this innovative project, which provides Quebec patients with better access to care.

At our annual conference held in Quebec City from October 2nd to 4th, 2025, we were pleased to present the AMRQ Merit Award to Dr. Gaëlle Chédeville, a pediatric rheumatologist at the McGill University Health Centre (MUHC), in recognition of her outstanding commitment to the discipline. We also inaugurated a new award: the Rising Star Award in Rheumatology in Quebec, presented to Dr. Arielle Mendel, a young rheumatologist at the MUHC whose research career is taking off in remarkable fashion.

Finally, we would like to emphasize that the past year has been rich in achievements, and that the coming year promises to be decisive for the improvement of our working conditions and the future of rheumatology in Quebec. The AMRQ will continue its efforts with determination, driven by the commitment of its members and the vision of its board of directors.

Together, we will continue to advance our specialty and provide quality care to patients in Quebec.

Hugues Allard-Chamard, MD, PhD, FRCPC
President of the Association des médecins rhumatologues du Québec
Montreal, Quebec

CPD for the Busy Rheumatologist

Maintenance of Certification: How Do I Begin to Navigate This Refreshed Approach?

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

Dr. Aki Joint, a member of the Canadian Rheumatology Association, remarked, "There is a new Royal College Maintenance of Certification (MOC) Program with different guidelines. However, I am uncertain about what they are."

Beginning January 1st, 2024, the Royal College of Physicians and Surgeons of Canada changed the requirements for its MOC program. This refresh was based on feedback from Royal College fellows and health care professionals. The MOC is an integral part of the process to remain a fellow in good standing of the Royal College of Physicians and Surgeons of Canada and meets the requirements of most medical regulatory associations (*https://www.royalcollege.ca/en/cpd/moc-program*). Additionally, residents may also earn credits and transfer up to 75 credits into their first 5 year cycle, with a maximum of 25 credits from each of the three sections (*https://www.royalcollege.ca/en/cpd/moc-program/resident-affiliates.html*). Each five-year cycle runs from January 1st to December 31st.

In 2024, the following changes were made to the MOC:

1) Each 5-year cycle now requires a total of 250 credit hours
2) A minimum of 25 credit hours per year
3) A minimum of 25 credit hours from Section 3
4) One activity must be completed in the "Feedback Received" category within Section 3 (no minimum credits required for this activity). For more information, please see RCPSC MOC Framework (*https://www.royalcollege.ca/en/cpd/moc-framework.html*).

The three sections of the MOC are:

1) **Section 1:** Group Learning activities include all knowledge, skills and abilities developed through partner, group and team learning experiences. All activities must include an interactive component with opportunities for discussion. This section's name is unchanged; and social media, case-based discussions, resuscitation courses and patient-partnered learning have been added.
2) **Section 2:** Individual Learning includes all knowledge, skills and aptitudes acquired through self-directed, independent learning. This section's name remains unchanged; and courses, individual task training, and patient-centred activity preparations have been added.
3) **Section 3:** Feedback and Improvement involves activities where feedback is received, feedback is given or a quality improvement initiative is undertaken. This section's name has been modified to explicitly recognize quality improvement activities. Some examples of additions are quality improvement initiatives, adverse event reporting, and coaching activities.

"I am now clearer about the changes to the categories," says Dr. Joint. "But how do I report the credits I have earned for the January 1st, 2025, to December 31st, 2025, year?"

Changes have also been made to the process by which Fellows are required to log their MOC credit hours and the module through which they do so.

1) MAINPORT has been changed to MyMOC and can be accessed at MyMOC *(https://www.royalcollege.ca/en/members/moc/dashboard.html*).
2) For Sections 1, 2 and 3 the following information must now be included:
   a. activity title
   b. one key message learned
   c. your responses to reflection questions (optional)
3) For Section 3 activities a brief description of what will be changed in your practice must also be included.

Table.

Summary of Royal College of Physician and Surgeons of Canada MOC Changes (effective January 1, 2024)

Aspect	Old MOC Program	New MOC Program (2024 Refresh)
Total Credits (5-year cycle)	400 credits	250 credits
Annual Minimum Credits	40 credits/year	25 credits/year
Section 1 & 2 Minimums	Required minimums	No minimums
Section 3 Requirements	No specific feedback activity required	Minimum 25 credits + 1 "Feedback Received" activity
Eligible Activities	Traditional CPD activities only	Includes social media, patient-partnered learning, case-based discussions
Credit Tracking Platform	MAINPORT	My MOC (launched August 2024)
Focus Areas	CPD documentation	Quality Improvement, physician wellness, modernized learning

(https://car.ca/news/royal-college-makes-changes-and-updates-to-maintenance-of-certification-framework/)

"I now have learned about the changes to the MOC program. With my cycle ending in December 2026, my earlier credits carry over unchanged, and I can enter my new learning activities into the new portal. I should make sure my residents know about these changes, as they can carry over some of their learning activities credits to their MOC."

Elizabeth M. Wooster, B.Comm, M.Ed, PhD(c)
OISE/University of Toronto
Research Associate,
School of Medicine, Toronto Metropolitan University

Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE
CRA Education Committee Past Chair,
Program Director and Clinical Associate Professor,
University of British Columbia
Director, Intensive Collaborative Arthritis
Program, Mary Pack Arthritis Program
Clinician Investigator, Arthritis Research Canada
Division Head, Rheumatology, Richmond Hospital
Rheumatologist, West Coast Rheumatology Associates
Richmond, British Columbia

Madelaine Beckett, MD, FRCPC
Adult Rheumatology Resident
University of British Columbia

Douglas L. Wooster, MD, FRCSC, FACS,
DFSVS, FSVU, RVT, RPVI
Professor of Surgery,
Temerty Faculty of Medicine, University of Toronto
Clinical Professor
School of Medicine, Toronto Metropolitan University

From Polyarthritis to Aggressive Nodulosis: An Unusual Evolution of Rheumatoid Arthritis

By Kavya Mulgund; and Tripti Papneja, MD, FRCPC

Case Presentation

A 61-year-old female with hypertension presented initially in 2011 with several weeks of joint pain, morning stiffness and fatigue. Examination demonstrated swelling of multiple metacarpophalangeal (MCP) joints with no extra-articular features. Laboratory testing revealed hemoglobin 88 g/L, ferritin 8 µg/L, ESR 71 mm/hr, CRP 34.8 mg/L, rheumatoid factor 299 IU/mL, and ANA 1:640 speckled. Anti-CCP was negative. She was diagnosed with seropositive rheumatoid arthritis (RA) and was started on methotrexate and hydroxychloroquine with good response. Her RA entered remission by 2013, and she elected to discontinue disease-modifying anti-rheumatic drug (DMARD) therapy. Between 2013-2024, she was treated for osteoporosis, transitioning from bisphosphonate therapy to denosumab injections. She continued on valsartan and amlodipine for her hypertension. She developed Raynaud's phenomenon in February 2023.

She was in Pakistan from April to May 2024 and started to feel very unwell with fever, marked fatigue and joint pain/swelling. She couldn't move her right elbow. She was started on prednisone 60 mg daily, to be tapered by 5 mg every 2 days. In June 2024, she developed nodules on her hands (Figure 1) and reported anorexia with 20 lbs. weight loss, intermittent low-grade fever, cough and xerostomia. Examination detected 6 swollen joints, predominantly affecting MCP and proximal interphalangeal (PIP) joints, and multiple, discrete, tender nodules over the dorsal and palmar aspect of both hands.

Bloodwork showed the following: hemoglobin 114 g/L, WBC 4.1 $\times 10^9$/L, platelets 219 $\times 10^9$/L, ESR 40 mm/hr, CRP 1.3 mg/L, persistent ANA ≥1:640 speckled, positive SSA/SSB (>8.0, normal is <1.0), mildly positive RNP (2.0, normal is <1.0), low complement levels (C3 0.80 g/L, C4 0.14 g/L), and negative anti-dsDNA, hepatitis B/C, HIV and Quantiferon gold TB testing. A working diagnosis of RA flare was made, and prednisone and leflunomide were initiated.

A punch biopsy of a hand nodule (August 2024) showed dermal proliferation of histiocytes and multinucleated giant cells containing eosinophilic "ground-glass" cytoplasm with sclerotic stroma, confirming the diagnosis of multicentric reticulohistiocytosis (MRH). Biopsy of a lesion on her back was consistent with granuloma annulare.

Given the diagnosis of MRH, malignancy screening was completed. Colonoscopy, mammography and CT scan of the head were normal. CT of the abdomen/pelvis revealed hepatic and renal cysts. CT of the chest showed cystic interstitial lung disease with multiple thin-walled cysts, most consistent with lymphoid interstitial pneumonia. Her pulmonary function test demonstrated restrictive defects. She had an endobronchial ultrasound on November 6th for sampling of mediastinal lymph nodes, results of which are pending. ENT is following her for a 3.7 x 3.0 cm right paratracheal mass, presumed to be due to an enlarged thyroid.

Discussion

Multicentric reticulohistiocytosis (MRH) is a rare, multisystem, class IIb non-Langerhans cell histiocytosis characterized by granulomatous proliferation of the mononuclear phagocyte system. It is marked by destructive polyarthritis and papulonodular skin lesions. Polyarthritis is often the first and most prominent feature, progressing to destructive arthritis and disability. We present a case of MRH and review current literature on its clinical features, diagnostic approach, and management.

Figure 1. Papulonodular cutaneous lesions on the hands of our patient.

Epidemiology

MRH is a rare disease with slightly more than 300 cases reported worldwide. The true incidence and prevalence of this disease is unknown. It predominantly affects Caucasian females in their fifth and sixth decade of life, with a female-to-male ratio of 3:1.

MRH is often associated with autoimmune conditions and internal malignancies. A Mayo Clinic review (1980–2017) of 24 cases reported autoimmune disease in 29%, malignancy in 25%, and five-year survival of 85% (95% CI: 74–100%).[2] MRH frequently coexists with autoimmune diseases, including Sjogren's disease, systemic lupus erythematosus, systemic sclerosis, dermatomyositis, celiac disease, and primary biliary cirrhosis.

While MRH cases have been associated with nearly all types of cancer both solid and hematologic, the most common malignancies observed are carcinomas of the lung, stomach, breast, cervix, colon, and ovary. Whether multicentric reticulohistiocytosis is a true paraneoplastic disorder is controversial, because no consistent type of cancer has been associated with MRH. In addition, as multicentric reticulohistiocytosis is very rare, the association with cancer may be coincidental. Moreover, a correlation between the removal of cancer and the disappearance or improvement of multicentric reticulohistiocytosis has not been established.

Clinical Features

In half of the patients, the first sign of the disease is arthritis. In one quarter, papules and nodules are the first sign. The remainder develop skin and joint manifestations at the same time. The most frequent joint manifestations include symmetric and erosive inflammatory arthritis affecting the hands in a distal predominance, but MRH can also involve the elbows, shoulders, hips, knees and feet, and when left untreated can lead to a progressively deforming and destructive arthropathy including contractures and arthritis mutilans.

Cutaneous lesions usually appear within three years of arthritis onset, as acral yellowish to reddish-brown papulonodules. These lesions most commonly occur on the upper half of the body, especially the face, ears, mucosal surfaces (lips, tongue, gums, nostrils, throat, eyelids), hands, and forearms. They range in size from 1-2 mm to several centimetres in diameter and arise in isolation or in clusters or crops with a cobblestone appearance. Mucosal lesions are present in approximately 50% of cases. The skin lesions may cause destruction of cartilage around the ears and nose. Lesions are usually asymptomatic, but one third of patients complain of pruritus. Periungual papulonodular skin lesions are pathognomonic and often coalesce creating the classic "coral bead" or "string of pearls" appearance. Nodules developed a decade later in our patient from the time of initial joint symptoms.

Common systemic symptoms include fever, malaise, and weight loss, often with elevated ESR, anemia, and hypercholesterolemia.[1] Systemic involvement may include pleural or pericardial effusions, cardiac failure, mesenteric lymphadenopathy, and urogenital lesions.[3]

Around one third show autoimmune serologies (anti-Ro, anti-CCP, ANA). Histopathology reveals lymphohistiocytic infiltrates with multinucleated giant cells containing eosinophilic ground-glass cytoplasm.[2] Pathogenesis involves monocyte/macrophage activation and osteoclastic activity.

When a case of MRH is suspected, the diagnostic tests in Table 1 should be considered.

Therapeutic Approaches

Treatment aims to control inflammation and prevent joint destruction. Since MRH is a rare disease, there are no standardized treatment guidelines. Therapies include corticosteroids, DMARDs such as methotrexate, azathioprine, cyclosporine, cyclophosphamide, chlorambucil, topical tacrolimus, and rituximab.[4-6] Tariq et al. reported methotrexate controlled arthritis in 28% and skin lesions in 38%, while cyclophosphamide achieved complete remission in 20% and partial improvement in 40–45%.[7] Anti-TNF agents, anakinra, bisphosphonates, Janus Kinase (JAK) inhibitors (upadacitinib), and tocilizumab are additional options.[8]

In many patients, multicentric reticulocytosis can go into remission after an average course of 8 years; however, by this time considerable joint destruction may have occurred. Arthritis mutilans may develop in 50% of cases. Patients are left with crippling, deformed joints and a disfigured facial appearance.

Early diagnosis and prompt DMARD therapy are crucial, as MRH often follows an aggressive, erosive course leading to joint destruction if left untreated.

Table 1. **Common Diagnostic Tests in MRH**

Category	Tests	Typical Findings/Remarks
Bloodwork	Complete blood count (CBC)	Mild normocytic anemia; leukocytosis occasionally present
	Erythrocyte sedimentation rate (ESR), C-reactive protein (CRP)	Typically elevated in active disease
	Rheumatoid factor (RF), anti-cyclic citrullinated peptide (anti-CCP), cases antinuclear antibody (ANA)	Usually negative; low-titer RF or ANA may occur in overlap
	Lipid profile	May show hyperlipidemia in a subset of patients
	Liver and renal function tests	To rule out comorbid diseases, or other organ involvement
	Immunoglobulins (IgG, IgA, IgM, IgE), serum and urine protein electrophoresis	Polyclonal hypergammaglobulinemia can be seen. To rule out monoclonal proteins
	Hepatitis B/C, HIV, tuberculosis (Quantiferon)	Expected to be negative; needed before immunosuppressants
Imaging	Radiographs of involved joints such as hands/wrists	Marginal erosions with relative preservation of joint space
	CT chest/abdomen/pelvis, mammography	Age-appropriate malignancy screening. Include colonoscopy as well
Pathology	Biopsy of skin or synovial nodule	Dermal and subcutaneous infiltration by multinucleated giant cells and histiocytes with ground-glass eosinophilic cytoplasm

Back to the Case

Despite treatment escalation with prednisone, hydroxychloroquine, leflunomide and methotrexate added in September 2024, she experienced persistent fatigue, arthritis, and progressive nodulosis. In August 2025, adalimumab was initiated. At the time of writing, she has completed eight weeks of adalimumab with no significant improvement in rheumatologic or dermatological symptoms. A change in therapy to tocilizumab is being considered.

Conclusion

MRH is a rare but severe systemic disease with distinctive skin and joint features. Its association with malignancy and autoimmune conditions necessitates thorough evaluation. Early recognition and initiation of immunosuppressive or biologic therapy improve outcomes.

Glossary:
ANA: Anti-nuclear antibody
Anti-CCP: Anti-cyclic citrullinated peptide
Anti-dsDNA: Anti-double-stranded DNA
Anti-Ro: Anti-Ro antibodies, also known as anti-SSA/Ro antibodies
CRP: C-reactive protein
ENT: Ear nose and throat specialist
ESR: Erythrocyte sedimentation rate
HIV: Human immunodeficiency virus
RNP: Ribonucleoprotein
SSA/SSB: Sjögren's Syndrome A antibodies/ Sjögren's Syndrome B antibodies
TB: Tuberculosis
WBC: White blood cell

References
1. Ashaolu O, Ng S, Smale S, et al. Multicentric Reticulohistiocytosis–A rare and disabling disease. *Clinical Case Reports*. 2023;11(9):e7846.https://doi.org/10.1002/ccr3.7846.
2. Sanchez-Alvarez C, Singh Sandhu A, Crowson CS, et al. Multicentric reticulohistiocytosis: the Mayo Clinic experience (1980–2017), *Rheumatology*. 2020; 59(8):1898-1905. https://doi.org/10.1093/rheumatology/kez555.
3. Mariotti E, Corrà A, Lemmi E, et al. Multicentric Reticulohistiocytosis Associated with an Early Form of Systemic Lupus Erythematosus: A Case Report of a Rare Disease, with Mini Review of the Literature. *Journal of Clinical Medicine*. 2022;11(21):6529-6529. doi:https://doi.org/10.3390/jcm11216529.
4. Bin FB. Multicentric reticulohistiocytosis in a Malaysian Chinese lady: A case report and review of literature. *Dermatology Online Journal*. 2009;15(1). doi:https://doi.org/10.5070/d34wm552ck.
5. Liu YH, Fang K. Multicentric reticulohistiocytosis with generalized systemic involvement. *Clinical and Experimental Dermatology*. 2004;29(4):373-376. doi:https://doi.org/10.1111/j.1365-2230.2004.01531.
6. Lim K, D'Souza J, Vasquez JB, et al. Looks Can Be Deceiving: A Case Report on Multicentric Reticulohistiocytosis Successfully Treated with Rituximab. *Cureus*. Published online May 3, 2017. doi:https://doi.org/10.7759/cureus.1220.
7. Tariq S, Hugenberg ST, Hirano-Ali SA, et al. Multicentric reticulohistiocytosis (MRH): case report with review of literature between 1991 and 2014 with in depth analysis of various treatment regimens and outcomes. *SpringerPlus*. 2016; 5:180. doi:https://doi.org/10.1186/s40064-016-1874-5.
8. Pacheco-Tena C, Reyes-Cordero G, Ochoa-Albíztegui R, et al. Treatment of Multicentric Reticulohistiocytosis With Tocilizumab. *Journal of Clinical Rheumatology*. 2013;19(5):272-276. doi:https://doi.org/10.1097/rhu.0b013e31829cf32b.

Kavya Mulgund
BHSc student,
Queen's University
Kingston, Ontario.

Tripti Papneja, MD, FRCPC
Clinician-Teacher,
University of Toronto
William Osler Hospital
Brampton, Ontario

Survey Results: Administrative Burden

In this issue's Joint Count survey, the CRA External Relations Committee polled the CRA membership about how increasing administrative burden associated with completing insurance forms is affecting members, in order to better understand the scope and impact of this issue nationwide. The survey received 94 responses, the most responses to any Joint Count survey in recent years. Respondents represented a broad cross-section of Canadian rheumatologists.

The first part of the survey asked members "Are you regularly required to complete insurance forms for patients to access medication?" A striking 99% of respondents answered "yes".

When asked if this was an issue, almost 96% of respondents affirmed that this requirement poses a significant issue in their clinical workflow.

In response to the question "Do you typically have additional forms to complete after the initial application was submitted to insurance to start a new medication?", 76% of respondents noted that additional forms are typically required after the initial insurance application, further compounding the administrative burden. The additional forms come from a variety of sources, including insurance providers (95.7%), third parties (e.g. Benefit Plan Managers 61.4%), and other sources such as provincial special access programs, pharmaceutical companies and compassionate access pathways (12.9%).

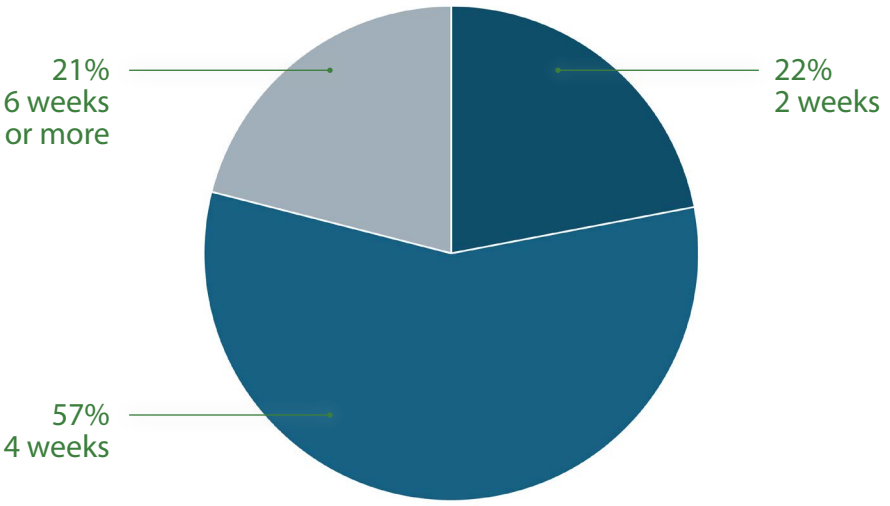
As shown in Figure 1 below, 78% of respondents reported experiencing unreasonable delays in accessing prescribed medications due to administrative requirements, with 57% reporting an average 4-week delay, 22% citing a 2-week delay, and 21% experiencing delays of 6 weeks or more.

Qualitative feedback from this survey highlighted the burnout and emotional toll from repetitive paperwork, the need for standardized forms, inconsistencies across insurance providers, and the impact on patient care, especially in urgent cases (e.g. tocilizumab for giant cell arteritis, off-label biologics for myositis or CNS vasculitis).

Overall, this survey underscores the significant administrative burden faced by Canadian rheumatologists in securing medication access for their patients. The CRA External Relations Committee will use these findings to advocate for streamlined processes, standardized forms, and improved communication pathways with insurers.

For questions or feedback, please contact *info@rheum.ca*.

Figure 1. **Reported Average Delays in Accessing Prescribed Medications for Patients due to Administrative Requirements**



The Impact of the COVID-19 Pandemic on Access to Rheumatology Services and Treatment — Key Findings from Population-based Evaluations

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

By Jessica Widdifield, PhD; and Bindee Kuriya, MD, SM, FRCPC

The COVID-19 pandemic disrupted health systems worldwide, with substantial implications for individuals living with rheumatic diseases. Through a series of population-based studies in Ontario, we explored how the pandemic transformed every stage of rheumatology care—from how services were delivered, to timely access to specialists, to use of COVID-19 antiviral therapies, and downstream consequences such as disability.

In our first study, we used Ontario-wide administrative data to understand how rheumatology care changed during the pandemic. When public health restrictions began in March 2020, in-person outpatient visits dropped by 76% immediately, accompanied by a rapid surge in telemedicine. Telemedicine represented half of all rheumatology encounters throughout 2021, demonstrating a sustained shift in care delivery. New patient consultations were particularly affected, declining by 50% at pandemic onset and never fully returning to pre-pandemic levels over the next two years. These sustained reductions raise concerns about delays in diagnosis and treatment initiation for inflammatory diseases.

Although nirmatrelvir/ritonavir (Paxlovid®) was available at no cost to eligible Canadians, including immunosuppressed individuals, rheumatologists were concerned that patients were not receiving this highly effective therapy to reduce COVID-19 severity. Using a validated population-based rheumatoid arthritis (RA) cohort, we identified all individuals aged 18-plus who received nirmatrelvir/ritonavir between April 2022 and January 2023. Strikingly, only 2.4% of RA patients with a positive SARS-CoV-2 PCR test received treatment. The use of nirmatrelvir/ritonavir was concentrated among older adults with multiple comorbidities, and just 60 prescriptions originated from rheumatologists. We found important sociodemographic inequities: individuals in higher-income and less diverse neighbourhoods were more likely to receive nirmatrelvir/ritonavir, despite more diverse communities experiencing higher COVID-19 burden. These findings underscore significant gaps in equitable access to antiviral therapy for individuals living with RA.

Our third study—the first to examine this issue at a population level in Ontario—showed a marked rise in disability claims related to RA among working aged individuals, peaking during the first two years of the pandemic. This trend may reflect worsening disease control due to delayed or reduced access to rheumatology care, treatment interruptions, or heightened COVID-19-related risks affecting work capacity.

Taken together, these studies provide a comprehensive, population-level picture of how the pandemic reshaped rheumatology care—from service delivery to the equitable use of COVID-19 therapy, to downstream patient outcomes. The findings underscore the importance of strengthening health-system resilience, closing gaps in access to specialty care and essential treatments, and safeguarding timely, equitable management for people living with rheumatic diseases during future health system disruptions.

Jessica Widdifield, PhD
Holland Chair in Musculoskeletal Research
Senior Scientist, Sunnybrook Research Institute,
Holland Bone & Joint Research Program
Senior Scientist, ICES Chronic Disease
& Pharmacotherapy Program
Associate Professor, University of Toronto, Institute
of Health Policy, Management & Evaluation

Bindee Kuriya, MD, SM, FRCPC
Assistant Professor, Department of Medicine,
University of Toronto
Staff Rheumatologist, Division of Rheumatology,
Sinai Health System & University Health Network
Principal Investigator,
Ontario Best Practices Research Initiative

Reflecting on My Place in the Rheumatology Community — and Asking You to Do the Same

By Dawn P. Richards

I'm privileged to have been invited to contribute a patient perspective to *The Canadian Rheumatology Association Journal (CRAJ)*. This request gave me space to reflect on some of my other privileges. I am an uninvited settler living in Toronto—the traditional home of the Mississaugas of the Credit, the Anishnabeg, the Haudenosaunee, the Chippewa and the Wendat peoples. I own my own home and hold a PhD from a prestigious institution. I'm a white cis-woman. And, put simply, I'm lucky to be living well with my rheumatoid arthritis (RA). When I was diagnosed with RA nearly 20 years ago, I was working at the Canadian Arthritis Network. There I benefited from my connections in arthritis research and rheumatology—I had access to expert clinicians for a timely diagnosis and evidence-based treatment. These privileges provide me a platform today to reflect, and share my hopes/perspectives with you. As you read, I invite you to reflect on your own positionality in rheumatology and in the broader world.

In writing this article, I've thought about things my own positionality has afforded me—even living with inflammatory arthritis. First, living in a large city has helped me access care affiliated with a research institution. I have participated in research, and through research, had treatment options that otherwise wouldn't have been available. My experience in research has also taught me how patients can contribute as partners in research.[1] As members of the research team, we bring views and perspectives and experiences that complement the learned experiences of others on the team. My professional work now sees me contributing to the research enterprise in Canada and beyond: helping people and organizations to engage patients as partners in research.

My positionality has brought me community through the rheumatology world in Canada and beyond. For a decade I've been part of the Steering Committee of the Canadian Arthritis Patient Alliance. I've also been a member of the Canadian Rheumatology Association Guidelines Committee, and have contributed to European Alliance of Associations for Rheumatology (EULAR) projects and other global rheumatology initiatives. I have observed a different side of healthcare and pharmaceutical policy in Canada, including all the imperfections and burdens heaped on patients at a time when we are already dealing with so much. I am learning about the inequities in rheumatology care—how for many people care is determined, not by the research evidence, but by their postal code, skin colour, and other socio-demographic factors.[2,3]

This article is my way of asking others to consider who is not invited regularly into our spaces. Who is disadvantaged through no fault of their own in the rheumatology world? After 20 years, I am actively taking a step back from telling my story. Instead, I am holding space for others. I am declining invitations and suggesting others in my place. I am helping build capacity and mentoring other patient partners to contribute to research as partners, and to ensure their lived experiences influence research. I am attending fewer conferences and stepping off committees and research teams. This is my way of creating opportunities for new perspectives, different from mine, that aren't well represented in these spaces.[4] It doesn't mean I am leaving the rheumatology community. I'm a member for life thanks to my combination of genes and environment. After two decades in this community, the least I can do to give back is to hold the door open for others.

Acknowledgement: Thanks to Dr. Clare Ardern for editorial review, and to Linda Wilhelm and Laurie Proulx for their reviews as well.

References

1. Canadian Institutes of Health Research's Definition of Patient and Patient Engagement [cited 2025 October 28]. Available from: *http://www.cihr-irsc.gc.ca/e/48413.html*.
2. Pianarosa E, Hazlewood GS, Thomas M, et al. Supporting Equity in Rheumatoid Arthritis Outcomes in Canada: Population-specific Factors in Patient-centered Care. *J Rheumatol*. 2021;48(12):1793-802.
3. Thomas M, Barnabe C, Kleissen T, et al. Rheumatoid Arthritis Care Experiences of Black People Living in Canada: A Qualitative Study to Inform Health Service Improvements. *Arthritis Care Res (Hoboken)*. 2024;76(4):470-85.
4. Abelson J, Canfield C, Leslie M, et al. Understanding patient partnership in health systems: lessons from the Canadian patient partner survey. *BMJ Open*. 2022;12(9):e061465.

Dawn P. Richards, Patient advocate
Toronto, Ontario

Dr. Jorge Sanchez-Guerrero – *CRA Master Award*

Originally from Mexico, Dr. Sanchez-Guerrero earned his MD degree from the University of Guadalajara before completing training in Internal Medicine and Rheumatology in Mexico City. He then pursued a post-doctoral fellowship in systemic lupus erythematosus at Brigham and Women's Hospital in Boston, followed by a Master of Science degree from the Harvard School of Public Health.

Over the course of his career, he has published more than 180 articles in peer-reviewed journals, including the *New England Journal of Medicine*. In 2001, he received the Edmund L. Dubois Award from the American College of Rheumatology for his research. He has also served as a member of the educational and scientific committee of the Lupus Foundation of America.

From 2002 to 2011, he was Head of the Department of Immunology and Rheumatology at the National Institute of Nutrition and Medical Sciences Salvador Zubirán in Mexico. He later served as Director of the Division of Rheumatology at Sinai Health System and the University Health Network in Toronto from 2011 to 2022. He is currently a Professor of Medicine at the University of Toronto.

Dr. Carrie Ye – *CIHR Early Career Researcher Award*

Dr. Carrie Ye received the Canadian Institutes of Health Research (CIHR) Early Career Researcher Award in Cancer in Spring 2025 for her project entitled: "Gaining Insight into Immune Checkpoint Inhibitor Associated Inflammatory Arthritis Using Administrative Health Data." This award, which was established to recognize research excellence at the early career researcher level, is given annually to early career researchers with the highest ranking (by percent (%) rank) in the Project Grant competition.

News from British Columbia

A Collaborative Provincial Initiative: Working Together to Enhance Access to Novel Therapies Through Clinical Research in BC

Excitingly, clinical trials are being revived to help improve access to medications for patients in Western Canada. Mary Pack Arthritis Centre (MPAC) includes quaternary clinics for various rheumatic conditions and facilitates training opportunities for health professional trainees. Dedicated to improving quality of life for patients, MPAC provides education programs for patients, infusions, nursing, and access to allied health. In Vancouver, Drs. Azin Ahrari, Neda Amiri, Antonio Avina-Zubieta, Corisande Baldwin, Natasha Dehghan, Daniel Ennis, Angela Hu, Raheem Kherani, Alice Mai, Jennifer Reynolds, and the team at the MPAC (Jeremiah Tan, Sofia Rieger-Torres; previously Anirudh Kotlo) have been working on re-building infrastructure for industry- and investigator-led clinical trials.

Following a 12-year hiatus, MPAC is the primary collaborative provincial initiative running trials for rheumatic disease, with support from Arthritis Research Canada and Vancouver Coastal Health Research Institute (VCHRI). Beginning with phase III studies in Sjogren's Disease, we are now running 10 studies covering six indications (myositis, osteoporosis, psoriasis, Sjogren's, systemic lupus erythematosus [SLE], and vasculitis). With various studies on the horizon, we are excited to be activating soon as one of Canada's first SLE CAR-T cell therapy studies. Our clinical trials centre is open for referrals for patients across BC!

Raheem B. Kherani, BSc (Pharm), MD, FRCPC, MHPE
Clinical Associate Professor,
University of British Columbia
Director, Intensive Collaborative Arthritis Program, Mary Pack Arthritis Program
Clinician Investigator, Arthritis Research Canada
Division Head, Rheumatology, Richmond Hospital
Rheumatologist,
West Coast Rheumatology Associates
Richmond, British Columbia

From left to right: Drs. Ann Marie Colwill, Antonio Avina-Zubieta, Shahin Jamal (recipient of the BCSR/UBC Teaching Award), John Wade, Neda Amiri (recipient of the Innovation Award), and Jason Kur; Dr. Simon Huang, recipient of the BSCR/UBC Advocacy Award, not pictured.

From left to right: Drs. Michael Nimmo and Brent Ohata (recipient of the VMDAS Award for Community Excellence).

From left to right: Anirudh Kotlo, Jeremiah Tan, Sofia Rieger-Torres, and Dr. Raheem B. Kherani.

Sofia Rieger-Torres, BSc (Biology)
Research Assistant, Arthritis Research Canada

Jeremiah Tan, BSc (Biology)
Research Coordinator, Arthritis Research Canada

Anirudh Kotlo, MSc Global Health
Data Coordinator, BC Cancer Breast and Sarcoma Tumor Group

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.

Inspired by patients. Driven by science.

REVIEWED BY PAAB

Pr Bimzelx® (bimekizumab)