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CRAJ SCR

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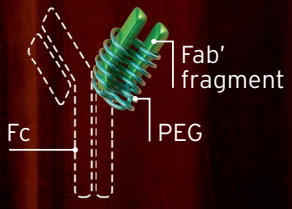
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1. CIMZIA® Product Monograph. UCB Canada Inc. November 13, 2019.
2. Health Canada Notice of Compliance Database. Available at https://health-products.canada.ca/noc-ac/?lang=eng. Accessed January 9, 2025.

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The Annoyance Economy

By Philip A. Baer, MDCM, FRCPC, FACR

I can date the start of this specific annoyance exactly: Saturday of the 2026 CRA ASM in Halifax, shortly after noon. I receive an email supposedly from my bank.

"Dear Philip,
On a regular basis, our bank reviews customer transactions, profiles and accounts. Our review identified missing/unverified information in your profile. This information is needed to ensure proper operation of your account(s) and ensure the Bank is compliant with current regulatory requirements.

If you are currently in North America, we would like to set up a phone appointment with you to review your profile. It will take approximately 10-20 minutes. Please respond to this email with a date, time and phone number that is convenient for you."

The email went on to provide the first name of the supposed sender, a toll-free number to call and an email address.

Of course, I was immediately suspicious. Anyone can spoof the bank's logo. Bank employees usually aren't working or e-mailing on weekends. There are only six big banks in Canada, so the fact my actual bank was mentioned could be random luck. Moreover, I had very recently visited my actual bank branch twice regarding some other matters that actually required updating, and I was then told there was nothing else outstanding.

I ignored the email and within an hour I received a voicemail with the same request. I ignored that as well.

I returned from Halifax and dropped in a few days later at my bank branch, which is fortunately very close to my home. I showed them the email on my phone. They confirmed that the employee's name, phone number and email address looked legitimate. They also reviewed my account and once again confirmed everything was up to date and nothing needed to be done.

Case closed. However, within two weeks, I received an email from someone else at the same bank:

"Hello XXX Medicine Professional Corporation,

Hope you are doing well. My name is XYZ, and I am a Personal/Business Banker at your bank. I would like to say thank you for doing business with us. To be stronger as a community, I am reaching out to clients around the neighbourhood, offering any help in regards to their banking. I am following up with you to see if you have any inquiry or need any assistance in regards to your banking. Please do not hesitate to contact me in case of any banking request."

This time the email was signed with a full name, not just a first name. The branch mentioned is one I use occasionally, but not my home branch. The email phrasing wasn't very professional, with a lot of extra spaces preceding commas and periods. I ignored this one as well.

So, what is going on? Why am I wasting time reading unsolicited emails and listening to voicemails, trying to distinguish spam from reality, and making an extra trip to the bank to sort things out?

Well, this is all part of what has been termed "The Annoyance Economy." I first encountered the term while reading the *New York Times* in April of this year. The term apparently was coined in a February 2026 report by two American economists working for the Groundwork Collaborative.[1] As stated in their introduction:

"It's become a defining feature of modern life: the steady grind of small hassles that eat away at our time, patience, and wallets. Everyday interactions that should be simple too often turn into fraught ordeals, leaving people feeling overwhelmed, ignored, or jerked around.

We call it the "Annoyance Economy"—what we pay in time, fees, and irritation to navigate our daily lives. These costs show up in many forms: hours spent on hold with customer service or lost in convoluted insurance paperwork; the relentless ping of spam calls or political messages warning of doom unless we donate; the steady creep of extra fees and surprise surcharges on everyday transactions. Each year, the Annoyance Economy costs American families at least $165 billion in wasted time and lost money."

This study was oriented to Americans, with a very different healthcare system, but it was interesting that health care figured prominently in the toll taken by the annoyance economy. The authors estimated that calls with health insurance administrators cost $21.6 billion and waiting for medical services such as doctors' appointments and tests accounted for $19.4 billion.

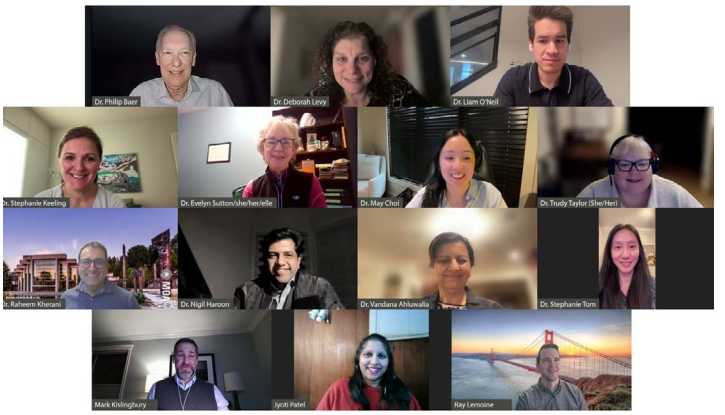
Interestingly, the annoyance economy itself creates the need for new services and new jobs aimed at prevailing against it. The study noted that "an entire cottage industry of so-called "healthcare concierge" services—available for a fee, of course—has emerged to spare consumers from the friction and frustration built into nearly every step of the health care experience."

This theme is familiar if you watch any Canadian television networks. Ads for Felix, My Rocky, and other companies show frustrated patients leaving the waiting

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The Annoyance Economy

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room of a doctor's office to obtain medications for weight loss, hair loss, and erectile dysfunction via an app, with discreet delivery to your door. If you watch American networks, you can add in ads for Ro, Him & Hers, and others. Whether this type of less annoying on-demand medical care is as good as an in-person visit is debatable, but it seems to be thriving. At the same time, concierge-style private medical practices are not uncommon in Quebec and may be coming soon to Alberta as well.

Meanwhile, rheumatologists are quite familiar with the impact of the annoyance economy on our practices. Administrative burden and burnout are the main ways we experience it. Special authorization forms, exceptional access programs, and compassionate use programs put us through hoops to obtain the treatments our patients desperately need and deserve. In the vast majority of cases, patients eventually do receive authorization, but the delays are burdensome for everyone involved and potentially worsen outcomes. Requirements for specific stop and start dates for disease-modifying antirheumatic drugs (DMARDs) initiated decades ago, and definitions of treatment naïveté that consider a single proscribed tablet taken years ago as an exclusion factor are examples well-known to Ontario rheumatologists. I am sure similar examples exist in other provinces and territories. Private insurance plans are often less transparent than public formularies, and forms are not standardized between companies.

The authors of the study also suggested the creation of a "Health Care Sludge Unit" charged with "monitoring and rooting out needless friction throughout the health care experience—leveraging tools like "blind shopper" experiments, public feedback lines, and direct engagement with industry to surface and fix barriers that waste patients' (and providers') time and erode trust." In Ontario, we do have a Ministry of Red Tape Reduction, and the Ontario Rheumatology Association is exploring how that might help with some of the challenges we face daily.

Meanwhile, my banking saga was not over. A few days later, I received a phone call from an actual person who worked at my home bank branch and whose name I recognized. Despite everything I had been told on my prior branch visits, there actually was a form they needed signed urgently to prove my corporation was Canadian rather than American. We managed that with DocuSign the same day, and I haven't heard from the bank since. I hope the silence is maintained for a long time.

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Building a Stronger Voice for Community Rheumatologists

As part of the Canadian Rheumatology Association's (CRA) 2026-2030 Strategic Plan, the association is strengthening its understanding of the needs and priorities of community-based rheumatologists across Canada.

One of the key initiatives supporting this work is the newly established **Community Practice Committee (CPC)**, a committee dedicated to ensuring the perspectives of community rheumatologists are reflected throughout the CRA's programs, services, and strategic priorities.

The CPC was created in response to feedback gathered during the strategic planning process. While the CRA has a long history of supporting members through education, networking, and professional development, many community rheumatologists identified opportunities for the CRA to better understand and support the realities of community practice. Increasing clinical demands, administrative pressures, and limited non-clinical time can create challenges that differ from those experienced in academic settings.

The committee's mandate is to identify evolving needs within community practice, explore practical solutions, strengthen engagement, and help integrate community perspectives across the CRA. The CPC will also collaborate with other committees and initiatives to help shape programs and resources that support practice sustainability, professional connection, and member value.

The CRA is pleased to announce that Dr. Fergus To has been appointed as the inaugural Chair of the Community Practice Committee.

Based in Vancouver, Dr. To is a Clinical Assistant Professor in the Division of Rheumatology at the University of British Columbia and maintains an independent rheumatology practice alongside his hospital-based roles. His experience working across both community and academic environments provides a valuable perspective on the opportunities and challenges facing rheumatologists in a variety of practice settings.

"I am excited to help lead this important initiative and contribute to the CRA's efforts to better support rheumatologists running an independent practice," says Dr. To.

Following the call for expressions of interest, all CRA members who applied to participate in the CPC have been invited to join, reflecting the strong interest and enthusiasm from community rheumatologists across the country.

The committee will begin its work this fall, and the CRA will continue to provide updates on the CPC's progress, priorities, and recommendations as it works to strengthen support for community-based rheumatologists and ensure their voices are represented across the Association.

If you have any questions or comments, please contact the CRA at *info@rheum.ca*.

CRA Planetary Health Task Force Concludes Two Years of Impact

When Dr. Stephanie Tom (current president of the Canadian Rheumatology Association) brought her passion for planetary health to the CRA in 2023, it sparked a conversation that grew into a national initiative. With Board support, the CRA launched the Planetary Health Task Force in 2024 to explore how environmental sustainability and high-quality patient care intersect within rheumatology.

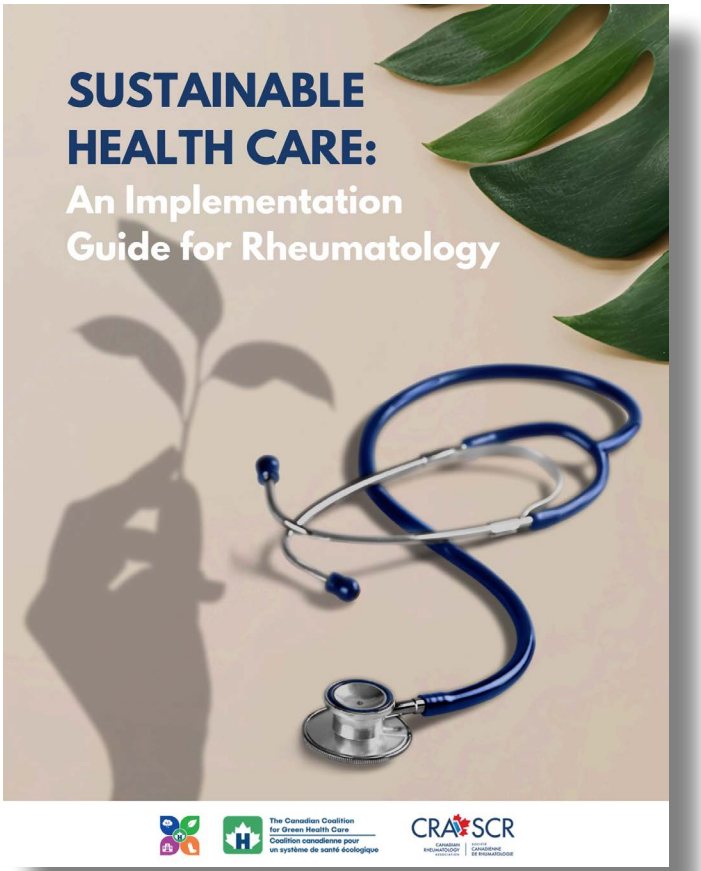
Over the next two years, Chair Dr. Stephanie Tom and task force members Drs. Philip Baer, Claire Barber, Sasha Bernatsky, Molly Dushnicky, Beth Hazel, and Fergus To transformed that interest into a range of practical resources and educational initiatives for the Canadian rheumatology community.

The task force developed the bilingual ***Sustainable Health Care: An Implementation Guide for Rheumatology toolkit*** (*rheum.ca/resources/planetary-health-for-rheumatology/*) produced English and French ***podcast episodes*** (*rheum.ca/resources/aroundtherheum/*), launched the interactive RheumBingo educational initiative, contributed to Choosing Wisely Canada's climate-conscious recommendations, and helped create a dedicated planetary health edition of the *CRAJ*. The group also shared its work through presentations, workshops, and collaborations across Canada and internationally.

As the task force concluded its mandate in summer 2026, the CRA extends its sincere thanks to Dr. Tom and all task force members for their vision, leadership, and dedication.

While the formal task force has concluded, ongoing monitoring of planetary health developments will be incorporated through the CRA's Quality and Innovation Committee and its Choosing Wisely efforts.

The Planetary Health Task Force demonstrated how a member-driven idea can grow into a national initiative through the CRA, creating resources, education, and lasting impact for the rheumatology community. Do you have an initiative or idea you would like to discuss with the CRA? If so, please email *info@rheum.ca*.



View the toolkit here:

Right Care, Right Time: Reimagining Rheumatology Follow-Up Through Appointments by Choice

By Claire E.H. Barber, MD, PhD, FRCPC

Rheumatology services across Canada face increasing pressure from workforce shortages, growing patient volumes, and long wait times. Traditional follow-up models often require patients to attend routine appointments every 6 to 12 months, regardless of disease activity or clinical need. Yet studies suggest that 20-50% of these visits may not result in treatment changes, highlighting opportunities to better align care delivery with patient needs.[1]

Appointments by Choice (ABC) is a patient-initiated follow-up model designed to address these challenges.[2,3] Developed through extensive engagement with patients, clinicians, and health system leaders,[4] ABC shifts care from routinely scheduled visits to a system where patients access rheumatology services when they need them.

Eligible patients with stable rheumatoid arthritis (RA) extend routine rheumatologist follow-up intervals, often to 24 months, while maintaining rapid access to care through a clearly defined pathway. The model includes patient education, shared decision-making tools, and a pharmacist-led model supporting rapid access to care when needed for flares or changes in health status.

A pilot implementation launched in 2024 within a multi-physician rheumatology clinic. Early results demonstrate strong feasibility and acceptability. Of 140 eligible patients, 76 (54%) enrolled, and nearly 90% remained in the program over 18 months. Safety outcomes have been reassuring, with only 7% of participants requiring a return to standard scheduled follow-up because of disease flares or changing clinical circumstances. Patients consistently reported high satisfaction, particularly appreciating reduced travel requirements and rapid access to support when concerns arose.

Key Impact: ABC reduced routine follow-up visits, freeing approximately 1,520 minutes of rheumatologist time, equivalent to 38 new patient consultations.

These early findings suggest that patient-initiated follow-up can safely improve access, enhance patient experience, and optimize specialist capacity. As healthcare systems continue to seek sustainable solutions, ABC offers a promising model for delivering high-quality, patient-centred rheumatology care while preserving timely access for patients with the greatest need.

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Rally for Rheumatology: The Momentum Continues



This September, during Arthritis Awareness Month, rheumatologists, patients, families, and supporters across Canada came together to Rally for Rheumatology in support of the Canadian Rheumatology Association Foundation (CRAF). Through matched gifts and community fundraising efforts, participants united around a shared goal: advancing the future of rheumatology and improving the lives of people living with rheumatic diseases.

Thanks to the incredible support received so far, we are pleased to announce that **Rally for Rheumatology has been extended until December 31st, 2026**, giving Canadians even more opportunities to participate and have eligible donations matched.

Every gift made through the Rally helps fuel progress in rheumatology. Funds raised support our vision of building a bright future for rheumatology through research, education and professional development opportunities, and innovations that strengthen patient care across Canada. These investments help researchers pursue new discoveries, support the next generation of specialists, and advance solutions that improve outcomes for patients.

The success of Rally for Rheumatology is made possible by a community that believes in the power of investing in the future. Every donor, Rally Champion, participant, and supporter plays an important role in advancing research, fostering education, and strengthening rheumatology care for years to come.

To everyone who has contributed so far, thank you. Your generosity and commitment are helping build a stronger future for rheumatology in Canada and creating opportunities for meaningful progress across research, education, and patient care.

While Arthritis Awareness Month has come to a close, the opportunity to make a difference continues. Matching opportunities remain available until December 31, 2026, allowing donations to go even further in support of CRAF's mission.

Whether you make a gift, support a Rally Champion, or help spread the word, there is still time to double your impact and help shape the future of rheumatology in Canada.

Learn more or make a donation at *RallyforRheumatology.ca*.

From Images to Better Decisions: How Technology Can Improve the Diagnosis of Spondyloarthritis

By Denis Poddubnyy, MD, FRCPC, PhD



Imaging plays a central role in the diagnosis of axial spondyloarthritis (axSpA) and in the assessment of axial involvement in psoriatic arthritis (PsA). Magnetic resonance imaging (MRI) can identify bone marrow edema—the principal imaging manifestation of active inflammation in the sacroiliac joints and spine—before definite radiographic damage develops. However, bone marrow edema is not disease-specific and can also result from mechanical stress, pregnancy, anatomical variation or degeneration. The emerging paradigm is therefore moving away from the isolated search for inflammation towards the simultaneous assessment of active inflammatory and structural lesions, interpreted within the clinical context.[1] This distinction has direct clinical consequences: an incorrect diagnosis may lead to inappropriate immunomodulatory treatment, whereas failure to identify true inflammation may delay effective therapy. Correctly distinguishing inflammatory disease from its mimics is also essential when interpreting treatment non-response and estimating prognosis.[2]

Technological advances are changing both image acquisition and the information that can be extracted from imaging. A recently evaluated high-resolution, deep-learning-reconstructed Dixon MRI sequence provided diagnostic performance non-inferior to a standard multisequence sacroiliac-joint MRI protocol while reducing acquisition time by 73%.[3] Faster protocols could improve access, reduce motion artefacts and make comprehensive MRI more feasible in routine care. At the same time, artificial intelligence (AI)-assisted generation of synthetic computed tomography (CT) images from MRI offers CT-like visualization of bony changes without an additional radiation-based examination. AI-supported reconstruction of low- and ultra-low-dose CT may further improve assessment of structural damage in the sacroiliac joints and spine while limiting radiation exposure.[4]

Technology can also connect expertise across geographical boundaries. In the prospective Improve-axSpA project, clinical and imaging data from 969 patients evaluated at 63 centres were reviewed centrally through a telemedicine platform. Only 53.8% of patients with a local axSpA diagnosis were confirmed centrally, whereas in 33.7% an alternative cause of back pain—most commonly mechanical or degenerative—was considered more likely.[5] Such telemedicine-based expert review could provide a structured second opinion for diagnostically challenging cases and support multidisciplinary rheumatology–radiology collaboration.

Artificial intelligence and deep learning may extend this approach by detecting lesions, quantifying inflammation and structural damage, and applying standardized scoring systems at scale.[6] Their value is relevant to both clinical decision support and research. In our recent population-based study of 11,163 adults, expert assessment and a deep-learning algorithm both identified sacroiliac-joint bone marrow edema in approximately 30% of participants—far exceeding the prevalence of axSpA.[7] This illustrates both the power and the limitation of AI: algorithms can identify imaging abnormalities consistently, but they cannot make a disease-specific diagnosis without clinical and structural context.

Looking ahead, molecular imaging is likely to gain broader application in rheumatology. Positron emission tomography (PET)-based techniques use radiolabelled ligands, including monoclonal antibodies, to visualize specific cellular or molecular targets in vivo, rather than merely depicting anatomical changes or nonspecific tissue responses. Target-specific uptake could help distinguish immune-mediated inflammation from mechanically induced or degenerative lesions that appear similar on conventional MRI. Radiolabelled therapeutic antibodies could additionally map target expression before treatment and potentially support treatment selection.

Early studies using, for example, fibroblast activation protein-targeted PET/CT demonstrate the feasibility of visualizing biologically active lesions in axSpA, although fibroblast activation can also reflect tissue repair and remodelling.[8] Ultimately, combining anatomical, inflammatory, structural and molecular information may allow musculoskeletal imaging to progress from solely lesion detection towards biologically informed diagnosis and treatment selection.

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AI in Rheumatology: Why Patient Literacy Matters

By Cheryl Koehn, President, Arthritis Consumer Experts; and Kelly Lendvoy, Vice President, Communications and Public Affairs, Arthritis Consumer Experts

"I think we need to be able to discuss AI recommendations with our healthcare provider to be sure they are accurate and fit the patient's individual needs."

– ACE National Survey on Artificial Intelligence and Arthritis Care, female respondent living with osteoarthritis.

Artificial intelligence (AI) is transforming rheumatology at an unprecedented pace. AI-enabled tools are now interpreting imaging studies looking for early signs of disease, tracking patient disease activity between visits, assisting with clinical note-taking, answering patient questions, and matching patients to the treatments most likely to work for them.[1,2]

People living with arthritis are using AI chatbots to make sense of their treatment options and help them manage their disease day-to-day. But they still want their doctor or specialist to remain central to shared decision-making. Amid the hype surrounding AI, one question is too often overlooked: are patients adequately prepared to use these tools safely?

In 2025, Arthritis Consumer Experts (ACE) conducted Canada's first patient-led National Survey on Artificial Intelligence and Arthritis Care to find out. We expected hesitation. We found appetite. Respondents expressed strong interest in how AI could support arthritis research (80%), self-care (77%), and treatment decision-making (73%). Four out of five respondents (79%) also believed AI could improve access to care, particularly in rural, remote, and other underserved communities facing specialist shortages.

The survey also highlighted a significant gap between interest and use. While respondents were optimistic about AI's potential benefits, 43% of respondents reported limited knowledge of how AI is currently being used in arthritis care. Actual use of AI-powered health tools remained low (51%), and many participants (67%) were uncertain how to determine whether AI-generated information could be trusted.

Research is finding that adoption of generative AI (such as ChatGPT) is outpacing patient education and health literacy supports.[3] Patients are already using these AI tools to seek arthritis information with little or no guidance on how to evaluate what comes back. Research suggests patients tend to overestimate the reliability of AI-generated medical answers, increasing the risk of misinformation and poor healthcare decisions.[4,5]

Trust emerged as a key issue in ACE's survey data. We found that 61% of survey respondents were most comfortable with AI when healthcare professionals remained actively involved in decision-making and could overrule AI recommendations. Take the human out and comfort collapsed. Concerns about inaccurate information (67%), loss of human connection (57%), and data privacy (53%) were frequently raised. These concerns are reflected in a 2025 study that found patients rated physicians who use AI as less trustworthy, less empathetic, and less competent when the AI's role is not clearly explained, in plain language, before the tool influences a patient's care.[6]

Health equity came up in the survey unprompted. In their open-ended responses, respondents asked whether these AI systems would work as well for people in rural and remote communities, for Indigenous Peoples and racialized populations, for older adults, and for anyone with lower digital literacy. The World Health Organization has raised the same flag, warning that AI could either shrink or widen existing health inequities depending on how these tools are designed and implemented.[7]

"Medical care needs to have a patient-centered focus and this needs to be taken into consideration when building the AI model to assess, diagnose, and treat arthritis patients."

– ACE National Survey on Artificial Intelligence and Arthritis Care, female respondent living with Sjögren's syndrome and dermatomyositis.

People with arthritis have told us what they need. While they recognize AI's potential benefits, they consistently emphasize the need for accuracy and human oversight. Getting there will require patient organizations, rheumatologists and researchers working together to build AI literacy among people living with arthritis. The technology will continue to advance. Patient literacy must advance with it. That's the next challenge for rheumatology.

For further information or comments, reach out to Cheryl Koehn at *koehn@jointhealth.org* or Kelly Lendvoy at *lendvoy@jointhealth.org*.

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AI Scribes Draft Great Notes, But Rheumatologists Also Need Help Entering Data: ROXI Is A New Tool That Does Both

By Tom Appleton, MD, PhD, FRCPC, Chair, ORA Informatics Committee

For decades, the rheumatology field has championed the importance of tracking basic clinical data in routine practice. After all, this is the data that we rely on to form our assessments and plans in everyday care. Embracing a treat-to-target approach depends on measurement of many things from swollen and tender joint counts to patient-reported measures, skin scores, and calculated disease activity indices, tracked visit over visit. International and Canadian data have made this point for years: Without structured clinical data, we cannot reliably know whether we are achieving the outcomes we aim for as individual specialists, let alone as an entire field.



Like most areas of health care, rheumatology carries a heavy documentation burden from note generation. And, since measurement and tracking are just as important to providing the best-possible care in rheumatology, capturing clinical data adds to that documentation burden. The recent wave of AI scribes has made it easier than ever to draft a clinical note and move on to the next patient, and that help was badly needed. But it hasn't touched the data side: AI scribes have not reduced the documentation burden of tracking and recording the measures that treat-to-target care depends on. Of course, a well-written note is truly important. It tells the story, and stories matter, especially in rheumatology. But a beautifully-written note is still just prose: the joint counts and outcome measures buried inside it are not captured as data unless someone manually re-enters them afterward. What if we had a tool that could reduce the documentation burden of both clinical data tracking and note generation, at once?

This is precisely the gap that the ORA's new ROXI (Rheumatology Optimized Expert Intelligence) AI suite is built to close. Deployed within RheumView™ (the ORA's digital rheumatology chart that plugs into conventional EMRs), ROXI is more than a simple AI note-generator. ROXI reviews the transcript and notes from the clinical encounter and extracts information directly into more than 600 rheumatology-specific structured data fields for more than 95 adult and pediatric rheumatology diagnoses, and delivers a high-quality, customizable, AI-generated note. Encompassing the same joint counts, patient-reported measures, and disease activity scores that treat-to-target care requires, every suggested entry is reviewed and confirmed by the treating physician before it becomes part of the record. Because ROXI was purpose-built for rheumatology, that structured data capture is native to the workflow, not an extra step layered on top.

That combination is what sets ROXI apart from the general AI-scribe market: outstanding clinical communication and a robust structured-data environment, generated from the same encounter, drastically reducing clicks. Each ROXI-empowered rheumatologist can finally examine remission rates, treatment patterns, and gaps in care; and, aggregated, de-identified data can give the ORA and the rheumatology community a real picture of how each rheumatologic disease is managed across Ontario.

None of this is meaningful unless it earns clinicians' and patients' trust. The College of Physicians and Surgeons of Ontario (CPSO), the Canadian Medical Protective Association (CMPA), and Ontario's Information and Privacy Commissioner have converged on similar expectations for AI in clinical care: accurate, clinician-reviewed output; physician accountability; data protected and





used only for its intended purpose; evaluation for bias; and transparency and meaningful consent for patients. RheumView™ and ROXI were built around these expectations. Patients are prompted for explicit, documented consent before any encounter is processed. Data is encrypted in transit and at rest, handled under zero-data-retention agreements with AI model providers, and never used to train AI models. The platform has undergone a formal privacy impact assessment and threat-risk assessment, with ongoing security review built into its governance.

AI in rheumatology should be judged by more than how well it writes a note. To truly reduce administrative burden, AI tools must help us measure, track, and act on disease activity over time; not just document it. Used well, tools like RheumView™ and ROXI can finally give our specialty what it has long lacked: a structured, measurable record that treat-to-target care was always meant to run on.

Tom Appleton, MD, PhD, FRCPC
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Chair, ORA Informatics Committee



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1. BIMZELX Product Monograph. UCB Canada Inc. December 12, 2025. **2.** Data on file, UCB Canada Inc.

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- 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

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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.

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CIMZIA® (certolizumab pegol)

The CRA's 2026 Distinguished Teacher-Educator: Dr. Susan Humphrey-Murto

You are a Professor of Medicine at the University of Ottawa with an active clinical practice in general rheumatology and osteoporosis. You began your career with a deep commitment to workplace-based teaching, serving for many years on the CRA Education Committee. You then became interested in education research and currently have 98 publications in leading journals such as Academic Medicine and Medical Education. Your contributions have been recognized with major honours, including the Royal College Duncan Graham Award for Outstanding Contribution to Medical Education, multiple University of Ottawa mentorship and education awards, and a Tier 2 Research Chair.



What are some of the highlights and challenges you have experienced throughout your career?

I recognize this may not be a common perspective, but my career has felt less defined by obstacles than by opportunities. Looking back, I smile because my only conscious career goal was to become a physician. After that, my path was shaped largely by remarkable mentors who saw possibilities that I didn't yet see myself. Dr. Douglas Smith encouraged me to pursue rheumatology. I would say that worked out rather well.

I also had little interest in completing a Master's in Education at the time—it was simply a requirement for my faculty appointment. Looking back, that degree changed the trajectory of my career. It opened doors to educational leadership, medical education research, and lifelong collaborations.

Medical education research was barely a "thing" when I started. My master's thesis focused on something that sounds rather dry—how we determine pass-fail scores for objective structured clinical examinations (OSCE) (and why "60%" isn't necessarily the right answer!). That unexpectedly sparked a lifelong curiosity about assessment and learning.

The early years, however, were challenging. There was very little infrastructure or mentorship for education research, particularly while raising a young family. Progress was slow. Things changed when Dr. Claire Touchie and I essentially co-mentored one another. We often joke that we stumbled our way forward together. Another pivotal influence was meeting Dr. Tim Wood, an exceptional psychometrician and methodologist. He patiently taught me how to think and write with greater clarity—a gift that has influenced every paper I've written since.

Perhaps the greatest challenge throughout my career has simply been finding time. Balancing clinical practice, teaching, administration, research, and family is a constant juggling act. I learned to be disciplined, persistent, and realistic about timing. I deliberately delayed building a major research program until my children were older. None of this would have been possible without my husband, an academic anesthesiologist and researcher, along with our caregiver and my late mother, whose love and support made family life possible.

I am also grateful that attitudes toward medical education research have changed enormously over the past two decades. While there is still work to do, the University of Ottawa and the Department of Medicine have increasingly recognized education research as a rigorous scholarly discipline. Holding my second five-year Research Chair reflects how far the field has come.

Over the course of your career, you have held several leadership roles, including Deputy Registrar of the Medical Council of Canada, Co-Chair of the Royal College Education Research Committee, Program Director for both Rheumatology and the Medical Education Fellowship, Associate Director of Education Scholarship at the Centre for Innovation in Medical Education, Chair of the Rheumatology Competence Committee, and now Division Head. Was this something you aspired to?

Leadership was certainly never part of my career plan. In fact, I usually wanted to run in the opposite direction! I remember as a junior faculty member telling my mentor, Dr. Meredith Marks, "Why would I take a leadership course? I have no interest in leading anything." She must have smiled knowing something I didn't.



Dr. Susan Humphrey-Murto receiving her award from then-CRA President Dr. Trudy Taylor at the CRA Annual Scientific Meeting in Halifax, which took place in April 2026.

Ironically, leadership opportunities kept finding me. The first was serving as Chief Resident in Internal Medicine, despite never putting myself forward for the role. Later, I was asked to direct the Ottawa examination centre for the national licensing OSCEs, which was an incredibly rewarding experience and introduced me to educational leadership on a much larger scale.

Since then, I have been fortunate to serve in many educational leadership roles, each one teaching me something different. What I have come to realize is that leadership isn't really about titles—it is about creating opportunities for others, bringing good people together, and helping them succeed.

That is what makes my current role as Division Head particularly meaningful. After benefiting from so many generous mentors throughout my career, I now have the opportunity to support the next generation of clinicians, educators, researchers, and leaders. That feels like a wonderful full-circle moment.

You have also made substantial local impact through the development of the Fellowship in Medical Education, the Healthcare Education Scholars Program, and the mentoring of more than forty trainees. What has mentoring meant to you?

Without question, mentoring has been one of the greatest joys of my career.

I love meeting with aspiring clinician-educators to talk about their ideas, their career aspirations, and their research questions. Early-career educators see the world differently—they ask questions I would never have thought to ask, and that curiosity is energizing. I often think I learn as much from my trainees as they do from me.

As a respected teacher-educator, what advice would you give to someone considering a career in rheumatology?

Follow your passion. Be persistent. Be honest. Be generous with your time and your knowledge.

Most importantly, surround yourself with smart, kind people you genuinely enjoy working with. Your career will be more productive and much more fun because of them.

Finally, very few careers unfold exactly as planned. Some of the best opportunities came from saying "yes" to things I had never imagined doing. Stay open to those opportunities—you never know where they might lead.

Susan Humphrey-Murto, MD, MEd, FRCPC
Professor of Medicine,
Division of Rheumatology
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University of Ottawa

Patient Perspective: Jeff Aarssen



It is February 1980, and I am in my final year at Western University. I wake up basically paralyzed, and I am rushed to the hospital. After a couple of days I am released on treatment with anti-inflammatories. The initial diagnosis is an attack of bursitis. I return to school, and since I was a runner at the time, I conclude that I could "run it off" and I started to run even more . . . upwards of 40-50 miles per week. This bit of self-diagnosis is not prudent and by August 1980 the pain, swelling and stiffness return with a vengeance, and I am officially diagnosed with rheumatoid arthritis (RA).

At the time I was incredulous that a 21-year-old student-athlete could even get RA. There was no history of it in my family, I had not suffered any type of traumatic injury, and I had not had any type of virus or illness prior to its onset. Perhaps the most disturbing news shared with me by my general practitioner (who actually dignosed me) was that I would likely be in a wheelchair by the time I was 30. Hooray for a positive bedside manner! That comment he shared with me, however, actually provided me with a personal mission to never let that happen. I was set firmly on a course to not let RA defeat me.

A month later I was hospitalized for 4 weeks to try to cool down my 58 inflamed joints. Literally, with daily ice baths, compresses, high-dose acetylsalicylic acid and other anti-inflammatories.

Needless to say, at the time I was bitter, and I am sure I was clinically depressed. Imagine the thing you most enjoy in life (in my case participating in sports) being taken away from you. It was a gut punch. I struggled with depression, anxiety, and worries about the future. What kind of life would I be able to live, and what restrictions would I have in terms of activities? However, once I fought through some of the darker days, and decided to "beat RA" it made all the difference in the world. My mental attitude was a game changer.

From those early days I was able to stay up to date with all the relevant treatments of the day, graduating from coated aspirin to chloroquine gold shots, prednisone, methotrexate and, finally, biologics.

As you think back to 1980 and the limited arsenal we had to fight RA compared to today's more effective treatments, it really does give you hope.

I have had RA for over 45 years. I have had 7 orthopedic surgeries along the way to correct deformities in my hips, knees and feet, and I have been hospitalized three separate times due to flare ups. In spite of all of that, I have been very lucky—I was able to enjoy a 39-year career with the same company which accommodated my needs at every turn.

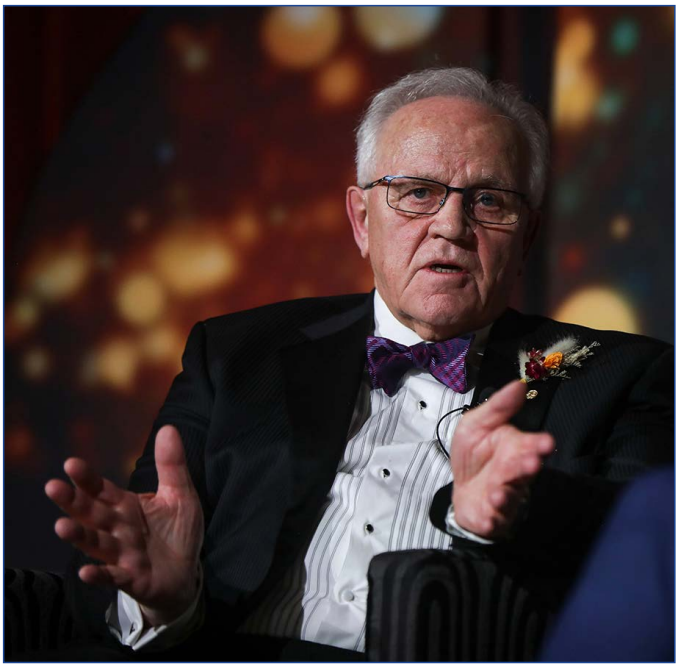
In my retirement now, I enjoy playing over 100 rounds of golf each summer; I attend fitness classes twice each week; I do all of my own yard work and landscaping; I enjoy activities with my grandchildren; I travel fairly extensively, and I still fight the fight for the Arthritis Society and the Canadian Rheumatology Association Foundation. That is a long way from being confined to a wheelchair.

A simple phrase I heard a long time ago has kept me positive and moving forward. "Without hope in the future, there can be no power in the present." The great news is that I am a living example over my 45-year journey with RA that there is tremendous hope in the future thus giving power in the present.

I would like to take this opportunity to express my gratitude for the tremendous support of all the medical practitioners I have had in my journey (it takes a village as they say). In particular, I have had two rheumatologists for 36 of my 45-year battle with RA who have helped me immensely and they are Dr. Hani El-Gabalawy in Winnipeg and Dr. Janet Pope in London for the past 28 years. They have been remarkable allies and practitioners.

Jeff Aarssen
Patient Advocate

Canadian Hero in Rheumatology: Dr. Marvin Fritzler



Dr. Marvin Fritzler was born in Vulcan, Alberta, the "Official Star Trek Capital of Canada." He is Professor Emeritus in the Cumming School of Medicine, University of Calgary, where he served as the Head of the Division of Rheumatology, Clinical Immunology & Dermatology (1985-1993) and Associate Dean of Research (1995-1999). His clinical practice centered mainly on systemic lupus erythematosus and systemic sclerosis, and he continues to speak at symposia focusing on autoantibodies as biomarkers for predicting, preventing, and treating autoimmune diseases. He also held the Arthritis Society Research Chair for 14 years and is the founder and director of the Mitogen Diagnostics Corporation. In 2015, he served as Director of the McCaig Institute for Bone & Joint Health, culminating in a $10M endowment from the McCaig family. Dr. Fritzler's research interests focused on the cell and molecular biology of autoantigens and the induction of autoimmunity by environmental exposures. The spectrum of diagnostic tests based on his discoveries reflects his commitment to knowledge translation and innovation. His research was continuously funded for almost 40 years by several agencies, most notably the Canadian Institute for Health Research with total funding greater than $80M. He has published more than 650 peer-reviewed manuscripts, and his work has been cited more than 46,000 times (h index 98; i10 index 459). He co-authored one of the top 100 citations in the *Journal of Immunology* (Autoantibody to a Nuclear Antigen in Proliferating Cells. *J Immunol* 1978 121:2228-34) and the book, "Ten Years of Progress in GW/P Body Research," which had >38,000 downloads.

In 2001 he was appointed to the Government of Alberta's Science, Technology and Innovation Policy and Strategy Board, and from 2005-2010 he chaired the Alberta Research and Innovation Authority (ARIA). He was inducted into the BioAlberta Hall of Fame, was awarded the Alberta Centennial Medal and the ASTech Foundation Award for his leadership in shaping the research and innovation system in Alberta. Dr. Fritzler spearheaded the inaugural International Congress on Systemic Lupus Erythematosus held in Calgary in 1986. He facilitates, organizes and co-chairs the International Workshop on Autoantibodies and Autoimmunity and the Dresden Symposium on Autoantibodies.

For his contributions, he was inducted into the American Lupus Society Hall of Fame in 1986; named Distinguished Alumnus of the University of Calgary in 1988; inducted as an Honorary Member into the Mexican Academy of Medicine in 2002; designated Distinguished Investigator by the Canadian Rheumatology Association in 2003; and received The Arthritis Society Hero Award of Distinction that same year as well. In 2010 he was inducted as a Fellow of the Canadian Academy of Health Sciences, and in 2013 he was designated a Master of the American College of Rheumatology, followed by being inducted into the Order of the University of Calgary in 2014. He has also been awarded the American Association of Clinical Chemistry—Carl R. Jolliff—Lifetime Achievement Award in 2016; *Le Prix Rogers Demers*, for International Contributions to Rheumatology in 2018; the Canadian Society Clinical Chemists Research Excellence Award in 2018; the Association of Medical Laboratory Immunologists Neter Award for outstanding contributions to laboratory immunology; Master of the Canadian Rheumatology Association in 2019; and InGen's City of Calgary "Top 7 Over 70" in 2025.

The four enduring principles he lives by include the following:

- **Reminder:** Science is both provisional and contingent;
- **Perspective:** Don't focus on the bugs on the windshield;
- **Progress:** Best seen by checking the rear-view mirror; and
- **Instill HOPE: H**elp **O**thers **P**ursue **E**xcellence

CPD for the Busy Rheumatologist
Maintenance of Certification: Exploring the Refreshed Section 2

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

"The Royal College of Physicians and Surgeons of Canada (RCPSC) has refreshed their Maintenance of Certification Program," muses Dr. Aki Joint. "Based on reading the article by Wooster et. al (Fall 2026 issue of the Journal of the Canadian Rheumatology Association), Section 1 – Group Learning remains largely unchanged; although I am glad to see that social media, case-based discussions, resuscitation courses and patient-partnered learning have been added." Dr. Joint continues, "It looks as though Section 2 – Individual Learning has undergone some changes. I wonder how I can maximize my credits within Section 2."

RCPSC Maintenance of Certification (MOC) Section 2 consists of these subsections: Educational Content Review, Courses (asynchronous), Individual Task Training, Activity Preparation, Postgraduate Studies (fellowships, Master's and PhD), and Traineeships. Each of these sections has specific credit hours associated with it. Table 1 delineates the credit hours associated with each section.

Educational Content Review includes all types of review activities, including reading journals (online or hard copy), listening to podcasts, and reading educational journals or watching webinars. These activities include those that do NOT have a formal discussion opportunity. If these activities include a formal discussion opportunity, the hours should be claimed under the appropriate subsection of Section 1.

Courses include all individual or group courses (online, hard copy) that do not have a formal discussion included in the course. If the course includes a formal discussion opportunity, they should be recorded in Section 1.

Individual Training Courses include any and all training to improve technical skills. If the training is to improve non-technical skills, then those hours should be claimed under Courses in either Section 1 or Section 2, depending on whether there is a formal discussion opportunity included.

Activity Preparation was previously titled Personal Learning Projects prior to January 2024. This subsection includes learning activities undertaken in preparing to complete a task. These tasks may include (but are not limited to) addressing a clinical or academic question; preparing to deliver a teaching session or presentation; preparing education for patients, families or communities; preparing a manuscript (book, chapter, article); preparing a grant application; addressing an administrative or systems-related question; and creating an oral or written exam question for submission. The time committed to the preparation of these tasks counts for 2 credits per hour of time. This does not include the actual time spent completing the actual task (i.e., teaching a session or doing research).

Postgraduate Studies include studies for a Master's or PhD degree or a formal subspecialty fellowship (must be structured and formally organized). A RCPSC fellow may claim 50 credits per year per initiative. For example, if a RCPSC fellow is completing a master's degree and the program of study takes 1.5 years they can claim a total of 100 credits over the two (calendar year) cycles.

Traineeships are formal learning opportunities that include learning objectives, a learning plan, receipt of formal feedback from a mentor or supervisor related to the learning objectives, and acknowledgement of completion of the activity, and are based on a previously identified professional learning need. Activities in this subsection can be claimed for 20 credits per year regardless of the number of traineeships or the length of time taken to complete them.

"It appears that if I focus my attention on activity preparation and ensuring that I record my "courses" appropriately between Section 1 and Section 2, I can be sure to maximize my learning and participation in my MOC," remarked Dr. Joint. "Once you start tracking progress as you go, things become much easier."

Table 1: **Sections and Associated Credit Hours (adapted from *www.royalcollege.ca/content/dam/document/cpd/refreshed-moc-framework-e.pdf*)**

Subsections and associated activities	Credit hours (note all credit hours for Section 2 are unaccredited)	Data required for credit entry into Mainport
Education Content Review • Reading • Listening • Webinars With no formal discussion included	0.5 credits per hour of activity to a max of 30 credit hours per year	For all activities in section 2, you need to include: • Activity title • One key message learned • Hours undertaken • Responses to reflection questions (optional)
Courses (asynchronous)	0.5 credits per hour of activity (no limit)	
Individual Task Training	0.5 credits per hour of activity (no limit)	
Activity Preparation	2 credits per hour of activity (no limit)	
Postgraduate Studies	50 credits per year, per initiative	
Traineeships	20 credits per year	

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Deciphering Ophthalmology Referrals and Assessments for Shared Care: A Practical Guide for Rheumatologists

By Alessana Carmona, MD; Brian J. Chan, MD, FRCSC; and Raj Carmona, MBBS, FRCPC

Introduction

As experts in inflammatory/autoimmune diseases and immunotherapy, rheumatologists are uniquely equipped to co-manage patients with inflammatory ocular diseases (IOD), both primary ocular disorders and those associated with systemic diseases. However, due to extensive use of abbreviations (Table 1) and short forms, as well as ocular investigations and assessments of disease activity that are less familiar to rheumatologists, interpreting ophthalmology referrals and ocular assessments can be like deciphering code. This article serves to crack that code and improve shared care of IOD patients.

Anatomic Involvement and Differential Diagnoses

Familiarity with ocular anatomy (Figure 1) aids interpretation of ophthalmic findings. The anterior segment includes the cornea, aqueous humor, iris, ciliary body, lens, anterior chamber (between the cornea and iris), and posterior chamber (between the iris and lens). The posterior segment includes the vitreous body, retina, choroid and optic nerve. The Standardization of Uveitis Nomenclature (SUN) Working Group classifies uveitis as anterior (iris +/- ciliary body), intermediate (vitreous and pars plana), posterior (retina and/or choroid), and panuveitis (entire uveal tract).[1] Referrals should specify the site of inflammation and anatomic extent, as this guides the differential diagnosis (Table 2).

Anterior Segment Findings on Slit Lamp Examination

Key slit lamp findings in anterior uveitis include ciliary injection, anterior chamber cells (leucocytes suspended in aqueous humor), flare (protein leakage causing a smoky appearance), keratic precipitates (inflammatory deposits on the corneal endothelium), posterior synechiae (iris adhesions onto the lens), hypopyon (pooled leucocytes in the anterior chamber), iris nodules, and cataract formation. Anterior chamber cells are graded using a 1 mm × 1 mm slit beam as: 0 (<1 cell), 0.5+ (1–5 cells), 1+ (6–15), 2+ (16–25), 3+ (26–50), and 4+ (>50 cells). 1+ or higher is considered active inflammation. Flare is graded 0 to 4+ according to increasing protein haze and impaired visualization of iris/lens details.[1]

Importantly, "granulomatous" uveitis refers to the clinical appearance of large "mutton-fat" keratic precipitates and iris nodules, rather than pathologic granulomas, and is associated with conditions such as sarcoidosis, tuberculosis, herpetic infections, syphilis, and Vogt-Koyanagi-Harada disease (VKH). Uveitis associated with HLA-B27-associated diseases is usually non-granulomatous, but exceptions occur.

Posterior Segment Findings on Slit Lamp Examination and Indirect Ophthalmoscopy

Despite being anterior in location, anterior uveitis may be associated with "spillover" anterior vitritis, and cystoid macular edema (CME).

Intermediate uveitis is characterized by vitreous cells, snowballs (inflammatory aggregates), and snowbanking over the pars plana. Inflammatory vitreous haze is graded as: 0 (clear), 0.5+ (trace), 1+ (mild blurring of retinal details), 2+ (moderate blurring, vessels still visible), 3+ (severe, only large vessels visible) and 4+ (very severe, fundus barely visible).[1]

Posterior uveitis may present with retinitis, choroiditis, chorioretinitis, retinal vasculitis, optic disc edema, and macular edema. Retinal vasculitis can manifest as vascular sheathing (coated appearance), hemorrhage, ischemia, and cotton wool spots. Chronic inflammation may lead to epiretinal membrane formation, retinal neovascularization, and optic atrophy.

Visual Acuity (VA) Assessment

VA is typically measured using a Snellen chart at 20 feet. 20/20 is normal visual acuity. 20/40 means the patient sees at 20 feet what a normal observer sees at 40 feet.[2] 20/200 is the threshold for legal blindness.[3]

Acute VA loss may result from corneal edema, active anterior chamber inflammation, vitritis, macular edema, retinal ischemia, or optic nerve involvement. Chronic reductions may indicate cataract, glaucoma, retinal scarring, or macular atrophy.

Figure 1: **Ocular Anatomy Cross-section**

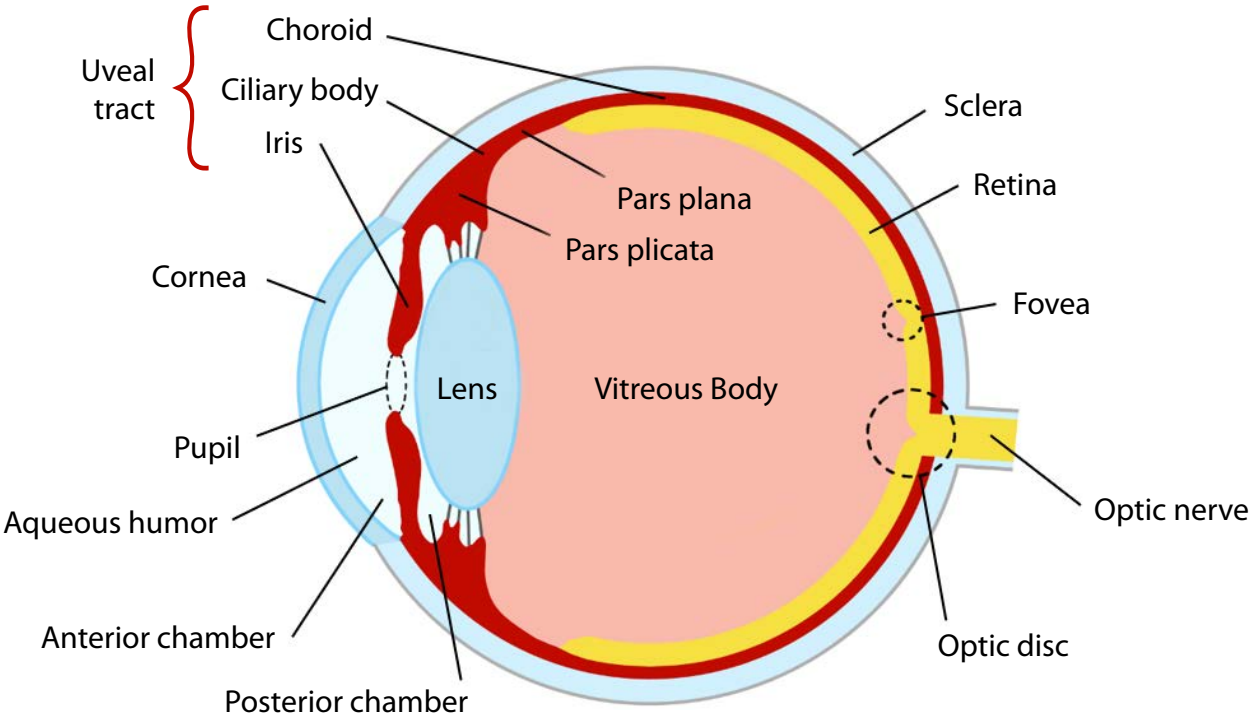


Illustration by Zachary Carmona, 2026.

Visual Field (VF) Assessment

Automated VF testing evaluates retinal sensitivity across the VF, often using Humphrey automated perimetry. The patient fixates on a central target while lights of varying intensities are presented at different retinal locations.

VF assessment is essential in glaucoma, optic neuropathy, retinal disease, and hydroxychloroquine screening. Hydroxychloroquine retinopathy classically produces paracentral scotomas on 10-2 VF testing, although Asian patients may demonstrate more peripheral defects on 24-2 or 30-2 testing.[4] Mild nonspecific defects are common and do not necessarily indicate retinal toxicity.

Intraocular Pressure (IOP)

IOP is usually measured using applanation tonometry. Normal IOP is generally 10–21 mmHg.[2]

Acute inflammation can decrease IOP due to ciliary body dysfunction, whereas chronic inflammation can increase IOP secondary to trabecular meshwork damage or synechiae. Topical, intravitreal/periocular, and systemic corticosteroids can increase IOP, potentially leading to secondary glaucoma. **Importantly, the ophthalmologic term "steroid response" refers to corticosteroid-induced (usually topical) elevation of IOP, rather than a therapeutic benefit.**[3]

Optical Coherence Tomography (OCT)

OCT is a non-invasive imaging modality that produces high-resolution cross-sectional images of the retina using reflected light waves.

OCT can detect macular pathology that may not be visible clinically, including CME. CME is a critical finding

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Table 1: **Common Ophthalmology Abbreviations**

AC	Anterior chamber	**IOP**	Intraocular pressure	**PS**	Posterior synechiae
ACC	Anterior chamber cells	**IRF**	Intraretinal fluid	**PSC**	Posterior subcapsular cataract
ACF	Anterior chamber flare	**K**	Cornea	**RD**	Retinal detachment
AU	Anterior uveitis	**KP**	Keratic precipitates	**SRF**	Subretinal fluid
C/D	Cup-to-disc ratio	**L**	Lens	**VA**	Visual acuity
CEIOL	Cataract Extraction with Intraocular Lens implantation	**LP**	Light perception	**VF/HVF**	Visual field / Humphrey Visual Field
CME	Cystoid macular edema	**LPI**	Laser Peripheral Iridotomy	**VH**	Vitreous hemorrhage
ERM	Epiretinal Membrane	**NLP**	No light perception	**Vit cell**	Vitreous cells
FA/IVFA	Fluorescein angiography / Intravenous fluorescein angiography	**OCT**	Optical coherence tomography	**Vit haze**	Vitreous haze
FAF	Fundus autofluorescence	**OD/OS/ OU**	Right eye / left eye / both eyes		
HM	Hand motion vision	**PAS**	Peripheral anterior synechiae		

as it can lead to vision loss. OCT may also demonstrate epiretinal membranes, subretinal fluid, vitreomacular traction, retinal atrophy, and disruption of photoreceptor layers. Serial OCT imaging is frequently used to monitor therapeutic response.[3]

Intravenous Fluorescein Angiography (IVFA)

IVFA involves intravenous injection of sodium fluorescein dye followed by serial retinal photography. The early arterial phase assesses retinal and choroidal perfusion, the venous phase evaluates vascular filling, and late frames identify leakage, staining, or ischemia.[3]

In choroiditis and chorioretinitis, active lesions are often hypofluorescent early and hyperfluorescent late due to staining and leakage. Retinal vasculitis produces vascular leakage, capillary non-perfusion, and optic disc leakage.

Behçet's disease classically demonstrates diffuse retinal vascular leakage, capillary dropout, and occlusive vasculitis.[5] Sarcoidosis commonly causes segmental venous leakage and periphlebitis ("candle-wax drippings").[6] VKH demonstrates multiple pinpoint leaks with pooling in serous retinal detachments.[7] ANCA-associated vasculitis may produce retinal ischemia, vascular occlusion, and optic nerve leakage.[8]

Table 2: **Key Differential Diagnoses To Consider By Site of Ocular Inflammation (list not exhaustive)**

Site[a]	Systemic Inflammatory Diseases	Infections	Primary Ocular Diseases
Keratitis / Peripheral Ulcerative Keratitis	RA, GPA, MPA, RP, SLE, SjS	HSV, VZV, bacterial	DED, exposure keratopathy, ocular rosacea, contact lens-associated keratitis
Episcleritis[b]	RA, AS, PsA, IBD, GPA, MPA, RP, SLE	HSV, VZV	Idiopathic (most common), DED, ocular rosacea
Scleritis	RA (most common association), GPA, MPA, PAN, RP, SLE, ReA, IBD, sarcoidosis	HSV, VZV, Syphilis, TB	Idiopathic
Anterior Uveitis[c]	HLA-B27 (without extraocular disease), AS, PsA, EnA, ReA, PsO, IBD, JIA, sarcoidosis, BD[d], TINU	HSV, VZV, Syphilis, TB	Fuchs uveitis syndrome, Posner–Schlossman syndrome, lens-induced uveitis
Intermediate Uveitis[c]	Multiple sclerosis[e], sarcoidosis, BD, IBD	Syphilis, TB, Lyme disease	Pars planitis, intraocular lymphoma
Posterior Uveitis[c]	BD, sarcoidosis, systemic vasculitis, VKH, SLE, IBD	Syphilis, TB, Toxoplasmosis, CMV	BCR, serpiginous choroiditis, multifocal choroiditis, intraocular lymphoma
Panuveitis[c]	BD, sarcoidosis, VKH, AAV, SLE, IBD	Syphilis, TB, endophthalmitis	Sympathetic ophthalmia
Retinal vasculitis	BD, sarcoidosis, SLE, GPA, PAN, PACNS, IBD	Syphilis, TB, toxoplasmosis, HSV, VZV, CMV, Bartonella	Eales disease, BCR

AAV: ANCA-associated vasculitis, AS: ankylosing spondylitis, BCR: Birdshot chorioretinopathy, BD: Behcet's Disease, CMV: cytomegalovirus, DED: dry eye disease, EnA: enteropathic arthritis, GPA: granulomatosis with polyangiitis, HSV: herpes simplex virus, IBD: inflammatory bowel disease, JIA: juvenile idiopathic arthritis, MPA: microscopic polyangiitis, PAN: polyarteritis nodosa, PACNS: primary angiitis of the CNS, PsA: psoriatic arthritis, PsO: psoriasis, RA: rheumatoid arthritis, ReA: reactive arthritis, RP: relapsing polychondritis, SjS: Sjogren's Syndrome, SLE: systemic lupus erythematosus, TB: tuberculosis, TINU: tubulointerstitial nephritis and uveitis, VKH: Vogt-Koyanagi-Harada disease, VZV: varicella zoster virus

a: Across each site of inflammation, about 60% of cases are idiopathic
b: Episcleritis is often idiopathic, benign, and self-limited
c: Sarcoidosis, Behcet's, Syphilis and TB can affect all uveitis categories
d: Behcet's can initially present with anterior uveitis, but most commonly as posterior or panuveitis
e: Strongly consider multiple sclerosis in female patients with intermediate uveitis

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Importantly, "retinal vasculitis" in ophthalmology is defined primarily by clinical and angiographic features such as vascular leakage, staining, sheathing, and non-perfusion, rather than the histopathologic vessel wall inflammation and necrosis seen in systemic vasculitis. Retinal vascular inflammation in infectious or immune-mediated posterior uveitis does not, in isolation, indicate a primary retinal vasculitis syndrome or systemic necrotizing vasculitis.

Topical Therapies for Non-infectious Anterior Uveitis

For non-infectious anterior uveitis, first-line therapy is usually a topical corticosteroid (e.g. prednisolone acetate 1%). Dosing is initially intensive (e.g. hourly) with gradual taper over 4-6 weeks. Adjunctive cycloplegic/mydriatic agents (e.g., cyclopentolate 1%) relieve pain by reducing ciliary muscle spasm and help prevent posterior synechiae by dilating the iris away from the lens.[3] There is usually no role for topical therapies in posterior segment involvement.

Indications for Systemic Immunotherapy in Non-Infectious Uveitis

Systemic immunotherapy is indicated for recurrent anterior uveitis, failure of local therapy or steroid intolerance, bilateral disease, posterior segment involvement, chronic uveitis, or any vision-threatening disease.

Systemic corticosteroids (e.g. prednisone 0.5–1 mg/kg/day or equivalent) are used for rapid suppression of active inflammation. Intravenous methylprednisolone is used in some cases of severe posterior or panuveitis, or retinal vasculitis.[9]

Conventional steroid-sparing agents include methotrexate, mycophenolate mofetil, azathioprine, and cyclosporine. Biologic therapy, particularly adalimumab or infliximab, is widely used in refractory non-infectious uveitis.[10]

Conclusion

Disease activity and treatment response are assessed by slit-lamp assessment of AC cells/flare, vitreous haze and retinal/choroidal lesions, OCT evidence of CME or serous detachment, IVFA leakage and non-perfusion, functional measures such as VA and VF, and topical corticosteroid requirements. Understanding ophthalmology terminology and assessment enables rheumatologists to participate more effectively in shared care of IOD patients, with timely escalation of systemic immunotherapy when indicated.

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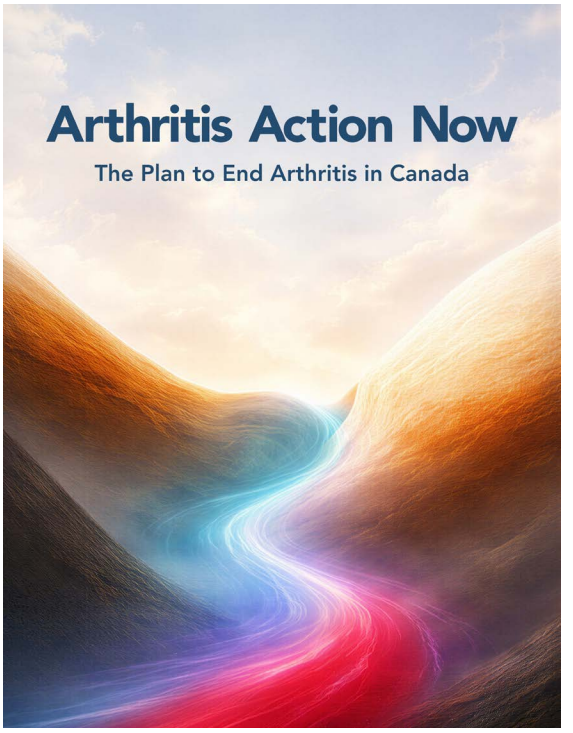
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Learn more at arthritisactionplan.ca.







Dr. Abraham Chaiton — *ORA Distinguished Member Award*

Receiving the Ontario Rheumatology Association Distinguished Member Award is a deeply appreciated honour. With over 50 years in rheumatology, one of the most rewarding parts of my career has been witnessing and contributing to the acceptance of musculoskeletal (MSK) ultrasound within our specialty.

I undertook the challenge of educating myself in MSK ultrasound at a time when it was not considered within the traditional scope of rheumatology practice. Recognizing its potential to improve bedside diagnosis and patient care, I became committed to advancing its use in Canadian rheumatology. That personal journey evolved into a national, educational initiative through my involvement in establishing the Canadian Rheumatology Ultrasound Society (CRUS), developing structured training programs, and teaching and mentoring rheumatologists across Canada.

Today, I am particularly impressed by the younger generation of motivated colleagues who continue to advance the science and application of ultrasound in the pursuit of better patient care. Their enthusiasm, curiosity and commitment leave me confident that the future of our specialty is sound.

Dr. Walter Maksymowych (for work done in collaboration with Dr. Robert Lambert)

EULAR 2026 Abstract Award for Clinical Research



Dr. Walter Maksymowych



Dr. Robert Lambert

We assembled a unique global collaboration of 21 rheumatologists from SPARTAN and 16 musculoskeletal radiologists from the Skeletal Society of Radiologists, all of whom are experts in axial spondyloarthritis (axSpA), with the aim being to define the essential parameters for magnetic resonance imaging (MRI) of the sacroiliac joints to be considered indicative of axSpA for the purposes of disease classification.

Qualitative parameters and a new quantitative component were derived for a definition of a positive MRI across the full spectrum of axSpA. Data analyses were based on assessments of MRI scans from 3 cohorts and 1,050 patients which culminated in the generation of more than 130 data tables. The abstract describing this work was awarded a EULAR 2026 top 10 abstract prize (from among 4,500 submitted).

MB

Update from Manitoba

By Cory Baillie, MD, FRCPC

We are in the dog days of summer as this update from Manitoba is written. We have been enjoying the summer weather with time off with family at our respective cottages, from Lake of the Woods and the Whiteshell in the east, to Riding Mountain National Park in the western part of the province.

Since our last CRAJ update, we are proud to report that the rheumatology section, in conjunction with Doctors Manitoba, has been able to successfully negotiate changes in our collective agreement with Manitoba Health. These changes help reflect the complexity of rheumatologic care and allow Manitoba rheumatologists to better care for our patients. We hope that these changes help make Manitoba a more attractive location for colleagues to join us. There are positions open in both the community and at the University of Manitoba, and we would love to welcome you.

Cory Baillie, MD, FRCPC
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