Summer 2026, Volume 36, Number 2

CRAJ SCR

The Journal of the Canadian Rheumatology Association

Spotlight on:

The CRA Annual Scientific Meeting:

Shifting Tides: Embracing Change in Rheumatology

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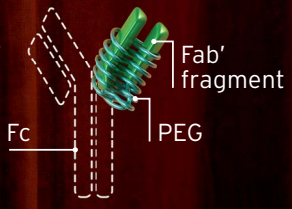

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The product monograph is also available through Medical Information Services at 1-866-709-8444.

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

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

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Looking Back to the Beginning

By Philip A. Baer, MDCM, FRCPC, FACR

"Begin at the beginning and go on till you come to the end: then stop."
— Lewis Carroll

I was recently gifted copies of Volume 1, Number 1, of the *Journal of the Canadian Rheumatology Association (CRAJ)* from September 1992. Prior to that, the oldest copy I could find in my possession was from 2007. As a bit of a packrat, I wondered why I didn't have a copy of the inaugural issue. Did I automatically become a member of the CRA on its creation, or did one have to be invited to join, or take the initiative to sign up? Who received the *CRAJ*? Our publisher has been STA HealthCare Communications from inception, so maybe someone there remembers.

I found the trip down memory lane very interesting. Firstly, while the *CRAJ* acronym existed from the beginning, it was originally the *Journal of the Canadian Rheumatism Association*. I can't recall when the CRA became the Canadian Rheumatology Association. Probably, it was around the time the American Rheumatism Association became the American College of Rheumatology (ACR). The European League Against Rheumatism eventually followed suit, becoming the European Alliance of Associations for Rheumatology, while retaining the EULAR acronym. Rheumatism is in Jack Cush's cemetery of rheumatology terms, and deservedly so.

Counting the front and back covers, the first issue was 16 pages long. We now routinely run double that. There were no graphics on the cover, just blue type on a grey background. A postage paid postcard enquired about the reader's reaction to the journal, and asked for ratings on the three main articles, as well as whether the journal would be read regularly, often, occasionally or never. We must have done well on the latter question, as we are still publishing 34 years later.

The founding editorial board was lean, with only eight participants—all men. Currently, we have 15 members—seven men and eight women, representing a diverse mix whether assessed by geography, age, and stage or type of practice.

Our inaugural advertiser was May and Baker Pharma, a division of Rhone Poulenc Rorer, both names that have been merged out of existence. Their colourful ad for sustained-release ketoprofen capsules featured a graphic not of any joints but of a pink GI tract. The product was touted for "older arthritic patients when tolerability counts most" and as "a logical choice for the older generation." Kudos to you if you can recall the brand name.

The first editorial was written by Dr. Paul Davis, the CRA President at the time. He highlighted the CRA as one of the founding societies involved in the Royal College's Maintenance of Certification (MAINCERT) Pilot Project, which went on to become fully established and continues to this day. Articles on obtaining what are now called Maintenance of Certification (MOC) credits continue to be staple features of the *CRAJ*, thanks to Dr. Raheem Kherani and his collaborators.

As well, Dr. Davis indicated that the CRA was trying to become more relevant to community rheumatologists. Interestingly, at the 2026 CRA ASM, it was announced that the CRA had a renewed strategic focus on community-based rheumatology, and was forming a new Community Practice Committee. Finally, an education subcommittee had been established, with plans to organize Canada-wide educational events. Dr. Davis also foresaw the CRA becoming more involved in medical politics and in advocacy for our patients. Fortunately, his vision has come to fruition.

The main article featured "A family doctor's perspective on RA" and covered the always important issue of good communications between primary care physicians and specialists. "Cognitive restructuring" of patients' negative thoughts about their disease was also emphasized, though perhaps we need to rethink that approach. As I learned in a recent *Medical Post* article by Dr. Ginevra Mills, "Wellness does not begin with the elimination of unwanted thoughts. It begins with a shift in how those thoughts are met. And sometimes, the most helpful thing we can offer is not another way to control the mind, but a way to step out of the quiet, exhausting effort to do so."[1]

There was a patient information article designed as a handout if your patient happened to ask, "What is the Schirmer test for dry eye syndrome?" No patient ever asked me that to my best recollection, but I would have been prepared if I had had this *CRAJ* issue on hand.

The most prescient article was entitled "Joint Collaboration" by Dr. Alan Rosenberg, calling for interactive

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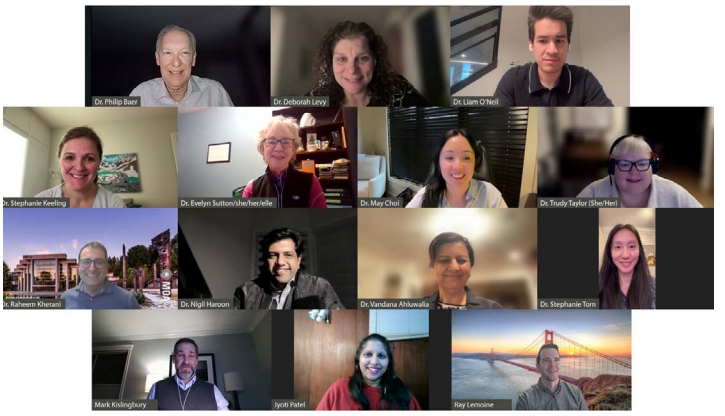
CRAJ EDITORIAL BOARD

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



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Looking Back to the Beginning

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research endeavours, including the development of comprehensive multicentre population-based studies and the establishment of disease registries. Canadian rheumatologists can certainly be proud of their accomplishments in this sphere, which extend not only nationally but globally.

Two nascent studies advised that they were looking for patients:

1. A genetic linkage analysis on families of patients with rheumatoid arthritis, led by Walter Maksymowych.
2. A maintenance gold discontinuation study, led by Robert McKendry and John Esdaile.

Since we long ago stopped initiating gold therapy, the second study result is now moot.

Here's hoping the *CRAJ* will still be around in another 34 years, and that our current content will stand the test of time.

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

Reference:
1. Mills Ginevra. The thoughts we tell patients to stop. Canadian Healthcare Network (website). Available at *https://canadianhealthcarenetwork.ca/thoughts-we-tell-patients-stop.*

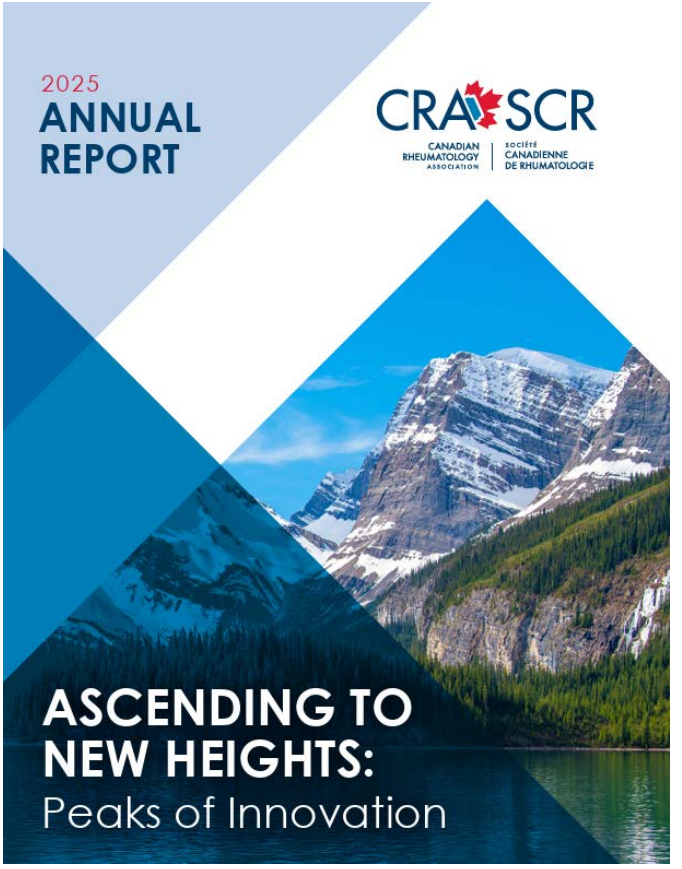
CRA Releases 2025 Annual Report: A Year of Progress and Impact

The Canadian Rheumatology Association (CRA) is pleased to share its 2025 Annual Report, a comprehensive reflection on a year marked by meaningful progress, collaboration, and impact across the rheumatology community. The report highlights key achievements and milestones that continue to advance the organization's mission to represent and nurture the diverse community of rheumatologists by enabling efficient delivery of care, fostering collaboration, and supporting education, research, and advocacy.

This year's report reflects the wide range of work undertaken by the association, including advocacy efforts, educational initiatives, clinical leadership, governance, and member engagement. It highlights how the CRA has continued to strengthen its national voice, support professional development, and respond to the evolving needs of its members and the patients they serve.

At its core, the 2025 Annual Report is a celebration of collaboration, recognizing the individuals and teams whose contributions drive the association forward. It also serves as an invitation to members and the larger rheumatology community to engage with the CRA's strategic direction and help shape the future of rheumatology in Canada.

The full 2025 CRA Annual Report is available online by clicking the link or scanning the QR code. *rheum.ca/wp-content/uploads/2026/04/2025-CRA-Annual-Report-EN.pdf*



Reimagining CIORA: A Stronger, More Impactful Future for Rheumatology Research

For nearly two decades, the CIORA program has played a vital role in advancing practice-relevant rheumatology research across Canada—supporting over 120 projects that improve care, access, and outcomes.

Today, CIORA is entering an exciting new chapter.

Guided by a comprehensive revitalization process, CIORA is evolving to better reflect the realities of today's research and funding landscape where impact, speed, transparency, and collaboration matter more than ever.

The renewed CIORA program introduces a more flexible and responsive structure, including a four-track funding model. New Catalyst Grants will support small, rapid, practical projects that deliver immediate, real-world tools and outputs, while Ignite Awards will fund larger, implementation-focused research designed to influence practice and policy. The Named Challenge Funds will target themed, multi-partner funding opportunities in priority areas such as access to care, equity, and real-world evidence. These initiatives will bring together public, private, and charitable partners while maintaining CIORA's commitment to independent, peer-reviewed decision-making.

In addition, CIORA has created a Community Research Fund for community-based rheumatologists to lead research enhancing patient care.

Across all streams, there is a renewed emphasis on visible outcomes, open-access deliverables, and meaningful knowledge translation, thus ensuring that research funded through CIORA can be quickly applied in clinical settings and benefit patients sooner.

This revitalization is about more than program design. It is about strengthening CIORA's role as a trusted, national platform that connects researchers, clinicians, and partners around a shared goal: improving the lives of people living with rheumatic diseases.

We invite you to explore the refreshed CIORA program and consider how you can be part of this next phase whether as a researcher, partner, or supporter.

Learn more:
Visit the CRAF website to learn more or connect directly with Virginia Hopkins to start the conversation at *vhopkins@rheum.ca*.

CRAF: Supporting the Future of Rheumatology at the CRA Annual Scientific Meeting

Students and trainees took centre stage at this year's Canadian Rheumatology Association Annual Scientific Meeting (ASM) in Halifax, bringing new research, fresh perspectives, and clinical insights. Their participation highlights the essential role that emerging clinicians and researchers play in advancing patient care and innovation across the field.

Through the Canadian Rheumatology Association Foundation (CRAF) bursary program, 36 qualifying students were able to attend the ASM, with registration fees waived thanks to the generous support of MitogenDx. By connecting trainees with clinicians and researchers from across the country, the meeting creates opportunities for collaboration and knowledge sharing that will support improvements in patient care.

The CRAF proudly supported this year's ASM and highlighted the critical role of philanthropic investment in advancing rheumatology education, research, and training across Canada.

CRAF's support for student participation reflects the Foundation's broader mission to advance rheumatology in Canada through education, training, and research.

With continued support from donors, sponsors, and community partners, the ASM remains an important space for connection, collaboration, and the exchange of ideas that help advance rheumatology care across Canada.

Would you like to support the CRAF's mission to advance rheumatology education, training, and research in Canada? Learn more and donate today at *crafoundation.ca*

Passing the Torch

Dear CRA Members,

It is hard to believe that two years have flown by so quickly! To have my term culminate in a fantastic meeting in my home city at the Annual Scientific Meeting (ASM) in Halifax was especially meaningful. As I reflect on the last two years as your Canadian Rheumatology Association (CRA) president, I am filled with gratitude for your engagement, and pride in what we have accomplished. Serving as your president has been an incredible honour, and I thank you for trusting and supporting me in this role.

During the last two years we have endeavoured to engage as many rheumatologists as possible across the country to better understand the needs of our diverse community and improve support for our members. This work has been essential in informing our new strategic plan with a focus to improve our offerings for community-based members while, of course, continuing our strong support of our academic-based membership.

The work and offerings of the CRA are only possible through your contributions. Our board, staff, and members have spent an incredible amount of time and energy on committees and in leadership roles to advance our mission to represent and nurture the diverse community of rheumatologists by enabling efficient delivery of care, fostering collaboration, and supporting education, research and advocacy.

As my term comes to a close, I am delighted to introduce Dr. Stephanie Tom as the new president of the CRA. Stephanie's extensive experience in board and leadership roles at the CRA and Canadian Rheumatology Association Foundation (CRAF) make her well suited to take the helm. Her understanding of the organization and visionary leadership will undoubtedly serve the CRA well in reaching our vision of empowering professional excellence and personal fulfillment for rheumatologists in Canada. It is my pleasure to pass the torch to such a thoughtful, capable leader. I am excited to see what the future has in store for us under her guidance!

Sincerely,

Trudy Taylor, MD, FRCPC
Outgoing President,
Canadian Rheumatology Association

Presidential Address

Thank you, Trudy, for your work as president of the Canadian Rheumatology Association (CRA) in actively engaging with members at national and regional meetings as well as supporting equity, diversity and inclusion (EDI) and planetary health initiatives. You truly exemplify kindness in leadership. Given your extensive track record in medical education, you were the most familiar face when I first joined the Board, and it's been a tremendous experience working with you.

From left to right: Dr. Trudy Taylor, Past-President of the CRA; Dr. Stephanie Tom, the current President of the CRA; and Dr. Nigil Haroon, who served as President of the CRA from 2022-2024.

I attended my first CRA conference as a University of Calgary internal medicine resident. I was surprised at how many people would greet each other with enthusiasm and hugs—it felt more like a family reunion than a typical scientific meeting. The hilarious Great Debate clinched for me that this community isn't just a group of colleagues but also friends. Thanks to Drs. Susan Barr and Chris Penney and that first CRA Annual Scientific Meeting (ASM) experience, I decided to pursue rheumatology at the 11th hour.

I joined the CRA Board in 2018 and after two maternity leaves and one global pandemic, I'm still here. I've developed a Canadian Medical Protective Association (CMPA) education curriculum, published musculoskeletal (MSK) ultrasound research, built a hospital division of 10 rheumatologists and two Advanced Clinician Practitioner in Arthritis Care (ACPAC) therapists and recently led the CRA Planetary Health Taskforce. Most days, I'm simply a busy clinician with an inflammatory disease practice scope at Trillium Health Partners in Mississauga. I also provide semi-monthly hybrid virtual care for northern Ontario communities with Arthritis Society Canada.

Regardless of our practice type, there are universal themes to our profession. We aim to deliver the best possible patient care within our practice environment, amplify the aspects that bring us joy (i.e. research, education, clinical care) and reduce non-value-added burdens (i.e. administrative paperwork). I look forward to championing the creation of more practice management tools and networking opportunities through our current committees and the newly announced Community Practice Committee.

Nous sommes une organisation canadienne, et il est important que nous offrions un environnement accueillant aux francophones. La langue est le fondement de la communication, et c'est en tissant ces liens personnels avec nos collègues que nous renforçons l'esprit de famille au sein de SCR. Je me réjouis à l'idée de mieux comprendre leurs besoins et d'explorer les moyens de collaborer pour nous soutenir mutuellement.

By supporting efforts to expand our practice management resources and grow collaborative networks, I look forward to working with all of you, our new CRA Vice President Nicole Johnson, CEO Ahmad Zbib, and all our wonderful staff. May we continue to build on the work of past leaders, members, and volunteers for a productive future as we adapt to an ever-changing world.

Stephanie Tom, MD, FRCPC
President, Canadian Rheumatology Association

The CRA's 2026 Distinguished Rheumatologist: Dr. Evelyn Sutton

Why did you become a rheumatologist? What or who influenced you along the way to do so?

I was a PGY3 and uncertain what path to take, when a rotation in Saint John, New Brunswick, under Drs. Virender Khanna and Eric Grant changed everything. I was captivated by the breadth and depth of the specialty, but even more so by the patients. Their stoicism, their understated expression of suffering, and their resilience convinced me that these were the people I wanted to serve.

You have held numerous leadership roles, including serving as President of the Canadian Rheumatology Association (2020–2022) and as Division Head of Rheumatology and Director of the Nova Scotia Arthritis Centre at Dalhousie University (2004–2015). You've also made lasting contributions to medical education, including developing a nationally recognized elective for senior residents and serving nearly two decades in the Deanery.

You have been an active CRA member throughout your career, contributing to numerous resident pre-courses, chairing both the Annual Resident Review Course and the Annual Scientific Planning Committee, and fostering strong relationships between the CRA and the Arthritis Society. You've been deeply involved in building partnerships, and you served a decade on the Arthritis Society's Board.

a) Across your leadership roles, what has been one of the most significant professional or organizational challenges you've faced, and how did you navigate it?

When I joined the Board of the Canadian Rheumatology Association, I was determined to restore constructive relations with the Arthritis Society. Historically, these organizations had worked closely together. The Arthritis Society—originally founded as the Canadian Arthritis and Rheumatism Society (renamed in 1977)—and the Canadian Rheumatism Association collaborated to advance rheumatology as a specialty. Notably, in the 1960s they jointly established Rheumatic Disease Units (RDUs) across Canada, supported residency training positions, and helped create the Canadian Council of Academic Rheumatologists (CCAR).

By the late 1980s, however, this collaborative legacy had eroded. As a young rheumatologist, I was struck by the degree of mistrust and open discord at annual meetings—at times escalating into shouting matches. By the time I joined the CRA Board, I had also served the Arthritis Society in both committee and Board roles. It became clear to me that, while the two organizations shared fundamentally aligned goals, they often held unrealistic expectations of one another's roles and capacities. This misalignment fostered misunderstanding, mistrust, and lingering resentment.

To address this, I advocated to both Boards for a more formalized and structured relationship. Fortunately, this proposal was supported. As a result, the Past President of the CRA now holds a position on the Arthritis Society Board. Today, when national issues affecting patient care arise, the Arthritis Society and the CRA collaborate closely to develop coordinated and effective action plans.

Recognized with multiple honours, including the 2014 CRA Teacher-Educator Award and a Certificate of Excellence from the Canadian Association for Medical Education. Your book, A Primer on Musculoskeletal Examination, underscores your lasting influence on training future medical learners.

a) In your view, what are the qualities of an excellent teacher?

Over the years, I've come to realize that what matters most is not just what we know, but how we share it—how we make space for questions, how we encourage thinking, and how we support growth.

Some of the best teachers I've known had a remarkable ability to take something complex and make it clear—not by simplifying it too much, but by organizing it in a way that made sense. They asked thoughtful questions, not to test, but to guide. They gave feedback that was honest but constructive. And perhaps, most importantly, they created an environment where it felt safe to say, "I don't understand," or even, "I made a mistake."

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

From where did your passion and interest in rheumatology stem?

My interest in rheumatology really took shape during residency. I found myself drawn to the complexity of the diseases—the way they cross multiple systems and often present as diagnostic puzzles that require careful thought and patience. I enjoyed that intellectual challenge, but what truly stayed with me were the patients.

Many were living with chronic pain and significant disability, yet they carried themselves with remarkable resilience. They rarely complained, and there was a quiet dignity in how they managed their illness day to day. I found that deeply moving. Over time, I realized it was not just the science of rheumatology that appealed to me, but the privilege of caring for this particular group of patients. That combination made the decision feel less like a choice and more like a calling.

What is the professional accomplishment of which you are proudest to date?

In the early 2000s, I recognized a gap in care for our systemic sclerosis patients who developed pulmonary arterial hypertension. I met with the Division Heads of Respirology and Cardiology to seek their support in approaching members of their divisions to establish a shared-care clinic. I also met with hospital administrators and presented a budget demonstrating that a dedicated program could reduce costs by decreasing hospital admissions and length of stay. In addition, I approached industry partners for support in developing a clinical database. After two years of planning, the QEII Health Sciences Centre Pulmonary Arterial Hypertension Program was launched in 2007. It remains a multidisciplinary initiative, and although I am no longer directly involved in the clinic, I am proud that it continues to thrive and is recognized as a program of excellence.

Evelyn Sutton, MD, FRCPC
Professor of Medicine,
Dalhousie University

The CRA's 2026 Distinguished Investigator: Dr. Cheryl Barnabe

Why did you become a rheumatologist? What or who influenced you along the way to do so?

My career selection process was a lesson in how chance encounters and being open to new experiences can work out really well. I entered medical school with very little awareness of all the different specialties available and fully intended to specialize in rural family medicine. I was signed up to do a 4-month rural family medicine clinical summer studentship at the end of my first year of medical school, but the program was cancelled shortly before it was to start. I was instead offered a position in the Bachelor of Science in Medicine program to complete a needs assessment project for rural family medicine physicians on education in palliative care. I joined the inpatient palliative care team during their rounds and resident teaching sessions so that I could learn about that specialty to be able to design my data collection materials. I met a phenomenal nephrology resident rotating in palliative care, and she inspired me to consider a specialty, and I was particularly drawn to dermatology.

When it came time to selecting my internal medicine subspecialty block, I decided on rheumatology thinking I would see many different skin manifestations of autoimmune diseases. At this time biologics were just starting to be offered in clinical care for rheumatoid arthritis (RA), so it was a very exciting time to see how impactful effective treatment could be for patient outcomes. The academic rheumatologists at the University of Manitoba were highly supportive of me and engaged me in their research as I completed the rest of medical school. I think they may have paid a bribe to the Canadian Resident Matching Service (CaRMS), and so I remained in Winnipeg for internal medicine. I found every other internal medicine specialty to be monotonous, so it became very clear that rheumatology was the specialty for me. Research remained a strong interest during my training, and I saw it as providing the opportunity to more fully understand a disease process or why different outcomes occur. It also offers the chance to intervene to improve those outcomes for a much broader population than just those in your practice. I then completed both residency and a Masters degree at the University of Calgary before joining the faculty of the Cumming School of Medicine as a clinician scientist.

What do you believe are the qualities of a distinguished investigator and rheumatologist, particularly in the context of advancing health equity and community-engaged research?

Investigators are naturally curious and need to simultaneously gain a deep understanding of a problem while keeping an open mind to a broad range of approaches to arrive at solutions. It is impossible to do research without collaboration, so you also need to be skilled at developing relationships and building a network that is fun to work in. Always keeping the "why" of what you are doing close to the heart maintains the inspiration even when there are setbacks or challenges in the program of research. The solutions to advance health equity are complex with political factors and individual beliefs and biases to address, meaning there is no easy route to make change, so it also takes persistence. Community engaged research is highly rewarding but does require being flexible and patient, as priorities may shift as the community responds to other events and situations that arise.

What are some of your other passions outside of rheumatology and research?

My daughters have been involved in ringette and box lacrosse for a decade. The community supporting these female youth sports is phenomenal and seeing both girls gain confidence and maturity through their experience in sport has led me to want to give back. I have served in many volunteer roles as a result, including team manager, assistant coach, trainer, board member, association president, and as a member of the host committees for both the Canadian Ringette Championships in 2022 and the World Ringette Championships in 2023. If I'm not in a rink I am sewing in my garden, or at the lake.

You have taken on a research leadership position as Director of the McCaig Institute for Bone and Joint Health. What are the best aspects of that role?

I am really enjoying the role. I get to interact with scientists from orthopedics, engineering, kinesiology, veterinary medicine, cell biology, and imaging science working across a variety of musculoskeletal diseases. My job is to facilitate and promote their work, build collaborative networks in bone and

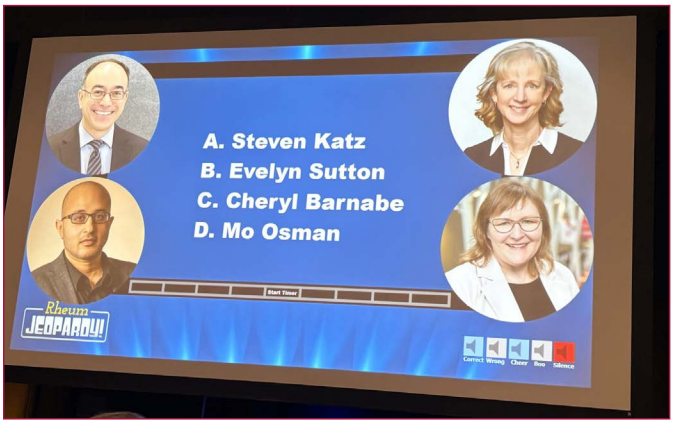
Dr. Cheryl Barnabe receiving her award from then-CRA President Dr. Trudy Taylor at the CRA Annual Scientific Meeting in Halifax, which took place in April 2026.

joint health research, and interact with philanthropists. The Institute also hosts several public education events and conferences so there is also a creative aspect in the role.

Cheryl Barnabe, MD, FRCPC
Director,
McCaig Institute for Bone and Joint Health,
Cumming School of Medicine,
University of Calgary
Canada Research Chair,
Rheumatoid Arthritis and Autoimmune Diseases
Arthur JE Child Chair in Rheumatology Research,
Professor,
Departments of Medicine and Community Health Sciences
Rheumatologist, Alberta Health Services

RheumJeopardy! 2026

By Philip A. Baer, MDCM, FRCPC, FACR



RheumJeopardy! returned as a plenary session at the 2026 CRA ASM in Halifax for the eleventh consecutive year, this time in a mid-afternoon timeslot on Saturday. I hosted and moderated from the Halifax Convention Centre. The 2026 event was again live only, with all attendees participating in answering the questions. Integration of the questions into the PheedLoop Go! meeting app and support from the BBBlanc and MKEM teams prevented any technical issues. After the East and West teams played to a scoreless tie in the 2025 edition, the prior East captain, Dr. Beth Hazel from Montreal, handled the duties of Chair and scorekeeper. We maintained the traditional East versus West format, with Toronto once again the dividing line this year. Our team captains were Michelle Bridge, an ACPAC-trained occupational therapist from Windsor-Essex, and the current President of the Arthritis Health Professions Association, and Dr. Amieleena Chhabra, a pediatric rheumatologist from British Columbia. For the second year running, the West captain met these criteria: a female pediatric rheumatologist with the initials AC (2025-Audrea Chen). Quite the coincidence.

As usual, only the members of the team whose captain had selected a question voted on the answer. The never-used option for team captains to overrule their team's answer was removed for this year. The team captains decided the Final Jeopardy wagers and answered the Final Jeopardy question on their own.

The session again drew a large audience of enthusiastic participants, including rheumatologists, trainees, allied health professionals and industry and patient attendees. The practice question related to the first female doctor to practice in Nova Scotia. The correct answer was Maria Angwin (1849-98), in whose honour the Dr. Maria Angwin Memorial Clinic was opened in Dartmouth, Nova Scotia, in June 2025.

Twelve questions were selected in the main game, all from the higher value 800-and-1000-point lines. Categories included OA/Pediatric Rheumatology, Guidelines/Criteria, Familiar Drugs-New Tricks, Sight Diagnoses, Potpourri, and Choosing Wisely, with the questions for the latter category provided by the CRA Choosing Wisely Subcommittee, spearheaded by Drs. Arielle Mendel, Nicholas Richard and Martin Cohen.

Questions are designed to be challenging, but the two teams fared well, answering 9 of the 12 selected questions correctly. Questions selected included those related to the RETREAT and GLITTERS OA trials, CANRIO and Obesity Canada guidelines, and premedications for rituximab infusions. Voters correctly identified the sight diagnosis of acute sarcoidosis (Lofgren's syndrome) but not the striatal hand deformities of Parkinson Disease. Questions that stumped the teams included one requiring a choice between four new and hard to pronounce biologics, with inebilizumab being the correct answer, and another on the single most important measure recommended in the CRA handbook on planetary health, which was deprescribing. Participants also knew the features of TAFRO syndrome, the Choosing Wisely recommendation not to do genetic testing for PFAPA syndrome, and the risks of using artificial intelligence (AI) to write essays.

At the end of the main Jeopardy round, the score favoured East with 4,200 points over West with 3,800. The Final Jeopardy category was "2026 CRA Awards of Dis-

From left to right: Michelle Bridge (Team captain of the East), Dr. Philip Baer (host and organizer), Dr. Amieleena Chhabra (Team captain of the West), and Dr. Beth Hazel (Chair and scorekeeper).

tinction Winners." The question centred on a sentence composed of famous song titles and lyrics by Steven Georgiou. The answer choices included Mo Osman, Cheryl Barnabe, Evelyn Sutton and Steven Katz. A hint suggested using right brain thinking and inversion to arrive at the correct answer, which was Steven Katz, as Steven Georgiou is better known as Cat Stevens.

Team East wagered 66% of their points while Team West wagered 33% on the Final Jeopardy question. Team East answered correctly, winning with 6,972 points, while Team West finished with a score of 2,546. This means Michelle Bridge will likely chair *RheumJeopardy!* in April 2027 in Vancouver if the ASM Scientific Committee grants us a place on the agenda for a twelfth year. I am already preparing a question bank if we are renewed for another season.

Thanks to everyone who participated in the *RheumJeopardy!* session. Special thanks as well to Drs. Shelly Dunne and Jane Purvis, my colleagues in Ontario, who took photographs of the event and tracked the questions we used in 2026 to ensure they do not reappear in future editions of *RheumJeopardy!*

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

The CRA's 2026 Leadership Impact Award Recipient: Dr. Steven Katz

Some time ago, I was a third-year internal medicine resident attending one of my first CRA annual scientific meetings. I gave my first oral scientific presentation and, at the annual dinner, I can recall when my name was called to receive an award for my talk. I remember standing on the stage next to Dr. Gunnar Kraag, an esteemed rheumatologist and then President of the CRA, with his deep, kind booming voice, standing to my left, leaning over and whispering in my ear: "Welcome to Rheumatology!"

Over two decades since, that moment has stuck with me. I am preaching to the choir to tell you how lucky we all are to practice within the best field in medicine, with science that is growing by leaps and bounds, with patients from all walks of life who you get to know and truly help year after year, and with absolutely wonderful colleagues who you get to work and play with every day, knowing they will be your rock in good times and bad.

I think it's because of all those things that I am here being honoured by my amazing colleagues with this award. I have been and remain inspired by rheumatology, by our patients and by all of you. I look forward to rheumatology every day, knowing the good that you and I are going to bring into this world. And so, knowing that, knowing all that we do, why wouldn't I want us to be able to do more, to be inspired, to make things easier and better for patients and rheumatologists alike. This award is given for impact of leadership, but it has been the immense impact all of you have made on me that continues to inspire me to listen, to build, to innovate, to have fun and to create a world where rheumatology is more.

I humbly thank the CRA for this honour. Thank you to Drs. Claire Barber and Stephanie Keeling for nominating me. Thank you to each and every one of my colleagues in Edmonton, who are individually amazing and collectively the best rheumatology team around. Thank you to the Queen's rheumatology group who have welcomed me with such open arms over the last year. And thank you to the rheumatology team in Winnipeg for setting me down this path many years ago. They nurtured my initial love of rheumatology, something I try to give back to every medical student and resident with whom I work.

So, you had me at "Welcome to Rheumatology!" So simple, so powerful, life changing and life affirming. Share the message with the next generation so we continue to grow and flourish. I will forever feel welcomed. Thank you for allowing me the privilege of being your colleague. Thank you all!

Steven Katz, MD, FRCPC
Professor and Chair, Rheumatology, Queen's University
Adjunct Professor, Rheumatology, University of Alberta

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The Product Monograph is also available by calling 1-866-709-8444.

* Comparative clinical significance is unknown.

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

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Pr Bimzelx® (bimekizumab injection)

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.

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- 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

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- 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-2500027E

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CIMZIA® (certolizumab pegol)

Spotlight on the 2026 CRA Abstract Award Winners

IAN WATSON AWARD *for the Best Abstract on SLE Research by a Trainee*

Sponsored by the Lupus Society of Alberta
Winner: Lucia Zhu, McGill University
Abstract Title: Trajectories of NT-proBNP in Systemic Lupus Erythematosus
Supervisor: Dr. Sasha Bernatsky

PHIL ROSEN AWARD *for the Best Abstract on Clinical or Epidemiology Research by a Trainee*

Sponsored by the Arthritis Society – Phil Rosen Memorial Award
Winner: Lana Mackic, University of Manitoba
Abstract Title: High-Resolution Thermography and Artificial Intelligence to Evaluate and Classify Rheumatoid Arthritis
Supervisor: Dr. Liam O'Neil

BEST ABSTRACT *by a Rheumatology Resident*

Sponsored by the CRA
Winner: Leigha Rowbottom, Mount Sinai/University of Toronto
Abstract Title: Enhancing Immunology Education for Rheumatology Trainees Using Artificial Intelligence: A Pilot Quality Improvement Initiative
Supervisor: Dr. Ahmed Omar

BEST ABSTRACT *on Basic Science Research by a Trainee*

Sponsored by the CRA
Winner: Kathleen Dyer, Memorial University of Newfoundland
Abstract Title: Assessing Genetic Factors Influencing the Variability in Psoriatic Arthritis Onset Among Patients with Psoriasis
Supervisor: Dr. Proton Rahman

BEST ABSTRACT *by a Post-Graduate Research Trainee*

Sponsored by the CRA
Winner: Reem Farhat, McGill University
Abstract Title: Increased Risk of Intrahepatic Cholestasis of Pregnancy in Women with Systemic Lupus Erythematosus Exposed to Azathioprine
Supervisor: Dr. Evelyne Vinet

BEST ABSTRACT *on Quality Care Initiatives in Rheumatology*

Sponsored by the CRA
Winner: Timothy Kwok, University of Toronto
Abstract Title: Health Care Utilization Patterns Among Patients Presenting to Emergency Department for Gout Flares in Ontario, Canada: A Population-Based Retrospective Observational Study

BEST ABSTRACT *by a Medical Student*

Sponsored by the CRA
Winner: Kaitlyn Ng Tung Hing, University of Edinburgh
Abstract Title: Phonophoresis for Enthesitis-Related Pain: Real-World Outcomes from a Retrospective Single-Centre Study
Supervisors: Drs. Melissa Holdren and Carter Thorne

BEST ABSTRACT *by an Undergraduate Student*

Sponsored by the CRA
Winner: Madeline Beron, Queen's University/University of Toronto
Abstract Title: Extremely High Maternal Anti-Ro/La Antibody Titers Predict Non-Cardiac Neonatal Lupus Erythematosus Manifestations
Supervisor: Dr. Linda Hiraki

BEST ABSTRACT *by a Rheumatology Post-Graduate Research Trainee*

Sponsored by the CRA
Winner: Greta Mastrangelo, University of Toronto, The Hospital for Sick Children
Abstract Title: Confirming the Validity of the New EULAR/ACR Classification Criteria for Pediatric Chronic Nonbacterial Osteomyelitis
Supervisors: Drs. Brian Feldman and Ron Laxer

BEST ABSTRACT *on Research by Early Career Faculty*

Sponsored by the CRA
Winner: Liam O'Neil, University of Manitoba
Abstract Title: Citrullination of Neutrophil Serine Proteases Enhances Proteolytic Activity, Stability and Autoantigenicity in Rheumatoid Arthritis

BEST ABSTRACT *on Pediatric Research by Early Career Faculty*

Sponsored by the CRA
Winner: Piya Lahiry, McGill University
Abstract Title: Impaired Dnase1L3 Activity from a Novel Mutation Identified in Monogenic Systemic Lupus Erythematosus

BEST ABSTRACT *on Spondyloarthritis Research*

Sponsored by the Canadian Spondylitis Association
Winner: Nam Nguyen, University of Toronto
Abstract Title: Evaluation of the Performance of Candidate Enthesitis Ultrasound Scoring Systems for Psoriatic Arthritis Diagnosis – Duet Study
Supervisor: Dr. Lihi Eder

BEST ABSTRACT *on Equity Diversity and Inclusion in Rheumatology*

Sponsored by the CRA
Winner: Alec Chu Ming Yu, University of British Columbia
Abstract Title: Improving Care for People Living with Rheumatic Disease and Extreme Poverty: An Interim Analysis of a Prospective Study on Honorarium and Outreach Supports
Supervisor: Dr. Brent Ohata

AWARDS, APPOINTMENTS, AND ACCOLADES

Dr. Jane Purvis – *Recipient of the CRA Master Award*

I am deeply honoured to receive the 2026 Canadian Rheumatology Association (CRA) Master Award. As a community rheumatologist, my career has been grounded in providing accessible, patient-centred care across a range of settings, from multidisciplinary clinics to smaller and rural communities. I have also been actively involved in physician advocacy, working with the Ontario Rheumatology Association, the Ontario Medical Association and other organizations to engage government and advance policies that improve access to care for patients with rheumatic disease. This award reflects the mentorship, collaboration, and shared commitment within our community. I remain passionate about strengthening rheumatology, creating a sustainable medical system, and ensuring patients receive high-quality care.

Dr. Proton Rahman – *Appointed Officer of the Order of Canada*

Congratulations to Dr. Proton Rahman on being appointed as an Officer of the Order of Canada. The Order of Canada is the cornerstone of the Canadian Honours System. Presented by the Governor General, it recognizes outstanding achievement, dedication to the community and service to the nation.

Based in St. John's, Newfoundland and Labrador, Dr. Rahman is a practicing rheumatologist and a Distinguished University Professor at Memorial University. He created the Newfoundland Genealogy Database, investigated the genetic basis of psoriatic arthritis and has played a key role in advancing public health and medical research as a provincial scientific advisor. Congratulations, Dr. Rahman.

Great Debate: Be it Resolved That Medications Should be Tapered in Patients with Inflammatory Arthritis in Remission

By Volodko Bakowsky, MD, FRCPC, on behalf of Alexandra Charlton, BSc, PharmD; Jaime Guzman, MD, MSc, FRCPC; Glen Hazlewood, MD, PhD, FRCPC; and Bindee Kuriya, MD, MSc, FRCPC

The Great Debate was once again one of the highlights of the Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM).

Arguing in favour of the motion were Drs. Glen Hazlewood and Jaime Guzman, while Drs. Bindee Kuriya and Alexandra Charlton reasoned against. The session combined rigorous data with humour and spirited exchanges, reflecting the complexity and clinical relevance of the topic.

The pro-tapering team grounded their argument in current CRA guidelines, which support offering tapering to carefully selected patients with rheumatoid arthritis (RA) and axial spondyloarthritis (axSpA) who have achieved sustained remission. They emphasized that tapering is not synonymous with abrupt discontinuation, but rather a structured, monitored process aimed at finding the minimum effective dose. Evidence from clinical trials and observational studies suggests that a meaningful proportion of patients can successfully reduce therapy without immediate flare, particularly when remission is deep and sustained.

From a patient-centered perspective, the potential benefits of tapering were highlighted. These include reduced exposure to dose-dependent adverse effects, decreased medication burden, and potential cost savings for both patients and healthcare systems. In pediatric populations, Dr. Guzman underscored the heterogeneity of juvenile idiopathic arthritis (JIA), noting that some subtypes may achieve drug-free remission. Tapering, in this context, offers an opportunity to assess whether ongoing therapy is required. The proponents also emphasized the importance of shared decision-making, arguing that involving patients in tapering decisions may improve adherence and trust, and may prevent unsupervised discontinuation of therapy.

In contrast, the opposing team challenged the assumption that remission reflects true disease quiescence. They argued that, in many cases, remission is maintained by ongoing pharmacologic suppression, and that tapering therefore risks reactivation of underlying inflammation. Across inflammatory arthritis conditions—including RA, axSpA, psoriatic arthritis (PsA), and JIA—they presented consistent evidence that tapering is associated with increased rates of flare. In axSpA, tapering biologic therapy may lead to relapse and ongoing structural progression,

while extending dosing intervals in patients with uveitis may increase the risk of extra-articular complications. In PsA, the multidomain nature of disease makes loss of control particularly difficult to manage once it occurs.

The evidence was most robust in RA, where tapering or discontinuing biologic therapy is associated with loss of remission and increased radiographic progression. Both clinical trials and real-world data show that only a minority of patients maintain disease control after tapering. In JIA, the consequences of flare may be especially significant, with potential impacts on growth, development, and long-term outcomes, and recapturing inactive disease is not always guaranteed.

Importantly, the opposing team emphasized that flares are not benign events. They are associated with structural damage, reduced physical function, and diminished quality of life, and often require use of corticosteroids, added medications, and increased healthcare utilization. As such, the perceived cost savings of tapering may be offset by downstream clinical and economic consequences. They further noted that, despite guideline support for individualized tapering, there are currently no reliable biomarkers or clinical tools to predict which patients can safely reduce therapy.

Overall, the debate underscored a central clinical tension: the appeal of minimizing treatment burden versus the risks of destabilizing disease control. While tapering may be right for selected patients within a shared decision-making framework, the discussion highlighted the need for caution, close monitoring, and further research to better identify those patients most likely to succeed. After the exchange of opposing arguments, it was time to vote.

The arguments for both sides were presented clearly and emphatically. Electronic voting ensued and the results proved a clear victory for the proponents, therefore the motion was carried!

Increased Risk of Intrahepatic Cholestasis of Pregnancy in Women with Systemic Lupus Erythematosus Exposed to Azathioprine

Selected for Podium Presentation and Winner of Best Abstract by a Post-Graduate Research Trainee Award

By Reem Farhat, MD, PhD-3; Maria del Carmen Zamora-Medina, MD; Sang-Cheol Bae, MD, PhD, MPH; Megan R.W. Barber, MD, PhD; Ann E. Clarke, MD, MSc; Paul R. Fortin, MD, MPH; Zahi Touma, MD, PhD; Carl A. Laskin, MD; Isabelle Malhamé, MD, MSc; Giada Sebastiani, MD; Christine Peschken, MD, MSc; Manuel F. Ugarte-Gil, MD, MSc; Alexandra Legge, MD, MSc; Sasha Bernatsky, MD, PhD; Évelyne Vinet, MD, PhD

At the 2026 Canadian Rheumatology Association (CRA) Annual Scientific Meeting (ASM) in Halifax, Dr Reem Farhat, MD, PhD, a student in the Graduate Program in Clinical and Translational Research at McGill University, presented new findings that may reshape monitoring strategies for pregnant women with systemic lupus erythematosus (SLE) receiving azathioprine. Conducted under the supervision of Dr. Evelyne Vinet, MD, PhD, Associate Professor at the McGill University Health Centre, the study identified a markedly increased risk of intrahepatic cholestasis of pregnancy among SLE patients exposed to azathioprine.

Pregnancy in women with SLE is already recognized as high risk because of increased maternal and fetal complications. Azathioprine, a thiopurine drug, is the immunosuppressive of choice in SLE pregnancies. However, emerging signals from inflammatory bowel disease cohorts and a recent United States Food and Drug Administration safety report have raised concerns regarding a possible association between thiopurines and intrahepatic cholestasis of pregnancy, a pregnancy-specific liver disorder associated with preterm birth and stillbirth.

To better understand this risk in SLE pregnancies, investigators analyzed data from the Lupus in prEGnAnCY (LEGACY) cohort, an international prospective multicentre study conducted across Systemic Lupus International Collaborating Clinics in Canada, South Korea, Peru, and Mexico. Pregnant women with SLE were enrolled before 17 weeks gestation and followed throughout pregnancy. Since intrahepatic cholestasis of pregnancy generally develops after 20 weeks gestation, analyses were restricted to pregnancies with at least one second trimester visit.

The investigators observed more than a 10-fold increased risk of intrahepatic cholestasis of pregnancy among women exposed to azathioprine. In a subgroup with available thiopurine metabolite data, all patients with intrahepatic cholestasis of pregnancy demonstrated second trimester metabolite shunting, characterized by preferential production of the hepatotoxic metabolite 6-methylmercaptopurine. Half of the patients exhibiting this shunting pattern subsequently developed intrahepatic cholestasis of pregnancy. Azathioprine-exposed patients also appeared to experience more severe disease, including earlier delivery, lower birth weight for gestational age, and higher bile acid levels.

This research impacts rheumatology care by supporting heightened vigilance for intrahepatic cholestasis of pregnancy in pregnant patients with SLE receiving azathioprine, while highlighting a potential role for thiopurine metabolite monitoring to help identify those at increased risk. The goal is to improve maternal and fetal outcomes while maintaining access to an important therapy.

You are invited to submit abstracts for presentation during the **2027 CRA Annual Scientific Meeting!**
Deadline for submissions is **Friday, November 20, 2026**.
Details will be available at *asm.rheum.ca*.

Road to Peer Mentorship

By Mollie Carruthers, MD, FRCPC; Raheem B. Kherani, MD, BSc (Pharm), FRCPC, MHPE; Diane Lacaille, MD, PhD, FRCPC; Greg Koller, MD, FRCPC; Kamran Shojania, MD, FRCPC; and Shahin Jamal, MD, FRCPC

Mentorship plays an essential role in rheumatology, a field characterized by the management of complex, chronic, and often ambiguous conditions. These clinical demands, combined with the need to build long-term patient relationships, can be deeply rewarding but also contribute to early career burnout. In this context, mentorship provides important support. Experienced colleagues can help early-career rheumatologists navigate clinical uncertainty, explore opportunities in leadership, research, and education, and develop strategies for maintaining balance and sustainability in their professional and personal lives.

In 2020, the University of British Columbia (UBC) rheumatology division launched a peer mentorship program under the leadership of Dr. Mollie Carruthers, with support from Drs. Shahin Jamal, Raheem Kherani, Greg Koller, Diane Lacaille, and Kam Shojania. From the outset, the program was designed with a deliberately broad scope. Rather than focusing solely on academic productivity, it recognized the diverse career paths within rheumatology, including clinical practice, research, education, administration, and advocacy. Equally important was the acknowledgment that personal well-being—such as family life, hobbies, and physical health—is integral to long-term professional fulfillment.

Central to the program's design was a thoughtful and individualized matching process. Mentor-mentee pairings were based not only on shared professional interests, but also on personality, communication style, and lifestyle considerations. This approach aimed to foster meaningful and sustainable relationships. In addition, the program emphasized a collaborative model of mentorship. Unlike traditional hierarchical structures often seen in training environments, this initiative positioned both participants as active contributors, encouraging reciprocal learning and mutual support.

The implementation process began with the identification and recruitment of experienced rheumatologists to serve as mentors. A list of participating mentors was then distributed to interested mentees, who were asked to rank their top three preferences. The organizing committee subsequently reviewed all submissions and determined pairings, drawing on their collective institutional knowledge across clinical, educational, and research domains. Particular attention was given to aligning each mentee's goals and areas for growth with mentors best suited to support their development.

The pilot phase of the program demonstrated strong engagement and positive outcomes. Between July 1, 2021, and July 1, 2022, a total of 46 one-on-one meetings were conducted, each approximately one hour in duration and held either in person or via videoconference. Participant feedback highlighted increased collegiality and a greater sense of professional connection, with many individuals reporting that they had developed a trusted relationship to support them through challenging situations. Subsequent funding from Vancouver Coastal Health enabled further expansion, adding 16 additional mentorship encounters.

Building on this success, the program was expanded across British Columbia in April 2025 with approval from the Specialist Services Committee. Approximately 30 participants were included in this phase, and the matching process was repeated using the same structured approach. Notably, both mentors and mentees received compensation for their time, reinforcing the program's commitment to recognizing mentorship as a valued and legitimate professional activity.

Key lessons learned include:

1. Structure is critical—careful matching and clear expectations were central to the program's success.
2. Peer mentorship is most effective when framed as a partnership rather than a hierarchy, allowing for bidirectional learning.
3. A broad conceptualization of mentorship—encompassing both professional development and personal well-being—enhances relevance and sustainability.
4. The use of institutional knowledge enabled high-quality matches that would not have been achievable through self-selection alone.
5. Protected time and compensation supported consistent participation and signalled the importance of mentorship.
6. Beginning with a pilot phase allowed for iterative refinement prior to broader implementation.

Overall, this experience underscores that effective peer mentorship at scale requires intentional design, organizational support, and ongoing evaluation (Figure 1). As the program continues to evolve, it offers valuable insights into how structured peer relationships can foster professional growth and strengthen community within rheumatology.

Figure 1: The peer mentorship roadmap (created with Microsoft Copilot).

Mollie Carruthers, MD, FRCPC
Clinician Investigator, Arthritis Research Canada
Clinical Associate Professor, Rheumatology
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Raheem B Kherani, MD, BSc (Pharm), FRCPC, MHPE
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Shahin Jamal, MD, FRCPC
Clinician Investigator, Arthritis Research Canada
Clinical Professor, Rheumatology,
University of British Columbia

CPD for the Busy Rheumatologist
Maintenance of Certification: How Do I Use the Royal College Portal Effectively

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

"Is there an easier way for me to track my Maintenance of Certification (MOC) credits?" wonders Dr. Aki Joint, a member of the Canadian Rheumatology Association (CRA). "There is a new Royal College Maintenance of Certification Program with a new portal, but I am not sure how to use it. What do I do?"

Logging in

When logging in (*royalcollege.ca/mymoc*), authenticate yourself using an email-based multi-factor authentication. This will enable entry into all the Royal College of Physicians and Surgeons of Canada (RCPSC) resources. There are no separate logins for My MOC, Accreditation, Royal College dues, etc. anymore.

Dashboard

Click on My MOC and it will take you to the Main Dashboard (Figure 1). There you can see an overview of annual and 5-year cycle requirements, including the number of credits achieved for Sections 1, 2, and 3 (Figure 2). On the left side panel, you can review specific activities, drafts and log new activities (Figure 3). This can easily be done on your web browser on your computer, tablet or phone, making it easier to record CPD activities while participating in them (Figures 4 and 5). There are reports that can be downloaded including Credit Summaries, Yearly MOC Adherence Reports, Transcript of CPD Activities, and MOC Cycle Completion Certificates (Figure 6). These may be useful for hospital privileges or dealings with your Provincial College.

Logging activities

On the left side of the panel, you can log new activities (Figure 4). Choose the applicable section, then enter the activity

Figure 1. **Main dashboard**

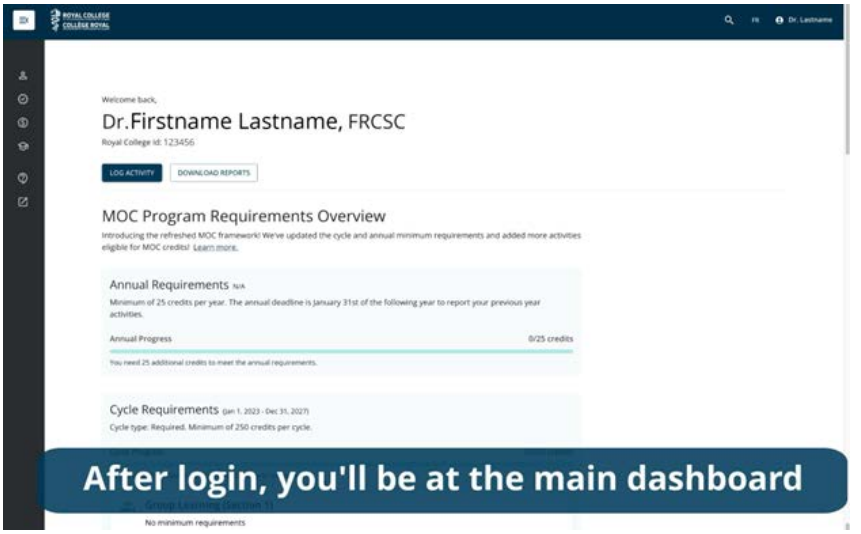


Figure 2. **Overview of your status**

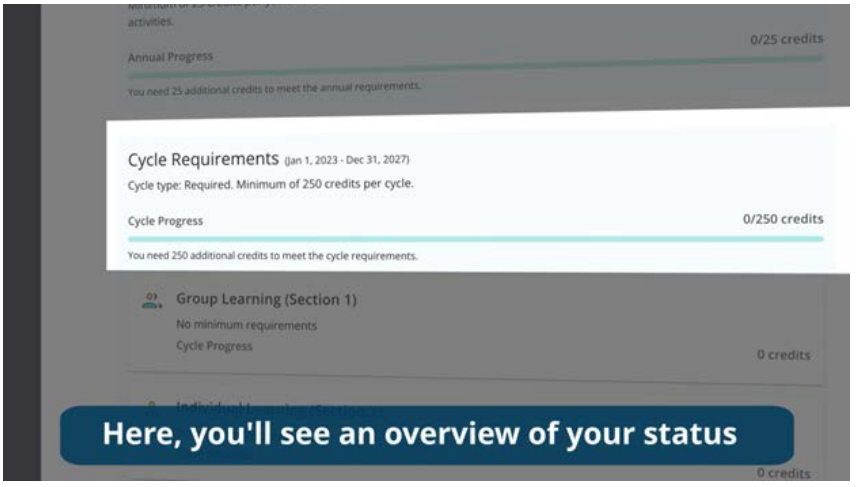


Figure 3. **Navigation menu**

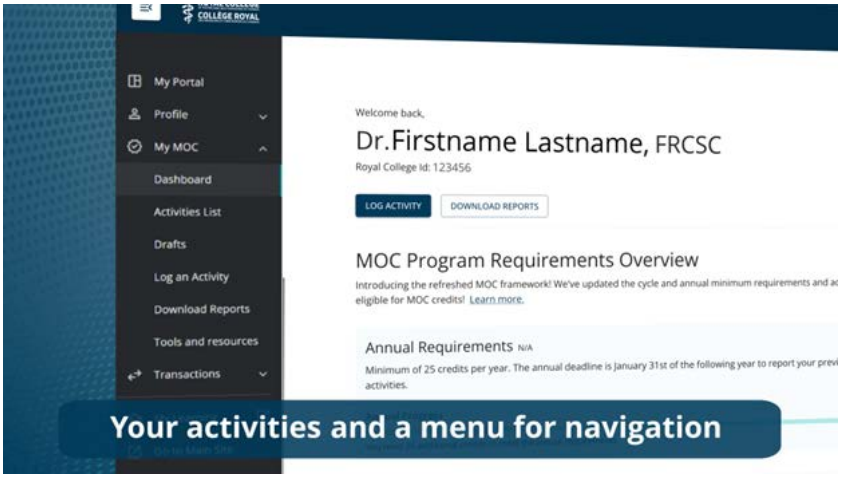


Figure 4. **Logging your activity**

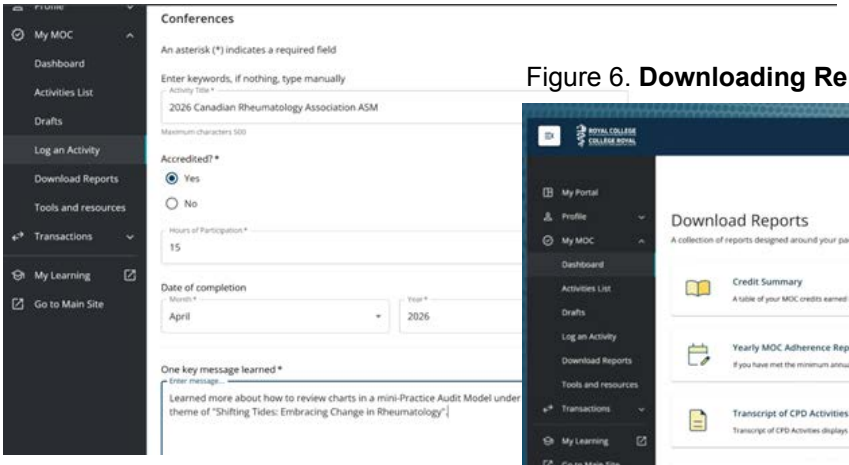


Figure 5. **Summary of logged activity**

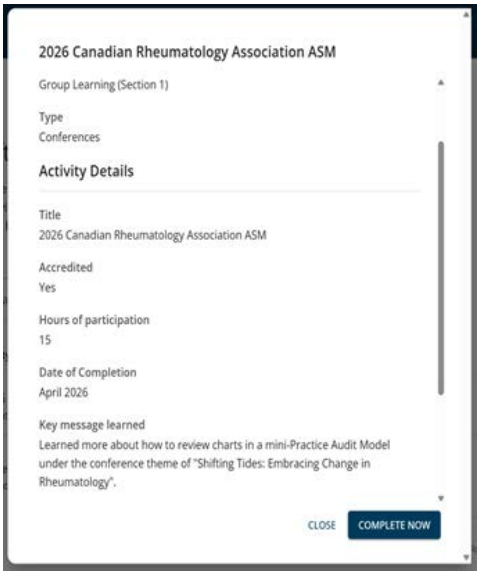
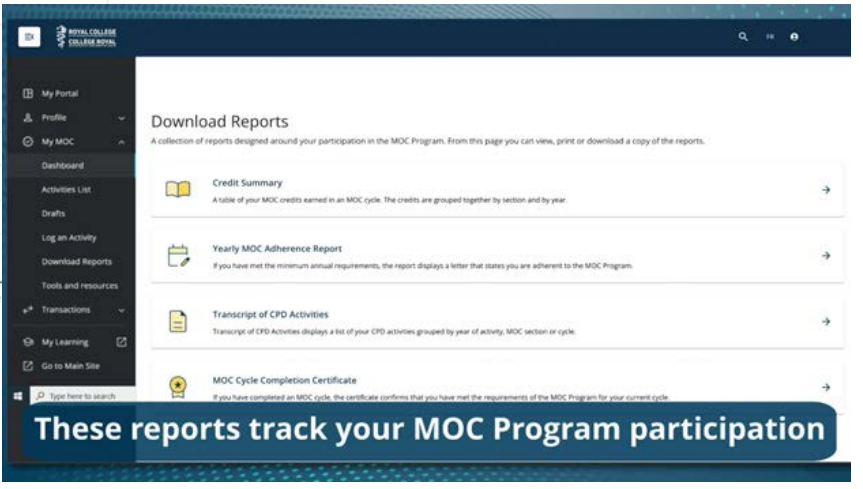


Figure 6. **Downloading Reports**



details, such as type of activity, hours of participation, date, key messages learned, reflections and add any relevant documentation, such as the conference participation certificate.

"Using the Portal regularly will make using MyMOC easier," exclaims Dr. Aki Joint. "If I keep track of sessions and document my learning, I can save a draft or directly submit my CPD-related activities. If I need help, I can contact the Royal College office or review the helpful My MOC resources online. That will make the upcoming changes in January 2027 easier to manage, and not be a struggle for me to remember what I did and what I learned."

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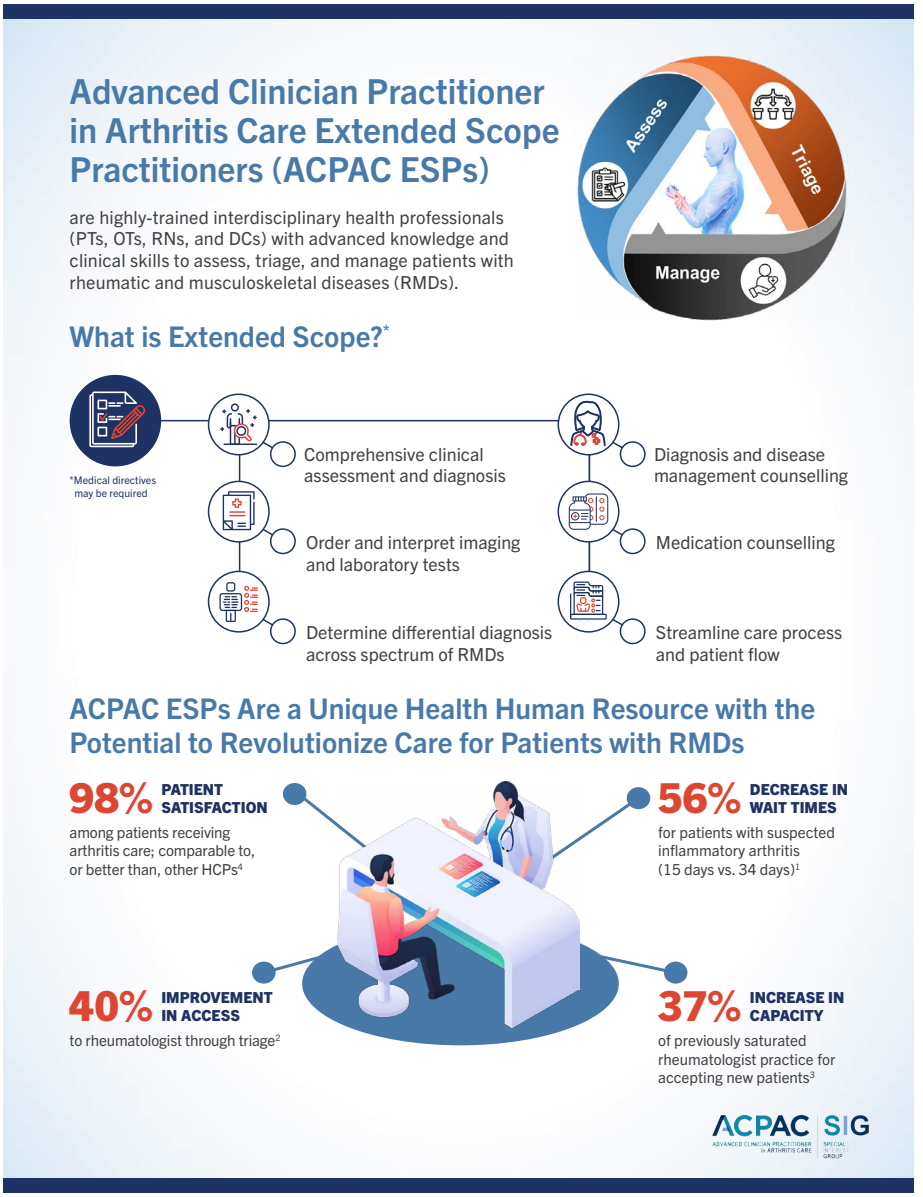
Celebrating the 20th Anniversary of ACPAC

By Julie Herrington, PT, MSc, ACPAC; Michael Denton, PT, MScPT, ACPAC; Michelle Bridge, OT Reg. (Ont.), ACPAC; Laura Passalent, PT, MHSc, ACPAC; and Leslie Soever, PT, MSc, ACPAC

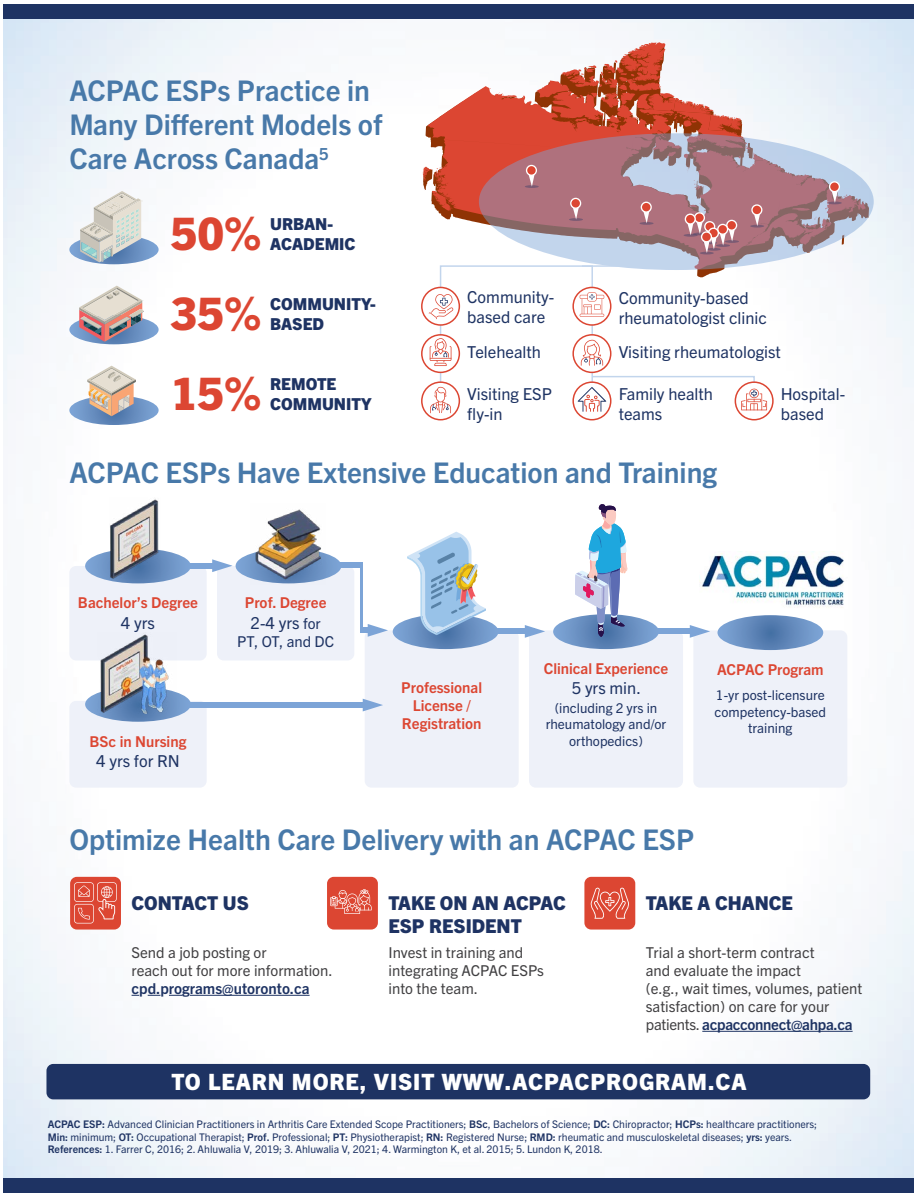
The Origins

The Advanced Clinician Practitioner in Arthritis Care (ACPAC) program is now in its 20th year, having graduated 140 clinicians with 12 currently in training. This program was modeled on a 1996 SickKids initiative by Dr. Ron Laxer that leveraged team expertise by up-training a physiotherapist to share the pediatric clinical caseload.[1] In 2005-06, modelled on the SickKids endeavour, rheumatologist Dr. Rachel Shupak and physiotherapist Dr. Katie Lundon expanded the concept, creating the ACPAC program.[2] It is a rigorous, competency-based, university-affiliated, educational program to train experienced physiotherapists, occupational therapists, nurses and chiropractors for extended scope practice roles across a broad range of rheumatic and musculoskeletal diseases (RMDs). Upon the retirement of Drs. Shupak and Lundon, in 2020, leadership transitioned to Canadian Rheumatology Association (CRA) members Drs. Amanda Steiman, Rob Inman and Deborah Levy; along with ACPAC graduates Laura Passalent and Leslie Soever; and orthopedic surgeon Dr. Christopher Nielsen.



How are ACPAC practitioners contributing to rheumatology care?

ACPAC practitioners work in models of care performing duties beyond their traditional professional scope of practice. A newly created infographic defines the extended scope tasks ACPAC clinicians undertake in various roles. Dr. Vandana Ahluwalia, an early adopter of these models of care, led investigations that have demonstrated improved system metrics when integrating ACPAC practitioners into rheumatology care.[3] A recent scoping review describing the contributions to peer-reviewed literature by ACPAC practitioners and the ACPAC program found 106 articles published up until June 2023, primarily in rheumatology journals



(38%), most often focusing on the impact of models of care (23%), with 86% of articles including an ACPAC graduate as an author.[4] Evidence of successful implementation of these models of care in other settings including rural care, transition clinics and pediatric environments is also growing rapidly.[5-7]

The ACPAC Community

Over the past seven years, ACPAC alumni have formalized as the ACPAC Special Interest Group (SIG) within the Arthritis Health Professions Association (AHPA). The ACPAC SIG provides targeted ongoing professional development in the form of education, research support, leadership opportunities and advocacy for this growing health human resource. A 2023 survey (n=67) characterized the working ACPAC community as 85% physiotherapists, with the majority working in Ontario in Rapid Access Clinics (39%), community rheumatology clinics (22%) and ambulatory hospital settings (22%).[8] The literature has seldom investigated the motivations or experiences of extended scope practitioners; however 65% of ACPAC SIG members indicated they are very or extremely satisfied with the roles they fill. Reasons for satisfaction include opportunities for collaboration with other medical professionals; having a positive impact on patient/family care, and the ability to engage in research, leadership, and education.[8]

ACPAC Clinicians are a Unique Health Human Resource

The ACPAC program celebrates its 20th anniversary with the graduation of the 2025-2026 cohort this June. The CRA ASM in Halifax in April 2026 marked our largest ever attendance of ACPAC practitioners (19), with four having presented workshops, three having presented posters, one having participated in *RheumJeopardy!* and many others contributing as poster authors. The ACPAC community is growing, offering

Celebrating the 20th Anniversary of ACPAC

Continued from page 27

workforce solutions in rheumatology and becoming strong advocates for improving the quality of rheumatology care in Canada.

Interested?

Consider taking an ACPAC resident for some of their required training hours. Reach out to the ACPAC SIG at *acpacconnect@ahpa.ca* for more information regarding how to integrate ACPAC-trained clinicians into rheumatology care.

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ACPAC SIG Past Chair, Advocacy Lead

Michael Denton, PT, MScPT, ACPAC
ACPAC SIG Chair, Orthopedic Lead

Michelle Bridge, OT Reg. (Ont.), ACPAC
Past President, Arthritis Health Professions Association

Laura Passalent, PT, MHSc, ACPAC
Co-Director, ACPAC Program

Leslie Soever, PT, MSc, ACPAC
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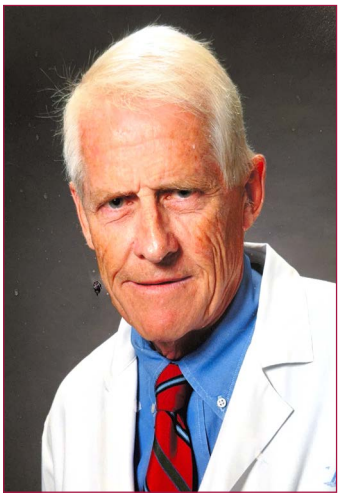
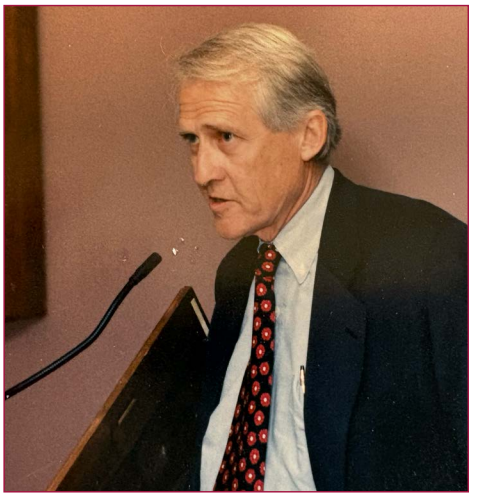
References:
1. Campos A, Graveline C, Ferguson J. The physical therapy practitioner: An expanded role for physical therapy in pediatric rheumatology. *Physiotherapy Canada.* 2001;3:282-6.
2. Lundon K, Shupak R, Canzian S, et al. Don't let up: implementing and sustaining change in a new post-licensure education model for developing extended role practitioners involved in arthritis care. *J Multidiscip Healthc.* 2015;8:389-95.
3. Ahluwalia V, Inrig T, Larsen T, et al. An Advanced Clinician Practitioner in Arthritis Care (ACPAC) Maintains a Positive Patient Experience While Increasing Capacity in Rheumatology Community Care. *J Multidiscip Healthc.* 2021;14:1299-310.
4. Herrington J, Caldana L, Whitney K, et al. The Advanced Clinician Practitioner in Arthritis Care Contributions to the Scientific Literature: A Scoping Review. *J Rheumatol.* 2025;52(Suppl 2):1-92.
5. Dushnicky MJ, Har-Gil ES, Lee JJY, et al. Pediatric Rheumatology Care in the Canadian Context: A Qualitative Analysis of Care Providers. *J Rheumatol.* 2025;52(5):498-504.
6. Herrington J, Clarkin P, Singleton J, et al. A Canadian Advanced Physiotherapist Practitioner Shared-Care Model in Pediatric Rheumatology Offers Safe and Quality Care in the Management of Juvenile Idiopathic Arthritis-Comparing Key Performance Indicators with the PR-COIN Registry. Children (Basel). 2025;12(12).
7. Steiman A, Inrig T, Lundon K, et al. Telerheumatology Shared-Care Model: Leveraging the Expertise of an Advanced Clinician Practitioner in Arthritis Care (ACPAC)-Trained Extended Role Practitioner in Rural-Remote Ontario. *J Rheumatol.* 2024;51(9):913-9.
8. Denton M. ACPAC SIG Clinician Survey. 2023.

Tribute to Dr. David Bell

By Lillian Barra, MD, MPH, FRCPC; and Ewa Cairns, PhD





We are deeply saddened to announce the passing of Dr. David Bell, our cherished mentor, and colleague on February 28th, 2026, after a long and courageous battle with progressive supranuclear palsy. David was a highly accomplished clinician scientist whose intellectual curiosity, generosity of spirit, and quiet integrity left an enduring mark on rheumatology and immunology in Canada and beyond. To those who knew him closely, he was a trusted friend, a thoughtful clinician, and a mentor whose steadfast encouragement launched many successful careers, including our own.

David completed his MD in 1963 at the University of Western Ontario, followed by internal medicine and rheumatology training in Toronto, and fellowships in rheumatology and immunology in Rochester, New York, and La Jolla, California. In 1972, he joined the Faculty of Medicine at Western, where he built a distinguished academic career. He served in numerous leadership roles, including Chair of the Division of Rheumatology (1988–1999), Chair of the Medical Advisory Committee at University Hospital, Co-Chair of the Functional Planning Committee at St. Joseph's Hospital, Member of Senate at the University of Western Ontario, and as a member of multiple committees for the Arthritis Society and the Canadian Institutes of Health Research and the editorial boards of the *Journal of Rheumatology* and *Lupus*. His contributions were recognized by both the Canadian Rheumatology Association and the American College of Rheumatology.

From a research perspective, David was a trailblazer and early adopter of emerging ideas and technologies who made several enduring contributions to the understanding of autoimmune disease. He was among the first to use human hybridomas to identify autoantibodies in healthy individuals, a finding that challenged prevailing dogma at the time but was foundational to the now accepted concept of natural autoimmunity. He also made important contributions to elucidating the key role of defective apoptosis in systemic lupus erythematosus.

Recognizing the importance of future discovery, he was a dedicated collector of biological samples from multigenerational families, laying the groundwork for biomarker studies long before they became commonplace. He personally drove across southwestern Ontario to meet families, educate communities, and ensure that research was grounded in genuine human connection. Among his most influential achievements was defining the molecular basis of the shared epitope and its critical relationship to citrullinated antigens in rheumatoid arthritis, transformative work that fundamentally advanced understanding of RA pathogenesis. Even late in his career, he was one of the first to recognize the potential importance of homocitrullinated antigens in RA.

As a clinician and educator, he modelled patient-centred care. He never rushed an encounter and took time to listen, explain, and teach. He mentored >100 trainees and early-career investigators. Mentees were encouraged to think critically, review evidence, and pursue their own ideas—an approach that fostered independence, confidence, and discovery.

Beyond medicine, Dave loved jazz, playing the piano and trumpet, art, travel, skiing, and summers at his cottage on Muskadasa Island, especially boating with his grandchildren. Our thoughts are with his beloved wife and family. He will be deeply missed by all who had the privilege to learn from him and call him a friend.

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Update from Saskatchewan

By Regan Arendse, MD, FRCPC, PhD

Clinic nurses play an indispensable role in the successful functioning of a modern rheumatology practice. Their contributions extend far beyond traditional nursing responsibilities, encompassing patient education, counselling, coordination of care, medication management, and emotional support for patients living with chronic rheumatological diseases. In an era where biologic therapies and advanced targeted treatments have transformed the management of inflammatory arthritis and autoimmune diseases, clinic nurses have become central to ensuring that patients receive safe, effective, and timely care.

One of the most important responsibilities of rheumatology clinic nurses is counselling patients regarding biologic therapies. These medications are complex, expensive, and associated with potential risks that can create anxiety for patients. Nurses spend considerable time explaining the purpose of the treatment, expected benefits, possible side effects, infection risks, monitoring requirements, and the importance of adherence to therapy. Through their compassionate and patient-centred approach, they help alleviate fear and empower patients to make informed decisions regarding their treatment.

Clinic nurses also play a pivotal role in facilitating patient enrollment into the various patient support programs provided by pharmaceutical companies. These support programs are helpful in assisting patients to access their biologic medications, coordinate drug delivery, and arrange ongoing monitoring. The administrative burden associated with biologic therapy initiation can be substantial, requiring prior authorizations, insurance forms, laboratory documentation, and coordination between physicians, pharmacies, and support agencies. Rheumatology nurses expertly navigate these complex systems to ensure that patients experience minimal delays in receiving therapy.

In addition, nurses are instrumental in securing financial coverage for these costly medications through provincial reimbursement programs and private health insurance plans. Without their dedication and organizational expertise, many patients would face significant barriers to accessing life-changing therapies. Nurses advocate tirelessly on behalf of patients by preparing submissions, obtaining supporting documentation, and communicating directly with insurers and reimbursement agencies. Their efforts frequently determine whether a patient can begin or continue essential treatment.

From left to right: Dr. Regan Arendse; Denise Carolus, who was awarded the prestigious Nurse Hero 2025 Sterling Trophy by Sandoz Canada; and Kevin McKay of Sandoz Canada.

As rheumatological diseases evolve over time, many patients require switching between biologic therapies due to side effects, intolerance, or loss of therapeutic effect. Rheumatology nurses facilitate these transitions smoothly and efficiently. They educate patients about the new medication, coordinate discontinuation and initiation schedules, and monitor for complications or adverse events during the transition period. Their continuity of care provides reassurance to patients during what can often be a stressful and uncertain process.

Another invaluable aspect of the rheumatology nurse's role is addressing patient concerns and questions regarding medication administration. Many biologic therapies are self-administered by subcutaneous injection, which can initially be intimidating for patients. Nurses provide practical education and hands-on training regarding injection techniques, medication storage, infection precautions, and safe administration practices. Their accessibility and willingness to answer questions foster patient confidence and improve adherence to therapy.

Despite their enormous contribution, clinic nurses, together with medical office administrators, often remain under-recognized for the critical role they play within rheumatology practices. Their dedication, compassion, and expertise are essential to the efficient functioning of the clinic and the well-being of patients.

It is therefore especially fitting that Denise Carolus, from the office of Drs. Regan Arendse and Sohail Awan in Saskatoon, was awarded the prestigious Nurse Hero 2025 Sterling Trophy by Sandoz Canada, presented by Kevin McKay, the Territory Manager. This distinguished recognition honours her invaluable service, unwavering commitment, and outstanding contribution to patient care within rheumatology. We pay tribute to Denise Carolus for her exceptional dedication and congratulate her on receiving this auspicious and well-deserved award.

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By Bindu Nair, MD, MSc, FRCPC

Hello from sunny Saskatchewan! Since the last update, our rheumatology community has grown. In Saskatoon or the "Bridge City", we are fortunate to have Dr. Shreyasi Sharma, Dr. Anton Moshynskyy, Dr. Michael Schinold, Dr. Tara Swami, and Dr. Sohail Awan join us. We are also delighted to welcome Dr. Chance McDougall, who is now practicing in Regina, the "Queen City."

There continues to be high clinical demand for rheumatology services, and our rheumatologists lead in providing high quality care. Dr. Keltie Anderson and Dr. Vanessa Rininsland both head combined Rheumatology-Respiratory Medicine clinics with pulmonary medicine colleagues. Dr. Vanessa Rininsland and Dr. Sarah Oberholtzer have developed a Northern Rheumatology Clinic to improve access and provide care for northern Saskatchewan communities. Dr. Ardyth Milne is the Clinical Co-Lead for the Immunoglobin (IG) Stewardship Program of Saskatchewan.

Dr. Sarah Oberholtzer chairs and organizes the Annual Rheumatology Meeting of Saskatchewan (ARMS). This yearly event delivers excellent evidence-based presentations from regional, national, and international speakers, providing a forum for lively discussion.

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