FOCUS ON
Sports Medicine and Rheumatology

EDITORIAL
Game On!

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Mission Statement
The mission of the CRAJ is to encourage discourse among the Canadian Rheumatology community for the exchange of opinions and information.
Can you name the Montréal rheumatologist who was an Olympian on the 1992 Canadian Swimming Team? Who is the spondyloarthropathy expert who was a running back for Yale University? Which CRA President was drafted by the Winnipeg Blue Bombers?*

The interface between sports and rheumatology is large. At an individual level, there is a spectrum of involvement from the weekend warrior to the elite athlete. Doctors are a very competitive group: there seems to be inordinate pleasure about who has the bigger grant or the longer suffix behind the MD title. The consequence is that sports and medicine often are complementary pursuits. Just remember the heroics of the CRA soccer team in Acapulco which will be exaggerated forever!

It is difficult to be involved in more physically demanding sports forever. But as the saying goes “those that can do; those that can’t—coach.” This year I was “promoted” to be the head coach of an under-15-years-old boys soccer team. As an assistant, and now head coach, I have learned a lot about about flexibility (physical and mental), pronated feet and ankle injuries, the attention span of teenagers, and why many parents should be banned from watching their children’s sporting events. I now also know why it is so difficult to get volunteers to take on the role of head coach. Beyond the thrill of victory and the agony of the feet, I have learned a lot which I have tried to translate into my practice. Few of my patients may ever want to kick a soccer ball, but I hope I have influenced some to think about their bodies the way that an athlete does. No pro shows up for the game without proper preparation. Like the athlete each person has certain physical demands in their lives from prolonged sitting at a computer to digging a garden. Does it not make sense to consider what warmup exercises should be done before one goes to work and what prior physical training is required to prevent injuries on the job and at leisure?

In this issue, we interview rheumatologists whose role is to professionally care for the athlete. Dr. Claire LeBlanc from Ottawa and Dr. Jean Gillies from Vancouver tell us of their experiences in dealing with individuals from the young athlete to the elite superstar. The personalities of the professional athlete can create challenges for any physician. Dr. Murray Urowitz and Dr. Hugh Smythe both recount their time as one of the Toronto Maple Leaf’s hockey team physicians.

Dr. Robert McDougall is both a consultant rheumatologist in Regina and the team physician for the Saskatchewan Roughriders. The critical thinking skills which make a good rheumatologist are frequently called into play when dealing with professional athletes. The roles of the physician in serving both the team as well as the individual athlete are explored. Hall-of-Fame Offensive Tackle and CBC Broadcaster Chris Walby knows a few things about injuries and physicians from the other side of the bench. What qualities do athletes value in their doctors?

This has been one of the most fun issues to put together. Every individual who was approached to participate did so with great enthusiasm. That is perhaps why sport is so important. The passion for a game or a team gives us energy and some temporary respite from everyday burdens. Sports are about heart and commitment and we can learn from those who have set great personal examples. So even though I live in Winnipeg and support Chris Walby’s Blue Bombers, my sentiments are with the Riders. Did I mention that I was named after my late uncle Tom who played halfback for the Roughriders team that played in the 1934 Grey Cup?

Glen Thomas Davidson Thomson

*answers on p. 17

Dr. Thomson is the Editor-in-Chief of the Journal of the Canadian Rheumatology Association.
When did you first become interested in sports medicine? What in your medical school experiences lead you to choose rheumatology as your specialty?

I remember being interested in sport medicine from the beginning of my medical school training. I had always participated in sports at a competitive level and thought sports medicine would be an interesting direction to follow. Beyond that, I had no idea what was involved or how to pursue that interest. In medical school, at the University of Saskatchewan, a mentorship program was in place. In the first few weeks, I had met with my mentor who was a neurosurgeon, and the typical question asked was "where do you see yourself as a first-year medical student?" I indicated I was interested in sports medicine and my mentor looked at me with a funny, jaded expression almost saying "you and a million other medical students." That was my first exposure to the concept of sports medicine and my first rebuff. Incidentally that was our only meeting.

In truth, doing some form of sports medicine was always in the back of my mind. During the different rotations in medical school, you imagine yourself in a specific specialty at times only to find that that is not the direction you want to take. I did think about orthopedic surgery but found that it was not as stimulating to me as internal medicine. I found rotations in rheumatology to be very interesting and appealing from an academic perspective. In particular, as a result of the musculoskeletal (MSK) component of medicine, rheumatology allowed me to circle back to that interest in sports medicine. Finally, while interning in Regina, I did an elective in Saskatoon with a very talented group: the late Dr. Don Mitchell, Dr. Earle DeCoteau, Dr. Ken Blocka and the late Dr. John Sibley. I would have to say that those four doctors solidified my interest in rheumatology.

Did your medical training encourage you to pursue sports medicine?

Throughout my training program, directors were reluctant participants but, after some convincing, willing enough to allow me to pursue sports medicine during electives. I did this in medical school and during my internship. While doing general internal medicine at the University of Calgary, I was also allowed to do electives in sports medicine. This was pivotal for me and I am thankful that in general those managing the programs had enough foresight to see that this was a path I needed to take. In Calgary in
particular, this stretched the bounds of what I suspect other internal medicine programs would have considered viable.

What was your first exposure to the world of professional sports? During my medical school training an elective in social and preventative medicine was required. After considerable lobbying, I was able to arrange an elective focusing on sports medicine and the prevention of injuries. I had written to several major league baseball clubs and received a positive response from the Kansas City Royals' baseball club. I was able to attend spring training of 1985 held in Florida. With that we kindled a relationship and I was asked to return as an invited guest to spring training between 1987 and 1991 working with the medical staff. It was an incredible opportunity to work in a first-class professional organization such as the Kansas City Royals. I learned about the complicated world of sports medicine and dealing with a professional sports team and its athletes.

You have been the team physician for the Saskatchewan Roughriders since 2000. What have been some of the highlights of your time with the team? It is difficult to pinpoint specific highlights but I would say it is not much different than a rheumatology practice where the positive outcomes of complicated cases are the reward. In rheumatology we often work hard with chronic and at times acute and very ill patients and of course it is rewarding when these patients benefit and improve. Similarly in sports medicine, we often see athletes with significant and potentially career altering injuries, and the highlight is always their return to play.

In my view, the best job to have working in the CFL is as a team physician with the Saskatchewan Roughriders. This is simply because it is probably the franchise best known throughout the country. No matter where we travel, there is an amazing Saskatchewan Roughrider fan base. This is of course magnified here locally. It is not lost on me how great it is to be involved with this organization and I suppose this is in itself a highlight.

You received national media exposure when one of the Roughriders tested positive for HIV. Describe that experience and what you learned from it. What I have learned from the experience is to expect the unexpected. Athletes are of course more human than we tend to portray them and to have an athlete with HIV is in itself not surprising. I did however think that this would be the last thing I would have to deal with in sports medicine, particularly on a national level. I was asked by the football club to address the media and answer the medical
questions. To face eight to ten cameras and the multitude of questions by the national media was surreal. I think that most of us in rheumatology toil away in relative anonymity. We are not high-profile specialists like neurosurgeons or cardiovascular surgeons nor do we aspire to be. I think that most rheumatology training programs do prepare you to answer questions in a concise, accurate and evidence-based way which I certainly drew from. Prior to the experience, I had thought that the public awareness regarding HIV was advanced, particularly given the Magic Johnson story which was well publicized. I think I learned that it is important to educate but equally as important to continue to educate the public in different areas of medicine.

In sports medicine, the relationship is somewhat different. You have a responsibility to the organization for which you work (the professional team) but in addition you have a responsibility to the athlete and you can’t function independently from that athlete.

Do the responsibilities of a team physician differ somewhat from a doctor treating an individual patient?

When we deal with patients on a one-on-one basis in our office, it is really quite simple in a sense. There is a doctor-patient relationship. A family member may enter into the relationship and at times such a relationship is stressed to a certain extent when workers’ compensation and other interested parties are involved, but basically we see our patient and we become the patient’s advocate.

In sports medicine, the relationship is somewhat different. You have a responsibility to the organization for which you work (the professional team) but in addition you have a responsibility to the athlete and you can’t function independently from that athlete. Because you administer care to the athlete, he/she needs to be fully informed of the events. At times however, there is information that the organization has, in terms of what their plans are at present and in the future for a player, to which the athlete does not necessarily have ownership. On the other hand, the athlete

is a patient and may have a medical history that is personal and not related to their professional sport, under which circumstance the organization has no right to know. The relationships can be complicated. So I feel that there is a triad of responsibilities: the organization you work with, the athlete, and in the end, yourself as a physician. Above all, you have a responsibility as a physician to make the right medical decision.

What aspects of rheumatology training have helped you most in dealing with the health problems of professional athletes?

Ultimately, the decision to become a rheumatologist was easy. I chose this area of medicine because of the academic and clinical challenge that complicated cases presented. The next challenge was to define what I wanted out of life as a physician and how I could incorporate my interest in sports medicine. No doubt the MSK training component of rheumatology was particularly helpful. I think most rheumatologists would agree that when it comes to doing a complete MSK examination no other specialty does as thorough an evaluation. In my view, this relates to the training programs of rheumatologists where clinical assessments take such a high priority. It became clear to me that choosing rheumatology would be an asset in sports medicine rather than a detriment. The internal medicine component of training is also a major benefit as sports medicine requires that you deal with all aspects of the athletes health not just the injuries.

I think many people would look upon rheumatology and sports medicine as not being a good fit and I have
had colleagues even question what a rheumatologist would be doing working with the Saskatchewan Roughriders. I think what I have learned is that people don't have a good understanding of what exactly a rheumatologist does. Most don't understand the depth of training and experience that a rheumatologist has. In the end, people should not be surprised that rheumatologists do sports medicine, I think it is a perfect and natural fit.

What advice would you give to a physician who may be contemplating becoming a team physician?
There are rewards but there are a lot of things to consider. I think it is important to think it through and critically evaluate the pros and cons of that decision. There is a huge time commitment, and personal and family sacrifice. There are financial and professional sacrifices as well. Like other aspects of professional life there are politics, perhaps more than I would have expected. Involvement with a professional team is at times highly demanding and one must decide in the end whether it is worth it. There are rewards and benefits but this is mostly being able to do something you love and truly want to do.

I think it is important to note that, particularly in Canada, we are able to fashion our practices in medicine the way we want. I think everyone should reserve a certain percentage of their practice to pursue something that is of a particular interest and fulfilling. I think this keeps you sharp in your rheumatology practice as well.

Do you still enjoy the simple pleasure of watching a game of football or do you find yourself working intellectually—analyzing the players and their abilities on the field?
I expect I would do that anyway because if you are truly a sports fan you watch and critique. I will say that when I see injuries on the television I am observing the mechanism of injury and predicting diagnosis. Was it an anterior cruciate ligament injury, was it a cartilage injury, is he concussed? I suppose I watch sports from a different point of view. When you see the athletes from the inside, from their perspective you see how hard they work and when you see and hear the wrath of the fan, I perhaps see more the human side of the athlete. Some good and some bad.

Will you continue to work in sports medicine?
I believe so. I have always been involved in sports medicine at some level and, in addition to the work with the Saskatchewan Roughriders, a certain percentage of my practice does include my seeing other athletes as well. In the end though, I am very happy to be in Regina, Saskatchewan, my home province. I am happy with my rheumatology practice. If sports medicine were not available to me here in Regina I don't think that I would pack up and leave. If I had to choose one over the other it would be sad but I would sacrifice sports medicine, as in the end, I am a rheumatologist first.
How did you first become involved as a physician for the Maple Leafs? How many years did you perform in this capacity?

I began working with the Toronto Maple Leafs because I worked initially in the same unit as Dr. Hugh Smythe, who had a long-standing connection with the Toronto Maple Leafs, a family connection and a professional connection. His father was the founder of the whole Toronto Maple Leaf organization and Maple Leaf Gardens. So Dr. Smythe was involved in this early on as a team physician.

When it was time for him to step aside, I was working with Dr. Smythe, and he suggested that I take over for him and so a childhood dream came true!

It was really wonderful...for me, having grown up in Canada, hockey was a big issue. I played hockey at a young age and while I had no great talent in that area, I had a great time! But I also enjoyed being a spectator and was a great fan!

So here was an opportunity to get involved in a game I loved...

The Maple Leafs actually had an interesting team of physicians. There was myself, as a general internist, we had an orthopedic surgeon who was Dr. David Hastings initially and then Dr. Earl Bogoch, and a plastic surgeon Dr. Leith Douglas who handled all the cuts. The three of us were there at every game so we obviously saw a lot of each other and became a team within a team. So that meant that for me, from 1972-1989, every Wednesday and Saturday night I was at the Maple Leaf Gardens.

What were your responsibilities as a team physician for the Maple Leafs?

My responsibilities were the general health of the team. I did the physical examinations before training camps, I looked after all of the medical illnesses players may encounter through the course of the year and also I was in charge of the medical problems in the Maple Gardens throughout the game.

In what ways was the interaction with the players the same as or different than with clinic patients? Are athletes more demanding or difficult as patients than the general public?

I’ve always done multiple things in my career. I’ve never been focused exclusively in one area. In my academic career, I’m a rheumatologist, I do clinical care, I have a large research program and I’ve always been involved in University medical education.

In the hockey sphere, I was involved as a general physician, because I was not only looking at rheumatic problems but all of the players’ medical problems. So that was a change for me. That’s where I learned about things like conditioning and training camp preparation, a little bit of a different type of practice compared to my university practice. Also it was a different because you really got to know your “patients.” You got to know them very well and see them very frequently both in their personal and their professional lives. That’s a different kind of experience for me.

With many of the players like Darryl Sittler and Lanny MacDonald, I had a close relationship…not just a doctor-patient relationship.
What events highlighted your time as a Maple Leaf physician?
Unfortunately, if you look at the statistics, we never won a Stanley cup while I was there, we never got to the finals, however we got close to the finals… into the quarterfinals and once into the semifinals.

The highlights for me were just being involved in hockey, which I love, even today as a sport and with the players. It became apart of our family’s lives.

What are the attributes that a doctor needs to be a good team physician?
Like anything else you do, you have to like the job, otherwise you’re not going to be very good at it. This was a commitment. This was two evenings a week… you and your family have to accept that. Secondly, you have to become proficient in those areas that are important for that job. For hockey it was general health for people who have physically grueling jobs. They would play two to three days a week and they would practice the rest of the week. As you know, hockey is a very physical sport. So you have to make yourself aware of the medical issues regarding that kind of occupation.

Also, these were young male athletes so you had to get know all the issues that young males in their twenties are involved with in life in general. These people are just coming into their own. They are beginning to find permanent relationships and are people who, very early on in life, come into large amounts of money that they and their families probably never even dreamed of. So they can on occasion get into trouble or they can come and ask for advice. So you have to make yourself aware of all of those issues. The knowledge of looking after a grueling occupation, the knowledge of dealing with young, suddenly wealthy males are all things that I had to learn as it wasn’t apart of my usual training up to that point.

What should a rheumatologist consider if approached to become a physician for a professional sports team?
A rheumatologist is probably a good general physician to have as a team physician as they would have the expertise to treat joint problems, as well as the general medical knowledge that is necessary to look after a sports team. One should not expect that working with one professional team could be the major source of one’s livelihood. That’s probably not possible. But if you are a sports enthusiast and would like to be involved and are willing to make the commitment, a great reward awaits you!
How did you first become involved as a physician for the Maple Leafs?

This may seem odd, but I started at the bottom of the ladder, as “stick boy” or mascot for the team in my early teens. When a break occurred, I had to deliver the correct stick to Bingo Kampman (#7) as quickly as to Syl Apps (#10). It earned me my name being inscribed on the Stanley Cup with the 1942 team, when the Leafs came back from a three-game deficit. It also meant that I was in the dressing room, and learned to respect the trainers and physiotherapists, with a relationship that evolved over my years as team doctor, from 1950 to 1969.

I learned nothing of value about sports medicine in medical school. My association with the team was treated as a forgivable defect by the academic physicians at the Toronto General Hospital.

In what ways was the interaction with the players the same or different than with clinic patients?

Given all the pressures, and the attraction of any fad that might give them an edge, the players presented few problems. Often, it was their advisors who caused problems. In many teams (not the Leafs), the players were expected to “play hurt.” My father had developed some rules. After an injury, a player was not allowed to skate until MDs pronounced them fully recovered. Reason: doctors tried to hurry the players back. Typically, the player would guard an injured knee, but pull the opposite groin. Furthermore, my father knew what his best players could do, but wanted to test how others could best contribute when given new roles in the playoffs. In the playoffs, the responsibilities were greater. Players could play with an injury, if we could assure them and management that permanent damage would not result.

One of the doctors would be a surgeon, but until the late 1960s, no orthopedic surgeon could be a team doctor. He knew some doctors were good at knees, others better for backs or head injuries, and he wanted referrals to the best for that player.

I had unique opportunities to earn the trust of the players because I was a fixture in the dressing room. Bobby Baun was involved in many collisions, but rarely complained. As he walked toward the shower, I saw one knee sag inward with each step—he had a complete tear of his medial collateral ligament. When asked how he was, he said “fine.” They all had high-pain thresholds, but varying complaint thresholds.

In the 1960s, new problems arose, as the players’ agents became powerful. They interfered with the choice of treatment and consultant. Bobby Orr did not get the best advice about his knee injuries. My career as team doctor was ended by Alan Eagleson, when he said “Smythe, you have a conflict of interest”—he was an expert at that. My successors were not given access to the dressing room except by invitation, which is perhaps why the Leafs won no more Stanley Cups.

What events highlighted your time as a Maple Leafs physician?

There were many, and some of the most dramatic must remain confidential.

Early on, I observed both Ted Kennedy and Gordie Howe after concussions. We were concerned about the risk of subdural hematoma, and checked their status every 2 hours over the next day; Ted in a hotel room in Boston, Gordie in the Private Patients Pavilion of the Toronto General Hospital. Concussions were much less common than now. Explanation: with today’s helmets, neck injuries are more common. The symptoms of neck injury include headache, imbalance, and other symptoms that mimic concussion, but persist or recur in the absence of correct diagnosis and treatment. No amount of padding can protect the neck or the knee.

Rocket Richard was totally fearless as he charged toward the net, dragging the strongest of our defensemen. But he was terrified of needles. I quickly put 5 stitches in his scalp without using local anesthetic, taking advantage of the relative numbness that occurs shortly after injury, so that the ordeal was minor and brief, rather than prolonged and tentative. Illogical fears were not rare in these heroes, especially fear of flying.
Most fans will remember that Bobby Baun scored a game-winning overtime goal against Detroit with a broken “ankle” or “foot,” depending on what account you read. The injury was an undisplaced fracture of the fibula about 3” above the ankle joint line. These fractures always heal, and permanent disability was not a concern. It was a mere pain problem, easily controlled with local anesthetic. Two nights later he played again with local anesthetic, when the Leafs won their second-last Stanley Cup.

Red Kelly also played that final game with the help of local anesthesia. He had a “sprain” of the medial collateral ligament of his knee. The bulk and strength of that ligament was intact, but there is a thin anterior fan, which is commonly stretched. With the knee locked in full extension, there was no pain or instability when the ligament was stressed. Palpation revealed the quite localised marked tenderness, abolished with injection. There was a good deal of pain after the “freezing” wore off, borne with the help of the Cup victory.

My father was strongly opposed to any performance-enhancing measures. In one Stanley Cup series, there was an oxygen tank beside the Detroit bench, designed to speed recovery from extreme effort. My father used this in his second-intermission battle address: “they know they’re licked. They know they’re not man enough to beat you without sucking on the gas pipe. All you have to do is go out and take it away from them.” And they did. In later years, the tanks never reappeared. (Quotes approximate)

Psychology was a challenge, and sometimes fun. In the famous 1967 series, The Montreal Canadiens had to choose between the perhaps fading veteran Gump Worsley as goalie and a less stellar Charlie Hodge. Their manager was Sam Pollock, and he introduced a young Rogie Vachon as an alternative. Pollock and Punch Imlach were two of the smartest men in hockey ever, knew each other well, and were fiercely competitive. Imlach welcomed the choice of Vachon, calling him a “Junior B goalie.” Pollock was had, and knew it. If he did not play Vachon and lost, he would seem to be pushed by Imlach. If he played Vachon and lost, he was just being stubborn. He had to win; but he played Vachon and lost.

Punch had built the losing team of the late 1950s into one that won four Cups in a row. The players remain heroes in our memories, but man-for-man, the Leaf players did not seem better than the best of the competition. As coach, Imlach had the most obstructed view of the game of anyone in the arena, but was very quick to identify who was playing well on a given night, and who of his role players could contain a Howe or a Béliveau. But the gamesmanship psychology that worked at the competitive level, was not always appreciated by his players.

What are the attributes that a doctor needs to be a good team physician?
Professional skills, empathy, access.

In the first decade, I sewed cuts, injected areas of tenderness, listened, learned from my colleagues, and puzzled about many “Medically Unexplained Symptoms.” I studied with Kellgren and re-read about referred pain, the missing chapter in sports medicine. Often the “pulled hamstring” was not very tender. Nor was the lateral epicondyle. In a community meeting in Brandon Manitoba organized by the Arthritis Society, a colourful Physiatrist named Max Desmarais explained that the tenderness in patients with lateral elbow pain was to be found inches away from the epicondyle, in the origin of the long extensor muscle to the third finger from the lateral inter-muscular septum; inject here and you get better results. If symptoms recurred, the symptoms often were more diffuse, with other regional sites of discrete tenderness, perhaps associated with pain in the back of the neck.

About this time, something very gratifying happened. Trainers from other teams—Detroit, Chicago, Boston, New York—began asking me to see their players who were having chronic symptoms, not improving with standard therapies. They knew my name was Smythe, but trusted me to give my best advice. Priceless.

But now, every newspaper brings news of diagnostic and therapeutic folly. Arthroscopic surgery for “torn glenoid labrum?” Surgical therapy for “bone chips” in the elbow (ossification of the triceps insertion) has been displaced by Tommy John surgery, followed by a year(!) of convalescence. Do these athletes have the medial elbow tenderness of the C 6-7 syndrome? We don’t know; many orthopedic surgeons will not refer to rheumatologists prior to proposed surgery.

What should a rheumatologist consider if approached to become a physician for a professional sports team?
Time, access and a collegial relationship with a surgeon. I assume the interest is there. It has been reported that 50% of Ontario’s primary-care physicians consider themselves qualified to practice sports medicine. I certainly wasn’t, learned slowly, and am still learning. My successors faced many barriers. Coaches, managers, trainers, agents, other physicians and surgeons may be friendly enough, but block access, to ensure that you serve only at their pleasure.
How did you become interested in treating elite athletes?
I have been fortunate enough to work closely with sports medicine physicians and physiotherapists who treat elite athletes. When the athlete is not responding to the scheduled treatment of these professionals or when there is a diagnostic dilemma, I have been consulted. Rheumatologists, as part of a medical team, contribute uniquely to an elite athlete’s care due to our expertise with non-surgical musculoskeletal (MSK) problems and because of our experience in treating arthritis, and inflammatory and mechanical enthesitis. However, my fascination with treating elite athletes dates from the 1960s when I was training as a physiotherapist at St. Thomas’ Hospital in London. As a student, I was privileged to treat several professional ballet dancers and two world-famous race car drivers who were referred to the hospital. I learned they were a very different type of person: they were totally focused and possessed enormous discipline. They healed faster and reached rehabilitation goals not thought possible: they defied the odds. They changed my perspective of what was possible. Silken Laumann is an outstanding example of someone who defied all medical expectations after a serious training injury which “sliced open” her thigh 12 weeks before the 1992 Olympic Games. After five reconstructive surgeries she went on to win a bronze medal in rowing. Regardless of the sport, I am fascinated by the way the well-trained body moves in space, defying gravity with grace and ease, and how the bodies of such high-performing athletes respond to treatment when injured.

Are professional athletes generally more knowledgeable about their health and conditions than non-athletes?
Yes. This, of course, is no surprise. Many athletes are certainly more knowledgeable about MSK injuries, basic anatomy, health promotion, and nutrition. The elite athlete though, could be more knowledgeable regarding the benefits of cross training and elite core training. Furthermore, I am not certain there is a generalization of knowledge into other areas of health. For example, I treated one elite hockey player who had cold-induced asthma that had not been previously diagnosed. The athlete presumed his shortness of breath at the rink was from being out of shape. The diagnosis was confirmed by a respirologist, and he is much improved having been prescribed inhalers.

Are professional athletes more difficult or demanding than the general public?
I find professional athletes to be much less demanding and much less difficult than patients with MSK problems who have been frustrated with the medical system for not solving their problem. However, I need to put that in context. The MSK clinic at which I work, the St. Paul’s Hospital Orthopedic Medicine Clinic, accepts tertiary and quaternary referrals for non-surgical MSK problems that are either a diagnostic challenge, or unresponsive to standard treatment. That being said, it is not surprising that a professional athlete is easier to deal with and less demanding. Athletes typically have very-high standards for themselves. They demand the same in their health-care team. I am not sure the average patient demands the
same very-high standard of expertise; they just want to be fixed and often their contribution to the solution does not involve the self-determination that athletes possess.

Does your training as a physiotherapist (before your medical and rheumatology training) give you an advantage in managing elite athletes?

I come with no unique skills of my own. I practice what I learned in the 1960s from Dr. James Cyriax, one of two consultants in the Department of Physical Medicine at St. Thomas’ Hospital in London, when I was training to become a physiotherapist. The defining moment for me was his approach to the diagnosis of the MSK system: active ROM, passive ROM, and isometric muscle testing. He gave the same lectures to the physiotherapists as he did to the medical students. Using his disciplined, systematic approach to the patient’s MSK history and examination, the diagnosis comes into focus. I have never seen any physician match Dr. Cyriax’s clinical examination skills since. His concept of capsular and non-capsular patterns of restriction of joints is brilliant. Without the Cyriax approach to the examination of the moving parts, I would have nothing additional to add to the athlete’s medical team. In terms of physiotherapy skills, I can certainly say that my training in surface anatomy and applied anatomy in physiotherapy school far exceeded the training I received in medical school. Although I learned MSK physical examination skills in medical school, it was Dr. Cyriax who trained me to interpret the data. Physiotherapists, in general, have an additional secret weapon in the examination of the MSK system: they have great eye-hand coordination and intuitively understand body mechanics.

What have been some highlights of your interactions with professional sports figures?

It is very thrilling to watch an elite athlete, whose career has hung in the balance from a significant injury, playing better and moving easier subsequent to recovering from an injury. Also, I could spend all day watching our world-class physiotherapists working with athletes, fine tuning their movements. It is a privilege to be part of a highly-trained medical team that works together for a common goal. The medical system could learn a lot from the sports medicine example of how to better work as a well-aligned team, building on the expertise of all members. Finally, elite athletes are also very gracious when they are helped and so it is very nice to impress my teenage daughter with free tickets to an NHL game—it puts me in the league of great mothers!
It is particularly gratifying to be able to share my career choices with the readers of The Journal of the Canadian Rheumatology Association. The emphasis of this issue dovetails precisely with my own areas of specialization as a pediatric rheumatologist and sports medicine physician.

I’ve been an athlete all my life and have played a variety of competitive sports. I played varsity fastball in high school and ice hockey in college and I continue to be active in many sports and recreational activities.

In the mid-1990s, as a pediatric practitioner in private practice, I was asked by a teammate if I would cover the Ontario girls’ high-school soccer championships. I agreed, and quickly realized I knew very little about the care of athletes, but I thought this would be a great way to give something back to the sports community.

In 1995, I was given the opportunity to leave private practice and work as a consulting pediatrician at the Children’s Hospital of Eastern Ontario in Ottawa. Here, I met a pediatric rheumatologist, Dr. Nina Birdi, who mentored my interest from within her specialty. After several years of this collaboration, I decided to specialize in this field and obtained my certification from the Hospital for Sick Children in Toronto in 2002. I immediately returned to Ottawa as the Head of Pediatric Rheumatology and Director of Pediatric Sport Medicine.

That was five years ago. I was recently recruited to join Dr. Janet Ellsworth as a consulting pediatric rheumatologist at the Stollery Children’s Hospital in Edmonton. In addition, I have been given the wonderful opportunity to develop a pediatric sport medicine program for northern Alberta. This program is in its infancy but has been designed with a strong emphasis on the education and rehabilitation of young athletes. It also includes the teaching of undergraduate and postgraduate students, and an opportunity for clinical research.

I conduct separate clinics for pediatric sports medicine and rheumatology. Patients in each specialty may suffer from a variety of musculoskeletal disorders and my knowledge in both areas enables me to provide the most appropriate care. Indeed, I am able to engage the patients and their families in a full range of treatment possibilities.

I believe in offering hope to all of my patients. I never fully rest the athlete with an injury. They are encouraged to cross-train to maintain cardiovascular fitness and psychological wellbeing. I never deny a child with arthritis the opportunity to fully participate in any physical activity once inflamed joints are stable. Any of these patients may become our athletes of the future.

It is very rewarding to deal with children and youth in their formative years to help them achieve their personal best. They are seldom lucky enough to find outstanding coaches who have been trained to teach them correct...
measures to prevent injury. Sometimes unrealistic expectations on the part of parents or coaches can cause extra strain on young bodies, which are still growing and developing. This can lead to early retirement from competitive sport and consequent inactivity.

At the moment there is an epidemic of childhood obesity. It is well known that exercise and healthy nutrition are essential for normal weight and vigor. Children with rheumatic diseases may be at higher risk because they are in general less active and some of their required medications are associated with weight gain.

Through a sound appreciation of exercise and sport medicine, physicians caring for children with rheumatologic disorders can reduce the likelihood of long-term obesity. They can help their patients maintain mental wellness, reach ideal bone health and achieve complete rehabilitation. Rheumatology residents should be encouraged to expand their knowledge in this specialty. Indeed, rheumatologists are well positioned to become excellent sport medicine physicians. We have considerable expertise in internal or pediatric medicine as well as a great working knowledge of the musculoskeletal system.

I believe now is a wonderful time to practice my specialties of pediatrics, rheumatology and sport medicine. I am committed to encouraging all children under my care to adopt healthy active lifestyles.

**SPORT VIGNETTES**

Long before I was ever a rheumatologist I would be the medic at high-school football games in Saskatoon. You never saw an injured player get better so fast as when they saw a young female intern medic come to examine them!!!

*Dr. Janet J. Markland*

* Editorial Page answers: Dr. Beth Hazel, Dr. Robert Inman and Dr. Gunnar Kraag,
An Athlete’s Perspective: An Interview with CFL All-star Chris Walby

Chris Walby was inducted into the CFL Hall of Fame in September of 2003 after playing for the Winnipeg Blue Bombers for 16 seasons as an offensive tackle. In this interview, Chris Walby, a CFL analyst on the CBC, gives us his impressions from “across the bench” on the relationship between an athlete and the team physician.

Does a professional athlete think differently of the team physician than their own personal doctor? Is the “team doctor” taking care of the team or the player? This is really a very tough question because every team has a number of “team physicians.” I have had the experience where the physician definitely supports the team before the player. I had the misfortune of tearing my bicep muscle in a game in Birmingham. Upon my return the decision was made that it should not be repaired surgically as it would not allow me to return to the field as fast. In the end, I was informed I would be playing 3 weeks later, with a rubber sleeve and my arm taped up like a cast to prevent it from bending. I have also had the experience where a team physician decided that playing with an injury would do me more harm in the long run and to make sure to take care of the injury first. In the end though, I am sure there is a common feeling that the “team physician” is different than your personal general practitioner (GP) or family physician (FP). The GP or FP is not under the same type of pressure from the club to get you back on the field as soon as possible...

After an injury, who on the team provides advice on when the athlete should return to play? If an athlete gets conflicting opinions, how does the athlete resolve the differences in advice? After an injury, the player is given clearance to play by the team physician in major injuries, after surgery, and if there is no surgery (i.e., groin pull, muscle pulls, etc.) this decision is left up to the team physiotherapist. People do not realize the pressure that is put on an athlete to get better fast. There was always the saying that “you can’t make the club in the tub” when a player was getting any type of treatment, and not on the field playing. As a result, players sometimes do not tell the truth about the nature of their injury, to avoid long layoffs, and possibly unemployment. If a player gets conflicting opinions... then that player would go to his own physician or an unbiased physician for a second opinion. This has resulted in many cases of wrongful dismissal in regards to a player who is in fact hurt and has the backing of an independent doctor but the team physician states he is healthy enough to play.

Osteoarthritis is often the long-term consequence of joint injuries. In your experience, do team physicians place enough emphasis on the long-term effect of injuries and need for rehabilitation before returning to the play to prevent long-term damage to joints? In a one-word answer...NO!! Their job is to get you back on the field as soon as possible. I played professional football for 16 years, and as I look at my fingers and body joints now, I wonder if I would have stayed in the game as long as I did had I known. If it wasn’t for my love of the game I know for sure I would have never played more than a few years. I do not know how a team physician can do anything about this factor because it is the player’s livelihood, the way he pays his bills and takes care of his family. We all make sacrifices and probably wouldn’t have listened to the team physician anyway.

In your opinion, what personal qualities are necessary for a doctor to be a good team physician? I believe he or she really has to have that individual’s best interests at heart. Therefore I believe the qualities would have to be honesty and integrity.
Sports and Rheumatology

By Jackie Stewart, MD, FRCPC

One of the reasons that practicing rheumatology has been the best career choice for me, is the ability to have time to do something other than medicine during your waking hours. We all believe exercise is important for good health and I am fortunate to be able to do this to the extreme. I only took up long distance running about 15 years ago and now have logged 7 marathons (2 more coming up this fall, including Athens!) How do I find the time? The answer is to move to British Columbia—this is where a large proportion of people incorporate exercise into their lifestyle.

I learned you can never forget you are a doctor when in race events. In my very first marathon in Ottawa, I came across a runner at the 4-km mark having a grand mal seizure. Stopping to give assistance cost me at least 15 minutes and I missed my qualifying time to run the Boston marathon. I just did it again the next year and made it! My most satisfying marathon was last year in New York. I raised $9,000 for the Arthritis Foundation within their Joints in Motion program and ran with Dr. Marguerite Stolar who also raised a huge sum.

Now that I live in Penticton, British Columbia, (home to Ironman Canada) I have taken up triathlons. My medical skills were required again during a triathlon where I found a disoriented diabetic on the road who had fallen off his bike! I have now completed four Olympic triathlons and a Half-Ironman triathlon this year. My plan is to do a full Ironman next summer (3.8 km swim, 180 km bike, 42 km run). How does one find the time to train for such an event and run a busy Rheumatology practice? I used to commute from the Beaches in Toronto to Mississauga spending two or three hours a day driving. Now, I use that time to swim, bike and run through this beautiful Okanagan Valley. In addition, I can still work five full days and see lots of patients. I would also add that I am privileged to work with one of the best rheumatologists in Canada, Dr. Bob Offer.

I hope I can keep this up for a few more years—as long as my joints hold up. I was most inspired by a 77-year-old woman who completed the Ironman triathlon this year for the 20th time!

CRA NEWS

AIR2 IS COMING!

Following on the heels of the very successful Assessment in Rheumatology (AIR) program, the CRA is happy to announce the continuation of the program with AIR2, with continuing sponsorship through an unrestricted grant from Amgen & Wyeth.

We have listened and made several changes to make the process more user friendly. You will still be able to access your personal data and compare your answers to those of your regional and national colleagues while picking up those section 5 Continuing Professional Development (CPD) credits.

If you wish to pre-register, please email Diane Ferland: dferland.hmr@ssss.gouv.qc.ca.

Michel Zummer, MD, FRCPC
Giant Cell Arteritis and Sudden Blindness: A Different Focus

By Janine L. Johnston, MD, FRCPC

Not all clinically significant questions have been definitively answered by randomized double-blind placebo-controlled trials. The Hallway Consult by-line in the Journal of the Canadian Rheumatology Association will seek a consensus answer from rheumatologic experts for your difficult questions. Please forward questions for future issues to: Maeveb@sta.ca.

Case History: A 65-year-old man presents with monocular visual loss. He is diabetic, hypertensive and hyperlipidemic. He is taking appropriate medications to treat.

Question 1: What is the cause of this man’s visual loss? Can you tell from his case history that he has giant cell arteritis (GCA) prior to obtaining his blood work results?

From a neuro-ophthalmic point of view, determining the onset of the visual loss is important. Abrupt visual loss can indicate ischemic optic neuropathy, which could be arteritic or non-arteritic. The occurrence of retinal artery thrombosis or embolism is possible. Purely ocular causes such as retinal detachment or acute angle closure glaucoma must also be considered. Progressive and insidious visual loss is more in keeping with infiltrative or compressive optic neuropathies, macular degeneration, glaucoma or cataracts.

Accompanying symptoms are important factors in determining the cause of the visual loss. The presence or absence of pain is significant. Most vascular causes of visual loss are painless. If total global ischemia has occurred, then there must be occlusion of both external and internal carotid systems. This causes severe ocular pain (ischemic oculopathy). Classic temporal pain or headache and jaw claudication are not consistently associated with giant cell arteritis (GCA), but when present, are good clues. Diplopia can occur with GCA, but ocular pain and diplopia can also be associated with space-occupying lesions involving the orbit.

Involvement of the optic nerve can be verified by looking for a relative afferent pupillary defect (RAPD) or Marcus Gunn pupil with a swinging flashlight test. This is quick and simple. The unaffected pupil will constrict with the light but the affected eye will appear to dilate when the light is shone into this eye. This means that the optic nerve is most likely damaged.

Furthermore, viewing the fundus with a direct ophthalmoscope may show an abnormal optic nerve. In ischemic optic neuropathy, the affected optic nerve may be normal or swollen. If the ischemia is posterior along the course of the nerve (posterior ischemic optic neuropathy), then the disc will appear normal (see Figure 1a). If the ischemia involves the optic nerve head, this is called anterior ischemic optic neuropathy (AION), and means that the disc will be swollen, either in a small segment, or globally (see Figure 1b). This is not papilloedema, where the optic disc and blood vessels are swollen and there are hemorrhages (see Figure 1c). Rather, the optic disc is pale and the blood vessels are very small.

Finally, palpation of the temporal and facial arteries may show poor circulation or absent pulses in addition to tenderness.

While the diagnosis of AION can be made with relative certainty, the absolute diagnosis of GCA rests with the temporal artery biopsy. Arteritic AION cannot be definitively differentiated from non-arteritic AION in patients over 55 years particularly when the erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) level are not typical for arteritis. Fluorescein angiography can demonstrate significantly delayed choroidal filling which corresponds to occluded posterior ciliary arteries. This does not occur in non arteritic AION and is almost always diagnostic of arteritic AION.

Outcome: This patient described painless acute visual loss involving his left eye and jaw claudication. His ESR was...
35 mm/hr and CRP was slightly elevated. He was started on prednisone 60 mg daily. Left temporal artery biopsy was negative so prednisone was discontinued. Within 24 hours, he had further visual loss in the left eye with significant pain on orbital movement, diplopia and elevated intraocular pressure. Intravenous (IV) methylprednisolone 1000 mg daily was given for 5 days and vision in the left eye recovered to 20/30. Continued high-dose prednisone therapy has resulted in advancing cataracts, difficult control of glucose and hypertension and avascular necrosis of his left hip.

If the visual loss is dramatic or if there are signs of globe ischemia (e.g., acute cataract and glaucoma in addition to AION), then IV methylprednisolone is indicated. Visual loss is not irreversible and appropriate action when the diagnosis of GCA is considered can cause remarkable visual improvement. Even in the absence of a positive biopsy or elevated ESR or CRP, the constellation of AION and jaw claudication would make high oral prednisone therapy reasonable. Fifty percent of patients with GCA present with visual symptoms. From a neuro-ophthalmic point of view, the benefits of prednisone therapy for patients with arteritic AION always outweigh the risks, regardless of diabetes or hypertension. Involvement of the fellow eye can occur within one or two weeks, compared to 2 to 3 years in non arteritic AION.

Dr. Janine L. Johnston is a neuro-ophthalmologist practicing privately in Winnipeg in a multi-specialty group. She is also an Associate Professor of Ophthalmology, Otolaryngology and Medicine at the University of Manitoba.

Sponsored by an unrestricted educational grant from Pfizer Canada.

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The sibling diseases polymyalgia rheumatica (PMR) and temporal arteritis are seen with reasonable frequency in every adult rheumatologist’s office. The textbooks give classic descriptions but in practice these are some of the most trying diagnoses. Our “Joint Count” survey demonstrates that absence of a markedly elevated erythrocyte sedimentation rate (ESR) does not preclude the diagnosis of temporal arteritis for more than half of the responding rheumatologists. The overwhelming majority of respondents will order temporal artery biopsy to confirm the diagnosis. Unfortunately, access to rapid temporal artery biopsies ranges from the sublime to the ridiculous across the various health regions of Canada. Sudden monocular blindness, in the context of relatively normal acute phase reactants, should expand the diagnosis beyond temporal arteritis. The “Hallway Consult” section of this issue provides the neuro-ophthalmologic approach to diagnosis.

Many patients who are diagnosed with temporal arteritis cannot be successfully weaned to low doses of corticosteroid. Almost all rheumatologists in the survey will use methotrexate as a steroid sparing agent, despite contradictory evidence from randomized clinical trials.1,2 One quarter of the respondents will try either acetylsalicylic acid (ASA) or an anti-inflammatory as a steroid sparing agent. There is increasing rationale for the use of low-dose ASA from two retrospective

### Table 1. In your career, how many times have you made a clinical diagnosis of temporal arteritis with an ESR less than double the upper limit of the normal range?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>22.8%</td>
<td>29</td>
</tr>
<tr>
<td>once</td>
<td>22.1%</td>
<td>28</td>
</tr>
<tr>
<td>2-10 times</td>
<td>46.5%</td>
<td>59</td>
</tr>
<tr>
<td>&gt; 10 times</td>
<td>8.7%</td>
<td>11</td>
</tr>
<tr>
<td>skipped question</td>
<td>127</td>
<td></td>
</tr>
</tbody>
</table>


### Table 2. When you suspect temporal arteritis, how many patients will be referred for temporal artery biopsy?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
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<tr>
<td>never</td>
<td>2.4%</td>
<td>3</td>
</tr>
<tr>
<td>&lt;10%</td>
<td>0.8%</td>
<td>1</td>
</tr>
<tr>
<td>10%-50%</td>
<td>9.5%</td>
<td>12</td>
</tr>
<tr>
<td>&gt; 50%</td>
<td>21.4%</td>
<td>27</td>
</tr>
<tr>
<td>always</td>
<td>65.9%</td>
<td>83</td>
</tr>
<tr>
<td>answered question</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td>skipped question</td>
<td>2</td>
<td></td>
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</tbody>
</table>

cohort studies. A small number of rheumatologists have used anti-TNF therapy. There have been case reports indicating potential benefit but the only randomized trial using infliximab demonstrated disappointing results. Restrictions placed on the use of anti-TNF therapies by formularies generally preclude observational studies using other anti-TNF agents in those individuals who have failed ASA or methotrexate as steroid sparing agents.

Diagnosis and management of temporal arteritis would appear to be relatively clearcut compared to that of polymyalgia rheumatica. There is almost an even split between those rheumatologists who will make a diagnosis of PMR with normal acute phase reactants and those who do not. These disease processes, which are confined to the older-age population and are associated with considerable morbidity, have been relatively under studied. Perhaps as the population generally becomes grayer (along with physicians), there will be increased interest in research into these two common disorders.

References:

3. In those temporal arteritis patients who cannot be tapered off high-dose corticosteroids, which of these additional therapies have been helpful, in your experience, to make clinically significant reductions in the corticosteroid dose?

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>acetylsalicylic acid (ASA)</td>
<td>14.2%</td>
<td>16</td>
</tr>
<tr>
<td>anti-inflammatories</td>
<td>9.7%</td>
<td>11</td>
</tr>
<tr>
<td>methotrexate</td>
<td>93.8%</td>
<td>106</td>
</tr>
<tr>
<td>biologic (anti-TNF therapies)</td>
<td>3.5%</td>
<td>4</td>
</tr>
<tr>
<td><strong>answered question</strong></td>
<td></td>
<td>113</td>
</tr>
<tr>
<td><strong>skipped question</strong></td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>


4. In your career, how many times have you made a clinical diagnosis of polymyalgia rheumatica in a patient that was over 60 years of age with a normal ESR and C-reactive protein (CRP) level?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>34.9%</td>
<td>44</td>
</tr>
<tr>
<td>once</td>
<td>13.5%</td>
<td>17</td>
</tr>
<tr>
<td>2-10 times</td>
<td>35.7%</td>
<td>45</td>
</tr>
<tr>
<td>&gt; 10 times</td>
<td>15.9%</td>
<td>20</td>
</tr>
<tr>
<td><strong>answered question</strong></td>
<td></td>
<td>126</td>
</tr>
<tr>
<td><strong>skipped question</strong></td>
<td></td>
<td>2</td>
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</table>

This past year has brought to realization the accumulating pressures on The Arthritis Society (TAS) to maintain research funding in the face of diminishing revenue streams. The Medical Advisory Board as well as the Scientific Advisory Board conjointly advised the CEO of the most essential elements of Career Development and Research that had to be maintained, leaving open by default, those programs that would be left vulnerable to the budget process.

In the past few years, the board of directors has called upon the reserve fund just to maintain the status quo, while funding new initiatives and new grant applications, arthritis residency supplements, arthritis centre grants and career awards. Now these reserves have hit a dangerous low, and the Board of Directors of TAS has drawn a line and capped the total Research and Career Development (R&CD) expenditure at $4.1 million.

This means that grants and career awards made in previous years will be honoured. The two National Research Initiatives will be funded. The Clinical Educator awards will be maintained. For the current fiscal year however, there will be no call for new grant applications. The rheumatology specialty residency grants will be maintained where essential, but new money will not likely go into post-graduate clinical fellowships. TAS will likely ask the CRA to take greater responsibility for the Ogryzlo Fellowship grants. The Arthritis Centre grants may be decreased.

The Board and CEO of TAS have done a lot of housekeeping in the last five years. Operations of the organization are far less discordant and much more efficient. The rules of operation at the divisional and national levels are clearer, and TAS has started to work in a better team environment. However, despite a flourishing economy, TAS has not maintained its market share of donations, and a variety of fund raising initiatives have not been as profitable as planned. The new CEO will have fundraising as the most important first priority challenge, and will need the qualifications to meet this demand.

Obviously, the gathering clouds of sunset for the Canadian Arthritis Network in 2012 and diminished funding for the Institute of Musculoskeletal Health and Arthritis (IMHA) and the Canadian Institutes of Health Research (CIHR) in general make it essential that TAS work with these organizations to maximize efficiencies of funding research and career development. To this aim there will be meetings and much discussion as well as opportunities for input from the arthritis research and academic communities.

Now these reserves have hit a dangerous low, and the Board of Directors of TAS has drawn a line and capped the total Research and Career Development (R&CD) expenditure at $4.1 million.

Meanwhile, congratulations to Dr. Paul Fortin, Dr. Rae Yeung, Dr. Nader Khalidi, Dr. George Daoud and Dr. Francine Goulet for their career awards. Congratulations to the four rheumatology trainees who would not have been able to practice this specialty in Canada without their residency awards. And congratulations to the seven winners of new research grants who might not have otherwise been able to maintain research careers for arthritic diseases. TAS continues to be the wellspring of depth and development for our profession. Instead of objection and protest at this time of new challenge, we need to be the strength, the support and the facilitators for our friend of 60 years.

Arthur A. M. Bookman, MD, FRCPC
Past Chair, Medical Advisory Board
The Arthritis Society (TAS) has always played a pivotal role in rheumatology as a specialty in this country. They were responsible for establishing Rheumatic Disease Units across the country, supporting many arthritis researchers and training new rheumatologists. Over the years there have been new initiatives put in place, in order to foster the spirit of growth within the society. The role of TAS in the everyday lives of rheumatologists has changed with the evolution of the Canadian Rheumatology Association.

Currently there are many challenges facing TAS. There are leadership changes at more than one level and many tough decisions to be made if TAS is to move forward. A major problem we face is a decrease in revenue, mostly generated from donations. One priority for TAS will be to find innovative ways to encourage philanthropy. Another focus will need to be re-evaluating all the programs currently funded by TAS and keeping alive those initiatives considered essential. This will be the greatest and most difficult task that I anticipate being involved. As a third challenge, I believe that TAS needs to become more relevant to the rheumatology community as a whole. We cannot expect the public to support an organization unless it has a high profile among all arthritis caregivers.

I look forward to working with the new leadership in TAS to achieve these goals.

Joanne Homik, MD, FRCPC
Director, Division of Rheumatology
University of Alberta

**Letter to the Editor**

Dear Sir,

I am writing to your journal to express my sincere regret that the Arthritis Society has withdrawn its funding program for rheumatology residents. As a rheumatology trainee in Vancouver, I was grateful to receive this funding; now, as the program director of rheumatology at the University of Western Ontario, it is a constant struggle to acquire funding for rheumatology residents. This year it will take quite an effort to acquire funding to keep a trainee. Without this funding, this trainee may have to pursue a career in general medicine even though they really want to practice rheumatology. These situations are very familiar to other program directors throughout the country.

I understand that the Arthritis Society may feel that it is the responsibility of the Ministries of Health to fund resident training. However, in 1993-1994, the Ministry of Health in Ontario slashed 200 spots in medical schools as they projected we would have too many doctors—boy were they wrong. Given this past track record, it is clear that there is no vision of future human resource needs in medicine (there is nobody driving the bus). As practicing rheumatologists, every day we see the dire need for more rheumatologists in Canada.

I am sending a plea to the Arthritis Society to strongly reconsider supporting this program once again. If the Arthritis Society truly has a commitment to “Hope: through education, support, and solutions” they will realize that this is a solution to help all Canadians with arthritis.

Andy Thompson, MD, FRCPC
Chair, The Website Committee

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