Focus on International Rheumatology

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www.stacommunications.com/craj.html
Mission Statement. The mission of the CRAJ is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.
The theme of this issue is Canadian Rheumatologists reaching outside of this country to serve others. As the lead article demonstrates, sometimes this international contribution takes place in Canada through efforts to educate international trainees. In other cases, Canadian Rheumatologists have traveled far and wide to provide education or service. Especially at this special time of the year, many of the stories give us pause to reflect on just how fortunate we are to live and work in this country even at the most uncertain of financial times. The one sentiment that is repeated by all those who have contributed to these charitable endeavors is that service is a reward in itself. Hopefully this issue will inspire all of us to be more cognizant, supportive and involved with such international initiatives to improve the health of others.

A variation on this theme is the entertaining article by Philip Baer about his adventures as a cruise ship Educational rheumatologist. His nautical vocation may put him in line for the New CRA Educator Award by virtue of its very uniqueness.

Our President John Thomson and Vice President Jamie Henderson send their holiday greetings in this issue. This has been a momentous year for the CRA with its purchase of the international publication The Journal of Rheumatology. The CRA is now in the league of other major national rheumatology organizations, with a highly respected scientific journal serving as its flagship publication. The future success of The Journal of Rheumatology will be dependent upon the continued support of Canada’s most prominent arthritis researchers and their choice to publish their best works in this Canadian owned publication. Canadian Rheumatologists will be watching.

There was other big news at the American College of Rheumatology meeting that was held in San Francisco in October. Read all about it in the Joint Communiqué section and see the photos both in this publication and more photos on the online edition. Thanks to Gunnar Kraag for his keen observations and comments on the photos.

Next major event in the Rheumatology season will be the CRA annual meeting held for the first time in Kananaskis, Alberta on February 18th to 21st. Remember the annual CRAJ Photo contest continues this year, so be sure to bring your cameras!

From the editorial board members, STA Communications staff, and from the editor: cheery holiday greetings to all of you, Merry Christmas, Happy Chanukah, and all the best for the New Year. I wonder how much better all would be if we resolved, each in our own small way, to try and do something to make the world a better place in the coming year...

Dr. Thomson is the Editor-in-Chief of the Journal of the Canadian Rheumatology Association.
Greetings from the CRA President

My 16 year-old daughter, Bronwyn, asked me the other day where November had gone. Every Fall, it seems that the September through to Christmas period just flies by. So many important events, celebrations, traditions and rituals packed into this last part of the year, all occurring as long, warm summer days so quickly turn dark, short and frigid.

This is a productive time of the year for many of us and certainly the CRA gets back in to high gear after Labour Day. The CRA executive meets monthly via teleconference. At the recent ACR meeting we had our usual productive face-to-face Executive meeting.

Canada Night in San Francisco was again a howling success, held at the beautiful and historic City Club of San Francisco (thank-you again to Christine for putting this together). Plans are coming together very nicely for the annual meeting in Kananaskis in February. Christine Charnock, our Executive Coordinator has taken on much more responsibility this year regarding the organizing and logistics of the meeting. Christine has been preparing to take on these added duties for some time and we are excited to have these tasks handled in-house. Kananaskis is a beautiful, relaxing venue, only about one hour from Calgary. We will have full run of the hosting hotel, all Canadian rheumatology, 24/7, for four days. The hotel is a beautiful facility and outdoor activities abound in Kananaskis Country.

Alf Cividino and his Scientific Committee have again put together another very strong scientific program. World renowned keynote speakers, a host of workshop aimed to educate, and symposia chosen with your needs in mind, add up to a vital and important learning experience. Add over 100 posters, a high spirited debate, and a unique yearly chance to meet and socialize with your colleagues from across the country—this is clearly a meeting you don’t want to miss. We are very pleased that Alf has very kindly agreed to stay on as Scientific Chair for the 2010 meeting—Thank you, Alf!

This year again AHPA will be joining us at the Annual meeting. An AHPA pre-course will take place this year and we are expecting a good turnout of our AHPA colleagues. Thank you to Marlene Thompson, AHPA President for her wonderful work as the CRA and AHPA continue their ever-increasing collaborative interactions.

Speaking of annual meetings, as many of you know, we are planning another combined meeting with the Mexicans in 2011. Michel Zummer is our “Minister of Mexican-Canadian Affairs” and is taking a real lead in putting together this meeting. We are very pleased that Glen Thomson has agreed to be the Scientific Chair for this meeting. We have been meeting with our Mexican colleagues regularly and as it stands now we will likely be having the meeting in Cancun. Final details such as exact venue are still being worked on and should be in place by early to mid next year. We look forward to another successful combined meeting.

Our Website just gets better and better thanks to Andy Thompson, our Website Chair. We have recently signed on with “Advancing In,” a well known leader in web-based education. You will see more web-learning opportunities in the upcoming months. Heather McDonald-Blumer, our Education Chair, has worked very hard at bringing this to fruition and we are most grateful to her for this and all her other Education initiatives.

In addition to his Mexican duties, Michel Zummer is our Access-to-Care Chair. His work with AHPA, ACA (and much more) is invaluable, as is his sage advice on the executive. It’s hard to keep a Past-president down! Another Past-president, Barry Koehler has taken over from Janet Markland as Human Resources Chair and is clearly a fast-learner, getting up to speed on the portfolio quickly and enthusiastically. We thank Janet for her most productive years as Chair. Yet another Past-president, Arthur Bookman has been leading The Journal of Rheumatology Purchase committee—almost a done deal, I think! Art has done a tremendous job in negotiating this purchase. The CRA is extremely grateful.

Vivien Bykerk and Philip Baer are co-chairing the Therapeutics committee. They have been busy working on various therapeutic guidelines while occasionally fielding calls from the press regarding issues to do with rheumatologic treatments.

My fellow officers, Jamie Henderson, Vice-President; Gunnar Kraag, Past-president; and Cory Baillie, Secretary-Treasurer are a pleasure to work with and offer tremendous support to me. I could not do it without them. Finally, there is Christine Charnock, our Executive Coordinator who is truly the heart and soul of the organization. Christine knows everything and is the constant that keeps the CRA ship on course.

In closing, I would like to wish you and your loved ones a peaceful, safe, and relaxing Holiday season. I look forward to seeing many of you in Kananaskis in February.

Have a wonderful Festive Season,

John Thomson,
President, CRA
Another year has come and gone. The CRA board has had an exciting and challenging year and I would like to share with you some of the highlights.

One of the most challenging items has been the purchase of *The Journal of Rheumatology*. At our board meeting in October, we committed to purchase the journal. There was apprehension about the decision given the turmoil on the world's economic scene but the opportunity to make this purchase was felt to be worth the risk. The economic underpinnings of the *Journal* are sound and time tested. Our team of Arthur Bookman, Michel Zummer and Gunnar Kraag will represent us on the *Journal*’s management team and keep us informed of all developments. The scope of the CRA’s activities has truly expanded.

The CRA website under the tireless and skilled leadership of Andy Thomson has undergone a complete facelift. The new look of the website will now allow us to use the website as a platform for exciting new initiatives for CME. In the coming years, we will be able to access taped replays of lectures, symposia and other formats to allow members to stay up-to-date with advances in our rapidly changing world of therapeutic and diagnostic tools. Andy’s skills and vision are paying dividends for the membership. We have also taken steps to have the website pay its own way and no longer require funds from our regular revenue stream.

The CRA has endorsed Canadian Initiative for Outcomes in Rheumatology Care (CIORA). The mission for this group is to improve care for inflammatory arthritis patients in Canada. Grant proposals have been solicited from Canadian rheumatologists in three areas. The first is to aid in early recognition and referral of patients with inflammatory arthritis. The second is to assist in multidisciplinary management of arthritis care. Last, to assist in the assessment and evaluation of prognostic markers of patients with arthritis. The winners of this year’s grants are to be determined by December. Paul Haraoui is to be congratulated for his leadership of this group.

The CRA is also working with ACAP in their endeavors to see that Arthritis gets the full attention of the federal government. Michel Zummer is the CRA representative on this group that is co chaired by Diane Mosher and Gordon Whitehead. They are currently working on a business case for arthritis that will look at the long-term health and economic impact of arthritis in Canada. They will also look at economic benefits of various interventions to make a case to government for funding to reduce the burden of arthritis in Canada. They will examine the long-term health and economic impact of arthritis in Canada. They will then produce a national strategy that sets goals, strategic directions, roles, and resources to reduce the burden of arthritis. Other national disease advocates (cancer, heart, etc) have used similar strategies to secure funding for their organizations and have been successful. The CRA hopes that these endeavors will be as successful as well.

As always, the board is committed to providing a successful and appealing annual meeting. In 2010 we will be changing our venue to Quebec City. Many members have indicated they would like to see a shift from the recent ski venues so we will try an alternative location. This of course will be followed by another joint meeting with the Mexican College in 2011—exciting times ahead...

May the holidays bring you happiness and cheer.

Sincerely,
Jamie Henderson,
Vice-President, CRA
The Canadian-Mexican Resident Exchange

By Nader Khalidi, MD; Azar Bahrami, MD; and Victor Manuel Dimas Pecina, MD

Since the first Canadian-Mexican Rheumatology Congress took place in February 2006 in Acapulco, there has been a particular closeness between the two countries’ rheumatologists. As a result, there has been a wish to further exchange ideas and philosophies through the reciprocal hosting of residents in training. I was approached by Dr. Michel Zummer about the idea, and quickly appreciated the richness of the initiative and offered McMaster University as a place to host the first of these residents. In May 2008, we were pleased to host Dr. Victor Manuel Dimas Pecina. We were honored by his presence and impressed by his gentle, honest manner. He quickly absorbed many of our Canadian ideas and was well received by his Canadian colleagues. He was invited to participate in the Ontario Rheumatology Association while here, and presented a case that he had observed from his Mexican experience—which was informative and thought provoking. The following two sections espouse his experiences and those of one of our residents in training.

– Nader Khalidi

View from Mexico

By Victor Manuel Dimas Pecina, MD
Unidad Regional De Reumatología Y Osteoporosis, S.C.
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The following is a brief history of my rotation through the Rheumatology Service in Hamilton, Ontario, which was endorsed by McMaster University, which has recognized international prestige. During my pleasant and interesting rotation in Hamilton, I had very close contact with the local residents. I had the opportunity to share experiences with them and to discuss similarities and differences between our respective programs, which I believe are very similar with the exception of a few small differences.

From my own perspective, my rotation was enriching, particularly in regards to learning about McMaster’s rheumatology program. It included the opportunity to witness diverse and occasionally different pathologies (related to the large ethnic diversity of the area’s population), and to appreciate the quality and warmth of attention given to patients within this program.

Dr. Nader Amir Khalidi is in charge of the Rheumatology Training Program, with the support of several other rheumatologists. I had the opportunity to work and learn in two hospitals: St Joseph’s is the principal hospital of the service (for inpatient and outpatient consultations) and Hamilton General Hospital provides exclusively outpatient consultation). I also had the opportunity to attend a very interesting clinic which works jointly with the Respiratory Service for the evaluation of patients with rheumatic diseases and pulmonary complaints of potentially difficult diagnosis and treatment. I also attended the Osteoporosis Clinic with Dr. J.D. Adachi, who is a recognized expert on the topic.
Wednesdays in McMaster’s rheumatology program are exclusively academic days, and include a meeting of Rheumatology/Radiology which involves interesting cases chosen by the attached doctors of Rheumatology and active participation of the residents of both subspecialties. During these meetings, the patient histories are presented, followed by the support of the Radiology service which involves review of images from MRI, conventional radiology, and ultrasound investigations. The same day, during the afternoon, all of the internationally invited teachers meet. I had the opportunity to attend four of these meetings; it is important to note the quality of these exhibitors and their respective presentations.

On May 21, I had the good fortune to attend the 19th Annual Residents’ Research Day in Medicine, during which various papers and works are recognized by the different departments or services (including the Rheumatology service). Three abstracts and one oral exhibition from the Rheumatology service were presented.

It was very valuable and productive to attend the 7th Annual Meeting of the Ontario Rheumatology Association. I had the opportunity to participate, and I reported a clinical case of catastrophic antiphospholipid antibodies syndrome secondary to systemic lupus erythematosus. The meeting took place in the beautiful setting of Muskoka.

In summarizing the important aspects of my rotation in Hamilton, aside from the wealth of academic opportunities presented, it is necessary to highlight the amicability of my Canadian hosts, the interesting things about the ethnic variety of Hamilton’s population, the beauty of the area (with its expansive green areas, beautiful lakes and of course Niagara Falls), and McMaster’s impressive campus size and its advanced technology.

I wish to express my deepest gratitude to the Mexican College of Rheumatology (via Dr. Antonio Cabral) and to the Canadian Rheumatology Association (via Dr. Michel Zummer).

In addition, I feel especially grateful to Dr. Carlos Abud Mendoza (Unidad Regional de Reumatología y Osteoporosis, UASLP), Dr. Nader Khalidi (McMaster), Drs. E. Kaminska and T. Scoccia (St. Joseph’s), Dr. R Bobba and Dr. Carter Thorne (ORA) as well as to the residents (and friends) from the Rheumatology service at McMaster (Drs. Azar Bahrami and Mark Matsos), for the unconditional and unrestricted help given to me.

Again, thank you very much for the opportunity. I hope this exchange program continues to be carried out each year, for the sake of the Mexican and Canadian residents alike.

View from Canada:

By Azar Bahrami, MD

This past summer, I had the pleasure of meeting Dr. Victor Dimas, a rheumatology fellow from San Luis Potosi, Mexico. He was spending one month in Hamilton doing a rotation in rheumatology at McMaster University and I was completing my fellowship in rheumatology at that time. The experience was very positive for both of us.

From an educational standpoint, Dr. Dimas was exposed to many interesting patients. He attended vasculitis clinics under the supervision of Dr. Nader Khalidi, who is the program director of rheumatology. We often saw the vasculitis patients together and discussed diagnosis and management. Dr. Dimas also followed patients on the ward at St. Joseph’s Hospital and participated in discussions while reviewing different consults to Rheumatology service. He was very enthusiastic and excited about seeing many patients quite different from those he sees in Mexico. I also learned about the practice of rheumatology in Mexico. Although much of this practice is similar to that in Canada, I was quite surprised to learn that adult rheumatologists see a large number of pediatric patients and are extremely busy due to the shortage.

Dr. Dimas presented a case of antiphospholipid syndrome and lupus nephritis at the Ontario Rheumatology Association meeting. His presentation was very well received by all those who attended, and generated much discussion. He also attended the resident research day for internal medicine and found the posters and research presentations very interesting.

We also had the opportunity to spend time with Dr. Dimas in a social setting. He was very interested in seeing Niagara Falls and was so impressed that he went there twice during his short stay in Canada. In addition to sightseeing, we had a chance to get to know Dr. Dimas. He invited us to visit him and his family as well as the hospital where he works. We hope to do this in the near future.

This exchange program is available to rheumatology fellows at McMaster and in Mexico. Hopefully others will take advantage of this wonderful opportunity.
Discovering Laos PDR: A Country with Children in Need

By Lori Tucker, MD

Drs. Lori Tucker and David Cabral, pediatric rheumatologists from the British Columbia’s Children’s Hospital in Vancouver, recently had the opportunity to visit Laos PDR and meet with two U.S. physicians currently working there to promote medical education of local physicians. These two physicians, Dr. Leila Srour and Dr. Cindy Chu work for a group called Health Frontiers. Dr. Srour, a pediatrician, has been in Laos since 2002 and currently lives in a northern town/region called Muan Sing, Luang Namtha Province. She has assisted in an educational program to train Laotian pediatricians, which was initiated by Dr. Karen Olness in 1996. Pediatrics as a specialty, and pediatricians, were virtually non-existent anywhere in Laos prior to this time. The pediatric training program, sponsored by the Faculty of Medical Sciences of the National University of Laos, depends on volunteer pediatricians from other countries who come for teaching visits for periods from a few weeks to a year, usually traveling at their own expense. This program has been very effective in training Lao pediatricians who now work across the country. Dr. Srour provides educational support to these pediatricians, who are called the Lao Pediatric Teachers. Dr. Cindy Chu is the educational director of a similar internal medicine training program based in Vientianne, the capital of Laos.

About Laos
Laos is a generally poor country, and individuals must pay for medical treatment. For example, a family bringing an ill-child requiring admission to the hospital must pay in advance for the bed, blanket, food, all medications, IV tubing, etc. Even in an emergency situation, if a medication is required, the family must go off to a pharmacy and obtain the required medication in order for the physician to administer it. The most common pediatric problems in Laos are infectious diseases, with the most common causes of death being from malaria, pneumonia and diarrhea. Over half of these deaths are associated with malnutrition; the majority of children in Laos are undernourished. These malnourished children are more susceptible to disease, and then become more malnourished as a result.

The Lao Pediatric Teachers overwhelmingly agree that the problem is not food scarcity; rather, the problem is lack of parental education about how to feed children properly.

Prevalence of Rheumatic Diseases In Laos Children
Although the incidence in Laos of childhood rheumatic diseases such as juvenile arthritis or systemic lupus erythematosus (SLE) is unknown, they are likely to be as common as they are in neighbouring countries of similar ethnic background. However in relative terms, chronic arthritis appeared to be rare in these physicians experience—the more common joint and bone problem is chronic osteomyelitis, often presenting to physicians at a very advanced stage. In the north of Laos, where Dr. Srour lives, she explained that some families take their children to China for medical attention for osteomyelitis where a common treatment for advanced disease is amputation of the affected limb. Unfortunately, such child amputees are then left disabled, living in rural villages with very few services to assist them. The physicians presented us with several puzzling pediatric cases, and in some, SLE seemed a likely diagnosis. Although SLE is seen in Laos, differentiating it from infections may be difficult, especially since there are few serologic tests available and minimal capacity to perform renal biopsies. The doctors were aware that corticosteroids are available in Laos, but were uncertain about the availability of any other standard immunosuppressive drugs; in addition, the bureaucratic process for drugs becoming available in Laos was not known to them.
Rheumatology Abroad

By Graham Reid, MD, FRCSC

Thank you for asking me to comment on my limited rheumatology experiences in other parts of the world. I have had the fortune to travel to Sri Lanka, Ecuador and Tibetan China as a member of a medical team. There is no doubt in my mind that I personally benefited more than the recipients of any medical aid I could offer. The appreciation of just trying to help those with no material wealth is an amazing intangible reward.

As a rheumatologist working in a tertiary care teaching hospital in Canada my practice is not easily convertible to third-world countries. Ongoing chronic rheumatology care as part of team with access to multiple resources and medications was not an option in the places I visited.

Would it have been better if I had just donated money to an organization who could have acquired more regionally appropriate resources? Perhaps, but on a selfish level my experiences have left a lasting impression—The team traveling in the pitch black of night at 17,000 feet on the Tibetan plateau to a Buddhist nunnery had our horses led by happy chanting barefoot nuns. An early morning solitary walk on the idyllic beach at Arugam Bay after the tsunami was interrupted by a traumatized man who needed to talk about his tragic family losses. The young man with Ankylosing Spondylitis up high in the Andes who came in a wheel chair, pushed by his prematurely aged mother, was practically fused from head to toe in a seated position. He thanked me profusely for my caring, even though I was not able to offer any practical help. He had the only dry eyes in the clinic.

I have met inspiring, dedicated individuals who donated enthusiasm, time and compassion unstintingly in often extremely challenging and stressful circumstances.

Maybe there is a way, however, that my acquired rheumatology skills can be made more useful in less developed countries? Perhaps there are existing organizations of which I am unaware that can link rheumatologists like myself who are keen to volunteer as clinicians, educators, advisors or facilitators with small medical schools in other parts of the world? Is there a need for a bank of names of rheumatologists that medical schools or small clinics around the world might access for rheumatologist volunteers?

I would be interested in communicating with other like-minded rheumatologists who likely may have more experience than myself.

Dr. Graham Reid, Clinical Professor
Division of Rheumatology
University of British Columbia
Vancouver, British Columbia
Since 1994 I have been involved with an international development organization called CPAR, which stands for Canadian Physicians for Aid and Relief. CPAR is a non-sectarian NGO doing development work to reduce poverty and improve the health of communities in Africa. It is a small organization, working in some of the most impoverished communities in Ethiopia, Uganda, Malawi and Tanzania. Its approach is through integrated community development, addressing the various needs of a single community, because, in truth, everything is interconnected. The ultimate goal is to improve health, defined globally as the “well-being” of individuals, by addressing the root causes of poor health. For more information about CPAR you can visit their website at www.cpar.ca.

I became involved with CPAR after returning from Ethiopia. Between my internal medicine and rheumatology training, my husband and I decided to work and live in Africa for a while. For a year and a half we lived in Jimma, a small town in Ethiopia, where I practiced internal medicine and taught medical students and interns. It was an amazing experience both personally and professionally! As anyone who has worked in Africa will tell you, you receive a lot more than you give. Upon my return to Canada, I was looking for a way to become involved with development work, as I had realized that curative medicine was helpful and needed in Africa, but development work was what was needed to achieve a real impact.

Providing medical care seemed like just a drop in a bucket—actually, in an ocean. I stumbled upon an information session about the British Columbia Chapter for CPAR. I had witnessed CPAR’s work while in Ethiopia and knew they had a great reputation in the NGO world for doing a lot with little. So I eagerly joined the Chapter. We spent most of our time organizing events to increase awareness about the reality in developing countries and raising funds for CPAR. One thing led to another and, over the years, I took on different roles, leading me to get involved at the level of the Board and eventually to become the Chair of the Board in 2003.

You may ask: WHY? After all, with three kids and a full-on academic career with research and a part time rheumatology practice, it’s not as if I am looking for extra work to fill my time! The answer is simple. First, I derive tremendous personal satisfaction from my involvement with CPAR, it is extremely rewarding. My husband and I often talk about our time in Africa, as definitely one of the highlights of our life. Second, I feel that as a citizen of this world and as someone who was lucky enough to be born in a country where opportunities abound, it is my moral responsibility to help those with the unfortunate geographical fate of being born in other parts of the world where they face so much adversities. I did not do anything more than the woman in Northern Uganda, to deserve the lucky lot I got. Yet she is raising children one her own, as an AIDS or a war widow, with no education, no land and no money. Sure, I worked hard for what I have achieved, but so does she. Sure, the politicians in her country are
partly to blame for the poor fate of the people in her country—well, we won’t talk about the politicians in Canada! In any case, I am getting off on a tangent, as I so often do when someone gets me going on the topic of developing countries… All this to say that we are so lucky here, and that we can all make a difference. Help comes in many forms, but each one of us can do at least a little bit, and a little bit goes a long way in Africa.

Let me end by sharing one last story with you. I had not been back to Africa since our return to Canada in 1994. But just last year, in the spring of 2008, I had the chance to visit CPAR’s projects in Northern Uganda. We visited health centres and hospitals where patients outnumbered available medications, internally displaced persons (IDP) camps (where people sought shelter during the recent civil war that tore apart the North), agricultural projects for the people trying to return to their lands now that the war is over, and landmine survivors that had received small loans to help them gain a livelihood. We also saw income generating projects for women and other vulnerable members of the community, former child soldiers that have been reintegrated into society, and a number youth projects to help promote peace and reconciliation. It was an amazing experience, a reality that is difficult to conceive of, in the comfort of our North American homes. This time, I had the opportunity of sharing this experience with my 12-year-old daughter Katherine, whom I brought along with me. It was great to be back on African soil, and it was beautiful to rediscover it all through her eyes. Katherine decided she didn’t want to just be following her mother along, and thought she should take advantage of this opportunity to do something of her own. So she raised money at her school for school supplies for students in Loro Primary School, in Northern Uganda. She managed to raise $900 in two weeks, bought school supplies in Kampala that, once piled up, stood taller than her. It was enough supplies for 652 children for a year. She then got to hand out the supplies at the school, where she received an incredible welcoming reception with traditional African dances, songs, poems and, of course, the customary speeches. She visited the school, saw the classrooms with mud floors, where children, 86 students per class, sit on the ground until grade four, then share one desk per seven students. There are no blackboards, never mind computers and all the things students take for granted here. Her take-home message from this experience: it is a sad reality they live in Africa, it is not fair, but there is hope and even a child can make a big difference.

All this, to say that we are so lucky here, and that we can all make a difference. Help comes in many forms, but each one of us can do at least a little bit, and a little bit goes a long way in Africa.

Diane Lacaille, MD, MHSc, FRCPC
Associate Professor, Division of Rheumatology, University of British Columbia, Research Scientist, Arthritis Research Centre of Canada,
Vancouver, British Columbia
You are well known both in Canada and internationally for your work in the field of spondyloarthropathies. However, you have also been involved in the development of educational materials—specifically textbooks—for Ukraine. Could you tell us how and when you became involved in this project of translating medical textbooks?

Publishing was very cheap when I first started the development of educational materials in 1992, so it was very easy to organize the translation, printing and publication on just a few thousand dollars. There was a group of physicians from Edmonton who decided that publishing textbooks was a high priority project for the medical community of Ukraine.

Was there a desire after the breakup of the Soviet Union to incorporate more Western information into Ukrainian medicine?

That has grown exponentially in Ukraine—physicians consider themselves, like most of the citizens, as being European and they want to achieve European standards of care in their medical system. Therefore their interest is not just in medicine, but also in technology and the legal system. In all their facets of life, they want to introduce the same standards as Western Europe, so over the years they have become increasingly more anxious to develop partnerships and links with Western countries. In fact, the last time I was in Ukraine (which was this year) they were really anxious to set up more meetings with colleagues in the West so they could really strive to be at the forefront of medical care.

Has the atmosphere for collaborative efforts of this nature changed over time?

Yes, I do think it has changed—I think it has grown. There is much more potential for growth, particularly as the younger generation grow up in an independent Ukraine and see themselves very much as part of the European Union and adopt Western values—as far as society and democracy is concerned. So, yes, they are very keen not only to develop collaborations with Western Europe, but also North America.

How is Ukrainian medicine comparable and different than medicine practiced in Canada?

The primary problem is that Ukrainian medicine is much more directed towards specialty care. They don’t have a very well developed system of primary care and being a primary care physician is not held in high esteem in Ukraine. Therefore most people who enter medical school ultimately want to become a specialist. Even though their economy is not at this time very well developed, the fact that they don’t have a well developed system of primary care means that their healthcare system is in fact a lot more expensive then it should be.

The second problem is that there are still only relatively few people who understand English fluently so communication for them with their Western counterparts is difficult—though that is changing amongst the younger healthcare providers as more are becoming more conversant in English. This change is happening quite rapidly.
What are the current challenges to the delivery of care medicine in the Ukraine?

First off, medical care is expensive because it is based primarily on specialty care. Second, because their economy is underdeveloped, it's difficult for most to afford expensive technology. For example, MRI technology is very hard to come by. So, for the average person in Ukraine, it’s very hard to gain access to expensive diagnostic testing and therapies—although there is a flourishing private medical system where access to all of those technologies is readily available. Third, they have major problems with guaranteeing the quality of the medicines that they distribute. A rigorous system of quality control at the national level is nonexistent. Much of this relates to the lack of a rigorous regulatory framework at the National level. Last, healthcare workers are paid very poorly (around $1000 a month), which, for obvious reasons, doesn't make the medical profession very attractive to prospective students.

Is Rheumatology a well-recognized specialty in the Ukraine?

Rheumatology is an interesting specialty in Ukraine. Rheumatologists have evolved as cardiologists. This goes back to the days when rheumatic fever was very prevalent in Ukraine. This is changing though, as there is more of a focus on Rheumatology as a sub-specialty.

There are many Canadian rheumatologists who have Ukrainian roots. Are you aware of any opportunities to assist our Ukrainian rheumatology colleagues?

What the Ukrainian rheumatologist need as much as possible is to have the opportunity to converse with their counterparts in the West. There are phenomenal opportunities in Ukraine in several areas. The first is in collaboration with Canadian rheumatologist in the area of clinical trials. Ukraine has a huge population that needs therapeutics and they need to adapt better standards of care, as well as implementation of clinical trials to the same level as Canadians. I think there is an opportunity as a community of rheumatologists to work together. There is an opportunity to share in the experience that we have—tremendous educational opportunities. Ukrainian physicians have extensive backgrounds in such areas as biotechnology, genetics and basic science, as well as a strong pool of basic investigators—so I think there are opportunities for collaboration there. I think the real key for them is to have frequent contacts with us. Increasingly, they are holding bilingual (Ukrainian and English) meetings so that communication is becoming easier.

Is there anything else you would like to share?

Well, a little bit of advice if you’re planning on traveling to Ukraine—learn how to toast! When meetings are held in Ukraine they often have banquets (just a lot more of them) and you can bet they’ll ask you to raise your glass to a toast, and you will be invited to give the toast! Of all the countries I have been to around the world, nobody comes even close to giving more elaborate toasts than Ukrainian hosts do, so you really have to practice your your “toast master abilities.”

So would you consider yourself a “Master at toasting” then by now?

Well, I certainly have more expertise now as well as a stronger liver!

Walter Maksymowych is a Scientist at the Alberta Heritage Foundation for Medical Research, Consultant Rheumatologist and Professor of Medicine at the University of Alberta in Edmonton, Alberta.
In 2005, I accepted a position with the relief organization called Medecins Sans Frontieres (MSF) (Doctors Without Borders) and spent six months in Indonesia. Here, MSF, along with many other non-governmental organizations (NGOs), were helping in the aftermath of the earthquake and subsequent tsunami tidal wave. Over a 100 thousand people in the Aceh province had been killed instantly, with many more left homeless. Moreover, this catastrophic event occurred on a background of years of psychological and social stresses, due to conflict arising from a guerilla movement to free Aceh from Indonesia.

I arrived in Lhokseumawe, a city on the northeastern coast, about 10 weeks after the disaster. MSF had (along with other NGOs) been tending to the needs of the thousands of individuals still residing in camps or barracks (set up by NGOs and the Indonesian government). This primarily meant ensuring adequate access to clean water and sanitation, to prevent epidemics due to cholera and other organisms that can spread like wildfire through the camps of displaced persons. My main role, initially, was to act as a liaison with the local health authorities (Indonesia has a well-developed health system in many respects, although like anywhere, the system has deficiencies).

Besides water and sanitation, MSF’s main intervention in Aceh was to assist communities with the psychological aftermath of the tsunami. This program was run by psychologists, although I did help analyze a survey of psychological morbidity among tsunami-affected individuals, which demonstrated the persistent depression and distress that affected survivors, many months after the catastrophic event.\(^1\)

In the second month of my stay, after some brief on-site training, I was sent with members of the local health teams and MSF, to venture out to villages where there were suspected outbreaks of malaria. With the use of a simple diagnostic assay that uses a single drop of blood, we were able to identify Plasmodium falciparum malarial infections on the spot, and provide a course of treatment.

During my time in Aceh, interesting political events were developing (which eventually resulted in the signing of a peace treaty between the Aceh rebels and the Indonesian government). These events lead to better security in remote regions, which had previously been inaccessible to NGOs. Thus, in the last two months of my stay, we traveled by Land Rover to some of these areas, to assist with needs assessments in various communities. During this time, we encountered an entire village that had been displaced by earlier conflict between Aceh rebels and government forces.
We were able to provide some basic supplies (food, household goods, medical supplies, etc).

The entire experience impressed upon me that any physician (even a rheumatologist) can be of some use in an overseas project. I urge any of you reading this, who may be nurturing an interest in this type of work, to investigate organizations like MSF (www.msf.ca), World Vision (www.worldvision.ca), Mercy Ships (www.mercyships.ca), and many other agencies that provide a variety of opportunities to serve. You'll never regret it.

Reference:

Sasha Bernatsky, MD, FRCPC, PhD
Rheumatologist, Assistant Professor
Divisions of Rheumatology and Clinical Epidemiology,
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Montreal, Quebec

MSF school kids in their makeshift school “cafeteria.” These kids participated in some of the programs that MSF psychologists ran to help children recover from the trauma of losing homes and loved ones.

Henry Sims
1913 - 2008

Henry Sims passed away in Ottawa on November 21, 2008 in his 95th year. Henry was the first specialist to care for patients with arthritis in Ottawa. He was told that this was unwise, even foolish, because arthritis was a boring disease for which nothing could be done. Moreover, these patients were often disabled and would be unable to pay his fees. Fees were never an issue for Henry and along with his colleague, Harold Fireman who laid the groundwork for the Rheumatic Disease Unit at the University of Ottawa. He was made an honorary life member of the Arthritis Society for outstanding voluntary service both locally and provincially. He was a member of the teaching staff at the University of Ottawa and a consultant at the Ottawa Civic Hospital and recognized by the Academy of Medicine of Ottawa for 50 years of distinguished service to the profession and the community.

There was never any question that caring for patients was Henry's passion and priority and he was a caring and wise physician throughout a very distinguished career that included service as a physician in the RCAF during WWII. He was an emeritus member of the CRA at the time of his death.

The one thing that everyone said about Henry was that he had “class.” In fact, he exuded it and did everything with utmost dignity, while maintaining a fabulous and wry sense of humour.

As a clinician, teacher, volunteer, role model, and mentor, he received admiration and respect. As a human being, he was cherished and loved and will not be forgotten.

Gunnar Kraag
Growing up, my second choice career behind medicine would have been something to do with mathematics. Anything to do with sales seemed extremely unattractive—all that effort going into convincing someone else to buy something from you, with a high probability that the effort was wasted. The thought of making “cold calls” to prospective purchasers evoked all the negative emotions associated with telemarketers today.

After 20 years in practice, “selling” perhaps seemed less unseemly. After all, every patient encounter involves some degree of convincing that patient to accept the proffered diagnosis, and adhere to the prescribed therapies, monitoring and follow-up. That must have been my mindset in February 2005 when I saw an ad in Ontario Medical Review for the first Ontario Medical Association (OMA) sponsored CME cruise, scheduled for the Mediterranean in September 2005 in conjunction with Seacourses. I fired off an unsolicited email to the organizer at the OMA, offering my services and those of my wife Erica as lecturers on a future CME cruise.

I wasn’t really expecting anything. I had indicated we wanted to be considered for cruises down the road, when our children were older. One week later, I had a phone call back—could we provide 10 hours of lectures on the September cruise? I negotiated a week to decide. My secretary, an ex-travel agent, said it was the chance of a lifetime. The boys said “Go for it. What can go wrong?” (Plenty, when you’re leaving two fifteen-year-olds alone for close to two weeks). Erica was excited, but somewhat worried.

In the end we said yes—that was the easy part. Then we had to produce 10 hours of presentations for 50 doctors of varying specialties from across Canada, with a sprinkling from the U.S. and Australia. Erica created three talks on her special area of interest (pain management), and I developed seven talks on rheumatology topics. The lectures have to be entertaining and informative, as all the sessions are accredited. The kind of slides people put up at conferences where they apologize for cramming 25 lines of text into a slide are not welcome.

September 2005 arrived quickly. We left the boys with my mother, flew to Barcelona, and arrived two hours before sailing to board Royal Caribbean’s Brilliance of the Seas. The next morning, we were underway and it was time to lecture, despite jetlag and a little bit of queasiness as we got our “sealegs.” All of the CME takes place at sea, so there is no interference with port time. We found the participants keen, with excellent attendance and lots of questions. Our other faculty member was an internist/cardiologist who had done this before and was very helpful. When we weren’t lecturing, we were just ordinary passengers enjoying our floating hotel and the various ports in France, Spain, Italy, Greece and Turkey.

What are the business aspects of CME at sea? Faculty pay for the cruise like everyone else, but we don’t pay the course tuition fee. We are paid a fee per hour of lecturing,
based in part on the number of attendees. Usually, this will cover the cruise costs and sometimes airfare as well. So it’s a breakeven proposition financially, or, as we look at it, a free vacation with a little work thrown in. Most of the actual work is the preparation time before the actual cruise. You have to like cruising of course!

Our first experience was terrific. We returned home and awaited the course evaluations, which were fairly positive. We didn’t know if any future opportunities would present themselves, but in April 2006, we had a phone call from Martin Gerritsen, the doctor who runs Seacourses, offering us a cruise in French Polynesia in October 2007. This time, we were to be the only faculty with about 100 participants on a small luxury ship, the Paul Gauguin, carrying only 330 passengers. Twelve hours of lectures in a week! No children to worry about—they would be away at university by then, so it was a no-brainer to accept. Three hours on pain management, and nine hours of rheumatology would fill the time, including some interactive Photo Quizzes and Rheumatology-Pain Jeopardy! Again, preparation was the key, especially knowing we would be even more jet lagged after the 12 hours of flying between Toronto and Tahiti. You also appreciate how much things change in your field in just a couple of years: we started with our 2005 talks and quickly realized that they were out of date given all the new therapies, guidelines and studies that had materialized. Our skills at Powerpoint also improved greatly of necessity.

While we were preparing for Tahiti, Seacourses gambled and invited us on a third cruise for October 2008 to the Black Sea and Middle East. Ten hours out of a total of 25 this time, over two weeks, reunited with the British Columbia internist who had guided us on our first CME cruise. Added pressure: the owners of Seacourses would be on board hosting our group of 110 physicians. Only a year between cruises this time—surely our material wouldn’t outdate that fast. We accepted, and told the boys that for a second straight year, there would be no one home at Thanksgiving.

Tahiti was spectacular. We had two Canadian rheumatologists in our audience, and they were very tolerant, though I’m sure they knew all of the material we presented as well as we did. As I write this, we are on our Black Sea adventure, docked for two days in Istanbul with a spectacular view of the Bosphorus, dividing Europe from Asia. Preparations were intense, as the CME format changed yet again to meet accreditation standards. Once on board, though, it really does feel like a holiday. If you like cruising and talking, I highly recommend international CME on the Seven Seas. It sure is a nice break from a 40 hour week of seeing patients in the office, and the view out the windows is a lot more scenic.

Dr. Philip Baer, MD, FRCPC, FACR
Rheumatologist,
Co-Chair, Therapeutics Committee,
Canadian Rheumatology Association (CRA)
Vice-President, Ontario Rheumatology Association (ORA)
Chair, OMA Section of Rheumatology
Toronto, Ontario
The CRA at the ACR: 2008 Update

The CRA held a very successful Canadian night at the city club of San Francisco on Monday, October 27th, 2008. President John Thomson addressed the enthusiastic throng. Alf Cividino presented the outline of the upcoming Canadian meeting at Kananaskis. A draw was held for those CRA members who responded to the 2008 Needs Assessment. Limited edition CRA briefcases were awarded to Dr. Daniela Ardelean and Dr. Desiree Tulloch-Reid of Toronto and to Dr. David Cabral of Vancouver.

The $250.00 Future Shop gift certificate was presented to Dr. Sai Yan Yuen of Montreal. The Grand Prize of a free hotel and meeting registration plus limousine transportation for the Canadian meeting was graciously accepted by Dr. Andre Chow from Toronto.

A superb ambience of the meeting was ideal to catch up with colleagues from coast-to-coast. Many thanks to Christine Charnock for arranging this great evening.

The CRA executive conducted a board meeting while in San Francisco. The major item of business was the motion to purchase The Journal of Rheumatology. After a serious assessment of the current changes in the business climate, the majority of the board members voted in favor of the current purchase arrangement. Arthur Bookman, Michel Zummer and Gunnar Kraag will be the appointed stewards to oversee the CRA’s interest in The Journal of Rheumatology. Plans are proceeding for the 2011 joint CRA/Mexican College of Rheumatology Congress in Mexico. Michel Zummer is heading up the arrangements committee to insure another successful Southern meeting.

Two CRA members were elected as Masters of the American College of Rheumatology. Congratulations are in order for Dr. Tony Russell from the University of Alberta and Dr. Edward Keystone from the University of Toronto.

Congratulations as well to Dr. Sherine Gabriel who was elected as the president of the American College of Rheumatology. As many of our readers know, Dr. Gabriel completed her undergraduate degree at the University of Saskatchewan and her internship in Winnipeg. After her postgraduate training at Mayo Clinic she studied epidemiology at McMaster University and the University of Toronto.

Glen Thomson
Some time ago, my perspective of the Royal College of Physicians and Surgeons of Canada (RCPSC, the College or Royal College in this article) was limited to it setting the barrier to jump over at the end of my rheumatology training, but more recently, I saw it as the gate keeper for Maintenance of Certification (MOC) credits. However, given my recent involvement with the College, I have a new perspective and understanding of its role in the world of rheumatology.

The Royal College, which was established in 1929 by a special Act of Parliament, oversees the medical education of specialists in Canada. In this capacity, the College plays a central role in the accreditation (at the individual and national level) of specialists, and relevant to us, rheumatologists, wishing to practice in Canada.

Under the jurisdiction of the Education Committee and its sub-committees, the Specialty Committee for Rheumatology is responsible for compiling the documents which detail what the competent rheumatologist should know in order to practice within Canada. (The membership of the Specialty Committee includes the voting members [five rheumatologist who represent five geographic regions of Canada], plus the Chair and a Vice-Chair of the committee and the Program Directors of the rheumatology training programs, the latter being non-voting members.) The documents they prepare change over time to reflect new scientific knowledge and the changing social context within which we practice. Our current iteration of these are embedded within the CanMEDS framework. It is these standards upon which our recent graduates are evaluated when they sit at their Royal College examinations at the completion of training. The Examination Board, under the auspices of the Specialty Committee and the larger Education Committee, sets and administers the annual examination, which currently is held in the fall of each year.

In order for the Royal College to ensure that specialty medical education is able to meet the appropriate standards, the RCPSC has an accreditation process for all medical and surgical specialty training programs. As such, each of the 15 adult rheumatology programs in Canada as well as the three pediatric programs, undergo a six-year cycle of internal and external audits. This helps ensure that each program meets current standards as outlined by the Accreditation Committee of the College and the Specialty Committee in Rheumatology.

How does all of this apply to us in our day to day practice? We all (knowingly or unknowingly) set the standard of practice in rheumatology by virtue of the way we engage in clinical care, research and education. Collectively, we set the bar higher over time. It is this standard that the College reflects back to us, to our patients and to some extent, the world.

Heather McDonald Blumer, MD, MSc, FRCPC
Program Director, Rheumatology
University of Toronto
Toronto, Ontario
SLE: A Pre-pregnancy Consultation

By Carl Laskin, 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: mandiw@sta.ca.

Case History:
Ms. SE is a 30 year old G1P0 lady with a history of lupus. Her arthritis and dermatitis have been successfully controlled with hydroxychloroquine since her diagnosis three years ago. She is asymptomatic. She wants to get pregnant. She had an early first trimester miscarriage 10 years ago. Her labs reveal only antinuclear antibody (ANA) 1:80, normal complement levels, and a borderline elevation of IgM anticyclic lipoprotein antibody (venereal disease research test [VDRL], partial thromboplastin time [PTT], and lupus anticoagulant test are all within normal). She wants to know if she should discontinue the hydroxychloroquine before attempting conception and whether this would increase her risks of another miscarriage?

Response:
Ms. SE has been referred to you for a pre-pregnancy consultation. Such an assessment is ideal since this can be approached electively with no urgency in management. After the history and physical exam, a laboratory evaluation should be undertaken. Baseline biochemistry including renal status and relevant serology should be completed. The anti-extractable nuclear antigens (ENA) has not been provided so this should be completed before you render a final opinion. Recent studies suggest that weakly positive anti-Ro/La antibodies may not require antenatal fetal echocardiographic monitoring owing to a lack of association with congenital heart block or neonatal lupus erythematosus (NLE). However moderate to strongly positive have the association necessitating such monitoring during the pregnancy. Before dealing with the remainder of the lab, let us turn our attention to the clinical scenario.

Clinical Setting
SE has minor organ disease that is well controlled. She has not had a flare of her disease for the past three years. As such, she has a good prognosis with respect to a future pregnancy. In general, those patients under excellent control for at least six months prior to conception fall into the best prognostic groups.

Medications
Hydroxychloroquine has an excellent track record with respect to fetal toxicity. Studies published since 1985 indicate that there is no risk of anomalies to the fetus when the drug is used throughout pregnancy. Indeed, there is a greater risk of disease exacerbation upon discontinuation of the drug than any risk of fetal anomaly. In those situations where hydroxychloroquine is discontinued at the time of pregnancy diagnosis, both patient and physician must realize that owing to the long half-life of the drug, the fetus will continue to be exposed for the next six to 12 weeks or the entire first trimester. Therefore, the patient should be advised of the low risk to the fetus and the higher risk to the mother with exacerbation of disease, should the drug be discontinued. However, if in the opinion of the physician the drug can be withdrawn due to the patient’s clinical condition, i.e., prolonged remission, and such advice would be given regardless of pregnancy, then consideration can be given under these circumstances to discontinuation.

Lab Parameters
The last point to assess would be the lab parameters. I have already commented on the implications of anti-Ro/La positivity. The only other issue with respect to SE is the weakly positive IgM anti-cardiolipin antibody (M-aCL). As indicated in most studies, the IgG isotype of aCL has a
much greater association with thromboembolism and adverse pregnancy outcome. The IgM appears to be of far less concern. Moreover, weak positive levels of either isotype are of questionable clinical significance. I would only have a concern with levels strongly positive—at least at 40 units. The one early pregnancy loss had by SE is unlikely to be associated with her lupus nor the M-aCL. I would not recommend any intervention. Of note, there is some suggestion that hydroxychloroquine may actually be protective against the effects of aCL, so this may now represent another reason to maintain this agent during pregnancy.

To be complete, you should address the postpartum situation. SE has a low probability of flare postpartum. In addition, should she wish to nurse her baby, hydroxychloroquine is compatible with breast feeding according to the American Academy of Pediatrics.

Carl Laskin is an Associate Professor, Department of Medicine (Rheumatology), Obstetrics & Gynecology and Immunology, at the University of Toronto and a Medical Director at the LifeQuest Centre for Reproductive Medicine, in Toronto, Ontario.
Your opinion matters and it would appear that it is mattering more and more over time. Physicians are surveyed by their professional organizations, healthcare researchers and industry, with an alarming frequency. Two thirds of respondents to this survey reported at least five requests per month with 20% getting more than 10 requests in the same month. Telephone, facsimile, letter and e-mail questionnaires leave no place to hide.

The respondents express less interest in responding to industry surveys—unless remunerated. There is a more generous attitude towards research questionnaires from peers and from physicians’ organizations—providing that the inquiry is not lengthy. There is a consensus that there are too many surveys—so you won’t be getting another one from the CRAJ for three months!

Glen Thomson, MD, FRCPC
Past President, Canadian Rheumatology Association
Rheumatologist
Winnipeg, Manitoba

1. On average, how many requests to complete medical surveys (email, fax, or letter) do you receive each month?

<table>
<thead>
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<th>Number of Requests</th>
<th>Response percent</th>
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<tbody>
<tr>
<td>0 - 1</td>
<td>7.8%</td>
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<tr>
<td>2 - 4</td>
<td>25.9%</td>
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<tr>
<td>5 - 10</td>
<td>44.8%</td>
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<td>10 +</td>
<td>21.6%</td>
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2. Please respond to the following statements

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<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</thead>
<tbody>
<tr>
<td>I will fill out medical surveys if they are requested by a pharmaceutical company</td>
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<td>8.9%</td>
<td>25.0%</td>
<td>33.0%</td>
<td>33.0%</td>
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<tr>
<td>I will fill out medical surveys if they are requested by a pharmaceutical company only if I am remunerated for my time</td>
<td>13.5%</td>
<td>29.7%</td>
<td>17.1%</td>
<td>17.1%</td>
<td>22.5%</td>
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<tr>
<td>I will fill out medical surveys if they are requested by colleagues as part of peer reviewed research</td>
<td>32.1%</td>
<td>57.1%</td>
<td>8.9%</td>
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</tbody>
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Congratulations to this issue’s Joint Count survey winner Dr. Dafna Gladman from Toronto, Ontario!
The 2008 ACR Meeting in San Francisco

Chief Caption Writer: Dr. Gunnar Kraag

“If I approached you Christine as Secretary General with a coalition of Michel and Arthur, can I become CRA President again?”

Question: Has anyone seen our president socialize with male CRA members?

CRA divas waiting to be photographed with the President

Members of Travel Mexico, a wholly owned subsidiary of the CRAJ

Hugh trying to convince the group that Fibromyalgia exists and that the Leafs really have won the Stanley Cup!

Ladies Man!

How did I end up in this group? All of the other women seem to have interesting guys to talk to.

Check out the complete set of pictures from the 2008 ACR online! You can find us at: www.stacom munications.com/craj.html or click onto the CRAJ logo on the CRA Website

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