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Canadian Rheumatology Abroad

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And the Gold Medal Goes To ….

By Glen Thomson, MD, FRCPC

Spring is welcomed by all who survive a Canadian winter. However, this year’s distractions seemed to make the season more pleasant. In addition to Dr. Alf Cividino’s (Chair of the Scientific Committee) record setting Canadian Rheumatology Association (CRA) Annual Meeting in Quebec City, there was another important event: the 2010 Vancouver Winter Olympics. Dr. Jackie Stewart from Penticton, B.C. is featured on the cover as she carries the torch in Lillooet, B.C. However, the gold medal for endurance should be awarded to the people of Vancouver, as reported by Drs. Jason Kur and John Kelsall.

Just as the people of B.C. welcomed the world (and with Dr. John Esdaile’s help will welcome it again for Lupus Congress 2010 in June), Canadians do seem to thrive on interacting globally. The major theme for this issue, “Canadian Rheumatology Abroad” tells the stories of CRA members taking their skills and sharing their expertise internationally. Dr. Desirée Tulloch-Reid, who trained at the University of Toronto, returned to Jamaica and was just the second rheumatologist on her arrival home. The “three amigos” (Drs. Barry Koehler, Ian Tsang and Simon Huang) travelled to China and Dr. Paul Davis journeyed to East Africa, each imparting their knowledge at their respective destinations.

The Joint Count in this issue suggests that CRA members want the opportunity for more international interactions. The joint CRA/Mexican College of Rheumatology (MCR) Congress, taking place from February 10 to 15, 2011, in Cancun, Mexico, will help to fulfill that need. Dr. John Thomson has been our fearless leader in making this latest CRA/MCR event a reality. Unfortunately, the recent meeting in Quebec marks the end of Dr. Thomson’s steady hand at the tiller. He has piloted the CRA smoothly through some uncharted waters with the acquisition of The Journal of Rheumatology. Despite the major worldwide financial maelstrom, the CRA has emerged with a solid fiscal balance. Dr. Jamie Henderson, the new CRA president, and Vice President Dr. Carter Thorne begin their term with finances and operations running smoothly.

The CRA says farewell to another hero, Mike Puttick, who courageously battled cancer for many years. Mike was seen frequently at the CRA annual meetings before and after diagnosis. He contributed to a number of meetings including a memorable dissertation at the National Journal Club where he had the audacity to state the truth debunking the hype of a then popular therapy which lacked valid evidence. The shock waves reverberated for years; Mike will be surely missed.

Congratulations to the distinguished CRA award recipients who “owned the podium” at the national awards dinner—their interviews are in the Northern Highlights section. The distinguished investigator Dr. Earl Silverman will be featured in an interview in the upcoming issue. The photo contest winning entries adorn the back page. Many thanks to the other photographers whose efforts deserve more than silvers and bronzes, but our heartfelt appreciation must suffice.

Participation in the Journal of the Canadian Rheumatology Association (CRAJ) is always encouraged. If you have some extreme summer vacation plans let us know for our next issue’s theme “Rheumatholiday.” However, if you are too busy to get away, tell us your best office disaster story for the autumn edition. We don’t have medals, but a CRAJ backpack is no less coveted. Finally, thanks to all those who made this issue and all the CRA activities golden.

Glen Thomson, MD, FRCPC
Editor, CRAJ
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What to do while whiling away a hot summer in Vancouver? Well, what better thing than to go somewhere hotter! Dr. Ian Tsang and his wife Kim, Dr. Simon Huang and his wife Betty, and myself and my wife Mary junketed off to southern China the first two weeks of August to the cities of Hong Kong and Guangzhou, and the Hunan Province. Even though we sweltered in 30 plus degree weather, the folks we met and the outstanding scenery made it all worthwhile.

We did notice, however, that during the course of our trip, things were not always as they seemed. In Guangzhou, Dr. Tsang eagerly anticipated our visit to the Writers’ Park expecting to see exquisite calligraphy, and to see if it matched up to his own. Alas, while there were many interesting exhibits, only one was devoted to calligraphy.

There were no disappointments in Hunan Province, however. The classical mountain scenery at Zhang Jia Jie was breathtaking, and the group can proudly say that we sampled egg fu yung in Fu Yung county itself! The views from our room in Phoenix City (Fenghuang or Phoenix Old City) was outstanding as we looked out over the Tuojiang River. In the traditional inn, we also had our first experience of trudging down to the lobby to buy our towels which didn’t come with the room. The re-enactments of daily life from a few centuries ago in the preserved old commercial city of Hongjiang in the exact premises where they had originally occurred, were also very interesting.

Ever the adventurer, Dr. Tsang availed himself of a little medical shopping in Hunan Province. Having a sore neck, he was kindly treated at the Traditional Chinese Medicine (TCM) hospital with some manipulation and acupuncture. The latter was rather tranquil. The former, however, as witnessed by Dr. Huang and myself, was a cacophony of vigorous tugs, loud grunts and noticeable cracking. Dr. Tsang survived; the two witnesses vowed to continue to distance themselves from this type of “hands on” treatment. The acupuncture did help his neck pain immediately, at least according to the patient.

Our venture east, however, was not simply a trip of indulgences. Drs. Tsang and Huang met with their contacts at the Guangdong Provincial Hospital for Traditional Chinese Medicine (TCM) and the Zhongshan Medical School at Sun Yat-Sen University, a century old western medical school.

During this time, several meetings addressed the possibility of creating a study to evaluate TCM techniques in rheumatologic conditions. The study design would take into account the reality of the syndrome-type approach to illness that is the nature of TCM, and would allow traditional TCM methods to be used with no modification, but evaluated with standardized outcome measures. However, when touring the new TCM hospital in Guangzhou and seeing the increased use of western methods, including laboratory tests, x-rays, computed tomography (CTs) and magnetic resonance imaging (MRI), one can see that true TCM may disappear or be so diluted that there may soon be no opportunity to evaluate whether there are unrealized therapeutic benefits in this old medical tradition.

Drs. Huang, Tsang and I returned to China in early November at the kind invitation of Professor Wu...
Zhongdao, Associate Dean at the Zhongshan Medical School to give a course on lecture techniques for faculty members. It was an intensive week of teaching, with Dr. Huang acting as the point man in view of his extensive background in teaching techniques and practical teaching. The participants gave a 10-minute presentation (topic of their choice) in English, and this was then critiqued by the visiting professors and, as the week went on, by their colleagues who had already run the gauntlet. Dr. Huang’s mantra of “tell them what you’re going to tell them, tell them, and then tell them what you’ve told them” was repeated over and over. Dr. Tsang helped the participants learn to deal with questions in a more innovative fashion. I had the easy job of critiquing their English.

On this second trip, we also had the opportunity of meeting with some of the rheumatologists at the First and Third Affiliated Hospitals. They were a small but enthusiastic group, with some interesting research being carried out in the areas of spondyloarthropathies and lupus. You can appreciate their work load when a recent paper reported the ratio of rheumatologists:patients in China is 1:1,000,000. As a result of these discussions, a pilot project of teaching clinical rheumatology to small groups of senior medical students is going to begin in July of this year.

We eagerly look forward to this teaching opportunity, although we view with trepidation the high temperatures and humidity of that time of year.

Barry Koehler, MD, FRCPC
Clinical Professor Emeritus,
Department of Medicine,
University of British Columbia
Richmond, British Columbia

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**The Good, the Bad and the Downright Silly**

Of course you have a respected practice. But that doesn’t mean it’s devoid of light-hearted, hot-headed, heavy-handed or downright silly phenomena, right? Come along and share your stories with your colleagues, whether they’re about the landlord, the neighbors, patients, colleagues or staff.

Capture our interest and we’ll feature your story in a future issue of the CRAJ. Send your entries to Katherine Ellis at katherinee@sta.ca for a chance to be featured. Please indicate if you wish to remain anonymous.
In Jamaica’s 2008 national health survey, it was reported that five percent of adults between the ages of 15 and 75 years had self-reported arthritis, but that based on the total population of 2.7 million, there may be upwards of 50,000 people with significant rheumatic diseases that require treatment. Dr. Desirée Tulloch-Reid, who has been practising on the island since May 2009 after completing her rheumatology training in Toronto, is one of three rheumatologists in Jamaica. She states that even though it is impossible to treat the entire population with direct patient care to the patients who need it, things are never boring!

Dr. Desirée Tulloch-Reid grew up in Kingston, Jamaica, “the capital city of a very special island in the Northern Caribbean.” She stated that her eventual choice to become a rheumatologist was a gradual process, peppered with chance encounters with Canadian rheumatologists, family members affected by rheumatic diseases and a pronounced interest in lupus. “[When I was training to become a doctor] we were naturally exposed to rheumatic diseases a lot, primarily lupus, on the medical wards, but I probably did not grasp then that these conditions were occurring with particularly high frequency and severity in our population. In fact, by the time I graduated I had little concept of rheumatology as a specialty—we had only one rheumatologist on the island [at the time], and I had never actually met him,” she said. After her internship, Dr. Tulloch-Reid pursued training in primary care, but feeling ill-equipped to manage well the growing burden of chronic diseases in the Jamaican population, she pursued her residency training in the U.S. There, preventative medicine is the core of internal medicine, she said.

Traveling Abroad
It was at the University of West Penn that she was exposed to rheumatology as a specialty. “The chief of medicine and several faculty members were rheumatologists, and I had a chance to work with them in the academic setting and in the community. In the U.S., arthritis is the number one cause of disability in the population and is taken quite seriously. It struck me then how undeserved we were in Jamaica,” she said. “It was lupus that moved me the most,” she continued. “[It is] a condition that severely affects young women, even more so within the Afro-Caribbean population. [It was then] I made up my mind to [become a rheumatologist].”

Presently, Jamaican English-speaking doctors must typically pursue a formal fellowship in rheumatology abroad. For four years, Dr. Tulloch-Reid pursued her training at the University of Toronto. “Among the [rheumatology] programs, Toronto’s was the largest and seemed to offer the most diverse experience in terms of population and faculty,” she said. “Canadian training has a tremendous reputation for excellence and is highly regarded in Jamaica and the Caribbean. In the field of rheumatology especially, Canada looms worldwide, and so it was an easy choice.”

On the Island
Even though Dr. Tulloch-Reid says it is great to be home and to make a difference in her community, learning to practice rheumatology in Toronto and returning home to Jamaica did present a few obstacles. Both settings are quite different, from the terms of disease patterns, to the available resources, to the interactions and expectations between the physicians and their patients. Though the setting can sometimes be challenging, Dr. Tulloch-Reid said that she is learning much from her colleagues. “One of the things I am learning from my colleagues and my patients is how diagnosis and management of rheumatic
diseases differ in tropical settings where populations, disease patterns and available resources differ from those in North America,” she said. “For example, there is a fairly high prevalence of sickle cell disease and certain infections, such as HIV, HTLV-1 and tuberculosis, are endemic, and [therefore] feature more prominently in the differential diagnosis or may complicate the diagnosis or treatment. One is obliged to adapt one’s approach to this.” However, Dr. Tulloch-Reid did state that generations of clinicians and researchers in Jamaica have contributed tremendously to the knowledge pool, especially Dr. Karel DeCeulaer, whom she says is an invaluable source of information. Dr. DeCeulaer has been practising rheumatology (mostly solo) on the island for more than 30 years.

“One must also learn how to manage patients safely and effectively in a resource-limited situation,” she said. “Obviously one has to be prepared to make full use of clinical/bedside skills, be selective in use of investigations, and at times, flexible with treatments. This is something the growing rheumatology community in the developing world may have a lot to teach each other—and possibly the world in general—as healthcare costs continue to escalate in North America and Europe.” She also states that adapting to culturally accepted and effective forms of learning is very important, as the language of health and illness may be different, as well as the concepts of body and health when communicating with the patients and/or the community about their conditions and treatment/therapy options.

Even though the climate and resources are different, Dr. Tulloch-Reid said she does not have any training gaps. “I had the chance to work with experts in almost every branch of rheumatology, and that was invaluable. I am glad I had the chance to work with excellent pediatric rheumatologists at the Hospital for Sick Children [in Toronto] as I am called upon to see children here from time to time. But some further adaptation and learning when you leave the training environment is inevitable,” she said.

Kingston Public Hospital
Dr. Tulloch-Reid spends most of her time at the Kingston Public Hospital, a 200 year-old public institution and the largest tertiary referral centre in the English-speaking Caribbean. More than 100 new patients have been enrolled since she began working there five months ago. Most of these new patients are previously undiagnosed and treatment naive, leading to hectic days in the clinic. She also has a private rheumatology office that is open two afternoons a week and has approximately 200 patients under her care. However, she does state that the conditions of her patients at the hospital tend to be more severe. When not practicing rheumatology, Dr. Tulloch-Reid states she takes time to teach medical students and residents, as well as do presentations for general practitioners and community groups in an effort to raise awareness of rheumatology and rheumatic diseases in her community. “Another challenge is to make time for essential research that can have a wider impact on resource allocation and development in patient care,” she said.

All of the three Jamaican rheumatologists Dr. Tulloch-Reid, the previously mentioned Dr. DeCeulaer, and Dr. Keisha Maloney are based in Kingston, located on the eastern part of the island. But, her two colleagues each take the time to travel to Montego Bay once a month, the main city on the west coast. Still, with only three rheumatologists on the island, Dr. Tulloch-Reid said they are well below the World Health Organization’s standards which state they need at least 30 rheumatologists to properly treat the Jamaican population. Though she is not aware of any open recruitment efforts, Dr. Tulloch-Reid said she is hopeful that with more exposure to the specialty, more medical trainees will take interest in the field.

Even though there are many people to treat, the days are hard and the hours long, Dr. Tulloch-Reid states that, if someone were thinking about becoming a rheumatologist, they should go for it. “The field is rapidly expanding, science and treatments are advancing, and it has never been as exciting to be in rheumatology as it is now,” she said. “This specialty draws heavily on internal medicine and definitely keeps you on your toes. And more than anything else, you will be making a real difference in the lives of your patients.”

Desirée Tulloch-Reid, MBBS, FACR
Consultant Rheumatologist.
Kingston Public Hospital
Kingston, Jamaica
"Certainly, travel is more than the seeing of sights; it is a change that goes on, deep and permanent, in the ideas of living."—Miriam Beard, author, 1876-1958

On his last trip to Kenya in 2009, the fifth in the last five years, Dr. Davis said he had the chance to witness the Great Migration. “That is when hundreds of thousands of animals, mainly wildebeest and zebra, run an annual migration. They have to cross the Mara River for feeding purposes, but the river is full of crocodiles. I saw at least 10 or 11 crocodile kills on this trip. It was just like something you see out of National Geographic,” he said.

However, Dr. Davis’ trips, which range from two to three weeks, is not simply dedicated to traveling on safaris. Dr. Davis lends his rheumatologic and professorial expertise by volunteering at the University of Nairobi. On his latest trip, he was the external medical examiner for the university’s medical students and residents. Dr. Davis stated being an examiner was quite the experience as students and residents are presented with cases common to the sub-sahara, but rarely seen in Canada. “They have a lot of problems, particularly with tropical infectious diseases, HIV, tuberculosis and many different types of meningitis. A lot of Canadian physicians would see maybe one or two cases [of these diseases] in their professional lifetime,” he said. Dr. Davis also stated that in a country, such as Kenya, where resources are limited, treating and/or managing these diseases have often proved to be challenging for the medical professionals. “We have so many resources compared to the physicians [in Kenya] and [Canadians] are always complaining we don’t have enough. Compared to what they have, we are very lucky,” he said.

Dr. Davis has traveled to the continent for nearly 20 years. Originally visiting some relatives, he said that he fell in love with the countryside, the bush and going on safari (he is a great fan of African wildlife.) “Some ask Why do you fall in love with the Rocky Mountains?’ What is so special about them?’ Some people just don’t get it when you fall in love with a place,” he said. “One of my colleagues was in Uganda last year and told me ‘I don’t understand what you see when you go to Africa’. Not everyone has the same level of enthusiasm as I do. I like the country. The medical issues are challenging and it’s always nice to have a good challenge.”

In Kenya, Dr. Davis reported that much of the treatment of rheumatic diseases is completed by internists, rather than by actual rheumatologists. “There is a real need for specialists like rheumatologists. Unfortunately, the need for other types of doctors is greater and rheumatology takes a back seat,” Dr. Davis began volunteering in Africa in 1987 in Zimbabwe during a sabbatical year. At the time, Dr. Davis said that the country did not have a single rheumatologist. He taught rheumatology as a specialization at the undergraduate and post-graduate level, as well as conducted research regarding the rheumatologic manifestations of HIV. However, as the political climate and the health care system deteriorated in Zimbabwe in the mid 1990s, Dr. Davis sought another venture and made the acquaintance of a few doctors from Nairobi, Kenya. There, he learned that there was only one rheumatologist in country whose population rivalled Canada’s.

Dr. Davis continued his trips to Africa in various countries, including Tanzania and South Africa volunteering and traveling on safaris, and for the past five years, he has volunteered his time at the University of Nairobi. There, he
fills various capacities, including teaching the medical students about rheumatic diseases, but does recognize that it is quite different than teaching his medical students at the University of Alberta in Edmonton. “There is no point in me teaching students and residents in Kenya about biologic agents because they are not available to them. You must structure the teaching content and the format to fit the environment appropriately,” he said. “You can’t walk in as a Canadian professor and assume that it’s just like going to a classroom in Canada. There are different cultural and socio-economic factors. I think the most important thing [when teaching in Kenya] is to go right back to the basics, teaching the simple skills of clinical examination. The basic background skills, including interpreting physical findings in terms of what they mean and clinical skills, are almost non-existent in some African countries,” he said.

Dr. Davis’ latest project at the University of Nairobi is helping his Kenyan colleagues seek funding and support grants from international leagues and associations, including the International League of Associations for Rheumatology (ILAR), to develop a more formal rheumatology program in the next two years. “[The University] has some preliminary support, and the plan is to set up a more formal program, which will involve physicians from other countries, not just Canada,” said Dr. Davis. “I am part of the advisory committee and I help by determining on how to approach the grant proposals and decide which programs to develop. The needs in Kenya are different than ours; they need more basic things than we would offer our own residents,” said Dr. Davis.

“Ideally, we would eventually like to have a program to be able to teach the teachers,” he said. “The critical issue is to allow the teachers to educate their students and ensure they have the people and resources in Kenya to teach rheumatology, rather than indefinitely flying people in on a regular basis.”

Even though Dr. Davis is volunteering his time and must cover most of his own expenses while at the university, he wouldn’t have it any other way. “I go to Africa for two reasons: I think it’s worthwhile and much appreciated by [the doctors and students] who are very receptive and always glad to have important help from the outside, and [the work] is rewarding,” he said.

Dr. Davis’s travels to the continent, teaching and traveling, does not appear to be something he wants to stop anytime in the near future. “I think [Africa] is one of those things that happens to suit me,” said Dr. Davis. “I wouldn’t for one minute suggest that someone should pack their bags and go to Africa. It’s very different. For me, the difference and variety are some of the positives, and I think [that is] the challenge.”

Paul Davis, MD, FRCPC, FRCP (UK)
Professor of Medicine, University of Alberta
Active Staff, Departments of Internal Medicine and Rheumatology, The University of Alberta Hospitals
Edmonton, Alberta
1. Congratulations on your well-deserved nomination for the 2010 Canadian Rheumatology Association’s (CRA) Distinguished Rheumatologist Award. What do you believe are the qualities of a distinguished rheumatologist? Moreover, how do they apply to you? The terms of reference of this award stipulate that the candidate must be a CRA member in good standing and an accomplished Canadian rheumatologist of high professional caliber who has significantly furthered rheumatology in Canada in either patient care and/or service to the benefit of patients with rheumatic disorders and/or professional creative activities.

When I look at the accomplishments of people who have won this award, my own are dwarfed in comparison. However, I have practiced rheumatology in Calgary for 35 years, initially as a community rheumatologist and later as a geographic full-time appointment at the University of Calgary. Having had the opportunity to practice an equal amount of time in both camps, I feel I have a unique perspective of rheumatology. It is interesting that this year’s CRA debate at the annual meeting was entitled: “What is the Best Type of Practice: Academic or Community?” The answer is obvious: both types of practice are essential to the health and sustainability of rheumatology in Canada.

Also, I was one of the founding fathers of the rheumatic disease units (RDUs) at the University of Calgary in 1973, and have been heavily involved in medical teaching at the undergraduate and graduate level.

2. Before practising in Calgary, you studied under Dr. Charley Smyth at the University of Colorado Medical Centre in Denver. Why did you decide to study in the U.S.? How was it learning under Dr. Smyth? I did my undergraduate and post-graduate training in internal medicine at the University of Alberta. However, I think it is important to get away and see how medicine is taught and practiced in other parts of the world so one doesn’t develop tunnel vision in one’s views. I chose to go to Colorado as this was the centre where Dr. John Percy had recently trained. Dr. Percy, the first head of the RDU in Edmonton, was recruited when I was chief resident there in 1968. He became a mentor and encouraged me to become a rheumatologist as it would give me the opportunity to be involved in a discipline of medicine where immunology (a great interest of mine) was pivotal. As for Dr. Smyth, he was one of the elder statesmen of American rheumatology and it was a great privilege to learn under his tutelage.

3. You are well known for your teaching involvement at the University of Calgary. What have been the highlights of your academic career? Your private practice? When I first returned to Calgary in 1971, I joined Dr. D.L.G. Howard in private practice. Dr. Howard was the only rheumatologist in Calgary and was instrumental in developing the RDUs when the University of Calgary’s Medical School was established in 1968. Whilst in private practice, I had a clinical appointment with the university’s medical faculty and was heavily involved in teaching, not only rheumatology, but the spectrum of internal medicine at the undergraduate and post-graduate levels.

In 1985, I joined the Faculty of Medicine as a geographic full-time member. The highlights of my academic career were being the Academic Head of the Division of Rheumatology from 1993 to 1998 and the Associate Dean, Clinical Affairs from 1999 to 2007.

In addition, I was a member of the Council of the College of Physicians & Surgeons of Alberta from 1983 to 1994, as well as President of Council for three consecutive years.

An Interview with the 2010 Distinguished Rheumatologist: Dr. Martin Atkinson
4. You have had the opportunity to see many changes in rheumatology over the course of your career. What do you believe have been the most profound changes? I have seen many changes, both positive and negative. The negative changes include the demise of the RDUs with their dedicated beds for patients with rheumatic diseases. Another negative change has been the abolition of Clinical Fellowships by The Arthritis Society. This was the chief mechanism for training academic rheumatologists. Now, we are faced with an enormous dearth of qualified people to assume academic leadership positions.

The positive changes include our increased understanding of the mechanism and course of rheumatoid arthritis (RA) with the adoption of early aggressive treatment regimes that ameliorate joint damage, preserve function and prevent deformity. Another huge advance was the recognition, in the 1970s, of the effectiveness of methotrexate in RA, which has become the standard initial therapy in this disease.

The development, in the 1990s, of monoclonal antibodies (i.e., biologics) against a wide variety of cytokines that are part of the inflammatory cascade, has revolutionized the treatment of RA and other autoimmune diseases.

5. Due to recent economic trials, Canadian medicine is facing challenges now and in the future. Do you think that the economic downturn of the next few years will significantly alter recruitment and training of new rheumatologists? What can be done to mitigate this possibility? I think medicine is essentially recession-proof and the problems to do with recruitment and training are unrelated to the economic downturn. The recent astronomical increases in medical tuition rates will change the demographics of our students. Faculties of medicine will become more and more the purview of the children of the wealthy.

Furthermore, because of the limited exposure of students to rheumatology in their undergraduate years and the fact that rheumatology is one of the lower paying specialties, recruitment has been a constant challenge. This just underlines the importance of developing role models and mentors for young doctors considering a career in rheumatology.

6. What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges? The big challenges facing rheumatologists in the future include the impending manpower shortage due to the reasons given above. Another huge challenge is convincing government authorities that treating chronic diseases like RA and osteoporosis early, often with expensive drugs, is a good investment with considerable cost-savings down the road. For example, the vast majority of hip fractures in the elderly are due to osteoporosis. If we could reduce the fracture risk by 50% as a result of early and effective treatment the cost-saving and social benefits to society would be immeasurable.

Quite clearly, we are just on the cusp of the biological era and many more effective drugs are on the horizon, not just for RA, but for other rheumatic diseases as well. However, they will come at a price and we and the CRA need to constantly advocate for our patients with rheumatic disease to ensure they get the best possible treatment as early as possible in their disease.

Martin Atkinson, MD, FRCPC
Professor Emeritus of Medicine,
University of Calgary
Calgary, Alberta

Awardees at the 2010 CRA Annual Meeting

Distinguished Investigator:
Dr. Earl Silverman,
University of Toronto

Best Overall Presentation:
Dr. Nigil Haroon,
University of Toronto

Philip Rosen Award, Best Clinical Presentation:
Dr. Rita Lung,
University of British Columbia (medical student)

Ian Watson Award:
Dr. Amanda Steiman,
University of Toronto

Best Basic Science Presentation:
Dr. Mohammed Uddin,
Memorial University

Medical Student Poster Award:
Dr. Sarah Harding,
University of Western Ontario

- Provided by Dr. Proton Rahman
1. Why has education been such a priority in your career as a rheumatologist? Did certain individuals or events stimulate your interest in this field of rheumatology? The great thing about medicine is that it requires life-long learning. You can’t get bored, things are always changing and the challenge is to remain current.

I spent three months with Dr. Barry Koehler in Thunder Bay, Ontario, one summer as a third-year internal medicine resident. He enlightened me about what a wonderful field rheumatology could be and, as a result, I changed my career path. This was reinforced during my rheumatology fellowship in Toronto working with great teachers, such as Drs. Edward Keystone, Peter Lee, Jerry Tenenbaum and Murray Urowitz.

2. Why did you become a rheumatologist? Was it due to an individual or an event?

While I did have family members afflicted by rheumatoid arthritis (RA), it wasn’t until I did my rotation with Dr. Koehler that I knew it was the right choice for me. Rheumatology was a hot sub-specialty at the time, and there was fierce competition to be accepted into a program.

3. What have been the highlights of your academic career? Your private practice?

There have been several academic highlights, but receiving the Canadian Rheumatology Association’s Clinician Educator Award tops them all. Working in education on the frontline as a clinical teacher and later as a planner can easily be overlooked because it’s just expected by medical schools.

When I was awarded the Clinician Teacher Award from The Arthritis Society, my focus changed considerably. There was more time to develop new initiatives at McMaster University to encourage students to do electives in rheumatology, such as Musculoskeletal (MSK) Boot Camp and the Rheumatology Selective in Clerkship. Presently, we have 50 students a year who choose to complete their electives with us. Also, we are now seeing some of those students return as residents and trainees.

Promoting improved (MSK) assessment skills with the GALS screening exam has also been rewarding. We have validated it for general practitioners, nurses and physiotherapists as a screening tool for MSK disorders, and for physiotherapists to help detect inflammatory arthritis.

Lastly, my role as the Scientific Committee Chair for the CRA’s annual meeting has been rewarding. As for my private practice I continue to learn from my many wonderful long-standing patients.

4. What would your advice be to some of your younger colleagues who are interested in enhancing their teaching skills in rheumatology?

First of all, get involved, it is very rewarding. Second, seek out a mentor to guide you, and third, look at programs in faculty development. Mentoring eases the journey and helps to avoid pitfalls and provides a useful sounding board for issues that are bound to come along. Also, faculty development can be as simple as attending workshops on tutoring from a PBL curriculum to a more formal Masters in Education. Few are natural born teachers; it takes experience and training. Only at the university level is it expected to take place with such limited training.

5. What was your first thought when you learned that you would receive this award? Why?

I was very pleased and excited. It has been a long journey, over nearly two decades, and to be recognized by your peers this way is an outstanding achievement. There are many great teachers and educators across this country and I share this award with them. I would not have been able to accomplish anything without the support and contributions of my exceptional colleagues in Hamilton, in particular Drs. Rick Adachi, Nader Khalidi and Bill Bensen. Over the years, my colleagues across the country, including Drs. Janet Pope, Carter Thorne, Paul Haraoui and Paivi Meittunen, have also been very helpful.

6. Do you have any final comments for your colleagues?

I would ask my experienced colleagues to be mentors to their junior colleagues and students; it is a mutually rewarding experience.

Alfred Cividino, MD, FRCPC
Clinical Professor, McMaster University
1. Why did you focus your investigation on outcomes in systemic autoimmune rheumatic diseases, including prevalence, morbidity, mortality and economic impact? Chronic disease epidemiology is all about patterns of disease, outcomes, and impact. Like most people, I didn’t really know anything about epidemiology, even as a medical student and a rheumatology trainee. However, as a rheumatology trainee I had the great fortune to become a member of the Canadian Network for Improved Outcomes in Systemic Lupus (CANIOS). This is where I met a key group of people, including Dr. Paul Fortin, the program’s founder, who led me to begin post-graduate training in epidemiology. Dr. Fortin put me in touch with Dr. Ann Clarke, a brilliant immunologist and epidemiologist at the McGill University Health Centre (MUHC) Research Institute, and co-director (with Christian Pineau) of the MUHC Lupus Clinic, originally founded by John Esdaile. At the time, Len and Judy Funk introduced me to the patient group Lupus Canada. Without the support of Lupus Canada, I wouldn’t have been able to begin my epidemiology training. Many things came together, and it seemed clear to me that post-graduate epidemiology training at McGill and working with Dr. Clarke, would provide important tools that I would need for a career in clinical research. My thesis project revolved around an important type of comorbidity for people with systemic autoimmune rheumatic disease: cancer. My main project concerned cancer in systemic lupus erythematosus (SLE) and I worked with Dr. Clarke and many other wonderful members of CANIOS. I also looked at other types of rheumatic diseases and their outcomes. Economic impact is important, and I was very fortunate in that Dr. Clarke is a world-renowned expert on economic issues related to lupus and other diseases.

2. What other diseases have you focused on? I have done some work related to morbidity, access to care and quality of care for rheumatoid arthritis (RA) patients. Presently, I have the privilege of working with Dr. Claire Bombardier’s team in the context of the Ontario Biologics Research Initiative (OBRI). This affords me the opportunity to explore these issues a bit further, with novel approaches.

3. Why did you become a rheumatologist? When I entered medical school I did not have the faintest clue that there was a specialty like rheumatology. I entered medical school because I wanted to be a psychiatrist! But, I became captivated by internal medicine; it was so challenging, and I felt that if I conquered internal medicine, I would know everything there was to know. Early in the second year of my internal medicine training at the University of Western Ontario, I did a rotation in rheumatology. This exposed me to some very wonderful people, including Dr. John Thompson. From there, I just fell in love with rheumatology. The importance of a medical history and physical exam to properly diagnose the patient mesmerized me. I did more clinics with others, including Dr. Janet Pope, who confirmed my impression that all rheumatologists were brilliant, kind-hearted and “cool.” When I learned more about rheumatology, I found that all the things I liked best about internal medicine were what typified rheumatology: the challenges, the chance to learn and the opportunity to develop long-lasting relationships with patients.

If I had any doubts about the joy of rheumatology when I started my fellowship, they were completely dissolved in my first month by contact with the wonderful rheumatologists at the Arthritis Centre in Winnipeg where I had wonderful mentors including Drs. Hani El-Gabalawy and Kiem Oen who are still very important and influential in my life.

4. Do you have any final comments for your colleagues? I feel very lucky to be a member of the CRA community. Rheumatologists in Canada are the nicest people in the world. There are so many people who have inspired, mentored and supported me, and I am grateful to all those who helped in my rheumatology formation and in my research career. I am particularly grateful to the members of the rheumatology division at the MUHC. They have been so supportive of me, and I appreciate that so much. Sometimes, I believe that the saying “It takes a village to raise a child” could be paraphrased to, “It takes the whole CRA community to make a successful young investigator!”

Sasha Bernatsky, MD, FRCPC, PhD
Assistant Professor, McGill University
Montreal, Quebec
Michael Puttick, 1961-2010

By Stuart Seigel, BSc, MD, FRCPC

Michael Puttick, our friend and colleague, who had a busy rheumatology practice in Kelowna, B.C., passed away in the early morning of February 23, 2010, his wife at his side.

Almost 10 years earlier, Michael had been diagnosed with a brain tumor, but faced his illness with courage and determination. Upon completion of his initial therapy, he returned to his rheumatology practice which he loved dearly. He was dedicated to his patients and in return was adored by them.

Michael graduated from medical school in Toronto in 1985 and did a rotating internship at the Toronto East General Hospital. He was in general practice for a year in Nipigon, a community east of Thunder Bay in northern Ontario. There, Michael enjoyed fishing, and had many a tale to tell. One of his favorite stories is how he was once paid for a non-insured service with a large, fresh fish.

Michael completed his internal medicine and rheumatology residency in Vancouver, B.C. He often spoke of how Dr. Andy Chalmers and the late Dr. Howard Stein influenced his style of practice.

Michael set up a practice in Kelowna, B.C., and was extremely busy from his first day. He was also an active member of the local medical hockey team and the medical hockey tournaments were a highlight. I suspect many stories from those tournaments are not appropriate for publishing!

Sadly, Michael’s illness progressed and he closed his practice permanently a little over two years ago. He persevered in many ways where most of us would have simply given up. After a painful divorce, he fell in love again and married Sandra just this past November. Truly, he found an angel as Sandra organized his care in the last months with diligence and love.

Michael was 49 years old. He leaves behind his wife Sandra, and from his first marriage, a daughter Miriam and son Emile. He was very proud of his children and their accomplishments.

Michael will be missed by his family, friends and colleagues. He made a difference to those who knew him, and to his patients.

Peace, Michael. Peace.

Stuart Seigel, BSc, MD, FRCPC
Rheumatologist,
Kelowna General Hospital
Kelowna, British Columbia
The Vancouver Olympics was certainly the largest and most successful party ever thrown in the city. Other Olympic venues in Whistler, West Vancouver and Richmond hosted much of the games and cultural events as well.

In the months and weeks preceding this event, much thought was put into how locals were going to cope with the influx of visitors and disruption of regular activities, including transportation, business and, in some cases, school closures. There seemed to be two coping strategies, both of which were successful: “Get out of Dodge” or “Stay and enjoy.”

In the case of the Kelsall family, we packed up for Morocco, stopping for a few days to enjoy a cooler Paris. It was fun to watch and hear about the Olympics on European television and to see what others were saying about us. The reports were enthusiastic and complimentary.

The rest who stayed in town enjoyed the event in many ways. By all accounts, the Vancouver Organizing Committee for the 2010 Olympic and Paralympic Winter Games (VANOC) did a great job. The town was well-organized, transportation worked smoothly and the general consensus was that the overall “vibe” of the city was one of a big friendly party.

Preceding the Olympics, the torch relay wound its way through many Canadian communities with literally thousands of participants. Our own Ms. Lori Cyr, an occupational therapist at the Mary Pack Arthritis Centre, and Dr. Jackie Stewart, a rheumatologist in Penticton who ran the Canadian Ironman competition last year, had the honor of carrying the torch. Lori ran two spots after pro-basketball player Steve Nash and got to spend time with him in the relay bus after her run. Many others lived vicariously through the runners by catching glimpses of the passing flame or having the opportunity to hold or touch one of the torches.

Some were able to secure tickets to sporting events and saw exciting preliminary rounds, while others had the thrill of watching gold medal events! Moreover, a number of individuals had interesting volunteer experiences, including the opening ceremonies, and in the case of Dr. Jason Kur, working directly at one of the Olympic venues with athletes.

There were lots of events for the whole family. Dr. Kam Shojania and his family (Christianne, Alexander and wife Anna) test drove a bobsled, and there were reports of spontaneous hockey games occurring on what are usually busy downtown thoroughfares with many other joyous events abound. Not to be forgotten were the great opportunities to meet and greet people from all around the world.

I think it is more than fair to say that Vancouver hosted the games with great success. Although the games have now come and gone, the spirit in the city remains, and the memorable experiences enjoyed by all will long be cherished.

John Kelsall, MDCM
Rheumatologist,
Vancouver General Hospital
Vancouver, British Columbia

Buffeted by winds on the Eiffel Tower, the Kelsall family (John, Andrea and children Emily, Alison and Alec) travelled abroad during the 2010 Winter Olympics.

Canada won 14 gold medals at the 2010 Winter Olympics, a cause for celebration for many. (Dr. David Collins enjoying festivities with a new friend from Sweden.)
Our city of green was transformed into mitten crimson red. For many, the Vancouver 2010 Winter Olympics was the experience of a lifetime. For me, the Winter Olympics represented a once-in-a-lifetime opportunity to make a contribution to a world-class event that showcased the city and country outside the confines of my rheumatology clinic.

Vancouver is often viewed as a laid back city, even to the point of ennui at times. It was often wondered how we would react under the intense spotlight of the world’s athletes and media. As it turns out Vancouver owned the stage and Canada, the podium. As volunteers became the norm—the city of Vancouver had become a global community, where all were friends with the common purpose of promoting culture and sport. As volunteers, we wanted the Games to be a success, and as a community, for our visitors to experience the utmost in Canadian hospitality.

On the first day of my volunteer schedule, I was sent to Cypress mountain in my blue regalia. On the way down the mountain, I was approached by fans wanting to know how they could meet the Iranian downhill ski team. I told them that their team was staying in Whistler some distance away, but that didn’t dampen their enthusiasm! I met team physicians, members of the International Olympic Committee (IOC) and discussed Olympic experiences with members of the World Anti-Doping Agency (WADA). I was immersed for 18 days in talk of athletes, hockey and pavilions. The evenings were filled with recollections of medals won by Canadians at other venues.

I began my training with the Vancouver 2010 anti-doping team two years prior to the commencement of the Games. Selected as an anti-doping athlete chaperone, I had little knowledge of what exactly the position entailed. Several training sessions later and a stint working at the FIS Snowboard World Cup where I witnessed Shawn White “McTwist” walk away with the gold medal. After that event, I was part of a diligent team that was well-trained in its duty and ready for the big show in February.

The principles of fairness are at the heart of anti-doping in sport and are in fact very much parallel to principles of equality familiar to Canadian physicians. It is interesting to note that Canadians have been at the forefront of the anti-doping movement for many years now. From Richard Pound’s recent term as President of WADA in Montreal to Beckie Scott’s commitment to fair play in the arena of cross country skiing, the contributions have been profound. The Vancouver 2010 Games were no exception to these principles with a team of well-rehearsed Canadians acting to ensure fair play for all.

However, a few days before the Games commenced, it was announced that thirty athletes would not be competing in these Olympics because of positive findings in pre-Games testing. None of the athletes were believed to be Canadian, but there was a definite awareness that zero tolerance for cheating was going to be the policy in Vancouver. At the conclusion of the Games, there were still no doping scandals.

The position of being an anti-doping chaperone turned out to be one of the most enviable volunteer positions of all. The role comprised of an athlete assignment at a specific event. This athlete would need to be tested based on
the regulations set out by the IOC and their sport federation, and usually consisted of the top finishers with a selection of random athletes. From the field of play, we watched the drama unfold until our assigned athlete had completed the competition. In many instances, this was at the gold medal race. Once the event was over, we would spring into action. The process consisted of notifying the athlete of their rights and responsibilities and then chaperoning them through the doping control process, at all times remaining professional and observing for any discrepancies. Not only was it a privilege to meet and assist world-class athletes, but to do so in an effort to promote fairness in sport seemed a rather Canadian notion.

Cypress Mountain was the main site of my volunteer experience. Despite daily reports of the paucity of snow at the venue, the mammoth efforts of the team of volunteers to ready the site ensured a spectacular competition highly regarded by the athletes. Moreover, Cypress was extremely good to the Canadian team. Six medals were won there, four of which were gold.

My first shift on the mountain allowed me to witness history in the making. Our team was placed at the finish line for the men’s moguls competition when Alexandre Bilodeau clinched the gold. The slope-side stadium erupted. Canada’s first gold medal as an Olympic host nation was won by an individual whose enthusiasm and humility couldn’t have been more Canadian. Such a feat had eluded Canadian athletes in Montreal and Calgary, but it now was finally realized on the North Shore mountains where us locals like to hang out in winter to ski.

My final shift ended much as my first had started, with gold on Cypress, won by Jasey Jay Anderson in the Men’s Snowboard Parallel Giant Slalom. In less than ideal conditions, the local favorite carried the day on the final race at Cypress. What a fitting conclusion to an exhilarating competition on the mountains.

I concluded my Olympic experience like most other Canadians watching the gold medal hockey match on television. For the volunteers who toiled so much to make the Games a success, and to all Canadians for that matter, the hockey win was a perfect conclusion to our winter sport celebration. In 2010, Vancouver prospered by ‘Sea, Snow, Land and Air’.

Jason Kur, MD, FRCPC
Pacific Arthritis Centre,
Vancouver General Hospital,
University of British Columbia
Vancouver, British Columbia
The 9th International Lupus Congress will be held in Vancouver from June 24 to 27, 2010. In an effort to copy the potlatch theme of the indigenous peoples of the Pacific Northwest, the meeting will bring together the extended family of lupus researchers, clinicians, educators and lupus patients. All the participants will bring gifts of their personal knowledge and understanding, and exchange these gifts with all attending. We hope the meeting will close the gap between what we know, what we do and what we could do worldwide in lupus treatment, medical and public education, and clinical and fundamental research.

Dr. Peter Lipsky, the Basic Science Program Chair, and Dr. Matt Liang, the Clinical Science Program Chair, have assembled an impressive list of distinguished scientists and physicians to comprehensively review the state of the science and the state of the art in lupus. These invited faculty will lead “Meet the Professor” sessions and give special lectures. There will be plenty of opportunity for original papers and posters to be presented and, most importantly, to chat with colleagues. A series of workshops will focus on global lupus and set up networks for long-term collaboration.

An enthusiastic early supporter of the meeting was the Canadian Rheumatology Association (CRA). The CRA, along with the Canadian Arthritis Network (CAN), The Arthritis Society of Canada, the B.C. Lupus Society and Lupus Canada want to make this the best international lupus meeting ever. An important focus of the meeting is to support the coming generation of scientists. To this end, the CRA created five trainee travel awards which have been awarded to the Canadian trainees with the top rated abstract submissions, as seen on our website.

For registration, accommodation, the complete scientific program and late breaking abstract submissions, please consult the Lupus Congress website at www.lupus2010.com.

We are looking forward to seeing you in Vancouver!

John M. Esdaile, MD, MPH, FRCPC, FCAHS
Professor of Rheumatology,
University of British Columbia
Vancouver, British Columbia
The 65th CRA Annual Meeting: Report

By Jane Purvis, MD, FRCPC; and Fred Doris, MD, FRCPC

CRA Meeting Highlights: Dr. Jane Purvis
The CRA annual meeting was held in Quebec City from February 3 to 6, 2010, at the Fairmont Château Frontenac. The beautiful surroundings of la Belle Province, along with perfect winter weather for the famous Winter Carnival, made the free time a pleasure, while the excellent facilities and services of the Château made the meeting itself extremely pleasant. The CRA committees had obviously worked long and hard to bring a streamlined, relevant and up-to-date meeting for all involved, including CRA members, trainees and AHPA members, providing basic science, clinical information and collegiality, in the most enjoyable way.

My highlights for the meeting included Dr. Gillian Hawker’s lecture *Epidemiology of Osteoarthritis*. Her insights into this common chronic condition were excellent and served as a reminder that osteoarthritis (OA) remains a very large unmet need for our patients. Advances in rheumatoid arthritis (RA) therapy have left other disorders such as OA off the radar for many of us, and Dr. Hawker’s talk was timely and interesting.

Another ongoing success for the CRA meeting is the workshop section. This year, I was able to attend among others Dr. Walter Maksymowych’s workshop on *Ankylosing Spondylitis*. The case review format and open questions to the audience had us all participating. Reviewing the new Assessment of SpondyloArthritis International Society (ASAS) Diagnostic Criteria was key, and revisiting the pitfalls and benefits of MRI interpretation were very helpful for those of us working in the community.

My final highlight was the Dunlop-Dotteridge lecture, delivered by Dr. Iain McInnes. The lecture was an inspiration and I’m sure those in attendance wished we could move to Glasgow to work in his lab and clinic. Dr. McInnes’ ability to tie the research lab and the rheumatology patient together, along with his cutting edge science examining the actual cells involved in the early stages of inflammatory arthritis was an inspiration to clinicians everywhere.

CRA Meeting Highlights: Dr. Fred Doris
The CRA meeting held in Quebec City at the time of the Winter Carnival was once again a great success. All regions of the country were well represented by attendees and presenters, and the topics discussed were varied and well chosen.

I thoroughly enjoyed the excellent podium presentations by the rheumatology trainees. All six discussions were excellent and I was happy that I did not have to choose which six trainees got to present their research. I was also delighted that I did not have to pick a winner! As shown by these trainees, the level of research that is obviously present in this country will keep on doing us proud and moving science forward for decades to come.

Another highlight at the meeting was the workshop on vasculitis led by Dr. Patrick Liang. Cases presented were explored in a question and answer style that allowed for rapid information exchange while keeping us all on our toes. Reviewing the newest evidence for treatment of these serious and rare diseases was of great benefit.

My last highlight was the famed CRA debate. Watching the canny community rheumatologists try to awaken their academic colleagues from their meditation-induced slumber was a pleasure, and the dry wits of the moderator (particularly Dr. Robert Offer) had everyone agreeing with the obvious: community rheumatologists have it all. Except for maybe Dr. Gunnar Kraag’s enviable daily schedule!

Jane Purvis, MD, FRCPC and
Fred Doris, MD, FRCPC
The Peterborough Community Rheumatologists
Peterborough, Ontario
Many Western Canadian rheumatologists felt that the approval process to obtain biologic drugs for patients with rheumatoid arthritis (RA) could be cumbersome in the extreme and served no benefit either to funding agencies, nor, most particularly, to patients. Several of my colleagues and myself convened a meeting with representatives from all five western units to try and make recommendations to the Alberta government regarding a better approach to the approval process. These recommendations concerned those patients who had already met the provincial regulations re-eligibility for biologic therapy.

Key facts were noted and referenced, and included the following points: biologics have a relative equality in efficacy, except anakinra; there are no concerns with adverse events because of sequential use of biologics, although biologics in combination are not recommended; choice of biologic should be a shared decision between the doctor and the patient; and formulary policy should allow for the specialist physician to prescribe the “right biologic to the right person at the right time.”

At the meeting, a number of specific recommendations were made. Once a patient has been deemed eligible for a biologic there should be a seamless process if switching is required. If there is evidence of a fair response at three months but one not quite meeting the required criteria, an extension for re-assessment at six months should be permitted. We recommend that the provincial/territorial governments seek advice from rheumatologists in determining indication prerequisites, and that some form of appeal mechanism be set up that is satisfactory to patients, doctors and government, as has been done in B.C.

Anthony Russell, MB, ChB, FRCP
Professor,
Department of Medicine,
University of Alberta
Edmonton, Alberta
The Pediatric Rheumatology Division at the IWK Health Centre hosted its first Rheumatology Education Day in Halifax, Nova Scotia, for families of children living with juvenile idiopathic arthritis (JIA). The IWK Health Centre, affiliated with Dalhousie University, serves as the pediatric tertiary care center for Nova Scotia, New Brunswick and Prince Edward Island. The rheumatology team presently follows over 375 children with JIA. In a survey completed by parents prior to the education day, we found that coping with chronic disease and pain were the top two topics that parents wished to focus on. Previous participation at The Hospital for Sick Children’s Rheumatology Education Day in Toronto was very helpful in planning this event.

The event took place on a beautiful Saturday in early October. We were fortunate to have a great venue for children in which to host the day—a school with a playground, gymnasium and warm therapy pool. Over 70 parents and children from the three maritime provinces attended.

The day began with poster sessions for the parents ranging on information about the novel H1N1 virus, to the importance of screening eye exams for children with JIA, to the role of the hospital’s Child Life Department in helping children cope with arthritis. This was followed by a very competitive game of “Nutrition Jeopardy” led by our two pediatric dieticians. Dr. Lynn Breau, a clinical psychologist and researcher in children’s pain, along with our team’s physical and occupational therapists led a panel discussion on coping with pain with an emphasis on physical activity and sports.

The highlight of the day for parents and team members alike was a panel discussion led by IWK graduates. The panel consisted of a young woman and her mother, and another young woman, both diagnosed with JIA as toddlers. They shared personal stories of their journey with arthritis—reflecting on their most difficult times and what helped them through those times, the barriers they had to overcome, and the multiple personal successes they had achieved in their lives. It was a moving testament as to how arthritis can affect a child, but not become a child’s identity.

The children had a very busy day with tile-painting, yoga, relay races, a magic show and a swim to end the day. It was wonderful to see the children with JIA and their siblings getting to know each other by meeting other children with arthritis. The focus of the day was not their disease, but having fun together.

The feedback we received from parents was overwhelmingly positive. Parents enthusiastically endorsed recommending a day such as this to other parents of children with JIA. They commented on feeling less isolated and how feeling connected to other parents could help to reduce stress and make them feel less afraid. Our team’s social worker led a discussion around tips for initiating parent-led support groups or networks in their communities. For future Education Days, we plan to incorporate sessions on arthritis for the children and their siblings in attendance.

The Education Day was made possible through many volunteer hours by our team, other IWK staff, Dalhousie medical students and members of the local Pathfinders group. We are thankful to The Arthritis Society of Nova Scotia and other community members for generously supporting this event. We know everyone involved took home something valuable and we look forward to planning for next year!

Elizabeth Stringer, MD, FRCPC
Pediatric Rheumatologist, IWK Health Centre
Halifax, Nova Scotia
Greetings from the Nation’s Capital. Rheumatology in Ottawa functions quite differently from the major Canadian institution up on the Hill: the Canadian Parliament. Ottawa rheumatologists are intelligent, like each other, work well together and have never been known to pro-rogue anything.

There are five full-time hospital-based rheumatologists in the Division of Rheumatology with offices at the Riverside Campus of the Ottawa Hospital. These include Dr. Doug Smith, our Head; the beloved Dr. Gunnar Kraag; our “senior” rheumatologist Dr. Bob McKendry; energetic teaching star Dr. Sue Humphrey; and the wise man Dr. Jack Karsh. Helping carry the load of patient care, teaching and call duties are six other rheumatologists in the division with university appointments all with primary private offices in the community. These include globe-trotting Dr. Al Jovaisas; Dr. Brian Boate, Canada’s fastest moving and fastest talking rheumatologist; Ottawa rheumatology matriarch Dr. Pat Morassut; young dynamic Dr. Suneil Kapur; and yours truly, Dr. John Thomson. Dr. Charlie Shamess has recently stepped away from call duties and Dr. Debbie O’Keefe is active in the CTU Medicine service, but also maintains a busy rheumatology practice.

There are several other rheumatologists in Ottawa who are very active in patient care and interact regularly at the numerous educational events which take place. These include Drs. Kathleen Davis, Susie Duff, Suzanne MacMillan, Bin Liu and across the river in Gatineau, Quebec, Oleg Zadorozny. Dr. Jeri Waltin-James has very recently decided to retire.

Rounding things out are our pediatric colleagues based at the Children’s Hospital of Eastern Ontario: Drs. Johannes Roth, Roman Jurencak and Karen Palayew.

We have a nice scene in Ottawa. There is a collegial, cordial, and respectful atmosphere that helps make working an enjoyable experience. We are blessed with a physically beautiful city, just sophisticated enough but close, literally and spiritually, to the great northern lakes and forests. Ottawans love their city. We could do with some new rheumatologists, however, so why not come visit and stay awhile?

John Thomson, MD, FRCPC
Past President, Canadian Rheumatology Association (CRA)
Assistant Professor, Department of Medicine,
Division of Rheumatology, University of Ottawa
Staff, The Ottawa Hospital
Ottawa, Ontario
Calgary’s population has grown by more than 100,000 people over the past five years to reach the million mark in April 2009. Statistics indicate we have over 10,000 inflammatory arthritis patients to be managed by the 21 academic and community pediatric/adult rheumatologists practising in the city. Our allied health professional team now includes two nurse practitioners, six nurse clinicians, a physiotherapist, two social workers, and a pharmacist, not to mention several research assistants and clinical trial coordinators.

During the past two years, the University of Calgary’s Division of Rheumatology also contributed to the population surge with four new babies delivered to happy fellows and staff: Drs. Fifi-Mah, Ziouzina and Barnabe. In addition to being a new mother, Dr. Barnabe will be completing her Master’s Degree in clinical epidemiology in the summer of 2010, and joining the Division as an Assistant Professor. She will continue her research in highly sensitive imaging techniques in rheumatoid arthritis (RA) and cardiovascular risk assessment in rheumatic diseases. Dr. Ziouzina will travel to Toronto for some exciting fellowship work with Dr. Dafna Gladman before she returns to Calgary, and Dr. Fifi-Mah may take her twin girls (and the rest of the family) to Paris for some special training in vasculitis. Our other fellows, Drs. Mei Chu and Glen Hazlewood, are contributing as well. Dr. Chu had her baby and Dr. Hazlewood expects to deliver fascinating new research findings during his Masters training in Toronto over the coming two years.

We are delighted to have our ranks strengthened by three rheumatologists from “away.” Dr. Dianne Mosher became our new Division Head in 2009 hailing from Halifax, Nova Scotia. We are also pleased to have Dr. Rob Rennebohm from Ohio State University join the pediatric rheumatology group. Dr. Rennebohm, raised in the winter snows of Wisconsin and Minnesota, stated he has thoroughly enjoyed the Calgary winters. Also, that because of his admiration for Tommy Douglas, he has appreciated the opportunity to work within the Canadian healthcare system. His primary research interest is Susac’s syndrome and is leading a comprehensive international collaborative study of Susac’s syndrome (www.ucalgary.ca/susac).

Another exciting addition to the team is Dr. Heinrike Schmerling who has brought tremendous expertise and networks from Germany. There, she focused her research on pharmacogenetics in juvenile idiopathic arthritis (JIA) attempting to identify genetic determinants and how these genetic differences amongst individuals influence the variability in methotrexate and etanercept toxicity and efficacy. She hopes to develop a predictive clinical-biological pharmacogenetic model, which will serve as the first tool for tailored-individualized therapy in childhood arthritis. The research builds on an assembly of a large data collection from over 2,000 European JIA patients on methotrexate and etanercept.

The rest of our group is another year older and fully engaged in the never-ending work of medical education, patient care and general research.

Finally, we are sorry to report that Dr. Avril Fitzgerald will leave her post as a superb clinician and medical educator at the University of Calgary to pursue her other passions of gardening, family and fine culinary arts.

Dr. Steven Edworthy, MD FRCPC
Professor of Medicine,
University of Calgary
Member,
Division of Rheumatology
Calgary, Alberta
Rheumatology Beyond Borders

Many rheumatologists are traveling abroad, not just to vacation or travel to medical conferences, but to teach or gain knowledge about rheumatologic practises and rheumatic diseases in different environments. In this issue of The Journal of the Canadian Rheumatology Association (CRAJ), Drs. Barry Koehler, Desirée Tulloch-Reid and Paul Davis told us of their experiences bringing rheumatology beyond borders from the hot and humid summer in China, the tropical climate of Jamaica and the dry-heat of Africa, respectively.

The CRAJ asked rheumatologists across the country questions regarding what they would like to do given the opportunity to travel abroad. Nearly 70% of this issue’s Joint Count respondents said that they would like the opportunity to participate in medical education in a foreign country and nearly the same amount of respondents (67%) stated they would like the opportunity to practice rheumatology in a foreign country, but only 63% have travelled abroad in either capacity. However, 85% said they would like the opportunity to interact more with rheumatologists abroad, and nearly 60% of respondents stated they would like to host a rheumatologist or a trainee from abroad to provide them with the experience of rheumatology in Canada. Finally, 83% believe that the Canadian Rheumatology Association (CRA) should facilitate interactions with other foreign national rheumatology organizations and individuals.

An opportunity to brush up on your diplomatic skills and travel abroad will be available with our new venture south to visit our Mexican colleagues. The joint CRA/MCR meeting will be taking place in Cancun, Mexico, from February 10 to 15, 2011. Rheumatologists mark your calendars as this will be a great chance to learn from our colleagues abroad!
HALLWAY CONSULT

Lupus and the Brain

By John G. Hanly, MD

Not all clinically significant questions have been definitively answered by randomized double-blind placebo-controlled trials. The Hallway Consult department 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: katherinee@sta.ca.

Case History:
A 43-year-old woman with a 15 year history of lupus is taking hydroxychloroquine to help manage her dermatitis and arthritis. About 10 years ago, the patient began having increased problems with memory and cognition. Neurologic, psychiatric and neuropsychologic tests demonstrated findings consistent with central nervous system (CNS) lupus. Of note, she has never had any other clinical or serologic features of antiphospholipid antibody syndrome. Her neurocognitive defect progressed and she developed partial complex seizures. The patient was treated with prednisone and azathioprine and remained stable for several years. Ultimately, this treatment regimen failed, and her neurocognitive defect progressed and partial complex seizures recurred. She was treated with cyclophosphamide five years previous, but did not tolerate the hematologic side effects of this therapy after two cycles. The patient was then treated with mycophenolate mofetil for three years with relative improvement of her symptoms before this therapy failed. In the past two years, she has developed significant depression.

All of the symptoms have improved with high dose corticosteroids. She has had two successful cycles of rituximab (1,000 milligrams intravenous [IV] every two weeks) with a dramatic improvement of her symptoms. However, she has not had any measurable improvement following her third cycle of therapy. Another MRI was performed and her white matter lesions have remained unchanged over the past decade.

Nervous system disease has long been recognized in patients with systemic lupus erythematosus (SLE). It encompasses a spectrum of neurologic and psychiatric manifestations and has a significant negative impact on health-related quality of life. Neuropsychiatric (NP) events which have been reported in SLE include headaches, mood disorders, cognitive dysfunction, anxiety disorder, seizure disorders, cerebrovascular disease, mononeuropathies and acute confusional states. However, only 19% to 38% of all NP events are attributable to SLE.

Attribution and Diagnosis of Neuropsychiatric Events
In the case described, the clinical NP features are cognitive dysfunction, seizures and a subsequent mood disorder. All of these evolved following the diagnosis of SLE. None of the manifestations are specific to lupus. Thus, a thorough workup is essential to exclude other possible causes. Seizures in patients with SLE most frequently present as a single event often in association with active multi-organ systemic disease. A more indolent and persistent seizure disorder may occur in association with antiphospholipid antibodies with or without evidence of cerebral infarction. In the absence of another identifiable cause it is reasonable to assume that SLE is the most likely reason for the seizure disorder in the current case. Cognitive impairment should whenever possible be confirmed by formal neuropsychological testing in collaboration with a neuropsychologist. There are multiple causes for poor cognitive performance, including depression, which can cause significant cognitive impairment in its own right and frequently requires treatment. Although the white matter lesions detected by magnetic resonance imaging (MRI) are not specific for SLE and appear to have been present from the onset of her clinical NP disease, such changes are compatible with lupus, which has been associated with white and grey matter disease detected on MRI.

Pathogenesis and Implications for Treatment
Before considering additional diagnostic and therapeutic options for the patient, it is worth considering patho-genetic models of NPSLE. The combined evidence from animal and human studies suggests two separate and
potentially complimentary autoimmune/inflammatory pathogenic mechanisms:
(i) vascular injury involving large and small caliber vessels mediated by antiphospholipid antibodies, immune complexes and leukoagglutination that results in focal NP events, such as stroke, and in diffuse NP events, such as cognitive dysfunction;
(ii) inflammation mediated injury in which increased permeability of the blood-brain-barrier, formation of immune complexes, and production of inflammatory mediators, such as interferon-alpha, lead to diffuse NP manifestations, such as psychosis and acute confusional states.

Additional research involving sizeable cohorts of patients with well characterized NP disease, in association with neuroimaging to identify structural and functional abnormalities, are required to provide further validation of this pathogenic model. On this basis, the potential lupus-specific therapeutic strategies include anticoagulation to mitigate against the procoagulant effects of antiphospholipid antibodies, anti-inflammatory therapies to reverse a permeabilized blood-brain-barrier and/or brain inflammation and immunosuppression to remove pathogenic autoantibodies.

Investigation
Formal neuropsychological testing would be helpful to confirm and characterize the cognitive deficits. This would provide a basis for recommending lifestyle modification and other practical ways of dealing with specific deficits and establish a baseline for comparison with future studies. An assessment of brain structure has been obtained with MRI and brain function could be assessed by SPECT or PET imaging depending upon local availability and access to these neuroimaging modalities. Magnetic resonance angiography (MRA) may identify large intracranial vessel abnormalities and diffusion weighted imaging (DWI) will indicate acute ischemic processes affecting the brain parenchyma. If available the use of more sophisticated neuroimaging, such as magnetic resonance spectroscopy (MRS) and magnetized transfer imaging (MTI), can provide additional information on the levels of neurometabolites and white matter tract integrity, respectively.

The presence of white matter disease raises the possibilities of multiple sclerosis (MS) and infection. Depending upon the index of clinical suspicion, examination of cerebrospinal fluid (CSF) for oligoclonal banding (more frequent in, but not specific to MS) and to exclude infection (including the JC virus in progressive multifocal leukoencephalopathy [PML]) should be considered. A search for antiphospholipid antibodies has already been done and presumably includes anticardiolipin antibody and lupus anticoagulant. Although interesting data on other autoantibodies is emerging, their role in the clinical management of individual patients is not clear at this time.

Treatment Options
Treatment options include SLE specific and non-specific therapies. Experience with previous immunomodulating therapies in this case has been positive, at least in the short term, as would be predicted from the literature. Thus, an additional cycle of treatment with rituximab is one option that could be considered. There is no basis for anticoagulation, given the absence of antiphospholipid antibodies or accelerated atherosclerosis, a well documented complication of SLE. Symptomatic therapies include the use of anticonvulsants and antidepressants. Any improvement in mood should impact positively on cognition. Consultation with a neuropsychologist can provide counseling and practical advice on ways for dealing with the impact of cognitive difficulties on everyday activities. Finally, one of the challenges in the current case will be to determine how much additional benefit can be obtained by further disease specific therapy. It is possible that the current NP status is a consequence of damage rather that active autoimmune disease impacting the nervous system. A trial of therapy may be required to resolve this issue.

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Carolyn Thomas Award Winner: Carolyn Kennedy.

Barbara Hanes Memorial Award Winner: Philip Ambury.

Best Special Interest Award Winner: Lorna Bain (Marlene presenting to Dr. Carter Thorne on her behalf.)

Clinical Innovation Award Winner: Jocelyn Murdoch.

Extraordinary Service Award Winner: Paul Adam.
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