Focus on
CRA/MCR Joint Congress 2011

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The CRAJ is online! You can find us at: 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 editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.
The idea of warm weather at the Canadian Rheumatology Association’s (CRA) annual meeting was first floated at the CRA retreat in Winnipeg in 1999. At that time, the annual meetings were alternating between the ski slopes of Lake Louise and Mont Tremblant, drawing larger numbers of participants with each year. However, even before the turn of the millennium, it was anticipated that the demographics of the CRA would begin to shift. A tropical venue might bring out some of those rheumatologists less interested in moguls and alpine scenery. Dr. Michel Zummer spearheaded this effort which culminated in the very successful Acapulco Congress in 2006. It was not just another medical meeting in a hot paradise, but much more. The bonds which were forged with many of our colleagues in the Mexican College of Rheumatology (MCR) have been maintained and have precipitated a number of successful interactions over the past five years. There was considerable interest to have another CRA/MCR Congress to foster the relationship of our two organizations.

Almost three years ago, I was asked to be the chair of the CRA Scientific Program Committee for the Cancun Congress. It has been an interesting process developing the scientific and educational component of the event with our MCR counterparts. It could not have been done without the enthusiasm and able assistance of the CRA Scientific Committee: Drs. Diane Lacaille, Ricardo Cartagena, Joanne Homik, Arthur Bookman, Steve Edworthy, Alf Cividino, Lori Tucker and Eric Rich. And of course Dr. Zummer—who has served on the program committee and has been the overall organizer of the Congress. Dr. Lacaille deserves special praise for her Herculean effort as the chair of the abstract committee.

The meeting format is different than that of the last few CRA meetings. Podium presentations of the best of Canadian and Mexican research will be novel and welcomed; there will be three concurrent sessions each day. I guarantee that attendees will have a difficult time choosing which session to sit in on due to the excellence/reputation of each presenting speaker. In this issue, the speakers will give the readers a preview to help in your decision.

This year’s keynote speakers are highly sought after worldwide due to their expertise. Their brief interviews in this issue will highlight some of the new information they will share at the Congress.

There will also be poster discussion groups for academic debate; an informatics study group to create linkages; morning symposia to awaken you (or help you wake up); and clinical Pearls of Rheumatology to entertain and educate. And then there will be the social events. There will be the opportunity to meet your Canadian friends and new Mexican colleagues at the opening gala, the excursion to Xcaret, the CRA awards dinner and the closing banquet. This will, without a doubt, be a meeting to remember.

It has been an honor to serve as the Chair of the CRA Scientific Program Committee for this Congress. I hope that you have the opportunity to join your Canadian compatriots in the sun and sand of Cancun for this singular educational event.

At this special time of the year, may I wish you and yours a Merry Christmas, Happy Hanukkah, and especially warm wishes for the New Year.

Glen Thomson, MD, FRCPC
Editor-in-chief, CRAJ
Winnipeg, Manitoba

Memories of Acapulco 2006.
Greetings to all as the festive season approaches. I hope everyone will have an opportunity to spend precious time with family and friends and recharge the batteries once again.

The Canadian Rheumatology Association’s (CRA) Board is busy as we prepare for the joint meeting with the Mexican College of Rheumatology (MCR) this February. Dr. Glen Thomson and the meeting’s Scientific Committee have worked overtime (I can tell by the hour of his e-mails) to put the finishing touches on the scientific program. You have all seen, I am sure, the preliminary program available on our website; I think it will be a very successful meeting. Dr. Diane Lacaille has organized the abstract sessions this year and Dr. Eric Rich has put together the resident’s precourse. I want to thank everyone for their efforts at making this meeting one to remember. I expect the weather won’t hurt either. Remember your sunscreen!

Dr. Andrew Thompson continues to improve the CRA website and I am pleased to report the website’s traffic is increasing every year. Dr. Thompson has also begun modifying the website’s operating base to make it easier for the CRA to control content without the need of outside consultants. He has asked me to remind members there is now a portal to post job opportunities in your community. If you are looking for help, keep this chance in mind to let people know you are looking. Further, the website has an increasing amount of educational content and we expect this to grow as time passes (a good tool to keep in mind if you are in need of Maintenance of Competence [MOCOMP] points).

Further, Dr. Barry Koehler and the Human Resources Committee are seeking solutions to attract trainees to the pursuit of rheumatology. He will be attending a conference held by the Royal College of Physicians and Surgeons of Canada in December where all subspecialties will be attending to share their experiences and situations. It is hoped that the CRA will garner some additional insights as to how other subspecialties are attracting trainees.

Of note, the CRA has recently supported the creation of the Canadian Rheumatology Ultrasound Society (CRUS) whose goal is to assist rheumatologists in acquiring the skills necessary to incorporate the use of US in their practice. Some members of this group will help teach the US course, taking place before the CRA/MCR Congress in February. We wish them well in their (and our) future endeavors.

Once again, on behalf of the CRA Board, I want to wish everyone a Merry Christmas and a Happy New Year.

James Henderson, MD, FRCPC
President, Canadian Rheumatology Association (CRA)
Chief, Internal Medicine,
Dr. Everett Chalmers Hospital
Teacher, Dalhousie University
Fredericton, New Brunswick
How things have changed in 20 years. The 1990 Canadian Rheumatology Association’s (CRA) Annual General Meeting (AGM) had less than 10 members in attendance; in 1996, under the new format initiated by Dr. Paul Davis, there were 75 members (the year I was elected as Secretary-Treasurer, a position I was to hold until 2004). In 1996, the CRA did not have a mission statement, was not incorporated, had no secretariat, and had as its principal mandate the planning and execution of the AGM. I am now re-engaged on the Executive Board as the society’s Vice-President, and excited by the current CRA executive team and the committed Board of Directors as we approach new challenges and opportunities.

In a letter from your President, you have been reminded about our upcoming CRA/Mexican College of Rheumatology (MCR) Joint Congress, which will be taking place in February next year. The meeting will have an innovative format, that, I am sure, all will appreciate. The CRA’s President, Dr. James Henderson, has also discussed manpower issues and continuing changes/improvements to the website.

In keeping with our tagline, “Experts in Arthritis Care,” the CRA has sought input from its members and other arthritis partners to develop a number of other important initiatives, befitting an organization of maturity, now entering its 66th year of professionalism. As most of you are aware, The Journal of Rheumatology is now part of the CRA family. Its re-patriation was championed by Dr. Arthur Bookman, the current President of the Board of Directors of the Journal. The Journal, continues to be capably led by Drs. Duncan Gordon and Yvonne Pigott, and remains on track (i.e., financial milestones).

The CRA is also extending its voice and influence beyond its membership whilst still in support of its mission statement “[...] to represent Canadian rheumatologists and promote their pursuit of excellence in arthritis care, education and research.”

The CRA was a founding member and principal financial supporter of Alliance for the Canadian Arthritis Program (ACAP); the current co-chair is Dr. Dianne Mosher. An initial submission to the Public Health Agency of Canada has recently been followed by the submission of a detailed business plan, which, we hope, will provide an advocacy tool, at the national and provincial level. The CRA is also continuing to work with our Industry Council and hope to enhance our collaboration for improved outcomes in arthritis care, while respecting new guidelines on pharmaceutical relationships.

Reflective of our increased profile as the “Arthritis Experts,” we were invited to respond to the draft of the recent Canadian Agency for Drugs and Technologies in Health (CADTH) report on biologic agents, available at www.cadth.ca/media/pdf/Biologics_for_RA_TRP_Final_Recommendations_e.pdf. Though our concerns did not influence the final report, we remain optimistic for future consultations. Further, the CRA’s guidelines on the use of biologic agents will be presented at the upcoming CRA/MCR meeting, and we believe it will assist members in there better understanding of the use of biologic agents in the Canadian context, based not only on randomized clinical trials (e.g., CADTH), but also other references, including registries and expert opinion.

Other initiatives that we think will resonate with our members include a planned partnership with the Aboriginal Associations and the Canadian Life and Health Insurance Association (CLHIA) to improve access to arthritis care for our Aboriginal population. Finally, as your national organization constrained in advocacy, by healthcare in the provincial domain, we look to your comments on a new advocacy tagline: “National Standards & Strategies ... Optimal Outcomes.” Please send us your comments through our website or directly to any member of the board or executive.

I would also like to take this opportunity to wish all of our CRA members happy holidays!

Carter Thorne, MD, FRCPG, FACP
Vice-President, Canadian Rheumatology Association (CRA)
Past President, Ontario Rheumatology Association (ORA)
Medical Director, The Arthritis Program (TAP), Southlake Regional Health Centre Newmarket, Ontario
Dr. Sherine Gabriel, the Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress’ Dunlop-Dottridge Lecturer, completed her medical degree with distinction at the University of Saskatchewan, and completed her internal medicine residency and rheumatology fellowship at the Mayo Graduate School of Medicine. She also earned a Master of Science in Clinical Epidemiology from McMaster University. Dr. Gabriel has made many important contributions to the understanding of risks, determinants and outcomes of the rheumatic diseases, and has published more than 250 scientific publications. At the Congress, Dr. Gabriel’s presentation will discuss her research regarding the apparent increased risk of heart disease in patients with rheumatoid arthritis (RA), focusing on what risk factors are associated with increased risk of heart disease and how to reduce heart disease in these patients. In her research, Dr. Gabriel indicates that patients with RA are dying at a much higher rate from heart disease than those without RA with the same age, sex and risk factor profile. Dr. Gabriel sat down and answered a few choice questions with The Journal of the Canadian Rheumatology Association (CRAJ) to discuss her presentation at the Congress (including any controversies that might be addressed), and what areas of research she would like to focus on in the future.

1. In your presentation at the CRA/MCR Joint Congress, what new information will be highlighted in your presentation at the Congress?

At the Congress, I will discuss the research that I have conducted regarding heart disease and rheumatoid arthritis. In my research, I begin by initially understanding the risk and outcomes of heart disease, comparing the data of patients with RA and those without RA. Some of the data [we have already gathered] shows that the risks are higher in patients with RA and the outcomes are worse in these patients. I will also be discussing the contribution of traditional (i.e., smoking, high blood pressure and high cholesterol, among others) and non-traditional risk factors with the excess risk [of heart disease among persons with RA]. The third major area I will discuss will be the implications of those findings for the prevention of heart disease and RA.

2. Will any controversies be addressed in your presentation? If so, what are they?

I will not be addressing controversies, per se, but rather paradoxical events that occur when treating patients with RA and heart disease. For example, I will discuss what is referred to as the “paradoxical effect of lipids,” which means that high cholesterol present in someone without RA might mean something different in a patient with RA who has high cholesterol. Further, RA itself may impact the way we understand and interpret certain cholesterol values as some of the drugs that are prescribed to our patients [with RA] can raise his/her cholesterol level. However, it should be noted that that higher level may not translate into higher risk of heart disease, but may actually translate into a decreased risk of heart disease. Thus, it is a paradox. I will also discuss the body mass index (BMI) paradox. In patients without RA, a high BMI is associated with higher risk of heart disease, but patients with RA who have a low BMI have increased risk of cardiovascular disease and cardiovascular-related death.

3. As you know, this is the second CRA/MCR Joint Congress. What do you think are the positive contributions of having such an international conference?

I think it’s always valuable to bring people of the same specialty together from different countries because they have different approaches to healthcare, meaning they will have different insights regarding how to care for patients. [Canadian and Mexican rheumatologists] have different care practices and experiences, and deal with patient populations who have different exposures/presentation of rheumatic diseases and genetic backgrounds. Thus, it is always valuable to teach and learn from one another.

Sherine Gabriel, MD, MSc
Past President, American College of Rheumatology
William J. And Charles H. Mayo Professor,
Professor of Medicine and Epidemiology,
Co-Principal Investigator and Director of Education,
Mayo Clinic Center for Translational and Science Activities (CTSA)
Medical Director,
Office for Strategic Alliances and Business Development
Keynote Speaker: Dr. Hyon Choi

Dr. Hyon Choi, one of the Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress’ keynote speakers, received his master’s and doctorate degrees in epidemiology from Harvard University and rheumatology fellowship training at Harvard Medical School and Massachusetts General Hospital. Dr. Choi’s published discoveries include the link between fructose-rich beverages and the future risk of gout, and the inverse link between dairy products, vitamin C and coffee and the future risk of gout. He has also conducted large prospective studies that have clarified the role of conventional risk factors for gout, including alcoholic beverages, purine-rich foods and adiposity, among others. At the Congress, Dr. Choi’s presentation will highlight advances in the genetics of hyperuricemia and gout; discuss evidence-based approach to lifestyle modifications for gout; and list new pharmacologic options for gout. Dr. Choi answered a few choice questions from The Journal of the Canadian Rheumatology Association (CRAJ) to discuss his presentation at the Congress (including any controversies that might be addressed), and what areas of research he would like to focus on in the future.

1. What areas of research are you presently focusing on? My current research focuses on gout among women, the genetics of gout, clinical and cost-effectiveness of biologics in rheumatoid arthritis, and the epidemiology of psoriatic arthritis and psoriasis. The areas of research I would like to continue in the future include clinical and cost-effectiveness of medications for gout and the pathogenesis of and therapeutics for gout.

2. Why do you believe your presentation on the advances in genetics of hyperuricemia and gout, and lifestyle modifications/pharmacologic approaches to gout are relevant to the Canadian and Mexican rheumatologists who will be in attendance? Gout, previously called a “disease of kings,” has changed its epidemiology to a “disease of commoners” in the modern era. As foods have become abundantly available and lifestyle has become increasingly sedentary, the prevalence of gout has increased substantially over the past few decades, particularly in westernized countries. As gout is a common inflammatory arthritis that rheumatologists manage, this topic is directly relevant to rheumatologists in Canada, Mexico and beyond.

3. Will any controversies be addressed in your presentation? If so, what are they? As gout has been known since Antiquity, there have been substantial myths surrounding the condition, regarding what to do and what not to do. The aforementioned advances in our knowledge on the risk factors for gout have led to a paradigm shift to new lifestyle modification strategies for gout and hyperuricemia. This presentation will review an evidence-based approach to lifestyle modifications for gout.

4. Why have you chosen to present this subject? Gout is a common and excruciatingly painful inflammatory arthritis. Emerging evidence suggests that gout is strongly associated with metabolic syndrome and may lead to myocardial infarction, diabetes and premature death. Recently, there has been a considerable expansion in our knowledge of causes and management of gout, and rheumatologists should be aware of the practical implications of these advances.

5. As you know, this is the second CRA/MCR Joint Congress. What do you think are the positive contributions of an international conference such as this? Some of the key contributions are to create the opportunity to establish cross-border research collaboration and share experience in rheumatology care.

Hyon Choi, MD, DrPH, FRCPC
Professor of Medicine,
Boston University School of Medicine
Associate Faculty,
Rheumatology Division,
University of British Columbia
Faculty, Brigham and Women’s Hospital
Attending Rheumatologist,
University of British Columbia and
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Boston, Massachusetts
Dr. Ruben Burgos-Vargas, one of the Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress’ keynote speakers, completed his medical degree at the Facultad de Medicina, Universidad Nacional Autónoma de México in Mexico City and completed his post-graduate medical training at the following institutions: Hospital General de México and Facultad de Medicina, Universidad Nacional Autónoma de México, the Canadian Red Cross Memorial Hospital in Taplow, Berkshire and the Northwick Park Hospital, Clinical Research Centre in Harrow, Middlesex, U.K. Dr. Burgos-Vargas has focused his research on spondyloarthritis (SpA) and juvenile SpA for nearly 30 years. He and other collaborating investigators have also contributed to the characterization of clinical/therapeutic approaches of this group of diseases in children. Dr. Burgos-Vargas answered a few questions from The Journal of the Canadian Rheumatology Association (CRAJ) regarding his presentation (including any controversies that might be addressed), and what areas of research he would like to focus on in the future.

1. What areas of research are you presently focusing on? What areas would you like to focus on in the future?
I have focused on SpA and juvenile SpA for nearly 30 years. I collaborate with other investigators in research areas, including rheumatoid arthritis (RA), gout and medical anthropology. Besides clinical and therapeutic approaches, we’ve also extended our research on genetic and pathogenetic aspects of such disorders. We have also started some relevant epidemiological aspects, as well as classification and diagnostic criteria. Our research group is also very interested in medical anthropology, and we have finished a collection of papers we are expecting to publish very soon.

2. In your presentation at the CRA/MCR Joint Congress what new information will be highlighted and why is this relevant to Canadian and Mexican rheumatologists who will be in attendance?
My presentation will focus on the epidemiology and classification of SpA, an important group of chronic, potentially disabling diseases, in Canada and Mexico. Clinical presentation may be different among the two countries, but their classification, diagnosis, and treatment are very similar. Canadian and Mexican specialists in SpA share some thoughts about the role of new classification criteria and, therefore, issue common agreements and recommendations about them.

3. Will any controversies be addressed in your presentation? If so, what are they?
Some controversies that may be addressed include the role of new classification criteria and the two costly approaches to this disease examined in community studies.

4. Why have you chosen to present this subject?
The classification and epidemiology of SpA is certainly a hot topic, and we are trying to learn and evaluate their usefulness in different countries.

5. As you know, this is the second CRA/MCR Joint Congress. What do you think are the positive contributions of an international conference such as this?
Direct and personal contact with investigators from different countries help to understand the way we work, investigate, approach problems and resolve them with people interested in the same areas from each country. More importantly, we may plan collaborative projects and the results may be beneficial to Canadian and Mexican rheumatologists. Further, but no less important, is the social aspect of the meeting.

Ruben Burgos-Vargas, MD
Medical Sciences Investigator,
Department of Rheumatology,
Hospital General de México
Professor of Medicine,
Facultad de Medicina,
Universidad Nacional Autónoma de México
Mexico City, Mexico
Keynote Speaker: Dr. Mary-Carmen Amigo

Dr. Mary-Carmen Amigo, one of the Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress' keynote speakers, was born and raised in Mexico City and completed her medical degree at the Universidad Nacional Autónoma de México in Mexico City. She completed her post-graduate medical training in the rheumatology department at the Instituto Nacional de Cardiología Ignacio Chávez in Mexico City, and also had the opportunity to intern at St. Thomas' Hospital at the Rayne Institute, located in London, U.K. She is currently the Head of the Rheumatology Department at the ABC Medical Center in Mexico City. In this issue of The Journal of the Canadian Rheumatology Association (CRAJ), Dr. Amigo answered a few choice questions regarding her presentation at the CRA/MCR Joint Congress, including any controversies that might be addressed and what areas of research she would like to focus on in the future.

1. What areas of research are you presently focusing on? What areas would you like to focus on in the future?
Our focus is the research of the cardiovascular manifestations of antiphospholipid syndrome (APS) with emphasis on valvular lesions. [My research group and I] have contributed to the study of the clinical manifestations of APS, especially regarding cardiovascular, pulmonary and renal complications. Currently, we are developing an APS Damage Index and are planning to study the obstetric complications of APS.

2. In your presentation at the CRA/MCR Joint Congress, what new information will be highlighted and why is this relevant to Canadian and Mexican rheumatologists who will be in attendance?
I am going to present an update on the visceral manifestations of APS. I think it is relevant because the correct diagnosis and the treatment of these complications require extensive knowledge on this topic.

3. Will any potential controversies be addressed in your presentation? If so, what are they?
I will be addressing controversies regarding treatment in particular clinical scenarios (i.e., the anticoagulation intensity) that I will then comment on.

4. Why have you chosen to present this subject?
I am presenting this subject because APS is one of the most common autoimmune diseases which impacts patients in all branches of medical practice. Further, the optimal therapy for many clinical scenarios has not yet been defined, but important advances have taken place during the past few years.

5. As you know, this is the second CRA/MCR Joint Congress. What do you think are the positive contributions of an international conference such as this?
I believe this type of international conference helps promote the personal acquaintance of Canadian and Mexican rheumatologists and creates stronger ties between both nations.

Mary-Carmen Amigo, MD, FACP
Head, Rheumatology Department
ABC Medical Center
Member, Ethics Committee,
Instituto Nacional de Cardiología Ignacio Chávez
Mexico City, Mexico
Read on to learn what your Canadian rheumatology colleagues will be discussing during the Concurrent Sessions at the upcoming Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) 2nd Joint Congress, taking place from Friday, February 11th to Tuesday, February, 15th.

**Basic Science of Immunology Rheumatic Diseases**

**Chairs:** Dr. Joanne Homik (CRA) and Dr. Jorge Alcocer Varela (MCR)

**Diagnostic and Prognostic Serology in Rheumatoid Arthritis (RA)**

**Speaker:** Dr. Gilles Boire

**Learning objectives:**
1. Rheumatoid factor (RF) and antibodies to citrullinated protein antigens (ACPAs) are rheumatoid arthritis (RA)-associated antibodies and frequently co-exist in the same patients.
2. Anti-cyclic citrullinated peptide (anti-CCP) antibodies are ACPAs; are specific markers of RA; and remain stable over time. Their use is mostly diagnostic.
3. Anti-Sa and anti-mutated citrullinated vimentin (anti-MCV) antibodies are closely related ACPAs that are specific markers for poor outcomes. Their use is diagnostic and prognostic.

**Abstract:**
Rheumatoid arthritis (RA)-associated antibodies include rheumatoid factor (RF) and antibodies to citrullinated protein antigens (ACPAs). When present, ACPAs coexist with RF in more than 80% of patients. ACPAs are more specific for RA than RF, but they are also less prevalent in early inflammatory arthritis (EIA). Three ACPAs are now commercially available: anti-cyclic citrullinated peptides (anti-CCP), anti-mutated citrullinated vimentin (anti-MCV) and anti-Sa. Anti-CCP (50%) are more prevalent than anti-MCV and anti-Sa (25%) in EIA and, contrary to anti-Sa, tend to persist even with prolonged disease control. Anti-CCP, but not anti-Sa, may be present years prior to clinical onset of RA and in healthy relatives of RA patients. With intensive treatment of EIA, more than 50% of patients with anti-Sa, up to 25% with RF, but less than 10% with anti-CCP will lose their antibodies (seroreversion). In the case of RF, seroreversion is associated with good outcomes similar to initially seronegative patients. In many cohorts, anti-Sa and RF are more closely associated with poor outcomes than are anti-CCP. As a consequence, anti-CCP antibodies are most useful as a diagnostic aid, while anti-Sa and RF have both diagnostic and prognostic significance in EIA.

**The Use and Abuse of the ANA Test in Diagnosing SLE**

**Speaker:** Dr. Marvin Fritzler

**Learning objectives:**
1. Which is worse, false negative or false positive antinuclear antibodies (ANA) test results?
2. Is the ANA titer a critical factor?
3. What didn’t the laboratory tell you that you should know?
4. Are there compelling reasons to abandon the conventional indirect immunofluorescence (IIF) ANA test?

**Abstract:**
The antinuclear antibody (ANA) test has been widely used as part of the diagnostic approach to systemic lupus erythematosus (SLE) and other systemic autoimmune rheumatic diseases (SARD) for over 50 years. In the last decade, a number of new ANA screening technologies have emerged that are increasingly being used as a replacement for the time honored indirect immunofluorescence (IIF) ANA. While the ANA IIF test is known to be plagued by significant false positives, newer ANA screening tests are plagued by false negatives. Recently, a committee commissioned by the American College of Rheumatology (ACR) concluded that the IIF ANA test should be regarded as the “gold standard” screening test to detect ANA in SARD patients.
Neonatal Lupus
Speaker: Dr. Earl Silverman

Learning objectives:
1. Understand autoantibodies associated with neonatal lupus erythematosus (NLE)
2. Understand who and when to screen pregnancies.
3. Understand that NLE is more than a congenital heart block.

Abstract:
Neonatal lupus erythematosus (NLE) is characterized by the transplacental passage of maternal anti-Ro and/or anti-La antibodies, and characteristic illnesses in the fetus/neonate. The most significant complication is complete congenital heart block. It is most closely linked to anti-Ro52 antibodies although other specificities have been implicated. Current recommendations include screening of all at risk pregnancies with serial fetal echocardiograms and the use of fluorinated corticosteroids if heart block develops.

Overall non-cardiac involvement of NLE is more common than cardiac. Skin involvement is present in 15% to 25% of children with NLE. The NLE rash tends to be photosensitive, but may be present at birth and is most frequently seen around the eyes, not in the malar area. Asymptomatic elevation of liver function tests is seen in 10% to 25% of cases of NLE. Mild hepatomegaly may be present (neutropenia and thrombocytopenia are the common hematologic manifestations). Hematologic involvement is almost always asymptomatic.

Neurologic manifestations of NLE include: hydrocephalus, non-specific white matter changes, calcification of the basal ganglia, and a vasculopathy. The most unusual feature of NLE is the radiographic finding of stippling of the epiphyses (chondrodysplasia punctata).

These manifestations and autoantibody screening will be reviewed in the presentation.

Drugs in Pregnancy and While Breastfeeding
Speaker: Dr. Stephanie Keeling

Learning objectives:
1. To review existing data on the safety and use of medications for rheumatic diseases.
2. To reconcile the discrepancy between clinical experience and drug safety ratings, such as the U.S. Food and Drug Administration (FDA) Categories
3. To visit a few old and new drugs in the treatment of rheumatic disease, and where they fit in pregnancy and lactation.

Abstract:
Many rheumatic diseases occur in women of child-bearing age, thereby requiring careful consideration of medication use during this period and the possible effects they may have on the mother and the developing baby. While rheumatoid arthritis (RA) patients often improve or remit by the second trimester, some do not, and patients with conditions, such as lupus are less predictable during pregnancy. Corticosteroids remain the mainstay of treatment in the pregnant and breastfeeding rheumatic disease patient. Other commonly used medications include hydroxychloroquine and sulfasalazine, despite being FDA category B or lower. Underused but effective medications in the pregnant rheumatic disease patient, include gold and azathioprine. The use of TNFα-inhibitors peripartum is not clear, but are typically discontinued upon identification of the pregnancy. Intravenous immunoglobulin (IVIG) may show promise in reducing moderate-to-severe systemic lupus erythematosus (SLE) flares during pregnancy.

Agents, including methotrexate, leflunomide and mycophenolate mofetil are known teratogens and must be discontinued for drug-specific durations prior to conception attempts. Angiotensin-converting-enzyme-inhibitors and angiotensin-receptor-blockers for scleroderma renal crisis are contraindicated in pregnancy. In antiphospholipid antibody syndrome, low-molecular heparin and low-dose aspirin are considered safe whereas warfarin is contraindicated. Limited data exists for the newer biologics.
Systemic Lupus Erythematosus (SLE) in Canadian Aboriginal Populations
Speaker: Dr. Christine Peschken

Learning objectives:
1. Be aware of the heterogeneity of lupus prevalence and phenotype in North American Aboriginal populations.
2. Be aware of the similarities in clinical manifestations and outcomes across minority groups with systemic lupus erythematosus (SLE) in North America.
3. Be aware of the impact of socioeconomic factors on poor outcomes in Aboriginal patients with SLE.

Abstract:
While there is a relative paucity of literature on lupus in indigenous populations, available data demonstrate the marked variation in prevalence and phenotype of systemic lupus erythematosus (SLE) between different indigenous groups in North America. In contrast to the relatively uniform descriptions of high prevalence and severe disease for rheumatoid arthritis (RA), prevalence, severity, and phenotype appear to differ widely depending on the population studied, echoing the heterogeneity seen worldwide in SLE. Prevalence rates vary from extraordinarily high to much lower than expected, and disease features range from mild-to-severe with or without atypical features. This makes it clear that data generated from one group cannot be generalized to North American indigenous peoples as a whole.

In Manitoba, we have established a higher than expected prevalence rate, but the phenotype and severity are less well defined depending on the research method used. Outcomes (damage, and mortality) appear to be worse, however, the majority of this excess burden of disease is likely attributable to poverty and other socioeconomic factors. Further, patient care is complicated by higher rates of comorbidities and distance from care providers. Self-assessed disease activity is high, as is self-reported depression and poor self-rated health-related quality of life. These findings illustrate the complex interaction of sociodemographic, biological and health-related behaviors in patients with lupus.
Limited Scleroderma
Speaker: Dr. Janet Pope

Learning objectives:
1. To form a differential diagnosis of systemic sclerosis (SSc) mimickers
2. To identify the types of morphea.
3. To discuss treatment and understand that there are not proven treatments for generalized morphea.

Abstract:
Systemic sclerosis (SSc) can be confused with other scleroderma-like skin disorders, such as eosinophilic fasciitis (EF), generalized morphea, scleromyxedema and nephrogenic systemic fibrosis. In most of these conditions, Raynaud's phenomenon, sclerodactyly, and nailfold capil-
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Genetics
Speaker: Dr. Rae Yeung
Learning objectives:
1. To review current knowledge of the biologic basis of juvenile idiopathic arthritis (JIA).
2. To describe methodology for studying genetic basis of disease.
3. To present a new international JIA research consortium aimed at understanding the biologic basis for JIA.

Abstract:
Early aggressive therapy would reverse morbidity and long-term disability in childhood arthritis, but is restricted by poor capacity to detect early disease and predict outcomes.

Outcomes
Speaker: Dr. Ciaran Duffy
Learning objectives:
1. To review current knowledge and paradigms of studying outcomes for juvenile idiopathic arthritis (JIA).
2. To review the development of the Canadian JIA research cohort Research on Arthritis in Canadian Children-Emphasizing Outcomes (ReACCh Out) study.
3. To describe the short-term outcomes and predictors of outcome in the ReACCh Out cohort.

Abstract:
The Canadian Alliance of Pediatric Rheumatology Investigators (CAPRI) has developed a national research network that addresses outcomes in juvenile idiopathic arthritis (JIA). With strong input from an excellent steering committee and the collaboration of over 40 investigators from coast-to-coast, an initial study called Research on Arthritis in Canadian Children-Emphasizing Outcomes (ReACCh Out) has enrolled more than 1,500 patients with new-onset JIA. This study aims to permit a better understanding of the course and outcome of the disease, and to identify, at an early stage, the factors associated with and predictive of better outcomes. This study has also laid the foundation for studies focused on the biologic basis of the disease. One such study, Biologically-based Outcome Predictors (BBOP), seeks to identify environmental, genetic and biologic factors that might be predictive of certain disease outcomes, particularly health-related quality of life.

A recent additional focus is on exercise and physical activity in patients with JIA, the Linking Exercise, Physical Activity and Pathophysiology in JIA (LEAP) study.
New Spondyloarthritis (SpA) Criteria and Undifferentiated SpA
Speaker: Dr. Walter Maksymowych

Learning objectives:
1. To understand the rationale for the development of the new criteria.
2. To understand the principal elements of the new criteria and the special role of magnetic resonance imaging (MRI).
3. To understand how the new criteria may be implemented in clinical practice.
4. To understand how MRI can be optimized to diagnose pre-radiographic and undifferentiated spondyloarthritis (SpA).

Abstract:
Spondyloarthritis (SpA) is a group of inflammatory disorders associated with the HLA-B27 gene that primarily affect the sacroiliac (SI) joint, structures of the spine, large peripheral joints and entheses. Diagnosis still relies primarily on the demonstration of structural abnormalities in the SI joint on radiography. This is not only recognized as a potentially late feature of disease, but patients may experience considerable symptomatology for years before diagnosis and appropriate therapy. Magnetic resonance imaging (MRI) is capable of detecting inflammatory changes in bone marrow and soft tissues, and is now widely accepted as the most sensitive imaging modality for detecting sacroiliitis, the hallmark of SpA. It may therefore detect abnormalities in the SI joint prior to radiography. The recently published Assessment of SpondyloArthritis (ASAS) International Society classification criteria for axial SpA include, for the first time, a positive MRI demonstrating sacroiliitis as an acceptable imaging criterion indicative of SpA. An ASAS working group has also proposed a definition of a positive MRI for sacroiliitis, according to consensus opinion, entirely based on the presence of bone marrow edema on the short-tau inversion recovery (STIR) sequence or osteitis on the T1-weighted gadolinium (GD)-augmented sequence (T1 post-Gd). Systematic and standardized evaluation of SI joints in early SpA patients has shown that MRI has much greater diagnostic utility than documented previously.

Moreover, long-term follow-up has shown that active inflammation, as depicted by bone marrow edema on MRI, predicts the development of radiographic sacroiliitis, indicating that marrow edema is an important target lesion for therapeutic intervention. Early studies with anti-tumor necrosis factor (anti-TNF)-α agents in pre-radiographic SpA have demonstrated that reduction of marrow edema is associated with alleviation of symptoms. Consequently, it is important for clinicians to recognize and interpret these findings on MRI to facilitate management of their patients.
Inflammatory Myopathies
Chairs: Dr. Alfred Cividino (CRA) and Dr. Dionicio Galarza (MCR)

Autoantigens and Autoantibodies: Insights into the Pathogenesis of Autoimmune Myositis (AIM)
Speaker: Dr. Jean-Luc Sénécal

Learning objectives:
1. Discuss evidence that major myositis autoantigens are bifunctional molecules.
2. Review pathogenic mechanisms linking cancer and myositis.
3. Identify the major autoantibodies associated with autoimmune myositis (AIM).

Abstract:
Significant progress is being made in the understanding of the pathogenesis of autoimmune myositis (AIM). Evidence will be discussed that the Jo-1 autoantigen is a bifunctional molecule that acquires, when released extracellularly, cytokine-like activity.

We will also review pathogenic mechanisms explaining the link between cancer and myositis. The major autoantibodies associated with AIM will also be discussed.

A Novel Approach to the Classification and Diagnosis of Autoimmune Myositis (AIM)
Speaker: Dr. Yves Trovanov

Learning objectives:
1. Review the key diagnostic features of a novel classification for autoimmune myositis (AIM).
2. Identify, at presentation, myositis mimickers and cancer-associated myositis.
3. Describe novel and autoantibody-defined AIM clinical subsets.

Abstract:
Autoimmune myositis (AIM), also known as idiopathic inflammatory myopathies, may be described and classified clinicoserologically. Muscle biopsy findings may add diagnostic accuracy at presentation and help identify new subsets of disease. This novel classification may assist clinicians to identify and tailor treatment of key AIM subsets, and improve patient outcomes.

Rheumatoid Arthritis (RA) Management in Complicated Patients
Chairs: Dr. Denis Choquette (CRA) and Dr. Daniel Xibille-Friedmann (MCR)

Cancer and Rheumatoid Arthritis (RA)
Speaker: Dr. Sasha Bernatsky

Learning objectives:
1. Provide helpful answers to patient questions concerning the baseline risk of common cancers in rheumatoid arthritis (RA).
2. Defend the appropriateness of aggressive therapy to control disease in RA, keeping in mind the relative risk-to-benefit ratio for adverse events, such as malignancies.

Abstract:
Each year, we learn more about the pathogenesis behind “autoimmune diseases” like rheumatoid arthritis (RA). Simultaneously, there has been an explosion of knowledge in the field of oncology, including lymphoma pathogenesis. RA is a prime example of an autoimmune disease where concerns about malignancy risk (particularly lymphoma) have risen. In part because of the increased understanding of autoimmune disorders and malignancy, we have begun to comprehend why cancer risk may be altered in RA.

This presentation will review the literature regarding cancer risk and risk factors in RA.
**Biologic Therapies and Infectious Diseases**  
**Speaker:** Dr. Paul Haraoui

**Learning objectives:**  
1. Identify the risk factors for serious infections.  
2. Compare the different biologic agents.  
3. Review the routine screening procedures before initiating biologic therapy.  
4. Discuss relevant immunizations.

**Abstract:**  
With the large experience developed after almost a decade of widespread use of different biologic agents for the management of several rheumatic diseases, one of the major concerns is still the issue of infectious diseases.

This session will review the practical approach for the prevention and management of infectious diseases in daily clinical practice:  
- With proper screening and prophylaxis, tuberculosis is now a manageable issue.  
- The identification of risk factors for serious infections, such as the use of corticosteroids and the presence of comorbidities (i.e., diabetes and chronic obstructive pulmonary disease [COPD]) will help educate patients and improve monitoring.  
- An important issue is also the prevention of common infections by proper immunization.

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**Biologic Therapies for Orphan Diseases**  
**Chairs:** Dr. Simon Carrette (CRA) and Dr. Leonor Barile Fabris (MCR)

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**Oh Woe is Me. Where Did All the Lupus Trials Go?**  
**Speaker:** Dr. John Esdaile

**Learning objectives:**  
1. So many novel agents, so many negative trials. Let me confuse you.  
2. Understand what agents are left standing.

**Abstract:**  
The second decade of the new millennium was to be the lupus decade, just as the first decade had seen major therapeutic advances in rheumatoid arthritis (RA). Yet, studies of rituximab and ocrelizumab have been abandoned, mycophenolate failed a U.S. Food and Drug Administration (FDA) test, and abatacept is still unproven. Problems have included the failure to take into account the relapsing-remitting pleomorphic nature of lupus, the choice of outcomes that failed to capture clinical benefit, and, conceivably, that the initial scientific belief was incorrect.

However, all is not lost. Better use of old agents continues to improve outcomes and the anti-cytokine approach to lupus therapy is not dead. The second decade is just beginning.

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**Sarcoidosis and Biologic Therapy**  
**Speaker:** Dr. Nader Khalidi

**Learning objectives:**  
1. Briefly review the criteria for sarcoidosis.  
2. Review the musculoskeletal (MSK) manifestations of sarcoidosis.  
3. Review the use of biologic therapy in sarcoidosis

**Abstract:**  
This session will focus on sarcoidosis and, in particular, the role of traditional agents and their uses (i.e., hydroxychloroquine, methotrexate, azathioprine and cyclophosphamide) compared to trials studying etanercept and infliximab as steroid sparing agents.
Sports Medicine and Soft Tissue Syndromes

Chairs: Dr. Gunnar Kraag (CRA) and Dr. Juan J. Canoso (MCR)

Sports Medicine in an Adult Rheumatology Practice
Speaker: Dr. Robert McDougall

Learning objectives:
1. Examine the skill set of rheumatologists as they pertain to the practice of sports medicine.
2. Review strategies that incorporate sports medicine in a rheumatology practice.
3. Consider ways to promote rheumatologists in the area of sports medicine.

Abstract:
The practice of rheumatology is diverse and includes many branches of internal medicine, all while highlighting musculoskeletal (MSK) diseases. In recent years, physical activity as a means of promoting health, wellness and the prevention of disease has increased the profile of sports medicine and exercise. Activity-related MSK injuries are commonly seen in rheumatology practice in association with sports, recreation, occupational considerations and everyday living.

The rheumatologist is well suited for the area of sports medicine and MSK conditions. The understanding of joint disease (inflammatory and non-inflammatory) myopathies and neurology in the context of systemic disease and injury are all important assets for the practice of sports medicine. Knowledge of anti-inflammatory, analgesics, injection and aspiration techniques for diagnostic and therapeutic purposes are invaluable. In addition, the understanding of diagnostic imaging and the liaisons between occupational therapy, physiotherapy and orthopedic surgery make the rheumatologist well placed for the practice of sports medicine. The objective of the session is to examine the skill set of rheumatologists that complement the area of sports medicine, and provides strategies as to how to implement these skills in a manner that perhaps promotes rheumatologists in the area of sports medicine.

Reference:

Sports Medicine in a Pediatric Rheumatology Practice
Speaker: Dr. Claire Leblanc

Learning objectives:
1. To review the general concepts of pediatric overuse injuries.
2. To raise awareness of common non-inflammatory causes of musculoskeletal (MSK) pain that might present to pediatric and adult rheumatology practices.
3. To learn current treatment recommendations for several pediatric overuse injuries.

Abstract:
According to a recent longitudinal analysis of a Canadian pediatric rheumatology clinic population, Rosenberg found over 30% of the 2,026 patients had mechanical diagnoses. Many of these were overuse conditions commonly seen in the young athlete population. Given the high prevalence of these non-inflammatory conditions, there is a need to provide continuing medical education about various non-inflammatory mechanical diagnoses to rheumatologists.

The objectives of this session are to review the general concepts of pediatric overuse injuries and various strategies to prevent these conditions. Through several case-based presentations, the attendee should appreciate common non-inflammatory causes of musculoskeletal (MSK) pain that might be referred to pediatric or adult rheumatology practices. They should learn about current treatment recommendations, including appropriate referral to pediatric sports medicine specialists or orthopedic surgery.

Reference:
Prognostic and Diagnostic Markers and New Criteria for Early Arthritis  
Speaker: Dr. Hani El-Gabalawy

Learning objectives:
1. To review new clinical criteria for the diagnosis of early inflammatory arthritis (EIA).
2. To explore biomarkers that are of potential value in the diagnosis of EIA.
3. To explore biomarkers that are of potential value as prognostic markers for EIA.

Abstract:
Early inflammatory arthritis (EIA) frequently poses a diagnostic and prognostic challenge to clinicians. Although a wide number of disorders are considered, rheumatoid arthritis (RA) is typically high on the differential diagnosis. The 1987 American College of Rheumatology (ACR) criteria for RA have recently been replaced by a new set of criteria through a combined ACR/European League Against Rheumatism (EULAR) initiative. Formal testing of these criteria in a variety of clinical and research settings will be required to determine their value to clinicians and investigators.

There has been widespread interest in the identification of biomarkers that would be of additional value to clinicians in determining diagnosis, and in particular, prognosis in EIA. Candidate biomarkers have emerged from studies of autoantibody profiles and from studies using broadly based genomic, transcriptomic and proteomic techniques applied to peripheral blood, synovial fluid and tissue. Although, to date, few of these candidate biomarkers have reached the stage of widespread clinical testing, there are a number of promising approaches and candidates, which will be discussed in this presentation.

Early Management  
Speaker: Dr. Vivian Bykerk

Learning objectives:
1. To understand the rationale for treating within the window of opportunity for patients with new onset rheumatoid arthritis (RA).
2. To enable the physician to choose treatment strategies for patients with early RA that will optimize their long-term outcome.
3. To appreciate what guidelines are saying about the early treatment of RA in regards to the goals of therapy.

Abstract:
Several studies have shown that joint damage can occur as early as four months in patients presenting with symptoms of RA. Early treatment with disease-modifying anti-rheumatic drugs (DMARDs) can improve the signs and symptoms of RA, as well as lessen radiographic progression in patients with early RA compared with delayed treatment. Recent evidence suggests that there may be a “window of opportunity” to treat RA, and when treatment is initiated within this time the course of the disease can be modified leading to a higher probability of remission. The initial choice of therapy should be based on the patient’s prognosis. Most often this includes methotrexate in combination with other DMARDs and, if needed, short-term use of steroids. Data from the Swedish Pharmacotherapy (SWEFOT) study suggests that there are patients who will experience radiographic progression while taking methotrexate monotherapy even though they are in a low disease activity state. Another means to optimize outcomes for patients with early RA is to use a treatment to target (TTT) strategy. TTT refers to a strategy of treating RA to obtain a target level of minimal disease activity. Six randomized trials of TTT have been performed in RA. All TTT trials have been conducted outside of the U.S., and the largest of these trials had 384 subjects. Four of these trials have demanded that subjects in the intervention arm be treated with specific treatment algorithms, and two of these trials have allowed treating physicians to decide without giving specific options. The treatment target for patients in these trials is either a low disease activity state or remission. Patients treated to a target achieve significantly better control of their disease without an increase in adverse events.

Conclusion. Early assessment and treatment with close monitoring of patients with early RA, targeting remission where possible, is important to optimize long-term outcomes. Specific treatment strategies can be selected from the many proven options to obtain the best results for the individual patient.
Central Nervous System (CNS) Vasculitis
Speaker: Dr. Susanne Benseler

Learning objectives:
1. Recognize distinct disease entities in the spectrum of childhood primary central nervous system (CNS) vasculitis (cPACNS) and inflammatory brain diseases, including clinical presentation, laboratory characteristics, imaging and histopathology.
2. Consider differential diagnoses of cPACNS including secondary CNS vasculitis and non-vasculitis inflammatory brain diseases.
3. Evaluate current diagnostic and therapeutic approaches of childhood CNS vasculitis.

Abstract:
Primary angiitis of the central nervous system in children (cPACNS) is an increasingly recognized, inflammatory brain disease accounting for 80% of childhood vascular strokes. CNS inflammation was recently found to be linked to refractory status epilepticus, movement disorders, severe cognitive dysfunction, optic neuritis and psychiatric symptoms in previously healthy children. Distinct subtypes of CNS vasculitis have been identified, including progressive and non-progressive angiography-positive large vessel cPACNS, small vessel cPACNS, and, most recently, primary CNS venulitis.

A diagnostic approach has to be tailored to the clinical presentations of the distinct subtypes and the expanding spectrum of inflammatory and non-inflammatory brain diseases that have overlapping clinical features. The proposed diagnostic algorithm incorporates traditional and novel laboratory markers, tailored neuroimaging and brain biopsy protocols, and allows for rapid evaluation and initiation of targeted therapies. Studies have confirmed that early diagnosis and aggressive treatment lead to improved neurological outcomes and lower mortality rates. The presentation will summarize the recent data on diagnosis and differential diagnosis, proposed and evaluated treatment regimens, and outcomes of children with cPACNS.

Improved understanding of cPACNS facilitates a tailored diagnostic approach that results in earlier diagnosis and initiation of therapy for this potentially reversible condition.

ARCHiVe: Pediatric Vasculitis Registry
Speaker: Dr. David Cabral

Learning objectives:
1. To recognize the scope of the problem of chronic childhood vasculitis and to understand why childhood disease must be studied separately from adult disease (using a Registry for Childhood Vasculitis [ARCHiVe]) to define a cohort of children for study.
2. To learn about the clinical presentation (presenting features, classification and diagnostic delay) of children with Wegener’s granulomatosis and microscopic polyangiitis.
3. To describe and evaluate the current treatment strategies used by pediatric rheumatologists at the time of diagnosis of children anti-neutrophilic cytoplasmic antibodies (ANCA)-associated vasculitis.

Abstract:
Most knowledge about chronic primary systemic vasculitis (including anti-neutrophil cytoplasmic antibodies [ANCA]-associated vasculitides [AAV]—Wegener’s granulomatosis (WG), microscopic polyangiitis (MPA), Churg-Strauss syndrome—polyarteritis nodosa, Takayasu’s arteritis and primary angiitis of the central nervous system) originates from adult studies. However, disease features, treatment strategies, and outcomes likely manifest differently in growing children. A Registry for Childhood Vasculitis (ARCHiVe) was established using a customized online data-entry interface in 2007 and currently involves 40 U.S./Canada centers with time-of-diagnosis data collected on over 170 children with AAV.

The establishment of the ARCHiVe cohort has allowed us to demonstrate improved sensitivity and specificity of the new European League Against Rheumatism (EULAR)/Paediatric Rheumatology European Society (PReS) pediatric-specific classification criteria for vasculitis over the American College of Rheumatology (ACR) criteria. Pediatric criteria have included clinical features more common in children, such as subglottic stenosis in WG. Limited WG appears to be relatively infrequent in children at presentation compared to adults, and multisystem disease presentation is more common. Neither classification criteria uniquely defines patients with MPA. The range of treatments used for children with AAV, is similar to that described for use in adults, however there is a limited correlation of initial treatment choice with adult-defined disease severity scales. How this initial treatment variation influences outcome in children is not known.
In an effort to promote social activities outside of the Cancun Convention Centre between Mexican and Canadian rheumatologists at the upcoming Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress, our colleagues at the MCR have organized an off-site excursion (i.e., outside of the Convention zone) to Xcaret. If you would like a chance to experience Mexican culture firsthand, come join your Mexican and Canadian colleagues at this eco-archeological site located on the Mayan Riviera for a site visit, dinner and a show. Offering a unique chance to learn the culture and the history of the region, Xcaret is a place where “visitors from all over the world can enjoy the splendor of Mexico’s biodiversity and cultural heritage,” according to its official website.

The park is located approximately 1.5 hours from Cancun, and Congress attendees who have purchased a ticket will travel by bus to the site. Buses will leave the Cancun Convention Centre at 2:30 p.m.

Come join your rheumatology colleagues because, after all, what makes a better story?

Michel Zummer, MD, FRCPC
Associate Professor,
Université de Montréal
Chief, Division of Rheumatology,
Hôpital Maisonneuve-Rosemont
Montreal, Quebec

2011 Photo Contest

Have you captured a candid shot of your fellow rheumatologists or snapped something picturesque?

Don’t forget the batteries or the charger for your camera for the Sixth Annual CRA Photo Contest in Cancun, Mexico. Submit your best scenic and candid photos electronically by February 18th and you’ll have a chance to win a CRA backpack!

All entries will be published in the online edition of the CRAJ, and the winning photos will be published in the spring issue of the journal.

Please email entries to Katherine Ellis at katherinee@sta.ca
The traditional Resident’s Pre-course will be held Friday, February 11 at the second Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress, which will be taking place in Cancun, Mexico, next year. The pre-course promises to be much more interesting than a day at the beach.

With the help of Drs. Evelyn Sutton, Dana Jerome, Kam Shojania and Claire Barber (PGY5), we have set up a great program, which includes a review by Dr. Arthur Bookman on Sjögren’s syndrome; a presentation by Dr. Chris Pineau titled “All about MMF” examining mycophenolate mofetil; a presentation on inflammatory eye disease by Dr. Kam Shojania; a presentation on transition care by Dr. Nicole Johnson; and, finally, a presentation titled “ANAs: For Rheumatologists Only” where Dr. Jean-Luc Senécal will discuss anti-nuclear antibodies. After lunch, we will have the always very stimulating podium presentation of the six best abstracts of our residents as selected by the abstract committee.

You are all cordially invited to come hear (and challenge) the great work of tomorrow’s rheumatologists and, all the while, saving yourself from a bad sunburn.

Hasta luego y Viva la Reumatología!

Éric Rich, MD, FRCPC
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ICRE’s 2010 Program Director of the Year

The Journal of the Canadian Rheumatology Association (CRAJ) would like to congratulate Dr. Heather McDonald-Blumer on her most recent nomination by the Royal College of Physicians and Surgeons of Canada as the 2010 Program Director of the Year.

Dr. McDonald-Blumer was awarded this distinction at the Royal College’s International Conference on Residency Education (ICRE), which took place in Ottawa, Ontario, September 23 to 25. According to the ICRE website, the award is given to a program director who has demonstrated “[...] a commitment to enhance residency education as evidenced by innovation and impact beyond his or her program.”

Dr. McDonald-Blumer is the Program Director of the University of Toronto’s Rheumatology Division. For more information, please visit the ICRE website at: http://rcpsc.medical.org/icre/.

Dr. Heather McDonald-Blumer is the Program Director of the University of Toronto’s Rheumatology Division.
The Canadian Rheumatology Ultrasound Society Goes Live

By Johannes Roth, MD

The Canadian Rheumatology Ultrasound Society (CRUS) has recently been established to promote the use of ultrasonography by Canadian rheumatologists. It is anticipated that the introduction of musculoskeletal ultrasound (MSK US) in rheumatology practices will affect the clinical environment more profoundly than the addition of any other imaging technique in the past. In fact, US will have the unique characteristic of directly informing the diagnostic and clinical-decision making process.

Over the past decade, MSK US has been increasingly recognized worldwide as a useful method to support the clinical assessment in rheumatology practice, but Canada’s implementation of this imaging technique has taken more time. The need to bridge the gap between MSK US and rheumatologists was recognized, and over the past two years a group of adult and pediatric rheumatologists have worked on the proper implementation of MSK US in rheumatology practices in Canada. The main goal was to ensure that rheumatologists using MSK US had a reliable standard of skills.

Established in June of this year, the CRUS is a non-profit organization for Canadian rheumatologists, endorsed by the CRA. The first Executive Committee contains a varied and distinguished group of pediatric and adult rheumatologists, including Drs. Karen Adams, Artur de Brum-Fernandes, Alessandra Bruns, Vivian Bykerk, Abraham Chaiton, Margaret Larché, Visithan Khy, Johannes Roth and Michael Stein.

The Society is currently accepting membership application forms, which can be obtained via email from sonja.roth@femtec.org. Membership benefits include access to protected areas of the Society’s website with tools for ongoing maintenance of US skills; support in implementation and billing of US in a clinical practice; and ways to actively participate in shaping/creating this new Society.

The CRUS will provide rheumatology US certification with very high certification standards. This certification can be attained by any rheumatologist who has participated in a certain amount of training and who will then have to demonstrate his/her skills by means of supervised scans and a written exam. Recognizing the various needs among rheumatologists, there will be a limited certification focused on wrists, fingers and toes, and a complete certification, which would include all joints accessible by ultrasonography. Further, information on recommended training courses and certification are posted on the Society’s website: www.ecrus.ca.

The second major focus of the CRUS will be to foster research in the area of rheumatology US. Interestingly, the first activity of CRUS will combine both aspects by offering an educational study in which two methods of US training will be compared, and during which participants will also have the opportunity to become trained and certified in rheumatologic US. Three training weekends will be offered, with participants required to upload images for assessment and feedback.

We are convinced that the usefulness of ultrasonography for clinical practice and increased precision in research will be evident to anyone using this imaging technique in their clinical practice, and hope to have the support and active participation of all Canadian rheumatologists.

Johannes Roth, MD
Associate Professor of Pediatrics,
University of Ottawa
Head, Pediatric Rheumatology,
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Ottawa, Ontario
The Weather Outside is Frightful

By Glen Thomson, MD, FRCPC

Two thirds of the rheumatologists responding to this issue’s Joint Count survey believe that between 10% to 50% of arthritis patients are adversely affected by weather. Three quarters of the respondents rate “damp weather” as the greatest determinants followed by “changes in the weather” and “cold weather,” respectively. Less than a third of those replying believe that changes in barometric pressure affect joint pain (despite the classic works of Hollander in 1961). Less yet think that overcast skies have any influence despite the volumes of work on seasonal affective disorder (SAD).

Arthritis and the Weather: Is there a Link?
Not every patient with arthritis complains of weather-related phenomena. In my practice, only about one in three patients are “weather responders.” Those that are afflicted will often complain about their symptoms aggressively throughout our prolonged Canadian Winter; changes to therapies are often required. However, the majority of patients do not seem to have the same symptom alteration synonymous with environmental changes. Perhaps this is why some studies do not demonstrate any significant difference with weather changes in the cumulative population of patients with arthritis, as seen in the following studies: Osteoarthritis pain and weather by Wilder et al and Rheumatoid arthritis patients show weather sensitivity in daily life, but the relationship is not clinically significant by Gorin et al.\(^1,2\)

There is a dearth of hard scientific data about the etiology of increased pain due to environmental changes in those susceptible subgroups of patients with arthritis. Damp weather and cold weather will cause muscles to shiver more to maintain body heat, thereby producing traction on less than perfect musculoskeletal structures, which in turn may amplify pain. It has been indicated that cold weather exacerbates pain in patients with juvenile arthritis.\(^3\)

Further, changes in the weather, which usually indicate low-pressure systems, have often been associated with symptom aggravation in migraine sufferers. This has also been demonstrated in some patients with arthritis. It is postulated that the decrease in atmospheric pressure may increase mechanoreceptor firing in joint capsules, thus producing more pain.\(^4,5\)

What is the Solution?
Is the solution for these patients the consumption of more analgesics and anti-inflammatories or a trip to the travel agent? The respondents in this survey were roughly split on whether individuals who escape to more pleasant climates for the winter come back healthier. There is little question that individuals who are on holiday in warm locations are going to be given the opportunity to do more physical exercise than those of us confined by climate. There are also great psychologic benefits of not reaching the point of “igloo fever” late in the winter. Balanced against this is the predominant desire of the snowbird to not seek medical attention away from our paradise of no cost medicare. Some medical issues may go unattended for a number of months and, perhaps, reduce the perceived overall benefit of warmer climates to this patient population.

Best Places to Travel for Patients with Arthritis
Where, then, is the optimal winter location for individuals with arthritis? The prescription for the ultimate retreat would include sun to ward off SAD, lots of warmth to relax muscles, and a relatively stable weather pattern to prevent the barometric low pressures (especially storms) that seem to exacerbate joint complaints.

This issue’s survey respondents clearly think that dry weather is the icing on the cake for the arthritis traveler. Almost two thirds agree or strongly agree that Arizona is the best place to winter (just don’t forget your photo ID and passport documents). Almost half of our expert respondents agree or strongly agree that Mexico and other American sunshine states (equally) are good for our arthritis population. Shockingly, the sunny, high barometric pressure winter clime of Manitoba was just not competitive. And I thought that icing inflamed joints was good for them.

Glen Thomson, MD, FRCPC
Editor-in-chief, CRAJ
Winnipeg, Manitoba
(Planning to hibernate until the spring)

References:
We Can Work It Out: Occupational Medicine Tips for the Working Rheumatologist

By Brent R.J. Thomson, MD

John is a 42-year-old male with a seven-year history of rheumatoid arthritis (RA). He has had problems tolerating medications, and it has taken some effort to bring his RA under control. He has been absent from work for eight months, but was eventually able to return to his regular job as a machinist of small automotive parts. His current medications are methotrexate, an anti-tumor necrosis factor-α (anti-TNFα), a disease-modifying anti-rheumatic drug (DMARD) and an anti-inflammatory medication. Recently, he experienced a severe episode of bronchitis. The DMARD was held and, subsequently, the patient experienced flares in his joints. The patient has missed work for one month. His bronchitis is now resolved and, with the reinstitution of the DMARD, the patient’s flares are now controlled. The patient presents to your office (a rheumatologist) with a six-page “Abilities Assessment” form from his Human Resources Department. He explains that if you do not complete this form today, he cannot return to work.

Rheumatoid arthritis (RA) and the entire family of inflammatory arthritides have a significant effect on work ability. RA’s peak onset is well within the working ages of 18 to 65 years, and approximately two thirds of working patients with RA will have time lost secondary to their disease within the previous 12 months. With the advent of improved treatment options, the interaction between the rheumatologist and the workplace will increase as fewer employees leave the workplace on permanent disabilities which, until recently, represented a sizeable number of these patients. There will be increasing demands from workplaces for assessment and documentation for workers. We, as physicians, must control the process and insist that due diligence is followed by both the employer and the employee—our patient.

What are the Worker’s Responsibilities?

1) The Abilities Assessment form requires consent from the patient in question. It is prudent for you, as the patient’s rheumatologist, to have a separate consent form, signed by the patient (in this case John, as presented in the case study) in your office to reassure yourself that his workplace consent was not signed under duress.

2) Rheumatologists must also ensure that the patient informs you if he suspects that there are any other issues in the workplace that may have prompted the assessment request in addition to his absenteeism. For example, the patient may inform you that he is a strong proponent for unionization, and he feels that his superiors might be fishing for a reason to terminate John’s employment at the automotive shop. While such information is hearsay, it can be helpful in understanding the patient’s workplace dynamics.

What are the Employer’s Responsibilities?

1) The patient’s human resources department must be clear when describing exactly what information they require of the physician, as well as why the patient’s workplace requires the information. In the case of John, the automotive parts worker, it would be helpful to have the employer provide a job description or task analysis of the patient’s job. Additionally, you might also request the Bona Fide Occupational Requirement (BFOR) for John’s position (a list of activities of a job or position that are essential to the position in question). Should the employee be unable to accomplish these essential duties, even with ergonomic modifica-
2) The human resources department can also ask for a prognosis, return to work date, return to full or modified duties, and what limitations or restrictions may be required. If desired, these terms should be defined by the employer in their document before the rheumatologist’s assessment.

What are the Rheumatologist’s Responsibilities?
1) The rheumatologist’s first and foremost role is to advocate for their patient (John), but this advocacy must be based on sound medical evidence.

2) The physician must supply the information requested by the workplace. A non-response can result in a complaint to the Royal College of Physicians and Surgeons of Canada (which means a lot of paperwork) from either your patient or the patient’s workplace.

3) Although you are required to supply the information requested, you are not restricted to only complete the Abilities Assessment form. An oral response or a written report providing more context for the patient’s situation is also acceptable.

4) The patient’s human resources department may insist that you fill out an Abilities Assessment form. You may not wish to make statements about specific abilities and rather suggest that an Occupational Therapist or Physiotherapist perform the appropriate Functional Capacity Evaluations (FCE). You may or may not wish to help arrange, such an assessment, but regardless, it must be made clear to all that the employer is obliged to pay for the FCE and that only the employer will receive the report. After performing the FCE, the physiotherapist or occupational therapist, as part of their report, will compare the patient’s task analysis to the typical half to two days of functional testing. The FCE report may comment on whether John can accomplish the BFOR supplied by his employer. When the worker and employer disagree on the patient’s ability to return to work, the FCE may protect you from potential legal entanglement of being the sole medical opinion determining restrictions and limitations.

5) Any reports to the workplace are limited by ethical/confidential restrictions. Remember: diagnosis, treatment and dates of service are confidential. Do not refer to the patient’s arthritis, but rather his condition (despite your letterhead stating you are a rheumatologist).

6) Negotiate your own fee before you start the work.

Conclusions
“There is no substitute for hard work”—Thomas Alva Edison (an employer)

After completing the requested work, John gives your short note to his employer. You are paid $25.00 by the patient for completing the form. The human resources department insists on an FCE, which John agrees to, and the cost to the company is $2,500.00. In the end, the patient returns to work with the employer following the advice in your short note. John does well for two months, but then experiences another bout of bronchitis. The patient’s disease-modifying anti-rheumatic drug (DMARD) is held and his RA flares. He is absent from work another six weeks. He has called your office and needs an appointment to discuss some forms that need to be filled out. The circle is complete.

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References:

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