



The Journal of the Canadian Rheumatology Association

Fall 2011, Volume 21, Number 3

Hello...  
Hello?!

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**Announcement:** Dr. Glen T.D. Thomson is stepping down as Editor-in-Chief of the *CRAJ*. He has held this post since 2000. Dr. Thomson joined the *CRAJ* editorial board in 1994. He was the Scientific Committee Chair from 1994-1998, President of the CRA from 1998-2000, and was the Scientific Committee Chair for the recent CRA/MCR Congress in Cancun. He was awarded the CRA Young Investigator Award in 1995. GT has been quoted as saying, "I need a rest".

**Announcement:** Dr. Joanne Homik has recently stepped down from the editorial board. The Editor and Board of the *CRAJ* would like to thank her for her many contributions and enthusiasm as a member of the *CRAJ* Board.

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.

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## G2G

By Glen Thomson, MD, FRCPC

It is somehow appropriate to pair the paradoxical topics of ageism (page 4) and new information technology (page 6) in this, my last issue as editor. As a baby boomer struggling to remain relevant, I am constantly challenged by the exponentially evolving electronic world in which I exist. In order to remain conversant with the younger generation (*i.e.*, my now age-of-majority children), I have had to gain some facility with text messaging, although I still refuse to become involved in the Facebook phenomenon.

At the office, I spend more time and energy every year to keep the computers and server neatly documenting the minutia of my professional life, all of which comes to a grinding halt when the power fails (twice in two years). I will not surrender my paper charts to the vagary of the ether—yet. My world at home and work are much different now than 20 years ago.

So too since I paid my \$50 annual fee and joined the Canadian Rheumatology Association (CRA) in 1990. Back in the day, the attendance of the annual meeting numbered in the 30s and the annual budget was less than \$5000. I was fortunate to be there when the CRA cleaved itself from the Royal College annual meeting and began meeting as an organization in February each year (Paul Davis will rightfully take credit for the first winter symposium, although this was not a CRA annual meeting). Since then, the size of the meeting has grown greatly. The annual event now triples Dunbar's number of 150, the



"So long, and thanks for all the fish." (With apologies to Douglas Adams).



BITD.

number of individuals with whom we usually maintain some social relationship. The intimacy of the meetings has diminished, but to the benefit of greater opportunities to network and with increased revenues for the CRA. Still, I look fondly back at a time when I recognized most everyone at the meeting and knew most by their first names.

That is the one of the problems with getting older. We remember the "good old days" because the suboptimal parts of history are forgotten. Experience

and knowledge accreted with age should produce wisdom, or at least an appreciation for the complexity of most issues. Unfortunately, all this selectively accumulated information and overwhelming novelty may result in panicked inertia. A permanent retreat into the comfort of the familiar results in sclerosis of thought.

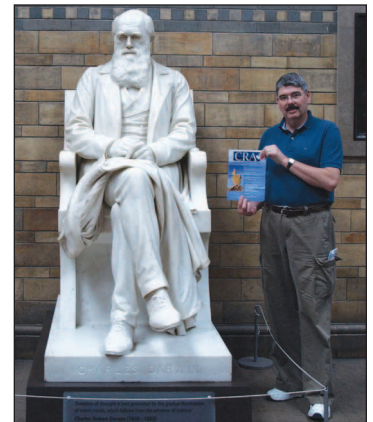
At the University of Toronto in 1987, I remember Hugh Smythe's introductory remarks to my new group of rheumatology residents. He stated that each generation thought that they were the first to invent sex. He recognized that each new generation had the confidence and optimism to think that they could solve the problems that had stymied the prior generation. There is an assumption that the parents' generation is part of the problem, not the solution. Only later comes an appreciation of the challenges of those who have gone before us. As Mark Twain has been quoted, "When I was a boy of fourteen, my



The Thomson Twins.



The Board, never bored, while on location in Cancun, 2011.



Hail to the Chief!

father was so ignorant I could hardly stand to have the old man around. But when I got to be twenty-one, I was astonished by how much he'd learned in seven years."

The boomers were not the first generation to invent sex, but were there during the tectonic movements in technology which were derived from affluence and driven by the space race. We can be encouraged that Bill Gates and Steve Jobs are the 50-somethings who led us into this era. While the torch of innovation has been passed to a younger generation, who have exploded onto the scene with the social media revolution, those of us

*It has been a sincere pleasure to communicate with the readers of this magazine over the last dozen years. Hopefully, there has been some mental grist for the intellectual mill and a few smiles along the way.*

on generous side of the half-centenary must become and remain comfortable with information technology if we do not want to contribute to a generational divide. Having said that, I may never understand the need for immediacy of some social media like tweeting, and I still need a translator to decipher some text messages from my kids.

Yet, there is some comfort in things that are old and familiar. The printed page still has a warmth and personal quality that a flickering screen does not. But in this age of immediacy, it is impossible for hard copy to keep up with the continual and rapid change in knowledge and information. Those younger individuals may never appreciate the blissful sensation of opening a brand new textbook. Stuffing a magazine into a briefcase for the flight is old-fashioned when your tablet can contain 10,000 newspapers. But, you can keep reading this print edition long after the flight attendant tells you that all electronic devices must be turned off.

It has been a sincere pleasure to communicate with the readers of this magazine over the last dozen years. Hopefully, there has been some mental grist for the intellectual mill and a few smiles along the way. I am deeply grateful to all of the editorial board members, writers and contributors over this geologic span of time. I must thank the STA HealthCare Communications' managing editors, Maria, Stephanie, Maeve, Mandi, Kate, Katia, and Russell, for their tolerance and support of my fluid notions of the journal's content and format. Paul Brand, STA's Executive Editor, was there for Barry Koehler's first issue in 1992 and has been the steady hand on the publishing tiller since. He has been a rock of professionalism. I will miss my interactions with all of you.

CYA PLO SIT KIR T+\* :)

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

\*CYA = see ya; PLO = peace, love, out; SIT = stay in touch; KIR = keep it real; T+ = think positive. From preceding page: G2G = got to go; BITD = back in the day.

# Help Stamp Out Ageism

By Monique Camerlain, MD, FRCPC; and Geneviève Myhal, PhD

“There is to my mind something inhuman in senility. Something crouching and atavistic; the human qualities seem to drop from old people, insensibly day by day.” - H.G. Wells, “The Red Room”, *The Idler*, 1896.

Ageism is a pervasive form of discrimination entrenched in modern North American culture and known to influence the provision of medical care, as demonstrated by a Senate Special Committee on Aging.<sup>1</sup> It is a negative bias or stereotypic attitude toward aging and the aged. According to Dr. Robert Butler, a Pulitzer Prize winner and past head of The International Longevity Center, it reflects a deep-seated uneasiness, a personal revulsion to, and distaste for growing old, diseased and disabled. It also reflects a fear of powerlessness, uselessness, and death.<sup>2</sup>

With the rising age wave of 80 million baby boomers, 70% of whom do not plan to retire but wish to go on serving their values, the perspective on aging is changing in North America. Life expectancy has increased by 28 years in the last century. The “old age 65” marker is out-dated. It was selected in the 1930s by President Roosevelt for the Social Security Act. Life expectancy was 61.8 years at the time.<sup>3</sup> A 65-year-old woman can now expect to live 19 more years and men of this age can expect to live another 14. As stated by Dr. Butler, combating ageism is now considered “a matter of civil and human rights.”<sup>2</sup>

Four factors contribute to the negative image of aging, according to Traxler:<sup>4</sup> They are: fear of death, the emphasis on the youth culture in North America, the emphasis on productivity and the manner in which medicine originally researched aging in long-term care institutions. Institutionalized elderly amount to only 5% of the aged population and cannot be considered representative of the group.<sup>4</sup>

The MacArthur Foundation has added two more factors to this list: the focus of the geriatric literature also on the more fragile and disabled elderly and the disengagement theory. According to this questionable theory, the elderly withdraw from others and from the world to make their ultimate departure less disruptive.<sup>5</sup>

There are two forms of ageism: one directed against others and one against the self as the susceptible individual mirrors and accepts cultural values. This may lead to depression and even suicide as part of a social disintegration syndrome.<sup>6</sup>

Known consequences of ageism in patient care include less prevention, less screening and diagnostic testing, and care gaps leading to insufficient and possibly even inappropriate treatment.<sup>6</sup> While older Americans are the biggest users of prescription drugs, between 1991 and 2000, 40% of clinical studies excluded participation of people over 75. Our research has furthermore demonstrated an ageist bias in 58% of healthcare providers in Canada.<sup>7</sup>

Care gaps in the treatment of elderly patients have been documented in rheumatology in chronic pain,<sup>8</sup> osteoporosis,<sup>9</sup> and rheumatoid arthritis (RA).<sup>7</sup> Less than 35% of the 756,000 Canadian osteoporotic women are diagnosed and treated, and current real-life management strategies in RA of the elderly may be based more on assumptions than evidence. Older patients receive lower doses of methotrexate (MTX). They are less likely to be treated with disease-modifying antirheumatic drug (DMARD) combinations, more likely to be taking prednisone, and are less often treated with biologics.<sup>10</sup>

How then can we as rheumatologists help to stamp out ageism? How can we help our patients on the road to healthy aging? First, through education, we must increase awareness of this prejudice among our peers and among our patients. Though the risk of complications is higher among elderly patients, no class of medication should be excluded,

*Care gaps in the treatment of elderly patients have been documented in rheumatology in chronic pain,<sup>8</sup> osteoporosis,<sup>9</sup> and rheumatoid arthritis (RA).<sup>7</sup>*

a priori, without a thorough evaluation of the patient's global needs and condition. We must stress equality of care for all based on evidence and on an unbiased evaluation of the

risk:benefit ratio.<sup>11</sup> We must also help patients to become active participants in their care and compliant to their treatment.

The Mayo Clinic website states that “healthy aging is a hot topic for boomers everywhere.” It describes the ongoing activities and behaviors people undertake to reduce the risk of illness and disease and increase their physical, emotional and mental health. It also means combating illness and disease with some basic lifestyle realignment that

*We must stress equality of care for all based on evidence and on an unbiased evaluation of the risk:benefit ratio.<sup>11</sup> We must also help patients to become active participants in their care and compliant to their treatment.*

can result in a faster and more enduring recovery. And yet, a study of 17,354 Canadians over 60 has demonstrated that a large proportion of these individuals do not meet the required criteria for preventive medical visits and diagnostic testing; 63.2% had made no effort to improve their health in the preceding year and 66.7% did not deem it necessary.<sup>12</sup>

Three elements characterize the essence of the clinical transaction between patient and physician: technology, caring and values. The most neglected of the three is values, despite their importance in governing the quality of the medical encounter on the personal level, and the social contract of healthcare on the political level.<sup>13</sup>

In our culture of the disposable and of planned obsolescence, the wisdom and experience of elders is given little attention or importance. In ancient China, the third age of man was considered to be the purpose of his life. Having fulfilled his family and social responsibilities he could now seek enlightenment. The Hindus added a fourth age where the enlightened elder's duty was to share his learning and discoveries. Perhaps we can learn from the perspective of these other cultures and improve the quality of our interaction with our older patients through adding new values to quality technology and caring.<sup>7</sup>



Educational effort on ageism for elders by the Arthritis Society in Quebec.

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# Top Ten Things Rheumatologists Should (And Might Not) Know About Geriatrics

By William Earle DeCoteau, MD, FRCPC

**I**n North America, arthritis is the most prevalent chronic condition among persons aged 65 years and older. An estimated 200,000 Canadians aged 25 to 34 have some form of arthritis, and more than four times that number are affected after age 55. There is clearly a need to discuss how best to care for elderly patients. In my experience, here are the top ten points rheumatologists should consider in approaching geriatric patients.

## 1) Gerontology ≠ Geriatrics

Physicians often use these terms interchangeably but **gerontology** actually refers to the study of the aging process while **geriatrics** is the study of health and disease in later life.

## 2) Elderly patients are highly heterogeneous

Everyone has a unique aging trajectory and it is important to keep in mind that a geriatric patient's physiologic age is not always in sync with his or her chronologic age. Factors such as genetics, lifestyle and attitude can create great disparity between one elderly patient and the next. Moreover, 65 years and over is a vast cohort. Clinically, there is often little difference between a young geriatric patient and someone 50 to 65 years of age. Meanwhile the same usually cannot be said of a 75-year-old patient versus someone approaching 100 years of age.

## 3) New-onset rheumatoid arthritis (RA) is uncommon among the elderly and becomes even less common among older geriatric populations

Geriatric patients with RA usually have been living with the disease for years. More often than not, an elderly patient will be seeking care from a rheumatologist or geriatrician due to complications of aging or major deformities left behind by RA after the disease has burnt itself out. As RA involves a highly active immune system, new-onset RA is especially uncommon among people aged 75 years and older.

## 4) Aches and pains aren't always arthritis; don't be fooled!

As with patients of all ages, joint pain and swelling in older patients deserve to be regarded with an open mind. Malignancy, for instance, will often mimic polymyalgia, so what might seem to be a rheumatic condition in an elderly woman may, in my experience, actually turn out to be breast cancer.

## 5) Treating RA can negatively influence other diseases

Geriatric patients often live with multiple chronic diseases. Before prescribing a course of therapy, it is imperative to assess and individualize treatment to match the needs of each patient and avoid iatrogenesis.

## 6) Aggressive therapies can be good for older patients

Although they are more appropriate for use among vigorous elderly who are not as prone to side effects, disease-modifying antirheumatic drugs (DMARDs) should not be denied to older RA sufferers simply due to their age. It is important to note that aging results in the degradation of matrix proteins, which are very important for muscle, bone and skin. Steroids can help geriatric patients combat RA but might not be an appropriate long-term course of treatment for patients whose matrix proteins are already largely depleted.

## 7) Geriatric "giants" can wreak havoc on therapy if ignored

Dr. Bernard Isaacs coined the term "giants" of geriatrics to describe incontinence, immobility, impaired intellect and instability—four problems that complicate all age-related health challenges. Loss of cognitive function is especially menacing, as it affects a patient's ability to make decisions about treatment, his or her motivation to undergo rehabilitation as well as capacity to tolerate surgery.

### 8) There should be more talking and less doing

This was the mantra of Dr. William Hazzard, a world leader in geriatric medicine. Providing elderly patients with the best care means understanding the full picture, and this requires an open and regular line of communication. Family members can also be extremely helpful in this regard and follow-up visits are crucial to ensuring success.

### 9) Geriatric units are great places for rehabilitation

When treating RA in the elderly, nonpharmacologic therapies are equally as important as, if not more, important than pharmacologic options. Inpatient rehabilitation specifically designed for geriatric patients can vastly improve treatment outcomes.

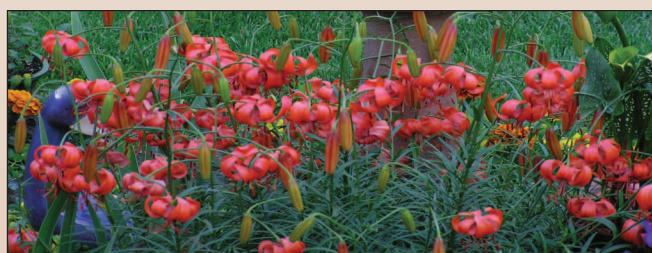
### 10) Geriatric medicine isn't rocket science

But for many physicians its basic principles are a mystery. Rheumatology is a great field to learn about the hallmarks of aging. When armed with knowledge about the “giants” of geriatrics, there is little need for a rheumatologist to refer an RA patient elsewhere, no matter what age.

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## Floral Impressions

Freshly picked news: Dr. Janet Markland's garden was recently featured by the local Horticultural Society of Saskatoon. She held a garden party to raise funds for the Lupus Erythematosus Society of Saskatchewan (LESS) and for the Scleroderma Association. A few of her blossoming beauties!



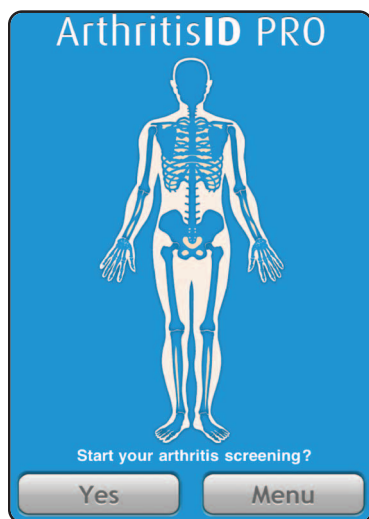


# Arthritis Goes Mobile

By John M. Esdaile MD, MPH, FRCPC, FCAHS; and Cheryl L. Koehn

Today, 80% of Internet users look online for health information and treatment. There is clearly a huge desire from primary-care providers and the public for quick, accessible health information and advice about arthritis. This year, co-leaders from the National Arthritis Awareness Program (NAAP), the Arthritis Research Centre of Canada (ARC) and Arthritis Consumer Experts (ACE) collaborated to develop a very exciting mobile tool—the most comprehensive, evidence-based iPhone/iTouch application for arthritis—ArthritisID (for the public) and ArthritisID PRO (for healthcare professionals).

ArthritisID PRO and ArthritisID are free applications (more commonly known as “apps”) that provide healthcare professionals and the public with arthritis information in English and French.



ArthritisID, a free companion app for the public, was designed to raise the level of understanding and conversation about the need for early detection and best management of arthritis. The software helps the public screen for indications of the disease and learn about some of the latest approaches to its treatment, management and prevention.

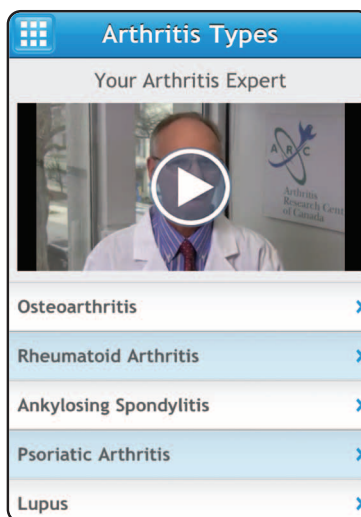
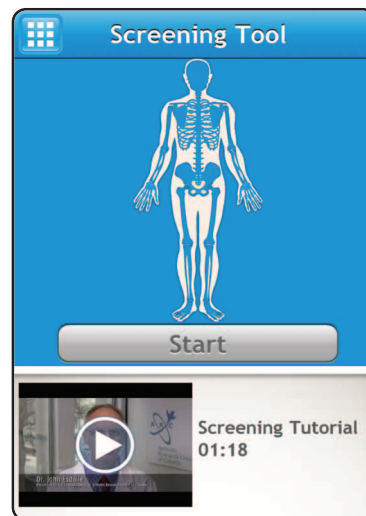
The raw material for these new arthritis apps’ interactive scale model for screening came from a previously developed point-of-practice arthritis tool leveraged by NAAP, which was conceived as a result of valuable consultation with the Canadian Rheumatology Association (CRA), The Arthritis Society and Dr. Gillian Hawker, who provided the

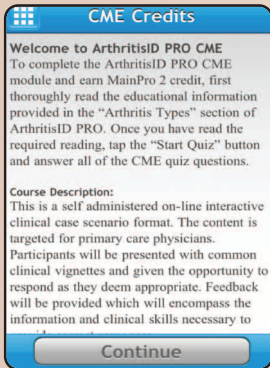
ArthritisID PRO was created to help family physicians, nurses, pharmacists, occupational therapists and physiotherapists screen for arthritis and understand the latest approaches to treating, managing and preventing the most common forms of the disease. All of the content on ArthritisID PRO is fully available in French and English, including instructional videos.

perspective of the Osteoarthritis Research Society International (OARSI). The point-of-practice arthritis tool incorporates the most recent classification criteria for rheumatoid arthritis (RA) by the American College of Rheumatology (ACR) and new information on osteoarthritis from OARSI. This tool made it possible to create the new ArthritisID apps’ interactive screening tool and develop an algorithm for a differential diagnosis quiz to assist healthcare professionals and patients in identifying key indicators and signs of seven of the most common arthritides.

Following a screening questionnaire (which contains slightly different questions for medical professionals than for the public), the ArthritisID apps’ screening tool offers feedback results on the user’s screening result, and connects the user to the “Arthritis Types” section to learn more. The Arthritis Types section features red flag “spotlights” with detailed information about treatment strategies. These include goals for treatment, medication and

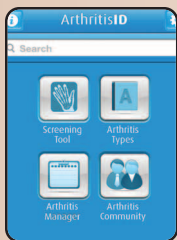
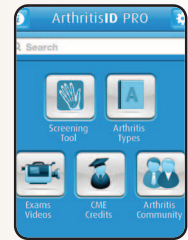
self-care information for seven types of arthritis: osteoarthritis (OA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), lupus, gout, RA, and juvenile idiopathic arthritis (JIA). This section also offers detailed information about medications, selfcare, and prevention strategies to support healthcare professionals and patients in making decisions about what they can do





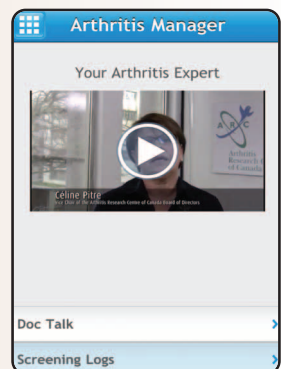
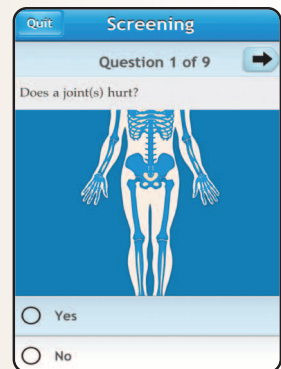
## ArthritisID PRO features:

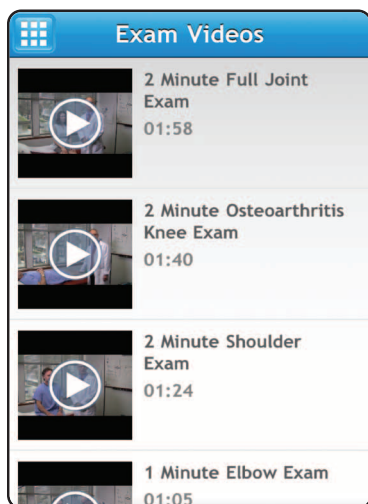
- Interactive arthritis screening tool and 13-question differential-diagnosis questionnaire
- Current “best practice” guidelines for detecting, diagnosing and managing arthritis
- Continuing Medical Education (CME) activity accredited by the College of Family Physicians of Canada (CFPC) providing Mainpro-M2 Credits
- Treatment strategies and medication information for osteoarthritis (OA), rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), lupus, gout and juvenile idiopathic arthritis (JIA)
- Five instructional arthritis joint-exam videos
- Self-care information for patients to better manage their arthritis, including details on exercise, prevention, diet, and nutrition
- Email information directly from ArthritisID PRO to patients or colleagues



## ArthritisID features:

- Interactive arthritis screening tool and nine-question “lay language” questionnaire to help individuals determine indications of a type of arthritis
- Treatment strategies and medication information for osteoarthritis (OA), rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), lupus, gout and juvenile idiopathic arthritis (JIA)
- Information on prevention of arthritis, as well as information about exercise, diet and nutrition
- “Doc Talk”: questions to ask a healthcare provider
- “Arthritis Manager” saves previous arthritis screening results
- Email information directly from ArthritisID





to maintain or improve their health.

For physicians and other healthcare professionals, ArthritisID PRO offers valuable educational resources. The app contains five detailed instructional joint-exam videos, in French and English, performed by Dr. John Esdaile and Dr. Diane Lacaille. These videos demonstrate the appropriate techniques for joint examinations, including a two-minute full-body joint exam, and individual videos of the knee, hip, shoulder and elbow.

As an additional feature, ArthritisID PRO also boasts a self-administered Continuing Medical Education (CME) credit (MainPro-M2), administered as an online, interactive clinical case scenario.

The interactive screening tool and questionnaire in ArthritisID helps the public self-check for signs of arthritis or check for indications of the disease among friends and family. The app also provides further information about different arthritis types, advice about arthritis prevention and treatment options, questions to ask healthcare providers, and the ability to save screenings for future reference.

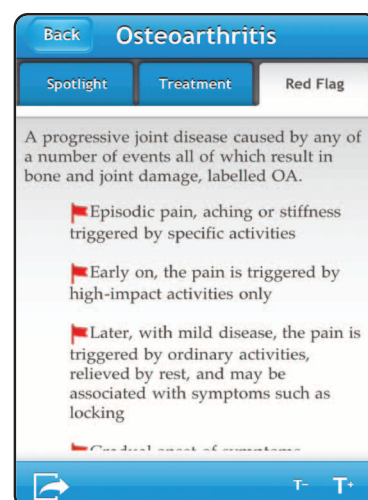
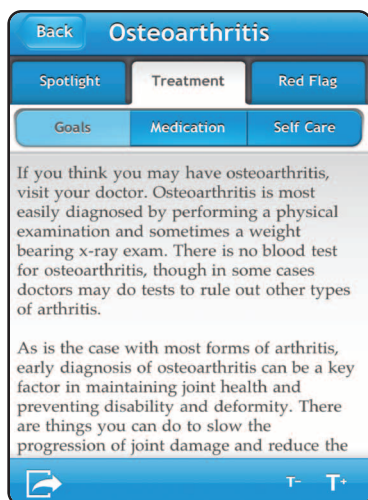
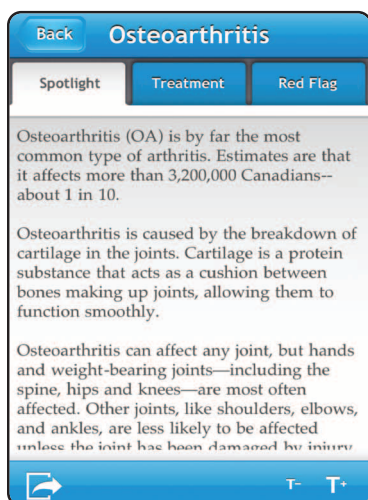
The NAAP is proud to release these two comprehensive ArthritisID apps for healthcare professionals and the

public, hoping to spark conversation, awareness and new dialogue about the early detection, diagnosis, treatment and management of arthritis. Designed specifically to meet the needs of the mobile masses, ArthritisID and ArthritisID PRO offer two new and effective ways to use world-class (and Canadian) arthritis research while making it more accessible and actionable for consumers and health professionals.

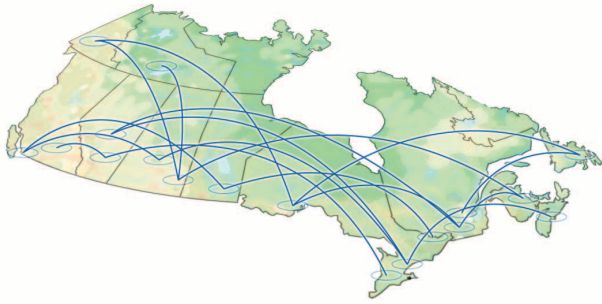
If you would like to learn more about the ArthritisID and ArthritisID PRO apps, or the NAAP, or to offer your feedback, contact us! Visit us online at [www.ArthritisIsCured.org](http://www.ArthritisIsCured.org), or connect with us on LinkedIn at <http://linkd.in/AICNAAP>, or on Twitter @ArthritisCured. You can also view the ArthritisID PRO videos on our YouTube Channel [www.youtube.com/ArthritisIsCured](http://www.youtube.com/ArthritisIsCured).

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Program (NAAP)  
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At your fingertips: The screens above detail the clinical description, treatment strategies, and “red flag” indicators to look for in identifying, for example, osteoarthritis (OA).



# FROM COAST TO COAST: Reports from Rheumatology Associations Across the Country

## Canadian Arthritis Network

By Claire Bombardier, MD, FRCPC

If you ask a dozen arthritis stakeholders how the [Canadian Arthritis Network \(CAN\)](#) has influenced the rheumatology landscape in Canada and around the world, you will likely get a dozen different answers. However there will certainly be consensus that CAN's work has made a significant difference and that the Network's impending closing in March 2012, when government funding ends, will be a noticeable loss for the research community here and abroad.

CAN was launched in 1998 after a successful application to the [Networks of Centres of Excellence program](#). The Network's vision is "a world free of arthritis" and its mission is to cure arthritic diseases by supporting Canadian research and development, an encouraging collaboration between the major players in the arthritis community.

As the Co-Scientific Director of CAN, I believe, on a personal level, that CAN has been instrumental to people's careers through salary support, professional development, grants, commercialization and intellectual property advice, and the nurturing of a community. Its early focus on osteoarthritis (OA) research, empowering patients and driving consensus-based decision making have had a ripple effect throughout the research world.

A short list of CAN's influences and milestones include:

- breaking down the silos that existed between arthritis researchers and encouraging a collaborative approach;
- providing incentives and support to persuade trainees and basic scientists to choose arthritis as a focus for research;
- offering consumers the opportunity to have a voice in arthritis research and giving them resources to carry their message to an international audience;
- funding multi-disciplinary, multi-institutional research in the form of five-year Strategic Research Initiative

(SRI) grants in OA, Inflammatory Joint Diseases and Bioengineering for the Restoration of Joint Function;

- supporting the formation of instrumental organizations such as the [Canadian Rheumatology Research Consortium \(CRRC\)](#) and the [Arthritis Alliance of Canada \(AAC\)](#), as well as research groups such as the [Understanding Childhood Arthritis Network \(UCAN\)](#) and the [Canadian Consortium of Rheumatology Cohorts \(CANCoRC\)](#) and dozens more across the country; and,
- spearheading the development of a new report with the AAC that outlines the burden of arthritis in Canada today and over the next 30 years, and offers implementable solutions and strategies.

As for the future, CAN's training program will continue under the direction of The Arthritis Society and advocacy efforts to improve arthritis care are underway with – you guessed it – the participation of the entire community.

To receive a copy of CAN's legacy strategy or *The Impact of Arthritis in Canada: The Next 30 Years*, please write to: [can@arthritisnetwork.ca](mailto:can@arthritisnetwork.ca). A video about the CAN Legacy can be viewed at:

[http://www.arthritisnetwork.ca/video/legacydvd\\_en.php](http://www.arthritisnetwork.ca/video/legacydvd_en.php).

*Claire Bombardier, MD, FRCPC*

*Co-Scientific Director, Canadian Arthritis Network (CAN)*

*Professor of Medicine and Rheumatology Division*

*Director, University of Toronto*

*Senior Scientist, Institute for Work and Health and University Health Network*

*Canada Research Chair in Knowledge Transfer for*

*Musculoskeletal Care and Pfizer Research Chair*

*Consultant, Rheumatology, Mount Sinai Hospital*

*Toronto, Ontario*

# Arthritis Alliance of Canada

By Michel Zimmer, MD, FRCPC

The Arthritis Alliance of Canada (formerly the Alliance for the Canadian Arthritis Program [ACAP]) was formed in 2002 to support people living with arthritis and find solutions to the challenges they face on a daily basis. Membership includes professional organizations (e.g., Canadian Rheumatology Association [CRA], Canadian Orthopedic Association [COA], Arthritis Health Professions Association [AHPA]), The Arthritis Society, patient groups, government agencies and industry partners. The executive is composed of Dr. Dianne Mosher (president and member-at-large), Steven McNair (The Arthritis Society), Dr. Claire Bombardier (Canadian Arthritis Network [CAN]), Jean Légaré (Canadian Arthritis Patient Alliance [CAPA]) and myself, representing the CRA.

The Alliance and its partners have recently commissioned two important studies intended to help arthritis organizations and public policy advisors make strategic decisions to benefit the arthritis community and improve Canada's healthcare system. The *Canadian Arthritis Funding Landscape Review* summarizes Canada's strengths, needs, and challenges in arthritis research. The report is available on the Media page at [www.arthritisnetwork.ca](http://www.arthritisnetwork.ca). In October, the Alliance will release *The Impact of Arthritis in Canada: The Next 30 Years* at CAN's Annual Scientific Conference in Quebec City, October 27-29, 2011. This report describes the burden of arthritis today and projects what it will be in 30 years. The report offers realistic solutions to mitigate the burden.

In addition to producing these strategic reports, the Alliance has also been hard at work developing a National Framework for Improving Pan-Canadian Co-operation and Co-ordination for Arthritis. The initiative has three components to it:

- 1) Advocacy & Awareness, led by Jean Légaré and Steven McNair, is designed to increase awareness of the burden of arthritis among policy makers and the public.
- 2) Research, led by Drs. Claire Bombardier and David Hart, will prioritize investments in arthritis research to support prevention and better care.

- 3) Models of Care, led by Drs. Cy Frank and Michel Zimmer, is designed to improve the efficiency and effectiveness of arthritis care and prevention.

The Research Working Group, together with the arthritis community, is taking the following approach to determine how to allocate scarce research dollars:

- Identify and prioritize gaps in our understanding of the burden, causes, prevention and management of arthritis in Canada;
- Identify and implement research strategies to address the established priorities; and
- Develop recommendations to federal/provincial/territorial policy makers and funders on a program of focused investments in arthritis research.

The objective of the Models of Care Working Group is to improve musculoskeletal (MSK) outcomes by setting a national strategy and standards for MSK models of care in order to provide the right care at the right time and place by the right team at the right cost. This would allow members of our community to be well-supported in advocating for and in influencing healthcare planning and funding for MSK diseases.

You may contact me at [zimmer@sympatico.ca](mailto:zimmer@sympatico.ca) for more information.

*Michel Zimmer, MD, FRCPC*

*Chair, Access to Care Committee, Canadian Rheumatology Association (CRA)*

*Montreal, Quebec*



Members of the Alliance Research Working Group.

## Society of Atlantic Rheumatologists

By Evelyn D. Sutton, MD, FRCPC

A small but enthusiastic group met at beautiful White Point Beach Resort on the weekend of June 11-12 for the annual meeting of rheumatologists wise enough to work or retire in Atlantic Canada. Wisdom is relative of course, and although I am no longer young enough to know it all (other parents of young adult children relate?), I do know that the Society of Atlantic Rheumatologists' (SOAR) annual meeting is one of the best small meetings for learning and interacting with experts, as well as maintaining connections with colleagues.

This year we were thrilled to have Drs. Dafna Gladman and Doug Smith as our invited guests. Dr. Gladman anchored Saturday morning and Dr. Smith was the cornerstone of the much coveted "morning-after-the-party" Sunday program.



Dr. Doug Smith, halfway through his 24-hour collection.

Both provided state-of-the-art lectures: Dr. Gladman on psoriasis diagnosis and management and Dr. Smith on lupus treatment and recognition of drug-induced lupus. Drs. Majed Kraishi and Pooneh Akhavan (who flew in Saturday night for a Sunday morning presentation) outlined the CRA's working group recommendations on current Canadian rheumatoid arthritis (RA) guidelines. Dr. Noreen Walsh, an eminent dermatopathologist, assisted this author in a case presentation on IgG4-related sclerosing orbital and cutaneous disease.

SOAR is not SOAR without golf and this year was no exception. Last year lightning sent teams scrambling from the course after only a few holes played, but this year we were blessed with beautiful sunshine and balmy breezes. White Point's nine-hole course is not one of Atlantic Canada's best, but then, arguably, neither are



White Point Beach Resort: where rheumatology flourishes and golf games sink.

any of the SOAR golfers! The views from several of the holes lining the coast however were nothing short of spectacular and served as a reminder of how fortunate and privileged we all are to be living in this part of the world.

Immediately after Saturday's lobster dinner, Dr. Peter Docherty hosted the golf awards ceremony. He did such an excellent job of prize selection and unbiased team score tabulation (translation, his team didn't win) we may adhere to the adage that no good deed should go unpunished and appoint him as lifetime tournament organizer! Campfire and s'mores for the kids, music and dancing for the adults completed Saturday night's activities, and at Sunday morning's business meeting Dr. Sylvie Ouellette was voted our next president. SOAR 2012 will be either at Fox Harbour or back in PEI, but wherever it is, I know I will make every effort to attend. Best wishes to all!

*Evelyn D. Sutton, MD, FRCPC*

*Society of Atlantic Rheumatologists (SOAR) President, 2009-2011*

*Professor of Medicine and Medical Education, Dalhousie University*

*Rheumatology Division Head, Capital District Health Authority (CDHA)*

*Director of Arthritis Center of Nova Scotia Halifax, Nova Scotia*



Some of those who SOAR (left to right): Dr. Evelyn Sutton, Mrs. Jen Khanna, Dr. Verinder Khanna, Dr. Dafna Gladman, Dr. Jamie Henderson and his wife, Dr. Barbara Bulleid.

# Ontario Rheumatology Association

By Vandana Ahluwalia, MD, FRCPC

The Ontario Rheumatology Association (ORA) celebrated its 10th anniversary this year. It started off as the vision of a small group of rheumatologists and one pharmaceutical company. As the voice of the organization was heard, momentum started to build. Over the past couple of years, we have made exceptional progress; we have brought together community and academic rheumatologists, adult and pediatric rheumatologists, all whilst working in conjunction with our allied health partners.

Informing our membership has become easier through the development of a contact list of more than 180 rheumatologists practicing in Ontario. We have been able to send email blasts, faxing when needed, and then posting updates on our new website to complete the loop. The ORA website is [www.ontariorheum.ca](http://www.ontariorheum.ca). It contains contact information for the ORA executive and administrative staff, links to the ORA/individual clinical review (ICR) biologics request form, and most importantly, Ontario Medical Association (OMA) and Ontario Health Insurance Plan (OHIP) fee code updates. Registration for this year's Annual General Meeting (AGM) was easily facilitated by this technological advancement. Jane Purvis, our secretary/treasurer, will be spearheading a major facelift of the website over the summer to make it more user-friendly.

Dr. Philip Baer, our vice-president and OMA section chair, continues to work diligently on enhancing our fee code schedule, bringing us closer to specialist relativity adjustments. He keeps us informed of the OMA contract changes and is proactive in the OMA models of care initiative. Over the past several years, Philip's presence has made a tremendous impact on the ORA's representation at the OMA level.

We continue to work with the Ontario Public Drug Program (OPDP) through a mutually respectful dialogue for improved access to synthetic and biologic disease-modifying antirheumatic drugs (DMARDs) for our patients. We were the only organization in Ontario invited by the Ministry to the Committee to Evaluate Drugs (CED) meeting last July, to discuss the Canadian Agency for Drugs, Technologies and Health (CADTH) report. In addition, Dr. Carter Thorne, our past president, was invited by the Ontario Citizens' Council to present our perspective on managing the Ontario formulary.

The ORA completed a much-needed overhaul of the criteria for the approval of biologics for the inflammatory arthropathies (IAs), namely rheumatoid arthritis (RA), psoriatic arthritis (PsA), and ankylosing spondylitis (AS), as well as new requests for juvenile idiopathic arthritis (JIA) and vasculitis. This was submitted to the Ministry for review in early April 2011. Our approval timelines for ICR drugs are well above the national average, being in the range of 30 to 60 days, whereas most provinces provide approvals within seven to 10 days. Diane McArthur, the executive officer of the OPDP, spoke at our recent AGM. She thinks that this timeline can be improved upon, and with her team, will work with us to meet the goal of a two-to four-week turnaround. Our members' utilization of the ORA biologics forms has significantly increased; this encourages the Ministry to be more efficient. Our skills have also been noticed by other sub-specialty organizations, which have asked us to help them with their Ministry negotiations.

Currently, we are collaborating with our colleagues locally and nationally to improve medical access through new Models of Care (MOCs) in rheumatology. Our committee consists of Drs. Thorne, Bombardier, Benson, Pavlova, and myself, along with Sandra Couto and Denis Morrice. We have consulted researchers, clinicians, and government officials to help with strategic development. The specific goal of this committee has been focused on understanding key elements that define successful MOCs. We want to identify and deliver care through regionalized efforts that ultimately lead to improved clinical and administrative outcomes. In this setting, the Ontario Biologics Research Initiative (OBRI), led by Dr. Claire Bombardier, can be used as a measure of quality care and facilitate practice enhancement.

An ORA survey was sent out to understand our members' needs. From these suggestions, we created a new committee to advocate for rheumatologists interested in switching to Electronic Medical Records (EMR). Five vendors joined an EMR expo at the ORA AGM in May, to showcase rheumatology-specific tools. Post-hoc, an EMR checklist was prepared and posted on our website to help our members negotiate a contract which now includes rheumatology-friendly templates.

Under the guidance of our scientific director, Dr. Janet Pope, we had a successful AGM; we continue to engage in practice enhancement initiatives, such as the OBRI and Metrix. Dr. Carter Thorne remains on the board of directors as an active consultant and mentor. Denice Morrice, our executive director, sits on many boards and represents us to various patient, physician and government organizations. I am looking forward to working with our committed board of directors, executive and administrative staff who tirelessly

indulge my proposals for yet another project that must be done. As this year closes, I reflect back on the beginnings of the ORA to realize how far we have really come, but there is still much more work to be done!

*Vandana Ahluwalia, MD, FRCPC*

*President, Ontario Rheumatology Association (ORA)  
Brampton, Ontario*

## Quebec Rheumatology Association

By Denis Choquette, MD, FRCPC

**G**ood news from the Quebec Rheumatology Association (QRA): The last 12 months of intense work at the Association have been very productive and very positive. In Quebec, the Association has to be accredited to deliver Continuing Medical Education (CME) to its members. This accreditation is performed by the Collège des Médecins du Québec, which evaluates all aspects such as needs assessments, financial support, delivery of the actual programs and their evaluation. The process is carried out under the guidance of the QRA's director, Dr. Anne St-Pierre. The program has been fully accredited with perfect scores in several areas. This is unprecedented and all the credit must go to Dr. St-Pierre.

Dr. Mark Hazeltine is also profoundly involved in two aspects of the Association's CME program. First, he is now organizing the 8th edition of "La Mise à Jour en Rhumatologie," the Quebec review course. Attendance is always high, a true reflection of the program's quality. Another program that was developed eight years ago and is also very successful is the Musculoskeletal (MSK) weekend for first- and second-year residents in medicine. Dr. Gilles Boire was the program's director for the past five years and Dr. Marie Hudson has taken over the position for the upcoming years. This program, plus the very high vivacity of the rheumatology community, has led to very successful recruitment in the rheumatology program of our four faculties. All the available positions have been filled at every year for the past five years. There are now 108 registered rheumatologists at the QRA, up from 74 in 2000. Unfortunately, as in every other province, a rheumatologist is very rarely a full-time clinical practicing one. We probably need 40 more.

We are also actively negotiating new services for the Quebec population. We are designing and negotiating a network of nurse assistants for all Quebec rheumatologists. We are also building service corridors between primary-care practitioners and rheumatologists. Several corridors are already in place, such as Parler with Dr. Mark Hazeltine and Passer with the Institute of Rheumatology of Montreal. An evaluation of their effectiveness is underway and, once completed, will be presented to the Ministry of Health with a request for government support. Support for ultrasonography will also be the focus of active negotiations between the Fédération des médecins spécialistes du Québec (FMSQ), Association des médecins rhumatologues du Québec (AMRQ) and the Quebec government. It is not acceptable that rheumatologists are not yet supported for such a basic and important clinical evaluation instrument in 2011 when it is now standard care in Europe.



President of the QRA, Dr. Denis Choquette.

*Denis Choquette, MD, FRCPC*

*Professor of Medicine, Division of Rheumatology,  
Université de Montréal (UdeM)*

*President, Quebec Rheumatology Association (QRA)  
Montreal, Quebec*



# Laurentian Conference of Rheumatology

By Carol Yeadon, MD, FRCPC

The 42nd edition of the Laurentian Conference of Rheumatology showed that being 40 or so allows maturity and novelty to co-exist well. More than 80 people followed in the footsteps of the conference's creators and pioneers, leaving the city behind and heading for the Laurentian hills to broaden their scientific and professional knowledge, exchange ideas, and meet and greet people with shared interests.

In the Laurentians, Mother Nature displayed her lovely pale green colors, announcing the arrival of a long-awaited spring. The inaugural poster session featured enthusiastic, bright and productive young investigators whose studies helped define the psychosocial impacts of scleroderma, the effects of antiphospholipid antibodies, and processes leading to osteoarthritis (OA). This format proved ideal to promoting the exchange of ideas and stimulating discussion, lubricated by beer or a glass of wine.

Throughout the conference, investigators and clinicians, young and old, presented findings with the potential to improve clinical skills; these included the confirmation of Lyme disease's arrival in Quebec and that hemochromatosis can present with hindfoot arthritis.



(Left to right): Dr. Jean-Pierre Raynaud, Dr. Carol Yeadon, Dr. Simon Carette and Dr. Boulos Haraoui. Photo courtesy of Dr. Frédéric Massicotte.

Guest speaker Professor Bernard Combe, of Montpellier, France, illuminated the elaborate process which resulted in the recent collaborative publication of the American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) Classification Criteria for Rheumatoid Arthritis. Professor Combe argued in favor of early, effective disease control. As President of the Société française de rhumatologie, he invited his Québécois cousins to increase their participation in the Society's meetings.

From the University of Maryland, Dr. Marc Hochberg, editor of the classic *Rheumatology* textbook, ably demonstrated how OA is a major disease threat to international health and wealth. Furthermore, although we have slowly and laboriously gained knowledge, he emphasized the need for further understanding before we have OA treatments as effective as those for other inflammatory arthropathies.

Québec City's beloved son and pillar of the Toronto rheumatology field, Dr. Simon Carette gave a truly state of the art talk on the management of antineutrophil cytoplasmic antibodies (ANCA)-associated vasculitis. The seven principles he put forth and admirably defended could well become the subject's "Seven Pillars of Wisdom."

The award dinner was a convivial occasion; honors went to Dr. Hochberg, recipient of the Roger-Demers Award, and Dr. Carette, who received the Jeff Shiroky Award. Our esteemed colleague, Dr. Jiri Krasny, was the recipient of the Marie-Thérèse Fortin Award for his outstanding professional and human qualities. On Saturday, the mountains became greener under spring rain as attendees bade one another "au revoir" until next year's "rendez-vous."

*Carol Yeadon, MD, FRCPC*

*Centre Hospitalier de l'Université de Montréal (CHUM) –  
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Associate Professor, Université de Montréal (UdeM)  
Montreal, Quebec*

# Eastern Ontario Rheumatology Annual Meeting

By John Thomson, MD, FRCPC

For the past 15 years, the rheumatologists of the Eastern Ontario region have been getting together for an annual educational meeting. Rheumatologists from Ottawa, Kingston, and Peterborough have come to appreciate our little gathering as a very valuable and unique regional experience, full of learning, camaraderie, and fun.

The meeting began as an industry-sponsored symposium, but as times changed it became an accredited meeting arranged by the group itself. Traditionally, we have had our meeting at the Chateau Montebello in Montebello, Quebec, about one hour east of Ottawa. The Chateau, an historic massive log structure built during the depression, is fantastic any time of year—a winter wonderland on the banks of the Ottawa River.

Our meeting spans one weekend. We gather on Friday evening and lectures start early Saturday morning. We try to finish up by early afternoon to allow us to enjoy the venue. Our annual dinner is on Saturday evening, followed again Sunday morning by another round of lectures.

Our lectures are guided by our needs assessment. We usually have one or two out-of-town speakers, but make good use of Ottawa area experts also. Over the past few years, meeting participants have presented interesting cases to the group. We also have an annual business meeting at the conclusion of our programme. Plans for upcoming meetings are discussed and regional issues are addressed.

Our little meeting is a special get-together. We learn, we discuss, we laugh, and we enjoy the camaraderie. Eastern Ontario has its own flavor and style, and once a year we get together and celebrate and take advantage of the wonderful group we have in this part of the world.

*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*

## Scientific Committee

By Joanne Homik, MD, MSc, FRCPC

Well, it was hard to beat the last Canadian Rheumatology Association (CRA) annual general meeting in Cancun, but this year's CRA Scientific Committee is going to try! We will be in beautiful Victoria, British Columbia, at the historic Fairmont Empress Hotel and Victoria Conference Centre. So that we can take advantage of the flowering trees and nice weather, the meeting will occur a bit later this year, taking place between March 28-31, 2012.

We will be planning an excellent range of topics, speakers and formats as accompaniment. The break in our North American schedule provided the opportunity to incorporate some of the successful features of the Cancun meeting. As such, we will be extending the trainee day to a full-day format and starting the general meeting with the national update at 5 p.m., to be followed by a wine and cheese reception. The trainee podium presentations will take place the next day; also scheduled is a plenary session where the top-ranked submitted abstracts will have an oral presentation. Building on the success of previous poster tours, those will continue as well. Our sponsored satellite symposia will take

place every morning with breakfast. We hope you'll join us in lovely Victoria next March for an excellent CRA meeting!

*Joanne Homik, MD, MSc, FRCPC*

*Associate Professor of Medicine,  
Director, Division of Rheumatology,  
University of Alberta  
Chair, Scientific Committee, Canadian Rheumatology  
Association (CRA)  
Edmonton, Alberta*



# Université de Montréal

By Boulos Haraoui, MD, FRCPC

As in the rest of the country, Quebec rheumatology has risen again from the ashes in the past five years. The rheumatology program at the Université de Montréal (UdeM) has recently trained 12 new rheumatologists, 10 of whom completed a fellowship or are undergoing further training in Montreal, Edmonton, Paris, Leeds, and Geneva, respectively. They are bringing back expertise in different areas: rheumatoid arthritis (RA), ankylosing spondylitis (AS), systemic lupus erythematosus (SLE), scleroderma, vasculitis, ultrasound and basic research in osteoarthritis (OA).

Young dynamic rheumatologists now populate a number of different regions in Quebec: The Greater Montreal area, including the South and North shores of the St. Lawrence, Trois-Rivières, Quebec City and Lévis. Nine rheumatologists have joined academic centers or university-affiliated hospitals.

A more open, collaborative atmosphere among the four provincial training programs has also emerged, thanks to the dynamic leadership of the program directors. Moreover, Drs. Eric Rich and Christian Pineau in Montreal have initiated a course aimed at all rheumatology trainees in the province. The first edition of "Introduction to Rheumatology" took place during the



Pavillon Roger-Gaudry at the UdeM.

first week of July, with the attendance of 15 rheumatology residents.

This year Dr. Rich accepted the 2011 Prix Esculape for "Best Teacher," as voted by the internal medicine residents at the UdeM.

As of 2011, Quebec's four rheumatology training programs are now part of the Canadian Resident Matching Service (CaRMS); all the available positions have been filled; and as a victim of our own success, the UdeM program had to turn down two excellent candidates.

Now our sights are focused on the future with the undergoing construction of the new University Hospital, the CHUM, in downtown Montreal.

With all these great advances made we can confidently look toward a brighter future for rheumatology in Quebec.

*Boulos Haraoui, MD, FRCPC*

*Clinical Associate Professor of Medicine, Université de Montréal (UdeM)*

*Head, Rheumatology Clinical Research Unit, Centre Hospitalier de l'Université de Montréal (CHUM) – Notre-Dame Hospital  
Montreal, Quebec*



UNIVERSITY  
OF MANITOBA

## Locum Rheumatology Position: Winnipeg

The Arthritis Centre at the University of Manitoba is seeking a rheumatologist for an immediate locum position in an academic clinical practice. The position is for a six-month term with possible extension to 12 months. Individuals who have successfully completed their rheumatology training and possess an FRCPC in internal medicine but have not yet written the Royal College Rheumatology exam are welcome to apply. Start dates are flexible.

Duties will include outpatient clinics, attending on the eight-bed rheumatology in-patient service, attending on the rheumatology consult service, and clinical teaching of medical students and residents. Opportunities are available for attending on the Medical Teaching Units as well.

The Section of Rheumatology at the University of Manitoba has an active post-graduate training program and is active in local, national and international investigator-initiated research endeavors. Compensation for this position is fee-for-service with very low overhead costs.

Interested individuals should contact:

David Robinson, MD, MSc, FRCPC  
Head, Section of Rheumatology  
University of Manitoba  
204-787-2208  
[drobinson@hsc.mb.ca](mailto:d Robinson@hsc.mb.ca)

# An Approach to Muscular Masses

By Lucie Roy, MD; and Alessandra Bruns, MD, MSc

The first patient is a 39-year-old man, working in construction, who was referred by the orthopedic service for triceps rupture and radial neuralgia. This is a healthy man, without medical or surgical antecedents, who presents with a voluminous painless mass of the right distal triceps, which had gradually increased in size over three months. He has no history of past trauma. He mentions intermittent paresthesia for three years in the median and ulnar nerve territory. On physical examination, a mass located distally to the right arm is noted. Furthermore, the vascular and cervical exams are completely normal and the patient has a full extension of his forearm (Figure 1). A musculoskeletal (MSK) ultrasound reveals a hyperechoic lesion of 9 cm by 3 cm on the medial chief of the right triceps (Figure 2) and a normal triceps tendon (Figures 3 and 4). The Doppler study is negative. An ulnar nerve subluxation on the right medial epicondyle was also noted. The magnetic resonance imaging (MRI) study reveals an enhanced intramuscular mass of 7.4 cm by 6.6 cm by 3.6 cm on T1-weighted images and a suppressed lesion on fat suppression technique that confirms the suspicion of intramuscular lipoma.

The second patient is a 64-year-old man who was referred for an impingement syndrome of the right shoulder. The physical exam reveals a full range of motion, a positive impingement manoeuvre and a deltoid mass (Figures 5 and 6). The ultrasound shows a small rupture of the subscapularis, a light internal impingement and a 7.9 cm by 1.9 cm mass located in the deltoid muscle. An MRI of the shoulder confirms the presence of a lipoma in the deltoid muscle.

Muscle masses can take different forms and the differential diagnosis of these masses is wide-ranging. Described above are the cases of two men with asymptomatic muscular masses who have undergone a complete investigation, including ultrasound and MRI. These imaging modalities point to the diagnosis of lipoma, though no definitive diagnosis could be raised, because there is no histologic proof. The differential diagnosis of a muscular mass is varied and includes traumatic lesions, abscesses, and tumors. These tumors are usually benign; though malignancy is rare (Table 1),<sup>1</sup> the occurrence of a malignant lesion should always be kept in mind when evaluating a mass, even if it occurs in the setting of a local trauma.

## Clinical Forms of Lipoma

Lipomas are the most frequently occurring soft-tissue neoplasia, accounting for 50% of cases. They affect approximately 1% of the general population at any age, with an incidence peak between 40 and 60 years of age.<sup>2</sup> They usually form as a unique lesion, but can present as multiple lesions in 5% of cases. The most common presentation is a mass of the subcutaneous tissue measuring less than 5 cm, but lipoma may affect virtually any organ in the body. Like the skeletal muscle, lipomas are almost always located in the trunk, the thigh, the shoulder or the arm. They are intramuscular and usually form a well-defined mass, except when an infiltrative non-malignant form exists.

Table 1

### Most Common Tumors of the Muscle<sup>1</sup>

Tumor	Description
Lipomas	Benign soft tissue tumor; usually subcutaneous, may occur in or among muscles.
Intramuscular cysts	Benign soft tissue tumor composed of liquid.
Hemangioma	Benign soft tissue tumor; often forms within muscle, typically in the thigh.
Liposarcoma	Soft tissue sarcoma, includes five subtypes. Not the result of malignant transformation of lipoma.
Myxoma	Benign tumor composed of fibroblast and myxoid deposits.
Desmoid	Aggressive soft tissue tumor of connective tissue; characterized by rapid growth and highly infiltrative.
Rhabdomyosarcoma	Most frequent malignancy of the muscle; usually affecting children.
Metastasis	Rare; usually painless. Most often from carcinoma of breast, lung, and/or colon.

Figure 1  
**Triceps mass (left) and full extension of the forearm (right)**

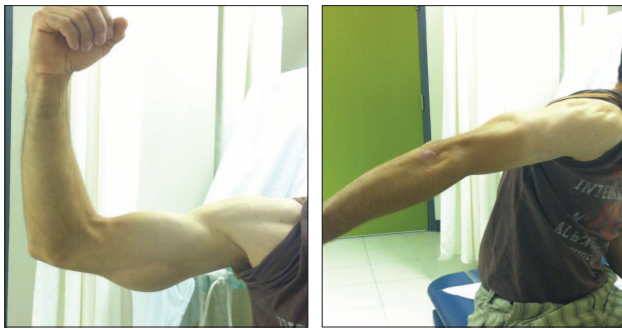


Figure 2  
**Triceps lipoma (panoramic view)**

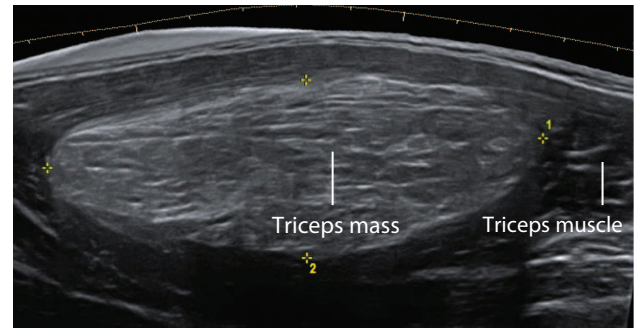


Figure 3  
**Triceps tendon (longitudinal view)**

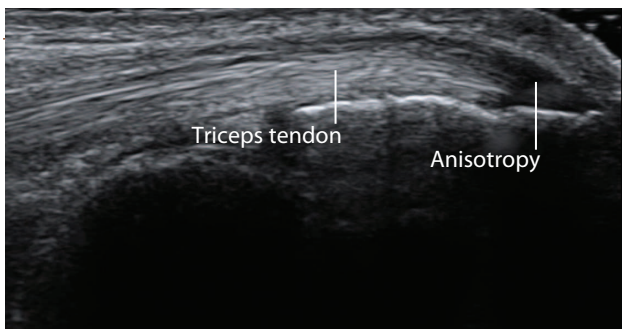


Figure 4  
**Triceps tendon (transverse view)**

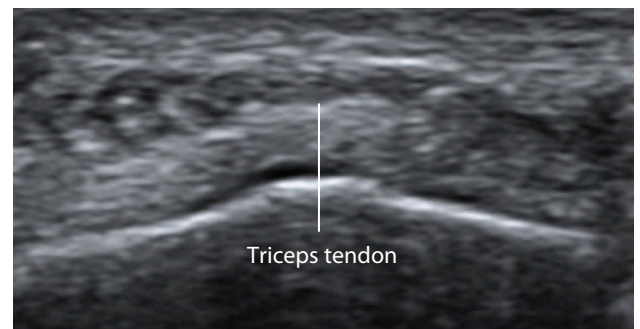


Figure 5  
**Deltoid lipoma (panoramic view)**

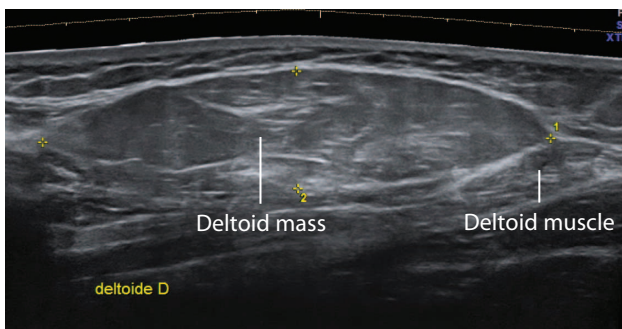
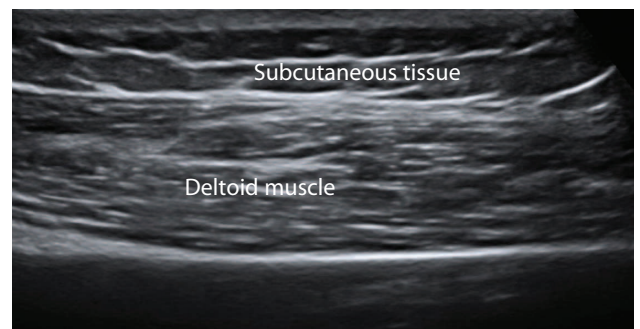


Figure 6  
**Contralateral normal deltoid muscle**



Clinically, lipoma forms a painless soft mass that usually grows slowly, although rapidly growing masses with compressive symptoms have been described. These symptoms might be vascular, respiratory and/or neurologic. Indeed, several case reports describe lipoma of the proximal forearm with radial nerve compression.<sup>3</sup> In a literature search on Pubmed, four cases of sternocleidomastoid lipoma,<sup>4</sup> two cases of deltoid lipoma,<sup>5</sup> and no cases of triceps lipoma were described.

### Imaging Modalities

Although subcutaneous lipoma typically does not necessitate the use of an imaging modality, care must be taken in the case of a large lipoma (more than 5 cm) or in the presence of

an irregular shape or with suspicion of myofascial involvement. Multiple radiologic modalities exist to help in the diagnosis of lipoma, with sonography, computed tomography, and MRI to rule out a malignant process. A rapid and accessible technique is ultrasonography. The most common ultrasound findings are a well-defined ovoid-shape lesion inside the muscle with the typical striated appearance of a subcutaneous lipoma. Intermuscular lipomas are a less common variant than intramuscular occurrences. In the well-circumscribed intramuscular lipoma, fatty tissue (hyperechoic appearance) is clearly delineated from the surrounding muscle (Figures 2 and 5). However, because of the different subtypes of lipoma, the sonographic appearance, in particular the echogenicity, is variable.

Intramuscular lipomas are generally non-compressible and the Doppler effect is negative.<sup>1</sup> Finding blood-flow signals in a lipoma-like mass with color and power Doppler imaging merits further investigation with contrast-enhanced MRI.

One study<sup>6</sup> retrospectively evaluated the accuracy of sonography to distinguish soft-tissue lipomas from other masses by using a histologic proof as the standard. This study concluded that sonography has low precision for the diagnosis of muscular masses because of the highly variable sonographic appearance. MRI remains the most sensible imaging modality for lipomatous masses and has a high negative predictive value.<sup>7</sup> The appearance of lipoma shows a fat signal intensity on all pulse sequences in MRI.<sup>8</sup> It is useful to distinguish a benign lesion from one that is malignant, which would present with an enhancing septae, nonadipose area, and a high T2 signal within the lesion. Despite these findings, some studies reveal difficulties with predicting a well-differentiated liposarcoma from a benign lesion, with a tendency to falsely identify many masses as a more aggressive entity. A definitive diagnosis can be posed with a biopsy or a surgical excision. The histologic features reveal well-circumscribed masses of mature adipocyte cells surrounded by a thin fibrous capsule. Note that there are different histologic variations of lipoma-forming subclasses, including fibrolipoma, myxolipoma, and many others.

## Conclusions

In summary, an ultrasound helps determine whether a mass is composed of fat or not, but is less useful for determining a lesion's degree of malignancy. As the appearance of most

soft-tissue lesions is sufficiently specific in MRI, it is likely that no further investigation will be necessary. If there is a doubt, a biopsy must be performed.

The usual treatment for lipoma involves surgical removal.<sup>2</sup> Cosmetic concerns, compressive symptoms, functional limitation and concerns that the lipoma might actually be a malignant tumor are typical reasons for surgery. Some research<sup>9</sup> also demonstrated positive results with steroid injection that allowed for the shrinking of the lipoma. The risk of local recurrence after removal is higher with an intramuscular lipoma (19%), compared to the recurrence rate of a subcutaneous lipoma (1% to 2%).<sup>9</sup>

To conclude, despite the fact that lipomas are a frequent entity, a systematic approach must be adopted with muscular masses to avoid missing a malignant lesion. For the first case of intramuscular lipoma presented here, given the cosmetic impact for the patient, a surgical excision was suggested.

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# App, App, And Away!

By Glen Thomson, MD, FRCPC

This issue's Joint Count survey revealed that the majority of respondents are living in the information age with devices that can download apps (Table 1). The iPhone is the single most popular device, with just under half of those surveyed in possession of this Apple technology. Ontario's own Blackberry is the second most popular hand-held device.

Of those surveyed, 86% thought that an arthritis app should include downloadable information about medications, while differential diagnosis (55%), individual disease manifestations (53%), and diagnostic tests (49%) were likewise deemed important to responders (Table 2). This downloadable information would be used mainly at the clinic (85%), in the hospital (57%) and at home (46%), responders felt (Table 3). A few unsafe drivers would download this information in the car (8%): please pull over to the side of the road and stop first! To those

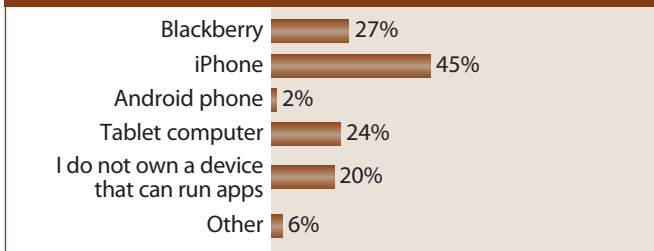
7% who would use this information elsewhere; remember, please turn off all electronic devices prior to the start of a concert.

Two thirds of the respondents currently download apps and 90% would welcome one dedicated exclusively to arthritis, much to the delight of Dr. John Esdaile (see "Arthritis Goes Mobile", page 7).

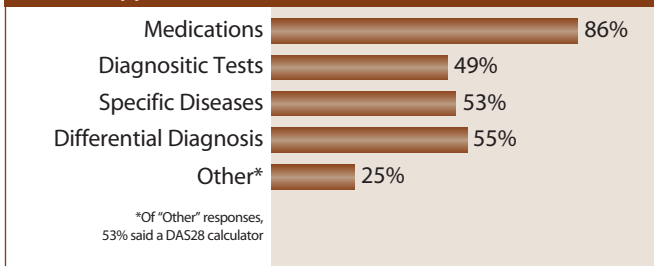
The final question in the survey was a trick question (Table 4). Only three individuals recognized that "app" is the acronym or abbreviation for all of the items listed. The technical language that each profession speaks can confuse those not initiated. Those who remember the Alan Parsons Project are dating themselves (see "Help Stamp Out Ageism", page 4).

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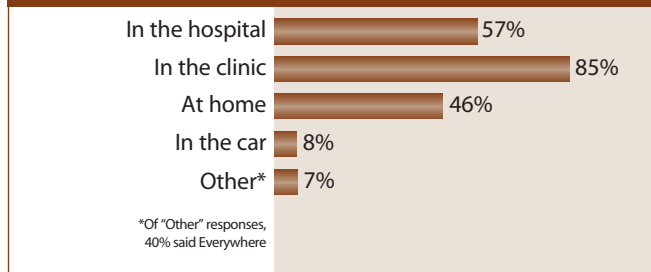
**Table 1. Which of the following devices that can run an app do you own?**



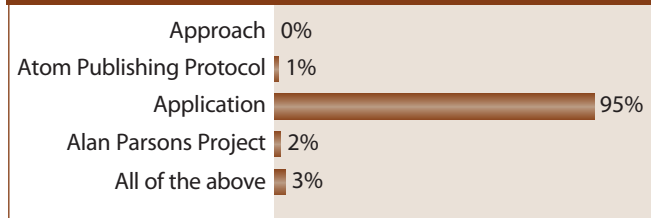
**Table 2. What information would you want to see on an arthritis app?**



**Table 3. Where would you use an app that would be specific to arthritis?**



**Table 4. App stands for:**



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