CRAJ

The Journal of the Canadian Rheumatology Association

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Focus on Summer Jobs

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CRA EDITORIAL BOARD

Mission Statement. The mission of the *CRAJ* is to encourage discourse among the Canadian rheumatology community for the exchange of opinions and information.

Announcement: Dr. Barbara Walz 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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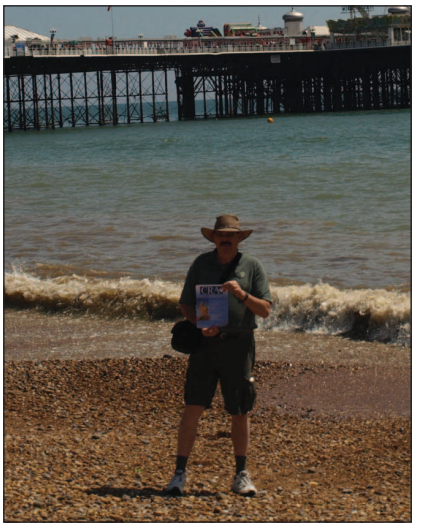
EDITORIAL

Mandatory Reading

By Glen Thomson, MD, FRCPC

In a land more renowned for its blizzards than beaches, summer is a much-anticipated and appreciated interlude. This is even more true for students. For many young people planning post-secondary studies in the autumn, the summer represents an opportunity to seek employment to fund their higher education. For a fortunate few, it is an opportunity to travel, seek experiences and learn without the need for a summer job.



Editor volunteering for the *CRAJ* at the seaside.

Volunteerism has in recent years become more visible and necessary to carry out many otherwise-unfunded activities within our society. I think those who of their own free will engage in activities to help the disadvantaged, preserve the environment, sustain their places of worship, and participate in political parties should be applauded for donating their time. Those who participate in these projects benefit by being part of a defined community and are rewarded by a higher sense of purpose.

I am concerned with "mandatory volunteerism." The term itself is an oxymoron. If you are not participating freely, then you are not really a volunteer. Unfortunately, many medical schools across Canada now have a requirement of a specific number of hours of "mandatory volunteerism." Presumably, this is to ensure that those young people planning a life in medicine will be the right sort of individual. In practice, I think it is prejudicial to those people of lower socioeconomic status who cannot afford time to volunteer while trying to pay for increasingly higher tuition fees.

It is not unreasonable to ask that future physicians have some interpersonal skills and an ability to communicate and empathize with the ordinary Canadian. Summer jobs have at least the same chance of providing this experience as mandatory volunteer positions. I recall my own earliest employment experiences working at the local horse racing track, as an Eaton's mail boy, and later as a city laborer on garbage and boulevard crews. Each of these new worlds was initially as foreign to me as, I am sure, ordinary people find the high-tech, frequently bureaucratic and impersonal world of modern healthcare. With my personal lack of volunteering experience, I doubt that I would currently be admitted to a contemporary medical school. I fear that "mandatory volunteerism" as a requirement for medical school may be leading to cynicism about collecting the necessary hours rather than focusing on the life experiences that create better citizens. In this issue, our lead article talks about summer jobs and what influences they may have had. The Joint Count Survey answers the question—what is the best summer experience for prospective physicians before entering medical school?

Accreditation of continuing medical education (CME) hours is also discussed in this issue by Drs. John Thomson and Carter Thorne. Accumulating these hours to maintain your Royal College Fellowship became mandatory more than a decade ago. A large bureaucracy has subsequently been created to oversee this enterprise, while Royal College fees have increased to support this endeavor. Now it takes almost as much effort and time to chronicle that which you have learned as spent actually learning it. After spending the better part of two decades involved in the development of rheumatology CME, I don't think that the quality or content of rheumatology CME or, for that matter, real participation in CME, is any better today than before the Maintenance of Competence (MOCOMP) programme became compulsory.

For the last CRA/MCR meeting, I had to put my signature on the mass of forms comprising an application to hold an educational event accredited for CME/continuing professional development (CPD) hours. The process is convoluted; long on the theory of educational needs and short on practicality. The CRA is rightly pursuing the privilege of being an accreditor of CME events so that future rheumatology education can be adjudicated by peers. The other policy advances from the CRA Executive Retreat are recorded in the issue's Joint Communiqué.

Before signing off for the summer, the CRA Editorial Board would like to express gratitude to our managing editor, Katherine Ellis, who is moving on to new challenges in the nation's capital. On a personal note, her enthusiasm for the *Journal of the Canadian Rheumatology Association (CRAJ)* has been infectious. Kate's creativity has elevated the bar for each issue. Thank you.

It is mandatory for all readers to have a safe and enjoyable summer.

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

Summertime and the Workin' is Easy

"A perfect summer day is when the sun is shining, the breeze is blowing, the birds are singing, and the lawn mower is broken."—James Dent

Ever wonder what your colleagues did before becoming such respected rheumatologists in the Canadian medical landscape? Or what they do to wile away the hours during the summer? Members of *The Journal of the Canadian Rheumatology Association (CRAJ)* Editorial Board graciously answered a few choice questions regarding their first summer jobs, first medical placement and what they will be doing this summer.

Before donning their pristine white lab coat and stethoscope, most doctors had never even entered a medical office other than for their annual check-up. Apart from spending time hanging out with friends, catching up on a few books or listening to good music, more than 80% of the respondents of this issue's Joint Count survey stated they worked during their summers before attending medical school (the full results are discussed in the Joint Count article *Get a Job*). Furthermore, 51% responded that they worked during the summer to pay for their education, while more than 24% entered the job market to gain work experience. As 63% of the respondents attested, working in a regular job and interacting with non-medical people was one of the life experiences that physicians should have before entering the medical profession. Members of *The Journal of the Canadian Rheumatology Association (CRAJ)* Editorial Board answered questions regarding their past summer jobs and first locums after becoming physicians. From being struck by lightning to working in a morgue, read on to learn what jobs shaped the rheumatologists you know and work with today. To see how well you know your colleagues, check out the "When I Was Young" quiz!

Tips on How to Spend your Summer

Check out the following list to see what some of the *CRAJ* board members will be reading this summer!

1. *Your Inner Fish: A Journey into the 3.5-Billion Year History of the Human Body* by Neil Shubin
2. *When Will There Be Good News* and *Started Early, Took My Dog* by Kate Atkinson
3. *A Short History of Nearly Everything* by Bill Bryson
4. *The Last Man Who Knew Everything: Thomas Young* by Andrew Robinson

Summer Jobs

Do you remember the rush during your first summer job? When you, as a teenager, were about to walk in to the world of adulthood, independence and, most importantly, paychecks? The first summer job is a milestone in any young person's life, be they teenagers in high school or young adults in university. That first experience pads your CV as you march off to new opportunities and future positions that may help you choose, and eventually take, the first steps towards your chosen career. Needless to say, some jobs are more memorable than others. When asked about his most memorable summer job, Dr. Stuart Seigel, the newest editorial board member of the *CRAJ*, stated it was when he was a camp counselor on Lake Temagami in Northern Ontario. "[It] was lousy pay, but tremendous fun and great memories," Dr. Seigel stated. And what made the job so memorable? "Getting knocked off my feet by lightning, twice," Dr. Seigel said. "Okay, so not every memory of that job was great. At least I lived to tell the tale. And for several years afterwards, if I ever saw even a small dark cloud, I was heading for shelter, which didn't do much for my golf game."

Dr. Carter Thorne, current Vice-President and President Elect of the Canadian Rheumatology Association (CRA), was an autopsy assistant at the provincial morgue while a medical student, and remarked it was "better to be at [my] end of the scalpel." Our current President, Dr. James Henderson, took a year off before medical school; he worked as an orderly in a large hospital for six months. "It was an opportunity to

WHEN I WAS YOUNG...

Match up the following rheumatologists in the left hand column to first locum or summer job on the right-hand column (answers are located on the bottom of page 6).

Names:	Jobs (and quotes):
1. Dr. Stuart Seigel	**A. Consultant for a rheumatology practice** "While still in training at the University of Toronto, I had a consultant rheumatology practice. There, I admitted difficult cases from the area (*i.e.,* Wegener's syndrome) to hospitals." **B. Summer student with the Entomology Section of Agriculture Canada** "I worked alongside two other students to record the prevalence of flea beetles in canola fields [one summer]. We had to sample the same three fields at time-points over the summer by vacuuming up 25 soil samples per field with a big backpack vacuum (similar to a leaf blower today). At the end of the summer, we took all these little plastic bags out of the freezer and tried to count the flea beetles before they warmed up and hopped away!" **C. Cleaning staff** "I worked as a cleaning girl one summer at Woods Hole Oceanographic Institute in Woods Hole, Massachusetts. I thought it would be a great way to get involved in science. Instead, I was cleaning dirty bathrooms for PhDs and post-docs!" **D. High school football physician** "I attended games to ensure proper care for injured (mainly concussed) players. A great gig in the late summer and early autumn—a misery in sub-freezing temperatures during evening games at the end of the season." **E. Emergency Room physician** "Huntsville, Ontario is in the Muskokas (cottage country), where tourists flood the area during the summer. When it was my turn to be on back-up call, I put my pager in a waterproof bag and went wind surfing!"
2. Dr. Glen Thomson	
3. Dr. Joanne Homik	
4. Dr. Carter Thorne	
5. Dr. Lori Tucker	

Tips on How to Spend your Summer

Check out the following list to see what some of the *CRAJ* board members will be eating this summer!

1. Wine with anything
2. Fresh-picked Okanagan fruit
3. Home-made ice cream and peaches and nectarines from the B.C. Okanagan
4. Salmon
5. Some goat cheese and olive crostini, or avocado crostini, and a nice cold bottle of New Zealand Sauvignon Blanc

see patients in a hospital environment when no other healthcare was around," Dr. Henderson stated. "Insights from that experience have shaped my bedside manner ever since. It gave me a unique insight into all members of the healthcare team and beyond. Everyone has their role and each is indispensable in their own way. I, therefore, acknowledge contributions from all healthcare workers whenever possible."

"Insights from that experience have shaped my bedside manner ever since. It gave me a unique insight into all members of the healthcare team and beyond. Everyone has their role and each is indispensable in their own way. I, therefore, acknowledge contributions from all healthcare workers whenever possible."(Dr. James Henderson)

As for Dr. Lori Tucker, she ventured south of the border to work at the Woods Hole Oceanographic Institute (WHOI) in Woods Hole, Massachusetts, and was a cleaning girl one summer during her university years. WHOI, a research institution located in a beach town in Cape Cod, is "dedicated to research and higher education at the frontiers of ocean science," according to their website. "I thought it would be a great way to get involved in science," said Dr. Tucker, "instead, I was cleaning dirty bathrooms for PhDs and post-docs." However, she did note that there was a good group of college students who had a good time together. "We hardly learned any science [there] and I almost switched my major when I realized how nerdy the researchers were," Dr. Tucker remarked. "All those guys wearing black socks with their bathing suits at the beach."

As for our illustrious Editor-in-chief Dr. Glen Thomson, he worked as an entomology technician for the Faculty of Agriculture at the University of Manitoba in Winnipeg—seconded to the "Mosquito Abatement Program." There, Dr. Thomson had to stand in a field at dusk for 15 minutes, bare-chested, and allow mosquitoes to land on his skin to then suck them up into little cages for later experiments. "These were the longest 15 minutes of my life," Dr. Thomson noted. "Unfortunately, it was repeated frequently that summer."

Favorite Summer Activities

With those summer jobs past, the board members have their chance to make the most of the coming summer months. Dr. Homik will take advantage of her summer by blasting her Glee playlist and reading books, such as "One Good Turn" by Kate Atkinson, while sitting by Falcon Lake in Whiteshell Park in Winnipeg, Manitoba. There, she stated, "Sitting on the deck or by the water in mid-afternoon, I will bring out some goat cheese and olive crostini or avocado crostini, and open a nice cold bottle of New Zealand Sauvignon Blanc." She describes this activity as being pure heaven. Dr. Thorne will be puttering around the cottage as well, drinking wine, and will take advantage of his vacation by spending time with his granddaughter.

No matter what you do this summer, from salmon fishing and golfing in New Brunswick like Dr. Henderson; picking up weekend editions of the regional and national newspapers and taking a moment to catch up on the news while on your deck like Dr. Seigel in Kelowna; or cycling, hiking, kayaking and reading the *CRAJ* like Dr. Tucker and her family in Vancouver, the *CRAJ* Editorial Board would like to wish all the CRA members a wonderful summer, and hope you enjoy your much deserved vacation!

Answers to "When I was Young": 1e, 2d, 3b, 4a, 5c

Evolution of the CRA and Accreditation

By John Thomson, MD, FRCPC; and Carter Thorne, MD, FRCPC, FACP

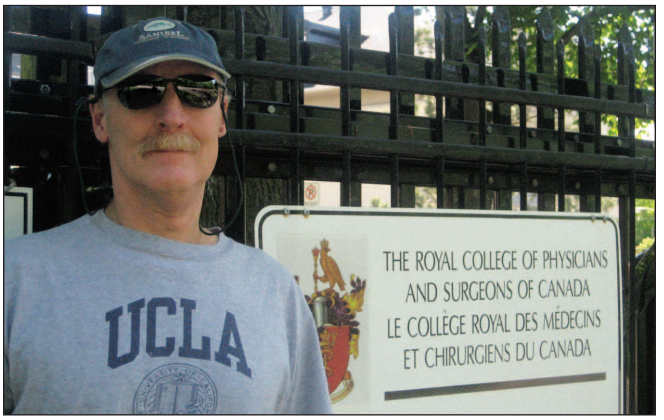
The topic of accreditaton is an important issue for learners, educators, regulatory bodies and the public in general.

What is accreditation and why is it important?

Accreditation, as it applies to medical education, is a process by which educators ensure that educational programs meet a certain defined standard. The standards attempt to ensure a high-quality unbiased product with defined educational characteristics, such as interactive audience participation. There is no question that the presence of these criteria is important to help maintain the integrity of medical teaching. It is important to the learners, the educators, the regulating bodies and the general public. This is not to say that so-called unaccredited programs do not have educational value. A teaching initiative may not qualify for accreditation for any number of reasons, some of which may be administrative. All of us have learned important material from unaccredited programs over the course of our careers.

Who does the accreditation in Canada?

Accreditation in Canada is generally carried out by approved accrediting bodies, most often through universities with medical faculties. Specialist societies may also qualify to become accrediting bodies. In order to qualify, strict criteria as laid out by the Royal College of Physicians and Surgeons of Canada (RCPSC) must be adhered to. In essence, the ultimate accreditor in Canada is, in fact, the RCPSC. The RCPSC sets the standards and rules for accreditation, and must approve any organization that applies to become an accrediting body. At present, the Canadian Rheumatology Association (CRA) is in the process of applying to become an approved accreditor.



A casual Dr. John Thomson in front of the Royal College building in Ottawa, pondering accreditation and life in general.

Is our annual CRA meeting accredited?

Our annual CRA meeting is definitely an accredited educational activity. The content of our annual scientific meeting is entirely under the control of the CRA. We meet all criteria for RCPSC accreditation.

What about the satellite symposia at the CRA's annual meeting?

This has become a more difficult issue for the CRA and other specialist societies. For several years now, the CRA's Scientific Committee has invited industry sponsors to submit applications for symposia. Industry sponsors are made aware of the needs assessment of the membership. The merit of all applications for symposia are assessed blindly by the scientific committee, who then make suggestions for improvements; these suggestions are communicated back to the industry sponsors. The industry sponsors then have an opportunity to make changes to their application. Following any such changes, the scientific committee members reassess the applications and these are voted upon. The CRA believes that it has been able to maintain high-quality industry-sponsored symposia using this method of assessment; unfortunately, according to RCPSC criteria, these symposia are not accreditable (vide infra). It should be mentioned that at the last two CRA annual meetings, there has been a "CRA symposium," which is entirely under the control of the CRA. This symposium would qualify for accreditation.

What is "tagging" and is it important to the CRA?

Currently, it is considered ethically permissible to link a session within an accredited group learning activity to the name of the sponsor (*i.e.*, a symposium) under certain conditions. When soliciting an educational grant from a sponsor for a session within an accredited group learning activity, a RCPSC-accredited continuing professional development (CPD) provider must have independently, and prior to solicitation:

- conducted a proper needs assessment;
- determined the topic and scientific content of the session;
- determined the speakers they intend to invite;
- included the following statement in the program materials, namely that "this session is supported in part by an educational grant from …"; and
- ensured that each speaker invited to serve as a member of the faculty is fully informed about the decision to tag the name of the sponsor to the session.

If these conditions are met, the session (*i.e.*, symposium) in question is eligible for accreditation under Group 1.

As of June 2012, however, tagging to a specific session will no longer be permissible even under these conditions. Sponsors will only be recognized generally in the program.

At least 75% of our meeting is directly under our own control, and the issue of tagging and accreditation of industry-sponsored symposia does not affect this component. Nevertheless, the CRA is of the opinion that our method of vetting and choosing symposia has been rigorous and has allowed us to maintain high-quality industry-sponsored educational symposia. The reality of the RCPSC guidelines, however, is unlikely to change substantially and we will have to work within these guidelines. We are confident that our annual meeting is an extremely valued educational experience for our membership. Changes in regulations will not change the quality and attractiveness of our meeting.

What about the CRA accrediting its own events, including the Annual General Meeting (AGM)?

In the past, CRA events such as the AGM have received accreditation from university CME departments, including the University of Alberta (under Paul Davis as Director) and, more recently, the University of Western Ontario. It has become more difficult to meet the requirements of these University accreditors, as their mandate is rapidly evolving to meet and support their local needs. Thus, in keeping true to our Mission Statement "to support education of its members," the CRA has embarked on the rather onerous task of being approved as an accrediting agency and fulfilling the robust requirements of the Royal College. Our Board and Executive believe that this represents a natural evolution in the maturation of our organization, one which will better allow it to respond to the learning needs of its members, and result in a more complete branding of the CRA members as "Experts in Arthritis Care."

Is industry sponsorship important to the CRA?

Industry sponsorship at our annual meeting provides an important source of funding, thus allowing the CRA to function as the important and vital organization which it is today. The activities of the CRA are important, not only to rheumatologists, but to the rheumatology community at large, including people who have arthritis and other systemic conditions. Our educational initiatives (*i.e.*, annual meeting, web-based learning, *The Journal of the Canadian Rheumatology Association [CRAJ]* and *The Journal of Rheumatology*) are well-known and well-used by the membership. Initiatives in the area of human resources, such as the student preceptorships, have reaped very tangible benefits in terms of producing new rheumatologists. The Canadian Initiative for Outcomes in Rheumatology Care (CIORA), our research arm, has permitted important clinical research to occur across Canada. Exciting initiatives, including the much-anticipated and soon-to-be published CRA guidelines for the treatment of rheumatoid arthritis, are extremely important initiatives which will help practicing rheumatologists and raise the profile of Canadian rheumatology internationally.

Summary

Development of ongoing CPD activities, and their required accreditation, are best carried by specialist societies. The RCPSC does not have the mandate, expertise, or resources to carry out these important activities. We are hopeful that RCPSC regulations will not be so restrictive as to impede our abilities to carry out these important functions as a specialist society. The CRA is working on your behalf to help ensure the ongoing long-term viability of our organization.

John Thomson, MD, FRCPC
Past President, Canadian Rheumatology Association
Assistant Professor, Department of Medicine,
Division of Rheumatology, University of Ottawa
Staff, The Ottawa Hospital
Ottawa, Ontario

Carter Thorne, MD, FRCPC, FACP
Vice-President, Canadian Rheumatology Association
Past President, Ontario Rheumatology Association
Medical Director, The Arthritis Program (TAP)
Chief Division of Rheumatology,
Southlake Regional Health Centre
Newmarket, Ontario

The Canadian Rheumatology Association's 2011 Committee Reports

From the Canadian Rheumatology Association's Executive Board meeting, April 29th to May 1st, held in Fredericton, New Brunswick.

Report from the CRA President

By James Henderson, MD, FRCPC

On the weekend of April 29th to May 1st, the Executive Board of the Canadian Rheumatology Association (CRA) gathered in Fredericton for their annual executive retreat. The most important date on the calendar for the board, it is an opportunity for new members to meet existing members, and to get their head around the full spectrum of CRA activities.

We camped out at the Crowne Plaza in downtown Fredericton with the St. John River lapping at its shores at near-flood levels. Luckily, the river was nowhere near the record levels we have seen in recent years.

This year, we added a new twist where, on the Friday, the full board and committee chairs participated in a facilitated review of the board structure and function. It is an exercise we had not performed in several years and was long overdue, given the increasing complexity and breadth of board responsibilities in the past few years. We examined committee structure, policies and procedures, decision making, and general effectiveness of the organization. The purpose was to develop an aligned vision and strategic direction for our organization; we also looked at internal and external impacts on the CRA. As we completed the exercise, we determined what was working and what needed improvement. The conclusion of the facilitator was that we are a mature organization that functions well, with a talented and committed group on the board, with a few adjustments to be implemented going forward.

The next day and a half was spent going over the full spectrum of our board activities. Brainstorming sessions were held on topics including education directions, therapeutics, access to care, the website, human resources, the annual general meeting, management, Allied Health Professionals Association issues, and the Canadian Initiative for Outcomes in Rheumatology Care (CIORA, now a CRA responsibility). After each session there were reports to the full board on priorities that were identified in each session, which will be reported to members by each committee chair subsequently in this issue.

At the end of two and a half days of intense discussion, a tired group left town to head home. My sense was that all participants felt we had a productive weekend that will steer the CRA confidently into the future.

I want to thank all participants for their energy, candor and enthusiasm. The CRA will be a better organization for their involvement.

James Henderson, MD, FRCPC
President, Canadian Rheumatology Association
Chief, Internal Medicine, Dr. Everett Chalmers Hospital
Teacher, Dalhousie University
Fredericton, New Brunswick

After a long day in meetings, Board members sample some Maritime flavours to end the day.

Access to Care Committee

By Michel Zummer, MD, FRCPC

At the Canadian Rheumatology Association (CRA) executive retreat, there was much discussion of problems related to access to care, with proposed issues to be addressed by the Access to Care Committee.

The availability of medications remains difficult in many provinces. Upon release of the CRA recommendations for the treatment and management of rheumatoid arthritis, it was suggested that each province's criteria be compared to the CRA recommendations to evaluate how they meet the standard of care. This could then be used as a basis for discussion with provincial formularies and private insurers.

Access to imaging, particularly magnetic resonance imaging (MRI), is a problem, especially when required for diagnosis of the spondyloarthritides. Professional radiology organizations will be approached to discuss this problem.

The Models of Care project at the Alliance for the Canadian Arthritis Program (ACAP), which is co-chaired by Dr. Cy Frank (an orthopedic surgeon) and myself, is progressing well. We hope to be able to develop a strategy that will influence policy and will prioritize investment in musculoskeletal diseases, looking at optimizing the complete care path.

Anyone who has information or ideas on any of these issues, or would like to get involved, is invited to contact me at *zummer@sympatico.ca*.

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

Human Resources Committee

By Barry Koehler, MD, FRCPC

The Human Resources Committee's main project this year is being done in conjunction with Paul Adam of the Arthritis Health Professions Association (AHPA), and, as always, with the unstinting support of Christine Charnock. This project has been a survey of functioning models of care across Canada; the results will be published once they have been collated and analyzed.

Dr. John Thomson and I attended a combined meeting of the Royal College and the National Specialist Societies in Ottawa in early December 2010. There was general concern regarding the ability to reliably and repetitively survey the membership of the various organizations, to evaluate current numbers and intensity of practice, as well as potential attrition of respondents. A number of speakers addressed methodologies to achieve this. Articles around this area include the internal medicine on-call survey of Canadian rheumatologists, published in *The Journal of the Canadian Rheumatology Association (CRAJ)* Summer 2010 issue, and a status survey in the *British Columbia Medical Journal (BCMJ)* in April 2011. (Anyone wishing a copy of a nice review of methodologies to evaluate human resources can contact me and I will email it to you).

Dr. John Hanley has kindly made available the information regarding academic human resources. As with the British Columbia data, this reflects static numbers, along with increasing age.

At the retreat, there was emphasis on the need to inform and attract medical students to rheumatology as early in their training as possible. A focus of the Human Resources Committee was felt to be an annual review and sharing of activities that different divisions carried out over the previous year. The necessity of medical students to choose a training track so early in their educational program was decried; however, given this sentiment, efforts to have internal medicine residents have a rheumatology rotation in Year 1 or 2 should be pursued, and having a rheumatology rotation being mandatory should be a goal.

Finally, there was some discussion of the large numbers of Canadians who are training in off-shore medical schools, the vast majority who wish to return to Canada to do post-graduate training and/or practice. Of these Canadian citizens, less than 10% will obtain training positions in our country.

I am stepping down as Chair of the Human Resources Committee and Dr. Thomson will be assuming this role.

My thanks to all of the committee members for their contributions. In particular, thanks to Dr. Paul Dancey; the viewpoints of pediatric rheumatology and your overall insights were invaluable. As always, it has been a great pleasure to be working with the CRA, and I would encourage all members to take an opportunity to spend time on a committee or in an executive position.

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

The brainstorming session was so intense that many of us developed alopecia.

Pediatric Section Committee

By Lori Tucker, MD

The Pediatric Section met this year at the American College of Rheumatology (ACR) meeting in Atlanta, Georgia, and again at the Canadian Rheumatology Association (CRA) meeting in Cancun, Mexico. The pediatric sessions at the CRA-Mexican meeting were interesting, and provided an opportunity for us to hear different aspects of pediatric rheumatology from Mexican colleagues, as well as a chance to showcase Canadian pediatric rheumatology research. Our Scientific Committee is already planning for the CRA meeting in Victoria next year, and I have no doubt that it will be fantastic.

The Pediatric Section has endorsed an educational resource developed by the Division of Pediatric Rheumatology at the Hospital for Sick Children (SickKids) in Toronto, called "A Resident's Guide to Pediatric Rheumatology (2011)." This guide was prepared by the pediatric rheumatology fellows at SickKids (supervised by Drs. Ron Laxer and Tania Celluci) and is intended to provide a brief introduction to basic topics in pediatric rheumatology. The guide includes excellent general information in the areas of juvenile idiopathic arthritis (JIA), systemic lupus, vasculitis, inflammatory myopathies, systemic sclerosis and associated syndromes, fever syndromes, uveitis, infection-related conditions, pain syndromes, and medications. Additional references are provided for more in-depth reading. The guide, completed in early 2011, has been distributed to the pediatric rheumatology centres for use in teaching. CRA members who would like to have a copy of this guide should contact Dr. Laxer (*ronald.laxer@sickkids.ca*) or Dr. Celluci (*tania.celluci@sickkids.ca*) at SickKids.

The Pediatric Section has also been working on determining the availability of biologic therapies for children with rheumatic diseases in Canada, the access and reimbursement programs of different provinces, as well as the experience of pediatric rheumatology centres. Our group is preparing a manuscript describing the results of this project. Highlights include the following:

- Access to biologic therapies varies by province, leading to inequities depending on where the patients live.
- Overall, coverage of biologics is quite limited, with etanercept being approved for coverage in nine provinces for JIA, but only for polyarticular-subtype disease in 45% of these.
- Most coverage is on a case-by-case basis. Thus, every biologic prescription requires significant work on the part of the pediatric rheumatologist, who must write a request letter outlining the case, often needing to provide references supporting the use of the medication with every application.
- Coverage and access to biologic medications for children with rheumatic diseases is significantly less than the access for adults with similar conditions.

We hope to publish a manuscript with our findings later this year, and use this information in advocacy efforts provincially and federally in support of improved care for children with rheumatic diseases in Canada.

Lori Tucker, MD
Clinical Associate Professor in Pediatrics,
University of British Columbia
Vancouver, British Columbia

Education Committee

By Christopher Penney, MD, FRCPC

The Education Committee recruited seven new members during 2010 and all regions of Canada are now represented. We have members in private clinics, as well as in university/hospital practices. We also have members in small communities and large urban centers.

The primary purpose of the Education Committee is to facilitate continuing medical education (CME) for the Canadian Rheumatology Association (CRA) membership. Later this year, once the CRA becomes a Royal College Accreditor for Maintenance of Certification (MOCERT), a subcommittee of the Education Committee will function as the accrediting committee for CRA educational events.

The Royal College is currently reconsidering its rules on what constitutes educational activities that qualify for MOCERT credit. Likely, the College will de-emphasize Section 1 (rounds and conferences) and Section 2 (other learning activities), in favor of Section 3 (self-assessment programs) and Section 5 (practice reviews). The Education Committee will work with other CRA committees and organizations such as the Royal College, to develop programs for our members. These programs will include practice audit modules (rheumatoid arthritis [RA] guidelines) and we will promote/develop self-assessment programs, such as the Royal College Bioethics module. The Education Committee strives to ensure that CRA members meet the Royal College MOCERT requirements. The chairman of the Education Committee will do a Workshop on MOCERT Secrets (a.k.a. "MOCERT for Dummies") at the upcoming CRA meeting in Victoria.

Many members are unaware of the electronic resources for CME available on the CRA website. First among these is the link to Advancing In Rheumatology—a high quality source of Category 1 Royal College-accredited CME. The upcoming redesign of the website will make this, and other to-be-developed e-education resources, easier to access.

Later this spring, a CME needs assessment will be circulated to the CRA membership. We know that most of you are tired of filling out questionnaires, but the CRA needs to know what you want in terms of CME. To combat that questionnaire fatigue, the CRA will award a WestJet trip for two anywhere in North America to one lucky person who completes the questionnaire! In addition, starting this year, the CRA will conduct focus groups on CME at the regional rheumatology meetings—again to find out what members want for their ongoing medical education.

Christopher Penney, MD, FRCPC
Associate Clinical Professor, University of Calgary
Rheumatologist, Foothills Medical Centre,
Calgary, Alberta

Management Committee

By Cory Baillie, MD, FRCPC

The Canadian Rheumatology Association (CRA) executive has just completed its annual retreat, held this year in Fredericton from April 29th to May 1st. In addition, the CRA Industry Council meeting, in which members of the CRA executive met with industry representatives, occurred May 2nd in Toronto.

The Management Committee oversees financial and governance issues of the CRA. The committee is made up of Drs. Jamie Henderson, John Thomson, Carter Thorne, Michel Zummer, and myself as committee chair. As the scope of CRA activities grows, so do the responsibilities of the Management Committee for oversight. One of the main roles of this committee is reviewing expenses and budgeting for upcoming projects. The CRA continues to be on strong financial ground. The recent purchase of *The Journal of Rheumatology* by the CRA has proven financially prudent thus far and hopefully will continue to be so in the future.

The CRA has just recently assumed responsibility for the oversight of Canadian Initiative for Outcomes in Rheumatology Care (CIORA). There has been extensive planning regarding the logistics of incorporating CIORA as a committee of the CRA, chaired by Dr. Paul Haraoui. With the increasing activities of the CRA there has been a need for increased administrative support. We have recently hired further accounting and support staff to help our CRA executive manager, Christine Charnock, with the expanding needs of the organization. Other ongoing management initiatives include, together with Ms. Charnock, developing a policies manual outlining current CRA policy for most issues pertaining to the association.

Cory Baillie, MD, FRCPC
Assistant Professor, University of Manitoba
Rheumatologist, Manitoba Clinic
Winnipeg, Manitoba

Therapeutics Committee

By Shahin Jamal, BScPT, MD, FRCPC, MSc

The Canadian Rheumatology Association (CRA) Therapeutics Committee has had another productive year under the leadership of Drs. Vivian Bykerk and Philip Baer. Although they have stepped down as co-chairs of the committee, they will remain actively involved. I would like to take this opportunity to thank them for their years of hard work and dedication.

The new Canadian guidelines for the management of rheumatoid arthritis, funded by a Canadian Institutes of Health Research (CIHR) grant, have been completed and will be published in *The Journal of Rheumatology* later on this year. The next step is a knowledge-translation plan to ensure dissemination and implementation of these guidelines. To this end, the Therapeutics Committee is working with the CRA Education and Access to Care Committees to facilitate the uptake of recommendations clinically and ensure access to appropriate medications provincially. The recommendations will also be presented at Canadian regional meetings in the coming months.

A needs assessment was conducted in the fall of 2010 which supported the development of clinical practice guidelines for the management of systemic lupus erythematosus (SLE). This will become particularly important as new medications are available on the market. Dr. Stephanie Keeling will be leading this initiative over the coming years.

There has also been interest in the development of a consensus statement on the management of gout, as well as the development of a central reference site for the use of biological therapies in orphan diseases. The Therapeutics Committee will be working with the Website Committee in facilitating this. If there is anyone who would like to participate in any of the above initiatives, or who has proposals for future initiatives, please feel free to contact me by email at *shahin.jamal@vch.ca*.

Shahin Jamal, BScPT, MD, FRCPC, MSc
Rheumatologist, Vancouver General Hospital
Vancouver, British Columbia

Website Committee

By Mark Matsos, MD, FRCPC

The 2011 Canadian Rheumatology Association (CRA) executive retreat provided an ideal opportunity for the Website Committee to reflect on the success of the website (*www.rheum.ca*) and plan the future of our online rheumatology community.

The national website continues to be a popular draw for members coast to coast—a recent analysis of our web traffic showed that the website is currently generating between 80,000 to 90,000 hits on an annual basis. Members accessing the website are looking for the latest news on upcoming events, utilizing the website's search features to find colleagues, and learning about the latest and greatest in rheumatology with regularly updated continuing medical education (CME) content. Trainees are also navigating to the website searching for opportunities to learn more about our great specialty. The CRA summer studentship program and our mentorship postings are frequent hits for students and residents looking to join the next generation of rheumatologists!

Over the next several months, the website will be undergoing revision to meet the increasing demands for online services. We hope to offer a fresh appearance and enhance the overall functionality so that version 2.0 of *www.rheum.ca* will serve as an online portal for everything rheumatology. This will include offering online renewal of annual membership, online registration for the annual general meeting, new opportunities for CME, and ongoing content for trainees keen on pursuing a career in rheumatology.

Thanks to our industry partners who continue to support the ongoing activities of the website, and to our webmaster Elisia Teixeira who continues to works tirelessly "behind the screen." A special thank you to Dr. Andy Thompson who, after many dedicated years of service, has handed over the reigns of the website and its committee. I look forward to following in his footsteps and exploring the many opportunities ahead.

Mark Matsos, MD, FRCPC
Assistant Professor of Medicine,
Michael G. DeGroote School of Medicine
McMaster University
Hamilton, Ontario

British Columbia Society of Rheumatologists: Update

By Jason Kur, MD, FRCPC

The British Columbia Society of Rheumatologists (BCSR) has had a very active year. In 2010, the BCSR elected a new President after many years of dedicated service from Dr. John Kelsall. There have been two major areas of interest for the Society over the past 12 months: the critical shortage of rheumatologists in the province and the need for new support for community rheumatology practices.

Critical Shortage of Rheumatologists

Focus has been drawn to the critical shortage of rheumatologists in the province. A member survey was undertaken in 2010 and published in the April 2011 *British Columbia Medical Journal*. The results were rather alarming. Currently there are only 32 full-time equivalent rheumatologists in the province. The age of rheumatologists in B.C. is also older than the national average for specialists. Estimates of 24 clinicians to retire in the next 5 to 10 years far outpace production by the University of British Columbia (UBC) training program. It is anticipated that demand for rheumatology services and the wait-times to see a rheumatologist are going to worsen. Given that many interventions for inflammatory diseases are required early to prevent long-term damage, this is going to present significant challenges. Changes to how out-patient care is delivered in the province will be necessary if quality care of inflammatory diseases is to continue.

Changes to how out-patient care is delivered in the province will be necessary if quality care of inflammatory diseases is to continue.

New Projects in B.C. Rheumatology

To that end, the BCSR has been working diligently on implementing new care items made possible by the Labour Market Adjustment Funding granted to rheumatology. These new funds, focused on four initiatives, should have significant impact on our practice. In the process of being implemented for spring/summer 2011 are the following:

- A multidisciplinary consultation that will provide rheumatologists the ability to involve a nurse in a patient's management plan.
- An immunosuppressant review tool that acts as a care plan check-list for patients receiving high dose immunosuppression.
- A complex consultation code, similar to other cognitive specialties, for complicated inflammatory diseases.
- A directed rheumatology-referral review mechanism, whereby rheumatologists can intervene in the work-up and management of patients before consultation, given the current lengthy wait times.

It is our hope these new initiatives will help the access and delivery of care in the province.

Enhanced Communication

The BCSR has placed greater focus on membership-engagement with the launch of a quarterly newsletter and regular member updates. The major meeting of the BCSR will occur in conjunction with the B.C. Rheumatology Invitational Education Series (BRIESE), which will take place on September 30, 2011, in Vancouver.

Jason Kur, MD, FRCPC
President, British Columbia Society of Rheumatologists
Pacific Arthritis Centre,
Vancouver General Hospital,
University of British Columbia
Vancouver, British Columbia

Lupus Clinic Celebrates 40th Anniversary

By Dafna Gladman, MD, FRCPC

The University of Toronto Lupus Clinic at the Toronto Western Hospital celebrated its 40th anniversary on April 2nd, 2011. It was a great cause for celebration, with the clinic also recognizing the more than 1,600 patients registered in what is one of the largest databases of lupus patients in the world, and probably the only one following patients prospectively, according to a standard protocol, since 1970. Moreover, it was an opportunity to pay tribute to Dr. Murray Urowitz, the clinic's founder and director, for his contributions to lupus care and research.

This milestone was celebrated by a symposium, attended by at least 100 people. The symposium included several podium presentations from previous Lupus Fellows, who presented work they have pursued since completing their training at the clinic. The presentations included the following:

- Dr. Ian Bruce of Manchester, England, presented "Accelerated Atherosclerosis in Systemic Lupus Erythematosus (SLE) and Rheumatoid Arthritis (RA): The Manchester View."
- Dr. Lai-Shan Tam from Hong Kong, China, discussed SLE and the human papilloma virus (HPV) infection.
- Dr. Mahmood Abu-Shakra of Be'er Sheva, Israel, discussed "Quality of Life, Coping and Depression in SLE" in his presentation.
- Dr. John Hanly from Halifax, Nova Scotia, presented on "Classification, Epidemiology and Outcome of Neuropsychiatric SLE."
- Dr. John Esdaile of Vancouver, British Columbia, was provocative as usual with his presentation, entitled "Patient Registries: Are they worth it?"
- Dr. Proton Rahman from St. Johns, Newfoundland, discussed potential advantages and limitations of incorporating recent genetic discoveries in a lupus clinic.
- Dr. Mandana Nikpour of Melbourne, Australia, discussed risk factors for atherosclerosis in SLE, a topic of her PhD thesis.
- Dr. Christian Pineau from Montreal, Quebec, presented "The Wolf Who Bit My Heart: Non-Atherosclerotic Cardiac Involvement in SLE."
- Dr. Zahi Touma of Toronto, Ontario, presented on "Responder Indices in SLE".

Front (left to right): Dr. Bevra Hahn, of Los Angeles; keynote speaker, Mr. Al (Sonny) Gladman; Dr. Dafna Gladman. Back (left to right): Dr. Jorge Sanchez Guerrero, incoming director, Rheumatology Division, University Health Network/Mount Sinai Hospital; Dr. Simon Carette, current Division Director UHN/MSH; Mrs. Judi Urowitz; and the man of the hour, Dr. Murray Urowitz.

In addition to the podium lectures, nearly 20 posters were presented by current and previous fellows attending the Lupus Clinic, on topics ranging from a combination of periodic peritonitis (FMF) and lupus, to renal disease, to patients with serologically active, clinically quiescent disease. Dr. Bevra Hahn of Los Angeles, California, was the keynote speaker on the topic of Treatment of SLE in 2011.

The day concluded with a gala dinner attended by more than 200 people, and at which it was announced that $300,000 had been raised towards the total goal of $600,000 for the Murray Urowitz Lupus Fellowships.

Dafna Gladman, MD, FRCPC
Professor of Medicine, University of Toronto
Senior Scientist, Toronto Western Research Institute (TWRI)
University Health Network, Toronto Western Hospital
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All the Luck in the World

By Jody Lewtas, MD, FRCPC

It is probably a good thing to reflect a little when you are nearing 20 years in practice. When I started my rheumatology residency, I would never have imagined how exciting the day-to-day practice would become. I always said that it was the variety of rheumatology that was so attractive. Cardiologists deal with chest pain, shortness of breath and syncope. Rheumatologists, on the other hand, seem to deal with every complaint known to man, and that turns out to be a lot of complaints! There is rarely a dull moment and that is the advantage. The disadvantage results in my writing more antibiotic scripts for urinary tract infections than most family physicians.

Although I could easily be accused of having blinders on to other specialties, the explosion in therapeutics in our field is still truly astounding. When I started practice, methotrexate was a cool drug and we started warily at 5 mg weekly. Eight effusions and mangled hands was a good outcome if the patient was not complaining of as much pain as before treatment. We spent lots of time in rounds discussing how individual deformities developed, something that people don't really care to know today. When we see patients in the office, we are so intolerant of swelling, trying to weigh the best course of action when there are so many choices at our fingertips. It seems that new pathways are presented at national meetings one year, with novel drugs to block those pathways the next. The science is fascinating and delivering the science to our patients, with their individual worries, comorbidities and tolerance for risk, really challenges the educator, salesperson and clinician in us all.

Dr. Jody Lewtas, reflecting on her luck in the rheumatology field.

When you feel you may have finally gotten a handle on some of the aspects mentioned above, the next patient on the day sheet hails from the strange land of Fibromalasia. It may be an okay place to visit, but I certainly would never want to live there. People are plagued with misery. They worsen with every appointment, and I have always found this mathematically mystifying as they are about as bad as they can imagine from the start. I find myself slipping into feel-good comments and motivational vocabulary that would embarrass Oprah (and the medical student I used to be).

I practice in Markham, Ontario, which is in York Region, just north of Toronto. The community is growing faster than methicillin-resistant Staphylococcus aureus (MRSA) on a swab. Our patients come from all over the world with stories of their lives that are nearly as fascinating as the practice of rheumatology. Nearly.

Jody Lewtas, MD, FRCPC
Rheumatologist, Markham Stouffville Hospital
Markham, Ontario

From around the CRA ...

Important meeting! Smart people! Big Decisions! (Who let Paul in?)

President Henderson: Talk about intense! Dr. Bookman: Somewhat less intense!

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Ontario Rheumatology Association: Meeting Report

By Philip Baer, MDCM, FRCPC, FACR

The Ontario Rheumatology Association (ORA) celebrated its 10th anniversary in fine fashion with its biggest and most successful meeting ever, taking place May 13th to 15th, 2011, in Muskoka. The growth of the meeting required a move to larger facilities at the J.W. Marriott Resort in Minett. This centrally located hotel and conference centre featured calming views of the Canadian Shield, perfectly suited to reducing the stress of the participants' busy professional lives. Registrants included 80 rheumatologists and fellows, as well as over 30 allied health professionals, and representatives from our industry sponsors.

Pre-meeting activities included a variety of Advisory Boards, an Arthritis Health Professions Association (AHPA) course, a rheumatology Objective Structured Clinical Examination (OSCE) session for trainees, and an electronic medical record (EMR) fair where vendors showcased systems tailored to rheumatology specialty practice.

The scientific program, assembled by Dr. Janet Pope, was of very high quality. Updates on the Ontario Biologics Research Initiative (OBRI), Canadian Rheumatology Association (CRA) guidelines for rheumatoid arthritis (RA) management, and new models of care were presented. A highlight was the presentation on improving drug access for patients with inflammatory rheumatic diseases, given by Diane McArthur, the Executive Officer of the Ontario Public Drug Program (OPDP). Other updates covered the "1,000 Faces of Lupus" project, the Spondyloarthritis Research Consortium of

Lake Rosseau and the J.W. Marriott resort.

ORA President Vandana Ahluwalia, Secretary-Treasurer Jane Purvis, Administators Phyllis Pardetti and Wendy Daechsel.

AHP at ORA: Lois Derrick and Lisa Denning, from Newmarket.

At the ORA dance.

Canada (SPARCC), and new therapies and guidelines for osteoporosis management.

The ORA meeting always features very interactive small group sessions. This year, workshops covered pain management, scleroderma, vasculitis, billing issues, anti-citrullinated peptide antibodies (ACPAs), EMRs, referral triage, and gout, amongst others.

Our ever-popular Thieves Market returned as well, with participants presenting their most challenging cases of RA, osteoporosis, scleroderma, seronegative arthritides and autoimmune diseases in pregnancy. Our expert moderators, led by Drs. Rick Adachi, Henry Averns, Peter Lee, Viktoria Pavlova and Raj Carmona, proved to be entertaining and very difficult to stump.

For the first time ever, meeting attendees participated in a private version of the "Walk to Fight Arthritis" fundraiser, one day ahead of the National Walk. There was a spirited competition between teams of ORA rheumatologists, Arthritis Society professionals and Advanced Clinician Practitioner in Arthritis Care (ACPAC) therapists. Despite muddy and rainy conditions, 50 participants completed a 5 km walk through the woods of Muskoka in fine form. Over $12,000 was raised to support the Arthritis Society and we hope to make this a feature of all our future meetings. After developing an appetite on the trail, participants and their families celebrated with a gala dinner-dance Saturday evening. Awards were presented to the ORA Rheumatologist of the Year, Dr. Claire Bombardier, as well as to the most successful individual and team fundraisers in the "Walk to Fight Arthritis." Entertainment was provided by our one-man band, Jamie Williams, who kept adults and children on the dance floor into the wee hours.

The ORA has evolved significantly as an organization in the past year. Not only did we move our annual meeting to a new location, but our executive team made a successful transition to a new group of leaders. Dr. Vandana Ahluwalia provided dynamic and indefatigable leadership as our new President. She is ably supported by Dr. Jane Purvis as Secretary-Treasurer, Dr. Carter Thorne as Past President, and myself as Vice-President. Thanks are also due to our administrative team, including Phyllis Pardetti and Wendy Daechsel, as well as our Executive Director, Denis Morrice.

If you missed this year's meeting, immediately rectify that oversight by marking your calendar now for next year's ORA meeting, tentatively booked for the same location, the last weekend in May, 2012.

Philip A. Baer MDCM, FRCPC, FACR
Vice President, Ontario Rheumatology Association
Chair, OMA Section of Rheumatology
Member, Therapeutics Committee, CRA
Scarborough, Ontario

Sustenance at the end of the "Walk to Fight Arthritis."


Preparing for a walk "Into the Woods."


Dance redux!

Rheumatology in Quebec

By Murray Baron, MD, FRCPC

Montreal is not only a rich cultural city, but we are also endowed with a richness of rheumatologists and rheumatology centers. The Jewish General Hospital in Montreal is one of the McGill teaching hospitals. We have probably had the fastest rate of growth of the rheumatology divisions in Montreal, as we have expanded from two to five full-time rheumatologists in the past five years. Although our salaries may not be the highest in Canada, it can be hard to beat living in Montreal!

For years, I and Laeora Berkson were the only rheumatologists in our hospital. The situation started to change when Dr. Marie Hudson came on board in 2006, followed by Dr. Sabrina Fallavollita in 2010 and Dr. Geneviève Gyger in 2011.

I have developed and directed the Canadian Scleroderma Research Group (CSRG) since 2004. The group has been funded by patient societies, industry and, most importantly, the Canadian Institutes of Health Research (CIHR), and has been very successful in terms of publications in the past few years. Dr. Berkson has an interest as a medical educator and has worked extensively in curriculum development. She was a Carter Wallace Scholar in medical education and a recipient of a Canadian Arthritis Society Clinician Teacher Award. An article on problem-based learning, published early in her career, is included in *Academic Medicine's AM Classics Collection*.

Dr. Hudson, who won this year's Canadian Rheumatology Association (CRA) Young Investigator Award, is the only full-time researcher of the group. She is funded by the CIHR and has published important papers about scleroderma. Her work has put the CSRG on the world map of scleroderma research.

Dr. Fallavollita has a particular interest in early inflammatory arthritis, and is in the process of developing expertise in musculoskeletal ultrasound. Dr. Gyger, our newest recruit, also has an interest in scleroderma, having spent a year as a fellow of the CSRG, and has now developed expertise in videocapillaroscopy. This technique provides spectacular pictures of nailfold capillaries and she will be able to provide this service to all McGill rheumatologists.

As I went through this hiring process in the past few years, especially of an academic physician, a few thoughts came to me which were reinforced when, at the recent CRA meeting in Mexico, I presented Dr. Hudson for her Young Investigator award. As I looked through the list of other recent winners of that award, I was struck by the fact that, for several years, no award was presented. In this country of over 30 million people, with an excellent cadre of rheumatology researchers, why did we go through years when we could not find a single new investigator worthy of this honour? We are either not attracting academically oriented physicians to our specialty or something is turning them off once they are in it. It is not hard to understand why someone who has spent years learning clinical medicine and then clinical rheumatology would want to stick with clinical practice. This may be especially true when you consider how difficult it is to find competitive funding for academics. Luckily, Quebec has instituted a new program for academics, in which the medicare payor funds academics (roughly defined as someone with a CIHR or equivalent salary support award) over and above their salary support up to the median, plus 10% of that specialty's earnings.

Dr. Baron and the team from the Jewish General Hospital.

If, as a rheumatology community, we want to continue to see the development of research in our field, we must begin to address the hurdles involved in turning our graduates into academics. I do not have the answers to this dilemma but perhaps it is time to start to think about this and advocate for what may be needed to strengthen our research community.

Murray Baron, MD, FRCPC
Chief, Division of Rheumatology, Jewish General Hospital
Associate Professor of Medicine, McGill University
Montreal, Quebec

Rheumatology in Paradise

By Robert Offer, MD, FRCPC, FACR

You might wonder how rheumatologists can make a living in the Okanagan Valley (a.k.a. the California of Canada). There are currently six full-time adult rheumatologists and one pediatric rheumatologist (Dr. Kathy Gross) in the Okanagan, a population of approximately 250,000. With a population of 147,000, Kelowna has four adult rheumatologists, while Penticton, a retirement community of 36,000, has two adult rheumatologists plus Dr. Gross, who supervises the pediatric program for the B.C. interior. Given the usually quoted ratio of one rheumatologist per 75,000, it would appear that we should be starving. Quite to the contrary, current workloads are ideal, with urgent referrals being seen quickly and routine patients waiting three to 12 months. Our workload is greater than population predictions for two reasons:

- many arthritis patients move to the warm and dry Okanagan; and
- a lot of our patients travel from afar as many areas, such as the Kootenays, have minimal arthritis services.

We have recently been joined by two young rheumatologists: Dr. Nima Shojania moved from Vancouver to West Kelowna, and Dr. Anick Godin departed Sherbrooke, Quebec, to join Dr. Stuart Siegel in Kelowna. Kelowna's fourth rheumatologist is the venerable Dr. Dan MacLeod. Drs. Shojania and MacLeod continue to travel to north and central B.C. on consultation trips.

Hailing from Sherbrooke, Dr. Anick Godin now calls Kelowna home.

Dr. Nima Shojania and his daughter enjoying the B.C. scenery.

Penticton's Dr. Jackie Stewart continues to stay in Ironman shape, having completed yet another race, and like the local wines, she states she is improving with age. Starting in 1975, I was the first to practice rheumatology between Calgary and Vancouver; though I am past retirement age, I consider my career only half over.

The Kelowna and Penticton rheumatologists get together frequently, usually at a scenic winery halfway between their locales. With the recent addition of Drs. Shojania and Godin, our journal club is flourishing and we are attracting visiting speakers. We are all delighted to have Dr. Godin bring her ultrasound skills to the valley. All in all, the rheumatology is as good as the wine in the Okanagan!

Robert Offer, MD, FRCPC, FACR
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Joint and Bone Manifestations in GPA

By Christian Pagnoux, MD, MPH

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

A 48-year-old man, who is overweight (body mass index [BMI] = 42) and with a long-standing treatment for high blood pressure, consulted for persistent rhinitis, recurrent bronchitides, low-grade fever, and some pain in his finger joints and middle back. These conditions have been awakening him at night, resulting in fatigue for two months.

Examination showed high blood pressure (155/90 mmHg) and normal chest and heart auscultation. He had no sensory or motor deficit and normal deep tendon reflexes. Nasal mucosa was erythematous, but without ulceration. There was no clinically obvious synovitis or joint deformation. Back pain was mid-dorsal, with some stiffness of the dorsal spine, but no elective pain on pressure of any of the spinous processes. Serum creatinine was 243 micromol/L and C-reactive protein (CRP) 135 mg/L. Urine analysis revealed red blood cell casts and proteins 0.7 g/24 hours. Anti-neutrophil cytoplasmic antibodies (ANCA) tested positive, with a cytoplasmic-labelling pattern by immunofluorescence and proteinase 3 specificity by enzyme-linked immunosorbent assay (ELISA).

A computed tomography (CT) scan of the chest (without iodine injection) showed no lung parenchymal involvement but revealed a right prevertebral thoracic lesion (T4 to T6-8), which was neither erosive nor infiltrating (Figure 1). A CT-guided biopsy of the latter lesion was performed; this showed infiltration with mixed inflammatory cells and necrosis of the small vessel walls, but no germ or malignant cells. The patient also underwent a kidney biopsy, demonstrating segmental necrotizing pauci-immune glomerulonephritis, further supporting the diagnosis of granulomatosis with polyangiitis (Wegener's syndrome, now GPA).

Granulomatosis with polyangiitis (Wegener's syndrome, now GPA) is one of the three anti-neutrophil cytoplasmic antibodies (ANCA)-associated small-sized vessel vasculitides, even though 20% to 40% of the patients are ANCA negative. There is no epidemiologic data on GPA available to date in Canada, but its annual incidence rate is five to 10 per million habitants, with a prevalence of around 50 to 90 cases per million in European countries that share the Canadian latitudes. Whereas ear, nose and throat (ENT; serous otitis, crusting rhinitis, erosive sinusitis, nasal septum perforation, saddle-nose deformity), kidneys (pauci-immune glomerulonephritis) and lungs (nodules, often excavated, alveolar hemorrhage) are the main target organs, joint manifestations are also within the wide gamut of other potential GPA clinical manifestations.

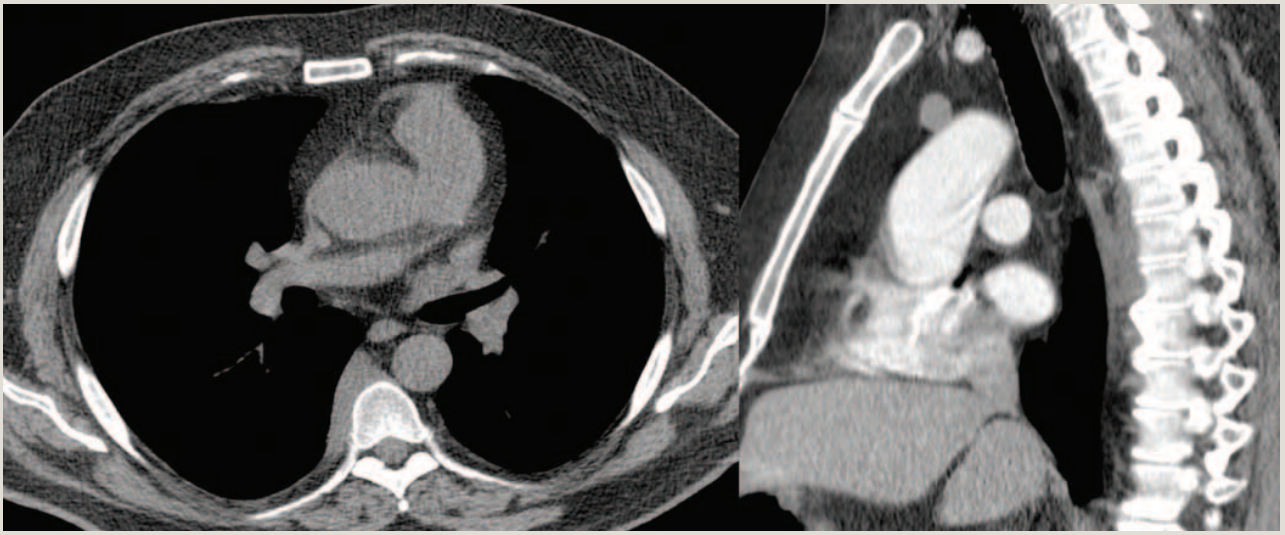
Clinical Joint and Bone Manifestations in GPA

Arthralgias are present at diagnosis or in disease flares in 50% to 70% of the patients with GPA. Polysynovitis and/or non-erosive polyarthritis (mainly wrists, fingers, knees and/or ankles) are not infrequent during flares, but to a lesser degree (generally fewer than 10% of patients, but up to 30% in one study). These joint manifestations can precede other more specific and/or suggestive manifestations of the disease. Rheumatoid factor (RF) can be detected in 37% to 50% of GPA patients, while anti-cyclic citrullinated peptide (anti-CCP) antibodies very rarely occur. The diagnosis can be challenging, however, at least during the first months after disease onset.

Other possible joint or bone manifestations are more exceptional; these may include prevertebral lesions, like those of the case study patient, or periosteal new bone formations, which are very rare and occur almost exclusively in the tibia(s) and/or fibula(s). Characteristics of these prevertebral lesions are listed below:

- they are usually dorsal;
- they can extend laterally to the prevertebral pleural spaces and/or anteriorly to the middle mediastinum;

Figure 1



Horizontal and reconstructed right parasagittal CT-scan images of the chest of the case-study patient. Para- and prevertebral thoracic T4 to T8 lesion.

- for an unknown reason, they are predominantly right-sided;
- they may be asymptomatic or cause non-specific and, usually, moderate dorsal pain; and
- they have not been reported to lead to compression of nearby structures.

When a computed tomography (CT) scan-guided biopsy is done, granulomatous inflammation, and more rarely, vasculitis, may be seen. The differential diagnoses to rule out mainly include infections, especially tuberculous spondylodiscitis, but also neoplastic diseases and other granulomatous diseases (*i.e.*, sarcoidosis, isolated inflammatory pseudotumor or histiocytosis). Imaging studies, especially magnetic resonance imaging (MRI), can be helpful to exclude spondylodiscitis.

Treatment Options

The treatment of GPA patients with severe manifestations, such as kidney involvement, is well established and codified. Patients must receive a combination of corticosteroids, usually starting with intravenous (IV) pulses of methylprednisolone (7.5 to 15 mg/kg/d for one to three consecutive days), then oral prednisone (1 mg/kg/d for two to four weeks, then progressively tapered), and cyclophosphamide (orally at the dose of 2 mg/kg/d, or with serial IV infusions of 750 mg/m² or 15 mg/kg every two weeks for one month, then every three weeks). Doses of cyclophosphamide should not exceed 200 mg/d orally or 1,200 mg per IV pulse, and are to be reduced by 25% when glomerular filtration rate is < 25 mL/min or the patient is 75 years or older. Plasma exchange should also be considered in those patients with severe renal disease and/or alveolar hemorrhage; the ongoing Plasma Exchange and Glucocorticoids for Treatment of Anti-Neutrophil Cytoplasm Antibody-Associated Vasculitis (PEXIVAS) trial is aimed at better determining whether plasma exchange is effective in such patients. As soon as remission is achieved, usually around four months after starting induction therapy, patients can be switched to a less toxic maintenance treatment. Using cyclophosphamide to treat newly diagnosed GPA patients at the recommended dosage and schedule, for no longer than necessary to enter remission, is not associated with the major risk of long-term adverse events (*e.g.*, bladder cancer, lymphoma) that have been reported in earlier studies where induction treatments lasted years and cumulative doses often exceeded 35 g. The risk of cyclophosphamide-induced hypofertility or sterility depends on patient's age and cumulative dose, with concerns essentially when the dosage is greater than 10 g to 20 g.

For maintenance therapy, cyclophosphamide is replaced by either azathioprine (2 mg/kg/d) or methotrexate (20 to 25 mg/week). The drugs were shown to be equally effective

and safe in maintaining remission, but renal insufficiency may increase the risk of methotrexate-related toxicity. The optimal duration of maintenance therapy remains unknown, but clearly must not be shorter than 18 months. Ongoing studies may help to better determine the treatment duration, possibly based on individual patient characteristics.

Granulomatous lesions, such as orbital tumors or lung nodules, may respond more slowly to conventional cyclophosphamide therapy; these lesions may also become fibrous but remain unchanged in size as non-active scars, and thus not require the continuation of induction treatment. As such, prevertebral masses often remain unchanged under therapy and intralesion calcifications can appear as a hypothetical scarring process.

Rituximab has recently been shown as effective and safe (at six months) as cyclophosphamide to induce remission in GPA patients, and was just approved in the United States by the U.S. Food and Drug Administration (FDA) for those patients with severe forms of the disease, in combination with corticosteroids. It is not yet approved for treatment of vasculitis in Canada, but may be soon. Whatever the decision of Health Canada will be, in my opinion and for most of the vasculitis experts across the world, rituximab use in GPA should, for the moment, be limited to those patients with severe disease, who are refractory, multi-relapsers and/or have contra-indication(s) to more conventional treatments (*i.e.*, cyclophosphamide, given according to the recommended regimen). Which maintenance treatment should follow rituximab-based induction is not yet determined; ongoing and planned studies will examine this point using either rituximab re-injections, systematically or based on CD19 T-lymphocyte count, or azathioprine. As for other biologics or diseases treated with biologics, patients receiving rituximab should ideally be entered into longitudinal observational studies or registries. One such registry is under development under the aegis of the recently created Canadian Vasculitis Network (*http://www.canvasc.ca*).

Conclusion

The case-study patient, mentioned above, received a conventional treatment combining corticosteroids and cyclophosphamide for four months, and was subsequently switched to azathioprine for maintenance. His kidney function and systemic manifestations, including finger joint pain, rapidly improved. The prevertebral mass size did not significantly change on a repeat CT scan at six months, but the back pain lessened and no longer required pain medications.

References:
1. Falk RJ, Gross WL, Guillevin L, et al. Granulomatosis with polyangiitis (Wegener's): an alternative name for Wegener's granulomatosis. Arthritis Rheum 2011; 63(4):863-4.
2. Barreto P, Pagnoux C, Luca L, et al. Dorsal prevertebral lesions in Wegener granulomatosis: Report on four cases. J Bone Spine 2011; 78(1):88-91.
3. Hamidou MA, Dupas B, Moreau A. Periosteal new bone formation in Wegener's granulomatosis. J Rheumatol 1997; 24(4):814-5.
4. Kamali S, Polat NG, Kasapoglu E, et al. Anti-CCP and antikeratin antibodies in rheumatoid arthritis, primary Sjögren's syndrome, and Wegener's granulomatosis. Clin Rheumatol 2005; 24(6):673-6.
5. Stone JH, Merkel PA, Spiera R, et al. Rituximab versus cyclophosphamide for ANCA-associated vasculitis. N Engl J Med 2010; 363(3):221-32.

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JOINT COUNT

Congratulations to this issue's Joint Count survey winner, Dr. Martin Cohen from Toronto, ON.

Get a Job

by Glen Thomson, MD, FRCPC

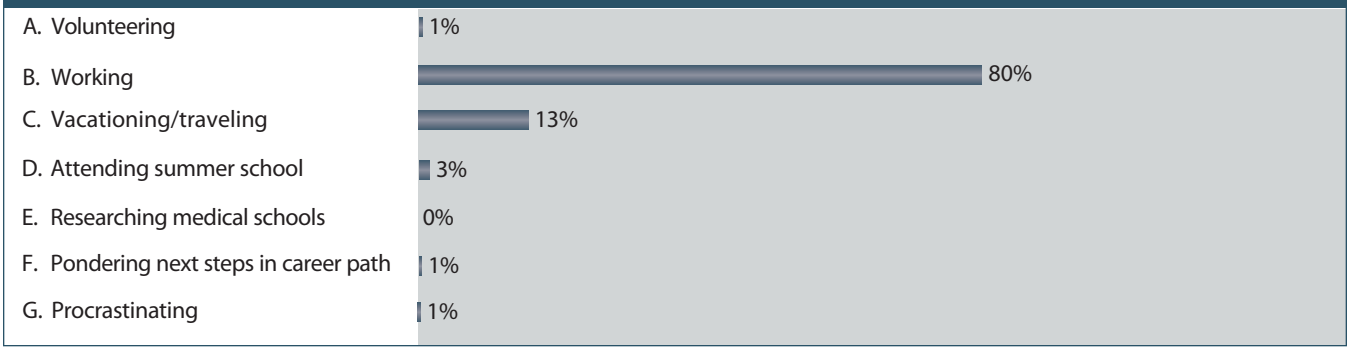
The *Journal of the Canadian Rheumatology Association (CRAJ)* asked you what you did in your summers before medical school, and 80% responded that you worked (Question 1). Of those who responded, half needed the money to pay for university and a quarter worked to gain life experiences.

The majority of respondents did not do any volunteer activities in those summers. Those who did volunteer were looking for life experiences, although some had volunteerism as a requirement to apply for medical school.

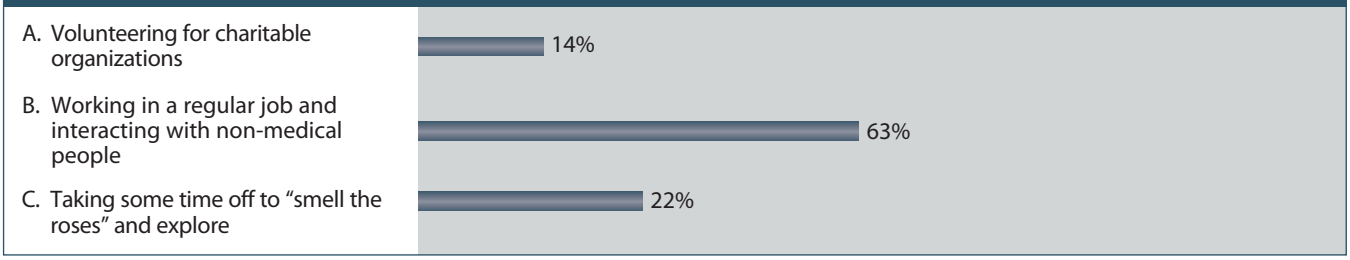
So, what should prospective physicians do in their last summers of freedom to best give them the life experiences necessary to enter medical school (Question 2)? More than one in five suggested that taking some time to "smell the roses" would be best, and volunteering was recommended by 14%. The majority concluded—in the words of the classic 1957 doo-wop song by the Silhouettes—get a job.

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

Question 1: How did you spend your summers before you went to medical school?



Question 2: Which of the following do you believe is a better life experience that doctors should have before entering the medical profession?



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