Mission Statement
The mission of the CRAJ is to encourage discourse among the Canadian Rheumatology community for the exchange of opinions and information.
At this time last year, Y2K loomed large as both a source of impending calamity and a hope for a new era, free of the problems of the past. Yet, just like the results of our recent federal election, the passing of Y2K hasn't resulted in much visible change. Change often occurs in subtle ways, however—many of which are only later recognized as being significant, perhaps even monumental. How many years ago was it that the Internet was only a fad enjoyed by “computer geeks”? So, too, goes the field of Canadian rheumatology, which is undergoing subtle changes that greatly affect many of the paradigms employed in our practices. Sound scientific data are accumulating to demonstrate the increased safety and efficacy of our symptom-relieving and disease-modifying drugs. Slowly, public policy at various levels of government is coming to respect this scientific data and pay for the patient's access to these new therapies.

The Canadian Rheumatology Association (CRA) has conducted an in-depth study of the rheumatology manpower needs for Canada's various regions. In the last issue of the CRA Journal, the article by Drs. Zummer and Henderson and the commissioned paper by Dr. Elizabeth Badley and Naomi Kasman were tangible proof of the commitment of the CRA to this topic. In this issue, Dr. Steve Edworthy elaborates on the critical subject of manpower (page 6).

In another direction, Dr. Art Bookman and the Media Committee's efforts and subsequent follow-up for the press conference this past September are documented in the Vice-President's Message (page 5). Such activities are opening doors for CRA members to discuss the needs of our patients and the requirements for specialty care in this new era.

Under Dr. Dianne Mosher's leadership, the CRA has created a working group with the pharmaceutical industry to better define guidelines for the interaction of the CRA and industry at the CRA annual meeting and in other projects. The creation of this “industry council” will emphasize the desire of the CRA to be fair and equitable to all members of industry, with transparent rules of interaction. Projects like this and many others set in motion by Dr. Mosher and the CRA Executive collectively demonstrate a continued spirit of activism in the Canadian rheumatology community. As partners in the Decade of the Bone and Joint, it is hoped that many of the items identified by Dr. Mosher and the CRA Executive will receive even more serious attention and contemplation by those who can make decisions and alter policies.

Finally, it is not too late to expect big changes in the “new millennium” year. In fact, because there was no year 0, many contend that the true millennium only begins this coming January 1—so our hopes for change at the start of a new era continue into 2001, as we pursue our many common objectives. With this in mind, we hope you all will join us at Mont Tremblant, Quebec, February 21-24, for the annual CRA meeting.

I wish to extend to you and your family my best wishes for a merry Christmas, happy Hannukah, and joyous celebrations of all special holidays this season.

I hope your New Year is a hope-filled one as we continue to proceed into the new millennium together.

Glen TD Thomson
Editor-in-Chief
As the year draws to a close, I would like to take this opportunity to thank many of you for your hard work and dedication to the Canadian Rheumatology Association (CRA). Due to the very good planning and leadership of Dr. Glen Thomson, the CRA established several committees in the past three years, and these committees have been most productive. The Manpower and Economics Committee, chaired by Drs. Michel Zummer and Jamie Henderson, produced a valuable manpower report (see the Fall issue of CRAJ). Under the direction of Dr. Arthur Bookman (and with the assistance of Sheila McEachen, at Cohn & Wolfe, and the Arthritis Society), we embarked upon a media campaign to increase public awareness about the challenges faced in the delivery of arthritis care. Thanks go as well to Dr. John Hanly, for the data from Canadian Council of Academic Rheumatologists, informing us that there were 37 Canadian rheumatology residents in 1998, 33 in 1999 and 29 in 2000—11 of which are foreign-funded. We now know that this means there will be only nine new rheumatologists in Canada next year.

In the spring of 1990, the Deputy Minister of Health commissioned Barer and Stoddart to seek a review of potential regional or national approaches to physician-resource policy in Canada. The team noted a concern over the mix of specialists being trained as well as difficulties with physician distribution. Barer and Stoddart were concerned that there were no controls on the total number of specialists and subspecialists being trained in Canada. The net result of their report, unfortunately, was a drop in the number of medical students and available medical-resident positions.

At Dalhousie University, this result represented a 10% decrease in medical students and a drop in resident positions of 20% to 30%. It was apparent even then, however, using population demographics, that there would be a tremendous need for physicians. It would not have been difficult to predict where these needs would be greatest.

The good news today is that the governments have decided there now needs to be an increase in medical-school enrollment and medical-residency positions. Our job, then, is to ensure that some of these positions are for training rheumatologists, and that we encourage students to accept these positions. Our data, and the continued work of the Media Committee, are essential tools in our efforts to lobby government and medical schools to these ends.

The second bit of good news this year was the establishment of the Institute of Musculoskeletal Health and Arthritis Research. The Arthritis Society was very instrumental in seeing that this Institute came to fruition, and I would like to thank the Society—in particular, Denis Morrice—for the tremendous efforts in this regard. In early December, Dr. Cy Frank of the University of Calgary was appointed the first Director of the Institute. Dr. Frank is a respected orthopedic surgeon and researcher, well known in the rheumatology community. He also sits on the National Board of the Arthritis Society. We wish him the best of luck in his new position.

Once again, many thanks to all those who contributed—prominently or “behind the scenes”—to the efforts and achievements of the Canadian rheumatological community during this past year.

Best wishes to CRA members and their families for a Happy Holiday and New Year.

Dianne P. Mosher
President, CRA

Dianne P. Mosher, MD, FRCPC
President, Canadian Rheumatology Association, Associate Professor, Dalhousie University, Active Staff, Queen Elizabeth II Health Sciences Centre, Halifax, Nova Scotia.
Vice-President’s Message:
Stand Up and Be Recognized

The time has come for the Canadian Rheumatology Association to stand up and be recognized. There is no doubt that rheumatologists in Canada have burning issues, and it is our intention that Canadian citizens and government take note. The CRA has done its homework, accumulating statistics about the status of rheumatology in Canada. This aggregation of factual information culminated in a September media launch that highlighted our concerns over sinking numbers and inadequate training facilities. Even we, the originators of the media program, have been shocked at our status as these numbers have rolled in.

Rheumatologists, the products of five years of post-graduate education, earn less net income per hour than any other Canadian physician. Our total number—only 270 for the entire country—will be 260 in 10 years at the current level of graduation. This small number of experts in the evidence-based care of arthritis is being asked to look after the four million people who have arthritis today—and the five million expected to have arthritis by 2016. Of the 16 rheumatic-disease units we had in the 1980s (all with inpatient beds and training programs), only 11 have Royal College approval to train rheumatologists today. Three other units have recently been given notice of approval withdrawal. Only three units can presently train pediatric rheumatologists, and only two still have inpatient beds.

The launch of this information to the media in September was picked up by CHCH-TV, Hamilton. The message was broadcast in Toronto, Calgary, Edmonton and Barrie. A telephone blitz ensured that the story was picked up by publications in most large cities and many small towns across the country. Television interviews occurred in Edmonton, Toronto, Quebec and Halifax. Many of you let me know that for the first time, your colleagues and patients had some appreciation for the patient load you have to carry.

Our ultimate aim is to get our message to the government. That lobby effort is underway as we speak. President Dianne Mosher has had an interview with the Deputy Minister of Health in Nova Scotia concerning training facilities for rheumatology there. I have an interview with the Liberal Health Critic for Ontario, Lynn McLeod, and have been informed that I will be contacted by the Deputy Minister of Health as well. Steve Edworthy has written to the Minister of Health for Alberta. We are seeking interviews with every provincial government.

Our aim is to right the deficiencies. With the release of $23.4 billion in new federal health funding, our opportunity is now. We must assure that each province has a strategy to deal with access to care for our patients: beds, rehabilitation, drugs and education. Rheumatologists must also have a better funding formula, to enable us to look after our complicated, time-consuming patient load. We must rectify the deficiencies in training and, in some provinces, we must address the poor distribution of rheumatologists.

In many of these endeavors, our greatest ally should be The Arthritis Society. Through the initiative of Denis Morrice, a Patient Advocates Program has been introduced, and a professional government-advocacy consultant has been hired. Your executive has met with members of the board of The Arthritis Society to attempt a reformulation of our somewhat troubled relationship over the past few years. We believe we can be successful at reintegrating rheumatology into the planning and direction of The Arthritis Society, and that we can be allies in our fight for patient rights.

Here’s to you, the membership of the CRA. Your executive needs everything you can contribute to this launch. We need your perspective, your contacts, your feedback and your effort. Call me. Write me. Email me.

Stand up and be recognized.

Arthur A.M. Bookman
Vice-President and Media Committee Chair, CRA
arthur.bookman@uhn.on.ca

Arthur Bookman, MD, FRCPC
Vice-President, Canadian Rheumatology Association, Associate Professor, University of Toronto, Clinical Coordinator, Division of Rheumatology, The Toronto Hospital, Toronto, Ontario.
HISTORICAL AMBITIONS GONE AWRY
In the 1940s, an ambitious plan for rheumatology was developed by leaders of the Canadian medical and lay communities. These leaders became the founders of the Canadian Rheumatology Association (CRA) and the Arthritis Society; they hoped to provide experts in rheumatic-disease care that would serve the population in a ratio of approximately one rheumatologist per 100,000 people.

Despite excellent training programs and concerted efforts by many leaders, Canadian rheumatology has never reached this initial goal—and currently is falling behind. More realistic estimates of population needs, requirements from diagnostic assessments, treatment-regimen complexity, and the demands of academic programs indicate that a more accurate estimate would be one rheumatologist per 70,000 people.

Canada is currently in a deficit situation of 230 rheumatologists if it is to meet minimum expectations for arthritis treatment. This manpower deficit will grow to 300 or more in the next 10 years, if current trends continue. From an ecological perspective, rheumatologists are currently on the endangered-species list. As the environment changes, and critical habitat in the medical community is lost, we face the distinct possibility of extinction. The niche we currently occupy will be filled by family doctors, orthopedic surgeons and internists—none of whom will have the specific medical interests in arthritis and rheumatic-disease care that rheumatologists currently cultivate. A large segment of the population will seek the advice of alternative-health practitioners, totally unaware of the benefits of proven rheumatic-disease diagnosis and treatment.

By the year 2025, one could predict that the Canadian public (25% of whom will be over the age of 65) will receive rheumatic-disease care similar to that provided in the 1940s. For those suffering from arthritis, expertise in the management of arthritic processes can lead to early treatment, a better ability to alter disease course and a better quality of life. Rheumatologists, specialists in medicine with at least five years of post-graduate training in the diagnosis and treatment of arthritis, can best address these problems. Rheumatologists are severely under-represented in the medical community, however, and are only able to meet less than half of the current population need.

BURDEN OF ILLNESS AND ESTIMATED NEED
The total burden of arthritic illness captured simplistically as the loss of gross national product (GNP) from disability is estimated to be $8.9 billion annually in Canada (based on 1999 GNP figures and estimates of work disability from the literature). Another consideration is that four million Canadians are personally affected by arthritis. People with inflammatory arthritis, such as rheumatoid arthritis (RA), have a three- to four-year shorter life span than healthy individuals.

Based on conservative population and disease-prevalence estimates, data projections indicate that Canada should have 500 rheumatologists right now, including 380 full-time community-based rheumatologists, 110 academicians and 10 full-time administrators. In 10 years, the population would need to be served by 600 rheumatologists, many of whom would have special interests in the rheumatic problems brought on by aging. This estimate is based on the following conservative assumptions of prevalence, clinical management time and training requirements:

- 1% inflammatory polyarthritis (1.5 hrs/year for all cases)
- 0.1% crystal arthropathy (1 hr/year for all cases)
- 0.1% connective-tissue disease (2 hrs/year for all cases)
• 0.05% vasculitis (3 hrs/year for all cases)
• 5% soft-tissue diseases, including fibromyalgia (1 of 20 seen for 0.75 hrs/year)
• 10% degenerative joint disease (DJD) (1 of 10 seen for 0.75 hrs/year)

(Note: no allowance has been made for osteoporosis, and the number of patients seen for DJD and fibromyalgia is conservative).

These calculations indicate that, with Canada's current demographic profile, a total of at least 850,000 hours clinical time per year is required for a population of 30 million. This requirement is twice what current manpower estimates show are possible. Ninety per cent of this clinical time would be provided by community rheumatologists, leaving 10% of care to be provided in training programs, which will hopefully increase the numbers of new rheumatologists.

A community rheumatologist working 46 weeks per year in clinic (five weeks holiday; one week conference), and spending 80% of a 55-hour week seeing patients, could contribute 2,024 hours per year. The clinical time includes triaging referrals, assembling laboratory and x-ray information, interviewing and examining patients, communicating with other health providers and patients, prescribing treatment, arranging and reviewing follow-up tests, documenting care and dealing with administrative problems. A total of 380 community rheumatologists seeing “joint and soft tissue” patients 40 hours per week, 46 weeks per year are needed to fulfill this expectation of health delivery using existing approaches to care.

An academic involved with training, research and presentations for 25% of a 60-hour week (including travel and conference presentation time) could contribute 690 clinical hours per year. The total number of academicians relates to the amount of training and research required to fill the gap over the next 10 years. Funding for research positions is expected to remain at a ratio of least 2 to 1, and, therefore, only 35 of the 110 academics would be dedicated to leading training programs in Canada’s 10 academic institutions that are active in rheumatology.

An administrator with a regional health authority, university or medical association working 5% of a 60-hour week in clinic could contribute 276 hours per year. Administrative estimates are based on the increasing demands of complex medical systems in urban settings, as well as the increased need to work with provincial organizations to plan for resource allocation, medication usage and program development.

The total contribution of 500 rheumatologists, therefore, would match the current clinical requirement of the population. Canada has about 270 rheumatologists, which includes those involved in community, academic and administrative settings. Over the next five years, attrition (i.e., retirement, death, illness, emigration) of 10% is expected, while graduations will provide a potential of 10 new rheumatologists per year. These predictions would give Canada 293 rheumatologists in five years, yet the requirement will have increased to at least 550 rheumatologists (due to increased DJD, more difficult management of inflammatory arthritis and greater public expectations). In 10 years, the gap will be greater (due to the increased rate of rheumatologist attrition and increased population need caused by population dynamics).

Clearly, the number of graduating rheumatologists must double immediately if 10-year targets are to be met. In addition, rheumatologists need to expand their capacity to deal with existing disease burden. Better clinical program support, new biological agents applied judiciously, tested remittive agents effectively monitored, improved input into community associations and better communication with general practitioners will help address some of the immediate need.

**CALL TO ACTION**

Canadian rheumatology is in a significant deficit situation, and will need to develop new strategies for recruitment, retention and increased effectiveness. Concerted actions to allow us to increase
our ability to deal with the existing and predicted burden of illness could include:

1. Increase reimbursement schedules for rheumatologists with an inclusion to supplement office staffing with “arthritis-qualified” health assistants and adequate information-processing tools, such as computers and Internet connections.

2. Increase the profile of rheumatology in medical schools by increasing the availability of clinician and research mentors.

3. Increase the number of slots for residents in at least 10 of the internal-medicine programs to a total of 20 per year (double the current number).

4. Initiate programs and find incentives for general practitioners to work as a team with rheumatologists.

5. Increase public awareness of the value of rheumatologists in the management of joint and soft-tissue problems.

6. Increase our integration with regional programs that allow better use of our time (e.g., through the use of information systems, laboratories, and radiology).

7. Use technology more appropriately (e.g., computerized registries, digitized radiographs, electronic data exchange of laboratory information, pharmacy information systems, and secure Internet communication).

8. Develop better communication with other disciplines (such as orthopedic surgery and physiatry) to improve the timing and delivery of these services.

9. Encourage applied research approaches, including assessment of novel health-delivery methods, psychosocial and behavioural approaches to improve patient care, in addition to the necessary basic science that will lead to new treatment regimens.

10. Position research differently, as with the program undertaken through the Canadian Arthritis Network (CAN). Their National Centres of Excellence (NCE) program has the potential to successfully position rheumatic-disease research in Canada; the new Institute for Musculoskeletal Health and Arthritis—part of the Canadian Institutes for Health Research (CIHR)—will also assist in this regard.

All of these action items require close coordination with federal and provincial governments, as well as universities and organizations such as the Arthritis Society and the Lupus Society. Our colleagues in internal medicine and surgery will also need to be supportive for success to occur in a substantial way. Maintenance of certification at the Royal College level will need to include activities that enhance our effectiveness to reach the targeted patient populations. The ineffective dissociation of national responsibilities, such as the Canadian Pension Plan for arthritis disability, and provincial responsibility for resource and medication allocation needs to be made patently clear to the voting public and the political leaders of all parties.

SUMMARY

The Canadian public is at severe risk of losing a valuable resource: the rheumatology profession. Patients with arthritis are waiting longer for diagnoses, receiving fewer expert opinions on investigative maneuvers, and turning in greater numbers to unproven remedies and alternative treatment. As the population ages, there is an increasing likelihood that they will suffer greater disability and more severe problems with disease and treatment. Although other diseases, such as cardiovascular and neurological conditions, will also be of concern in the near future, rheumatologists have the grave predicament of approaching extinction. Fewer academics, fewer training spots, more retirements and reduced clinical time by community rheumatologists all could lead to a downward spiral.

Concerted action needs to be taken to preserve our community rheumatologists, increase the attractiveness of the discipline, strengthen our training programs and improve our effectiveness with better tools and teamwork. The Canadian Rheumatology Association will take a leadership role in moving this agenda forward at a national level. Individuals in each province will be required to provide local direction and support.
EULAR CONGRESS SYMPOSIUM ON CHONDROITIN SULFATE

At the 12th Congress of the European League of Associations for Rheumatology (EULAR), held this past summer in Nice, France, attention was given to the subject of chondroitin sulfate (CS) as a treatment for osteoarthritis (OA) in a satellite symposium sponsored by IBSA Institut Biochimique and Laboratoires Genevrier. Many patients are either taking the product or asking for more information.

PROTECTIVE EFFECTS

In vivo studies have shown the beneficial effects of polysulfated polysaccharides in patients with OA, stated Dr. X. Chevalier, of Hôpital Necker Enfants-Malades, Paris. The macromolecules brought about by increased aggrecan synthesis in chondrocytes, he suggested, could act as chondroprotective agents in humans. Unfortunately, the protective effects on cartilage damage are still not fully understood.

Dr. Chevalier presented data from experiments with rabbit-chondrocyte cultures that demonstrated a definite increase in the amount of functional sulfated macromolecules, including aggrecans, in the pericellular environment of chondrocytes in vivo. These data, he suggested, imply that CS “may help the chondrocytes to build up a protective extracellular matrix against damaging molecules such as those found in osteoarthritis cartilage.”

PHARMACOLOGICAL EXPERIENCE WITH CS

Is orally administered CS absorbed through the gastrointestinal (GI) tract? And what proportion of it can be recovered from the plasma in its original form (a high-molecular-weight sulfated polysaccharide)?

For answers to these questions, Dr. G. Verbruggen of Ghent University in Belgium presented attendees with information from several studies.

Ordinarily, when orally administered, large proportions of polysaccharides such as CS are partially degraded in the lysosomes of the GI cells, Dr. Verbruggen noted. Resulting di- and oligosaccharides are absorbed and then rapidly cleared by the liver.

Recently, Dr. Verbruggen continued, the plasma concentration and the recovery of CS in the urine has been studied in healthy human volunteers after the administration of 4 g of exogenous oral CS. It was found that the administration of 4 g of exogenous CS by oral route increased the plasma CS concentration by 120%.

Further experimental evidence for the presence in plasma of exogenous CS has been found in proportional amounts of 4-sulfated, 6-sulfated and unsulfated disaccharides after the administration of chondroitin 4- and 6-sulfate by oral route.

Diurnal variations in the sulfation of CS are hardly expected and have never been reported, Dr. Verbruggen noted. After the oral administration of chondroitin 4- and 6-sulfate, however, the proportional amounts of 4- and 6-sulfated CS disaccharides increased in human plasma to 55% and 15%, respectively, whereas the proportions of unsulfated CS disaccharides had decreased to about 30%.

Assuming that plasma levels reflect the repartitioning of CS over the whole body fluid compartment (about 75% of body weight), Dr. Verbruggen noted, the plasma concentration and the recovery of CS in the urine has been studied in healthy human volunteers after the administration of 4 g of exogenous CS. It was found that the administration of 4 g of exogenous CS by oral route increased the plasma CS concentration by 120%.

The concentration of glycosaminoglycan in normal human plasma is about 6 µg/ml. The CS level in human plasma is approximately 2 µg/ml. The changes in the proportional amounts of unsulfated and 4-sulfated CS disaccharides in human plasma after the oral administration of 4 g CS suggest that the plasma levels of normally sulfated CS amounted to about 2 or 3 µg/ml.

At these concentrations, CS has been shown to affect chondrocyte aggrecan synthesis rates in in vitro experiments.

POSITIVE CS TRIAL IN KNEE OA

Can oral CS clinically improve patients with symptomatic knee OA? This was the question Drs. D. Uebelhart and F. de Vathaire of, Geneva, Switzerland and Villejuif, France, respectively, set out to answer for symposium attendees.
The team presented findings from their 12-month, placebo-controlled study, which comprised alternating three-month CS treatment cycles and three-month treatment-free periods. Secondarily, the team also offered its findings on the structure-modifying effects of the treatment by measuring joint-space narrowing (using quantitative radiology) and assessing the levels of biochemical markers of joint metabolism.

The findings presented showed that oral chondroitin 4- and 6-sulfate (830 mg/day) was effective (functional status improvement of 42% in the CS group using the Lequesne index) and well tolerated in the three-month treatment cycles. There also was a positive trend in global efficacy an walking time. Positive effects on joint-space narrowing were also shown, as no significant changes could be observed for the CS group, while placebo-group patients experienced significant decreases in three measurements.

Based on these findings, and on the preliminary results of the levels of some biochemical markers, Drs. Uebelhart and de Vathaire concluded that CS is effective in improving symptoms and has some structure-modifying properties, which influence the progression of this disease.

**LITERATURE ANALYSIS OF CS EFFECTS**

Dr. B.F. Leeb, of Stockerau Hospital in Austria, set out to obtain further insights into the potential efficacy of CS using a literature meta-analysis.

Pooling data found on personal, Medline and Embase searches, Dr. Leeb performed a statistical analysis of results from randomized, controlled trials of CS. Efficacy was determined by modified Glass scores of the Lequesne index and by the visual assessment (VAS) of pain at study terminations. Using the difference of the CS-treated patients minus the placebo results (standardized by the standard deviation of the placebo group), calculations were made.

Results showed that CS may be useful in OA. The Glass score for the pooled mean Lequesne index read 0.74, indicating that approximately 55% of patients will benefit from CS over placebo. Correlation of dose with VAS of pain or Lequesne index did not show statistical significance, although all seven publications reviewed reported statistically significant reductions in the consumption of nonsteroidal anti-inflammatory drugs (NSAIDs) and/or analgesics compared to baseline in the CS groups, and much less marked ones for placebo.

Dr. Leeb noted that the results of current, long-term, large-cohort trials will help to confirm the symptomatic, slow-acting drug activity of CS.

**NSAID/ANALGESICS REDUCTION WITH CS**

CS belongs to the slow-acting, anti-osteoarthritis group of drugs, stated Dr. B. Begaud of Hôpital Pellegrin-Carrere, Bordeaux, France.

Using a very original, large-scale trial method, Dr. Begaud supervised a study aimed at determining both patient responses to CS usefulness and a decrease in patients’ daily consumption of NSAIDs/analgesics due to CS use.

The study targeted two groups: 1) new users of CS and 2) repeat users of CS who had been treated for at least three months. Patients were questioned inside retail pharmacies in France; 144 pharmacies took an active role in this study, collecting 844 assessable files.

Dr. Begaud noted that there is clear evidence for interest in the use of CS for the treatment of OA, which was confirmed by the reduced number and dosage of analgesic drugs and NSAIDs consumed by OA patients taking CS for more than three months (reduction of 30%). According to the patients themselves, there was a clear improvement in 66.2% of those who had been treated for more than three months with CS.

**CONCLUSION**

There is some evidence that CS could have potential clinical benefits for patients suffering from OA. Larger studies that could resolve these issues are in progress. Animal and experimental models also support these hypotheses.

**SELECTIONS FROM THE ACR**

Canadians were well represented, as always, at the Annual Scientific Meeting of the American College of Rheumatology, which was held this year in Philadelphia from October 28 to November 2.

On the 26-person Annual Meeting Planning Committee, Katherine Siminovitch of Mount Sinai Hospital, Toronto, was one of three committee members from outside the U.S., and chaired the Frontiers in Basic Science committee.

Seven Canadians were also represented among the 39 international members of the ACR Abstract Selection Committee, which in total comprised 177 individuals. Canadians included Anne Clarke of Westmount, Quebec; John Esdale of Vancouver, BC; Edward Keystone of Toronto, Ontario; Johanne Martel-Pelletier of Montreal, Quebec; Jean-Pierre Pelletier of Montreal, Quebec; Janet Pope of London, Ontario; and Murray Urowitz of Toronto, Ontario.
Many Canadians also presented valuable research findings in lectures, workshops and abstracts.

ABSTRACT AWARD FOR PEDIATRIC RHEUMATOLOGISTS FROM SICK CHILDREN’S
Juvenile dermatomyositis (JDM) is a chronic disease that requires 40% of young patients to be on medication permanently by the age of seven years. Conventional treatment for JDM, however, is prednisone, which leads to universal side effects. Researchers from the Hospital for Sick Children in Toronto, Ontario, presented information at this year’s ACR showing that the early use of methotrexate as a second-line therapy will allow for good clinical outcomes, a much shorter duration of prednisone treatment, and potentially fewer drug-related complications for JDM patients.

Rheumatologists Nicola Campbell-Webster, MD and Brian M. Feldman, MD, MSc, FRCP, were awarded one of the ACR’s two “2000 Pediatric Rheumatology Abstract Awards” for their study describing the long-term efficacy and safety of methotrexate when used with prednisone as the first-line treatment for JDM.

The team observed 11 JDM patients whom they had seen since June of 1997, all treated with methotrexate and prednisone as a first-line treatment. As a comparison group, they studied all 11 JDM cases from 1994 to June 1997, followed identically.

The treatment group, it was noted, received methotrexate (10-20 mg/m²/week) and prednisone (2 mg/kg/day in divided dose). At six weeks—with an improvement in muscle enzymes, strength and rash—the prednisone was tapered, by about 10% every two weeks.

The control group was also treated with prednisone at 2 mg/kg/day. At six weeks, the control group began to taper prednisone at about 10% per month.

The median time on prednisone was less for the treatment group than for the control group (10 months vs. 25 months), although the control group had worse overall disease at the outset.

Only one treatment-group patient had methotrexate side effects that required discontinuation of treatment. Clinical outcomes were similar after one year of treatment.

While Drs. Campbell-Webster and Feldman noted that long-term follow-up studies are needed to determine the usefulness of this regimen, the information was received with great interest by those in attendance at the ACR meeting.

OTHER CANADIAN SCIENTIFIC ABSTRACTS OF NOTE AT THE ACR
#597 – Possible Role for Hepatocyte Growth Factor-Induced Collagenase-3 Production in Human Osteoarthritic Cartilage: Involvement of Both SAP/JNK Pathway and a Sensitive P38 Map Kinase Inhibitor Cascade. P. Reboul, J-P. Pelletier, G. Tardif, M. Benderdour, P. Ranger, J. Martel-Pelletier. Montreal, QC.

#598 – TGF-b-Induced Collagenase-3 Expression in Human Chondrocytes Is Triggered by Smad Proteins: Cooperation between AP-1 and PEA-3 Binding Sites. J. Martel-Pelletier, G. Tardif, P. Reboul, M. Dupuis, C. Geng, N. Duval, J-P. Pelletier. Montreal, QC.

#601 – Activation of Peroxisome Proliferator-Activated Receptor g Suppresses the Production of Degradative Factors in Human Chondrocytes at the Transcriptional Level. H. Fahmi, J.A. Di Battista, J-P. Pelletier, P. Ranger, J. Martel-Pelletier. Montreal, QC.


#F-4 – Early Treatment with Intravenous Immunoglobulin in Patients with Kawasaki Disease. S. Tse, E.D. Silverman, B.W. McCrindle, R. Yeung. Toronto, ON.


#2041 – The Application of HLA-DRb1*0401 Transgenic Mice to Examine the Role of MHC Class II Molecules in Rheumatoid Arthritis. D. Wang, J.A. Hill, G. Chen, E.W.A. Cairns, D.A. Bell. London, ON.

All abstracts presented at the ACR meeting can be accessed on the Internet at the following site: http://www.abstracts-on-line.com/abstracts/acr/
Please register early for the CRA Annual Meeting in Mont-Tremblant, Quebec, from February 21-24, 2001. Keep in mind that hotel rooms book up quickly; book under the CRA room block! Also, don't forget to register for the ski race this year. It will be the same format as last year.

The International League of Associations for Rheumatology (ILAR) 2001 meeting has made a call for abstracts and registration submission, which has been sent out to all CRA members. The 2001 meeting will be held in Edmonton, August 26-30.

CRA members who have taken advantage of the Searle/Pharmacia Internet connection over the last few years probably know that it had been stated that the service would end as of December 31, 2000. Fortunately, the company has agreed to extend the connection for one more year. Our thanks for Pharmacia.

Some news items that will be coming to you in the new year will include details of the Summer Studentship Program. As well, the CRA Needs Assessment has been completed, and details of the analysis will be forthcoming in future issues of this journal.

The Board of the Journal of the CRA would like to extend sincere thanks to Drs. Koehler (founding editor of Journal of CRA), Carette and Thorne, who have retired from the CRAJ. The editorial board welcomes the new members this season: Drs. Mosher, Kraag and Edworthy.

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**Millennium Moments**

Snapshots from the 2000 Summit of the CRA Executive

The Spring Halifax summit of the Canadian Rheumatology Association Executive

Gunnar Kraag and John Thomson trying to determine how to take a self-portrait.

Ken Blocha, Paul Haroui and Denis Choquette sacrificed birthday celebrations to discuss the business of the CRA in Halifax.

President Dianne Mosher and Executive member Denis Choquette discussing CRA business at the Spring summit.