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Nullus Cerebrum—Nullus Capitis Dolor

It's autumn and once again we engage in our most popular national pastime: healthcare reform. It is an isometric sport: much power and force is exerted with almost no movement. Following healthcare reform is like following the negotiations between millionaire hockey players and millionaire hockey-team owners. Ultimately, it is our money as taxpayers and/or sports fans that is being spent. The difference is that one can choose not to pay exorbitant prices for a hockey ticket (although the addicts would disagree), whereas we have no choice as common citizens but to pay for more and more studies of healthcare studies to be created to, "once and for all," reform medicare. Autumn is a great season to be a healthcare expert. The federal-provincial stalemate (or "agreement," as it was called) will infuse a little more money into Canadian healthcare, with strings, ropes and cables attached by the healthcare "experts," because our federal government cares (to be re-elected). The healthcare experts are usually defined by mathematical paradigms: a) expertise is inversely proportional to contact with patients and b) the number of healthcare consultants is directly proportional to the general mess of health delivery in this country. The Canadian medicare system remains as universal, accessible, and well distributed as National Hockey League franchises in this country (and usually in the same locations). However, the National Pharmacare Program threatened to create some equity, especially for arthritis patients. If access to care is not seen as a problem, then there is no need for a solution; no brain—no headache.

Against this backdrop, this issue of the *Canadian Rheumatology Association Journal (CRAJ)* features the CRA position paper on the treatment of early rheumatoid arthritis (pages 11-13). Vivian Bykerk and the other doctors who wrote this paper clearly have both the scientific expertise and clinical experience to understand this critical issue. It remains up to our governments to make available the therapies required and the expertise necessary to administer these therapies. The CRA should be applauded for its active approach to access to care for arthritis patients. The best news of the recent federal-provincial agreement is their plan to improve



The Editor-in-Chief, while doing field research at the Renaissance Festival in Minneapolis, finds the guiding principle behind current Canadian healthcare policies. Courtesy of The Sturdy Beggars at www.mudshow.com (with permission).

the inhumanly long waiting times for joint replacement surgery. Our orthopedic colleagues will be pleased to receive more appropriate resources to help arthritis patients. In this issue, five of Canada's top orthopedic surgeons answer your most timely orthopedic questions (pages 4-7).

Despite the challenges, rheumatologists are pushing ahead, as indicated from the report on the Frontiers Conference (pages 16-17) and reports from the university groups at Dalhousie and Sherbrooke (page 23). The man with all your money—our new secretary-treasurer, James Henderson—gives his perspective on the power of the CRA chequebook (pages 14-15). It would appear that, despite the devastating heat and fires of the British Columbia interior and the catastrophic floods around Peterborough, rheumatology is thriving in these parts of our country; and our Toronto-and-district correspondent has had his identity withheld at the suggestion of Canadian Security Intelligence Service (pages 20-22).

On a somber note, the *CRAJ* honours the memory of a friend and colleague, Douglas Kinsella (page 8). His many contributions during his distinguished career will continue to inspire us.

– Glen T. D. Thomson, MD, FRCPC
Editor-in-Chief, CRAJ

Skeletal Survey: Five Top Experts Cut to the Bone to Answer Your Questions on the Hot Issues in Orthopedic Surgery

What are the pros and cons of hip resurfacing (or Birmingham hip) vs. total hip replacement?

The one indisputable advantage of resurfacing arthroplasty is that less bone is removed from the femur compared to conventional total hip arthroplasty. This may make for easier revision operations. Resurfacings allow for the largest diameter femoral head implant currently available, which provides a greater range of motion and less risk of dislocation. The biomechanics of the femoral implant may be better for the health of the bone at the top end of the femur.

The above advantages mean that patients are being allowed to return to more vigorous and risky activities (however, there is no proof that this is safe to do.)

The major disadvantage of resurfacing is the lack of published results. We do not know the short-term results, other than those from a very few centers. Femoral neck fracture has been the most common complication. There is also concern over the long-term exposure to metal ions (chrome and cobalt, in particular) and what effect(s) this exposure might cause to various organs and tissues. Resurfacing requires a long incision and generous exposure; some total hip replacements are now being done through much smaller incisions. Since resurfacing is a new procedure, surgeon experience with it is limited.

– Jim MacKenzie, MD, FRCSC
Head of Arthroplasty Subsection,
Calgary Bone and Joint Health

What is the role of surgery in Legg-Perthes' Disease?

In light of current knowledge about this enigmatic condition, the inescapable answer to this question is: limited and unproven. Nevertheless, surgery remains a mainstay in the management of Perthes'. The generally accepted current principles of treatment among orthopedic surgeons treating children are maintenance of the range of motion (ROM) of the affected hip(s) and containment of the avascular but regenerating capital femoral epiphysis. It is the intuitive belief of a substantial majority of surgeons that if ROM can be maintained and the femoral head contained within the acetabulum, then the outcome will be more favourable than if these goals are not met. However, some skeptics favour "benign neglect"—a position that generates neither confidence nor acceptance from parents of affected children.

What do we know about Perthes' that may inform discussion about the role of surgery? The outcome roughly correlates with the age of onset (older age is worse), the extent of epiphyseal involvement (>50% is not good), the damage to the physeal plate (a short femoral neck leads to a permanent limp), and the shape of the femoral head at completion of regeneration (an incongruent joint leads to early osteoarthritis). Even these risk factors are not absolute—exceptions occur. Children younger than six years of age, those with <50% of the epiphysis involved and those who maintain a reasonable ROM (>30° ab-

duction, >20° internal rotation and 100° flexion) require no management other than observation and, fortunately, constitute 40%-50% of those affected. For those whose pain, limp and hip stiffness are not relieved by anti-inflammatory medication, physiotherapy and weight relief with the use of crutches, the surgical options are:

1. Adductor +\- iliopsoas tendon lengthening and application of Petrie casts (cylinder casts with a bar fixing the hips in abduction and internal rotation yet permitting flexion-extension and weight-bearing);
2. Rotational pelvic osteotomy (Salter and variants);
3. Proximal femoral osteotomy (varus or valgus depending on the stage of the disease process);
4. Combined pelvic and femoral osteotomies (so-called "hyper-containment"), typically for older children (>8.5 years); and
5. Hip joint distraction employing an external fixator attached by pins to the pelvis and femur with a hip hinge, thereby permitting motion while defunctioning the hip.

Each of these procedures (solo or combined) have advocates who consistently publish reports of retrospective series with 70%-80% good to excellent results, where typically the selection criteria is not described, there are no control groups and the patients are not consecutive. A noble attempt at a multicentre trial, commenced more than two decades ago,^{1,2} failed to demonstrate a statistically sig-

nificant advantage of one surgical method over another. This was presumably because each participant chose his/her favourite method of treatment as there was no randomization and case stratification was imperfect.

The regrettable conclusion to be drawn is that we know little more than we did three decades ago about the etiology, pathogenesis (evidence from post-mortem studies suggest there must be more than one avascular episode for the clinical picture to occur), risk factors (passive smoking³ and thrombophilia⁴ have been implicated), and predictability of the shape of the epiphysis after healing based on the radiographic classification at presentation and outcome (with or without intervention). I have not provided a bibliography citing the hundreds of published reports advocating one type of surgery over another, but instead have listed recent textbooks with excellent accounts and key references.^{5,6,7} Since the preferred management for Perthes' is in a constant state of flux, for any child presenting with the disease, I strongly recommend early referral

to an orthopedic surgeon who is an expert in children's hip conditions.

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– John H. Wedge, MD, FRCSC
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What is the value of acromioplasty in rotator cuff pathology?

Rotator cuff tendinopathy is recognized as a significant cause of chronic disability. In 1972, Neer popularized the term "impingement syndrome" by evidence of mechanical impingement of the rotator cuff and humeral head on the undersurface of the acromion and the coracoacromial ligament becoming a proliferative spur as a coracoacromial arch. Although it is the most frequent shoulder pain in adults, we must rule out other pathology: intra-articular (synovitis, labral tear), acromioclavicular, capsulitis, tumor, or referred pain. A good physical exam and proper imaging is of prime importance. Steroid injections are useful to differentiate subacromial pain.

Conservative measures of rotator cuff tendinopathy is effective in both younger and elderly populations and is the treatment of choice. Failure of conservative measures and long-term disability from bursitis, partial tear or complete tear of the rotator cuff is an indication for surgery.

The accepted surgical treatment for impingement syndrome is acromioplasty consisting of removing the anterior part of the acromion protruding in front of the clavicle and by thinning its undersurface (5 mm resection) to make it flat from a hook shape. According to the clinical picture, it is often associated with other acts, such as cuff repair, debridement or reconstruction, acromioclavicular resection arthroplasty, long head of the biceps tenodesis, labral repair or debridement. Rehabilitation is necessary for up to 12 weeks in all cases of acromioplasty with intact cuff.

Results of acromioplasty have been reported as very good^{1,2} but, to date, there is no randomized study. There is

little doubt that operative treatment of rotator cuff disease improves general health status in selected cases³ but appropriate selection of patients is considered the key to success.⁴

There is little difference between the results of arthroscopic subacromial decompression and open technique,⁵ but there is a definite learning curve to arthroscopy; cuff repair remains a less reliable technique in most hands than open reconstruction.

Today, arthroscopic acromioplasty is an effective and well-accepted method of decompression of the coracoacromial arch and improves patient- and surgeon-based outcome criteria for impingement tendinopathy. Beware of instability tendinopathy in the younger population where acromioplasty has little to no role. Other intra-articular, calcific and acromioclavicular pathologies must be addressed specifically.

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– Sylvain Gagnon, MD, FRCSC
Associate Professor of Orthopedic Surgery
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What surgical treatment is available for patients with ankylosing spondylitis and spinal deformity? What are the risks of surgery and long-term effects? Spinal deformity in patients with ankylosing spondylitis may develop; a deformity in the sagittal plane is known as kyphosis (Figure 1).



Figure 1. Normal spinal alignment compared to kyphotic deformity in ankylosing spondylitis that can occur in the cervical, thoracic or lumbar spine.

Kyphosis can occur in the cervical, thoracic or lumbar spine and, in some cases, the inability to straighten the pelvis can be secondary to hip flexion contracture. Patients may compensate for kyphosis by increasing the lordosis in mobile parts of their spine, flexing their hips and knees. The degree of kyphosis and the anatomic location may cause the patient to walk in a stooped forward posture with the inability to maintain horizontal gaze because of the inability to compensate for the spinal deformity.

To determine the anatomic site of the deformity, the patient is placed with hips and knees extended, so the

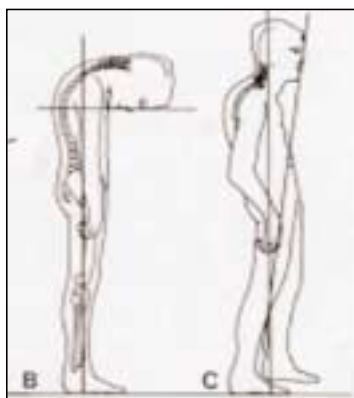


Figure 2. Chin brow to vertical angle in a patient with cervical kyphosis (left) and post-operative cervicothoracic osteotomy (right).

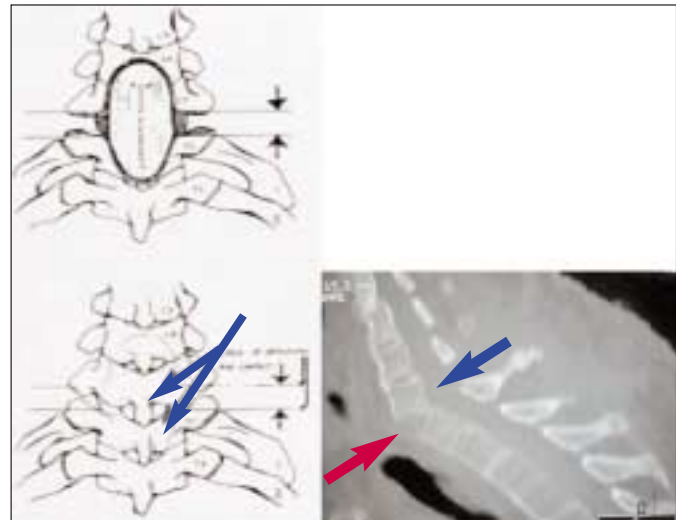


Figure 3. Cervicothoracic osteotomy between C7 and T1 with distraction through the C7/T1 disc space (red arrow); the posterior elements of C7 and T1 are removed prior to correction of the deformity (blue arrows).

lumbar, thoracic and cervical spine can be observed. The chin brow to vertical angle is observed (Figure 2). This is an angle formed between a vertical line intersecting with a line drawn from the chin to brow, measured with a goniometer.

Correction of a spinal deformity (after a flexion contracture of the hips has been ruled out) can be accomplished by a posterior osteotomy at the cervicothoracic junction C7-T1 (Figure 3) or mid-lumbar spine at L3 (Figure 4), and occasionally in the thoracic spine. An

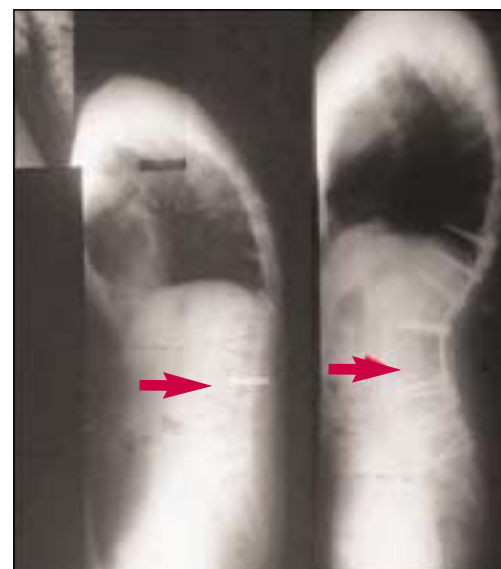


Figure 4. Pedicle subtraction osteotomy through L3 to restore lumbar lordosis (red arrows).

osteotomy serves to shorten the posterior aspect of the spine and increase the lordosis, thereby correcting the kyphotic deformity and improving the alignment of the patient. The risks to the patient are those inherent to a general anaesthetic and specific to the procedure, including: wound infection, implant or bone failure and recurrence of the deformity, transient or permanent neurologic deficit, bleeding and medical complications such as deep venous thrombosis, pulmonary embolism and myocardial infarction.

Patients find the correction of the deformity to be extremely gratifying as they can ambulate more easily and safely with their horizontal gaze restored. Deformity correction is usually permanent without recurrence and may require surgery at more than one spinal region to completely correct the alignment.

– *Michael J. Goytan, BSc, MD, FRCSC*
Head, Winnipeg Spine Program

When is surgery indicated for patients with atlantoaxial instability?

Atlantoaxial instability is the most common spine problem in rheumatoid patients.¹

In adults, instability is defined by an atlas to odontoid space of more than 3 mm. Surgical referral is indicated for patients with gaps of more than 5 mm, neurologic (bulbar or high cervical cord) symptoms, progressive instability on serial X-ray or the presence of subaxial instability on imaging.

My absolute indications for surgery are C1-C2 gaps of more than 9 mm or the presence of neurologic signs or symptoms. Relative but strong indications are gaps of 7 mm or more, severe pain, or progression of the instability on serial X-rays. Some clinicians have also proposed prophylactic surgery in milder cases to reduce the risk of developing subaxial instability.²

The surgical discussion will be limited to isolated C1-C2 instability with or without inflammatory pannus on the odontoid.

The first step is to determine the reducibility of the complex and rule out any neurologic compression in the reduce position. If, in the reduce position, there is persistent neurologic compression by the inflammatory mass or bone, a trans-oral resection of the odontoid process is required followed by the definitive surgery. This can be done in one or two operations. In the latter situation, the patient will require halo immobilisation between surgeries.

Although technically more demanding, C1-C2 transarticular screws with interlaminar bone graft and sublaminar cables have been shown to be far superior, both biomechanically³ and clinically, to isolated wires, cables or clamps.^{3,4,5} This procedure provides immediate fixation,

limiting movements in all axes of the C1-C2 complex. Performing this procedure with navigational assistance (e.g., Stealth Station, Medtronic, Memphis USA) is safe and very effective, with a fusion rate above 90%.⁶

The most feared complication is vertebral artery injury. This complication is greatly reduced by increased experience with the procedure and the addition of a navigational system. Other complications, such as infections, non-union, screw malposition and hardware failure are, fortunately, rare.⁷

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In Memoriam

T. Douglas Kinsella, CM, BA, MD, FACP, FRCPC (1932-2004)

Thomas Douglas Kinsella was born on February 15, 1932 in Montreal, Quebec. He was the middle child to his mother, Mary, and his father, Jimmy (Northern Electric employee). Douglas had an older brother, Howard, and a younger sister, Juanita.

When very young, Douglas was beset by rheumatic fever and, in conquering that illness, was left with the burning desire to be a doctor.

Following a Jesuitical education at Loyola High School in Montreal, he enrolled at Loyola College and joined the Royal Canadian Armoured Corps. In June 1955, midway through his medical studies at McGill University, Douglas and Lorna wed at Loyola Chapel. Douglas and Lorna were blessed with three sons, Warren, Kevin and Lorne.

After a clinical fellowship in rheumatology at the Royal Victoria Hospital, he moved to Dallas, Texas to pursue a research fellowship under the mentorship of Dr. Morris Ziff. In 1968, Douglas and his family returned to Canada where he was appointed Assistant Professor of Medicine at Queen's University. In 1975, after a brief return to Montreal and a professorship at McGill, he moved to Calgary where he was appointed Professor of Medicine and took up the challenge of building an academic Rheumatic Disease Unit at the Calgary General Hospital. In that setting, he established a credible basic and clinical research unit that explored the link between infectious agents and spondyloarthropathies.

At the University of Calgary, and at the Foothills Medical Centre, Douglas achieved international distinction for his work in rheumatology and immunology. He



later established the Conjoint Health Research Ethics Board and was the champion of health ethics and the dignity of human life at a national and international level.

Douglas served as President of the Canadian Rheumatology Association (CRA) from 1976 to 1978. His commitment to ethics and healing resulted in his being named a Member of the Order of Canada in 1995.

In 2000, Douglas retired from the University of Calgary. Douglas and his wife selected their retirement home in Kingston. At Kingston General Hospital—in the very place where he saved so many lives—Douglas's own

life came to a painless end in the early hours of June 15, 2004, felled by a fast-moving lung cancer. In his final strides to the finish line, Douglas echoed a spirit of hope, and firmly, but politely, declined offers of special treatment, or even a room with a nicer view of Lake Ontario.

There was much to admire about Douglas: a friend, colleague and physician. He was a mentor to over 15 clinical and research rheumatologists who emulated his love of rheumatology and respect for his patients. In the minds and hearts of the patients whose lives he saved or bettered over the course of half a century of healing, his compassion serves as a benchmark for other physicians. Canada and rheumatology worldwide has suffered a great loss. We extend our heartfelt sympathy to Lorna, their three sons and the extended family.

[Extracted with permission from a memorial written by Warren Kinsella, Douglas Kinsella's eldest son.]

Fickle Finger of Fame Award

Are you still taking Swedish lessons in the fading hope that the Nobel Committee may have misplaced your address?

Are you now well past the cut-off age for the Canadian Rheumatology Association (CRA) Young Investigator Award and well short of the 500 publications for the CRA Ancient Investigator status?

Are you more in the running for the CRA

*Extinguished—not Distinguished—Rheumatologist of the Year? **Do not panic!** The CRAJ wants to create hope for all its readers by announcing the Fickle Finger of Fame award. Your 10 minutes of glory are nigh if you are, well,*

“interesting”—yes, that’s all—interesting. We want to find Canadian rheumatologists who do more than just count joints, draw graphs, pipette cells and write long diatribes. The CRAJ is searching for rheumatologists with the most interesting pastimes, hobbies, locations, aspirations, vacations, facial hair, tattoos, children, you name it, etc. to be featured in interviews for our Holiday 2004 issue. Tell us about yourself or nominate a colleague in a brief note (photos are a bonus!). The CRAJ Editorial Board will then decide on this year’s group of most interesting arthritis specialists. The usual evanescent paraphernalia for such a prestigious and fleeting accomplishment will be presented at an appropriately effervescent

*time. **Please send your message and/or nomination today to***

***stephc@sta.ca**. Applicants must be at least 18 years old and do not need a working knowledge of any Scandinavian language!*

Canadian Consensus Statement on Early Optimal Therapy in Early Rheumatoid Arthritis

Vivian P. Bykerk, Murray Baron, Gilles Boire, Boulos Haraoui, Majed Khraishi, Sharon LeClercq, Janet E. Pope, Edward C. Keystone

INTRODUCTION

A subcommittee of experts of the Canadian Rheumatology Association (CRA) Therapeutics Committee was established to develop a consensus statement concerning optimal therapy in early rheumatoid arthritis (ERA). The objective of this ERA subcommittee was to identify critical issues in the management of recent-onset RA and develop a consensus of guiding principles to improve the outcomes of patients with ERA. Publications were reviewed from a literature search (search strategy using Medline, EMBASE, HEALTHSTAR and CINAHL, through OVID, using keywords “early rheumatoid arthritis”) and abstracts from the recent American College of Rheumatology (ACR) and European League Against Rheumatism (EULAR) meetings. The recommendations in this document are not to be regarded as practice guidelines, since definitive randomized controlled studies using newer agents in ERA still need to be completed, but rather to recognize there may be a “window of opportunity” in which early aggressive treatment of recent-onset RA may have long-term, substantial, beneficial effects.

BACKGROUND

Joint damage occurs early in RA. RA is a systemic inflammatory disease in which a proliferating synovitis causes cartilage and bone destruction, subsequent joint deformities and serious functional disability. A large body of evidence shows that joint damage is an early phenomenon and, if inadequately treated, will progress relentlessly over time. Recent studies have shown that joint erosions occur early in RA and up to 93% of patients with less than two years of disease may have radiographic abnormalities.¹ The rate of radiographic progression is more rapid in the first year of disease.² Radiographs may be inadequate to identify early erosions and magnetic resonance imaging (MRI) is more sensitive, as erosions can be detected by MRI within four months of onset.^{3,4,5}

Disability occurs early in RA. A significant number of RA patients will quickly develop major disabilities and almost 50% will experience work loss within 10 years of diagnosis.⁶ Severe disease is also associated with premature mortality.^{7,8}

Issues of early diagnosis of RA. The ability to make a definitive diagnosis of RA in the first few months of disease is difficult. Only 30% of patients present with a positive rheumatoid factor. Patients may not fulfill four or more of the ACR criteria. These criteria were not designed for diagnosis but for classification and were developed using patients with late disease. Testing for other auto-antibodies associated with RA in undifferentiated arthritis, although promising, remains investigational.⁹ There are still no validated early predictors of progressive destructive disease.¹⁰ The likelihood that an undifferentiated but suspected case of RA will go on to develop definite RA with evidence of joint destruction on radiographs is much lower prior to three months of disease.¹¹ It would thus be important that every patient with inflammatory arthritis of the extremities, lasting for at least two to three months, be evaluated by an arthritis-care specialist.

As RA affects about 1% of the adult population, approximately 300,000 people likely suffer from this disease in Canada. There may be up to 50% of patients with RA who have never seen an arthritis-care specialist.¹² Rheumatologists' waiting lists are long and often can only accommodate an urgent referral for a patient with ERA if the patient's RA is recognized by his/her primary-care provider (PCP) and the PCP communicates the urgency of the case on referral. There is no validated screening questionnaire that can be used to identify the patient with undiagnosed RA by other healthcare professionals. Identification of persistent synovitis on physical examination remains the most reliable diagnostic tool for patients needing urgent referral. Early recognition of persistent synovitis by the PCP is therefore critical for early referral and initiation of disease-modifying anti-rheumatic drug (DMARD) therapy.

RATIONALE FOR EARLY OPTIMAL THERAPY IN ERA

The recognition of a significant increase in the mortality rate associated with severe RA and recent data demonstrating the rapid onset of disability and early joint damage has resulted in a substantial shift in the therapeutic paradigm for RA.

A number of therapeutic strategies for bringing RA under more rapid control have been initiated, including: (i) the early use of DMARDs, (ii) combinations of conventional DMARDs and (iii) the combination of methotrexate (MTX) and biologic agents, specifically tumor necrosis factor (TNF) antagonists.

The concept of a “window of opportunity” in RA has been coined to reflect the observations suggesting that early use of DMARDs is more effective than use later in the disease.¹³ Support for the concept comes from several studies showing that even a brief delay in initiating DMARDs can adversely affect the long-term outcome of RA.^{14,15,16}

Early combination DMARD therapy in ERA. One recent therapeutic strategy in the treatment of RA is the early use of combination therapy with conventional DMARDs. Two studies have demonstrated that initiation of triple DMARD combination therapy results in better inhibition of joint damage than double or single therapy.^{15,17} As well, a brief course of high-dose steroids in combination with sulphasalazine and MTX in a step-down therapeutic paradigm resulted in a long-term effect in reducing radiographic progression.¹⁸ Considered together, the data support the concept that more aggressive intervention early in RA may profoundly affect the slope of progression over the long term.

Biologics and MTX combined in ERA. Given the observation that early and aggressive use of conventional DMARDs significantly limits disease progression in RA, the use of biologics earlier in RA has recently been evaluated. Etanercept was examined in ERA compared with rapidly escalated high-dose MTX. While modest differences in clinical and radiographic efficacy were observed over 24 months, the diverging slopes of radiographic progression strongly support the likelihood that continuing MTX even in responsive patients may not provide an optimal therapeutic benefit relative to etanercept. This study also set a precedent for the use of more rapid escalation to higher doses of oral or parenteral MTX in early disease. More recently, initiation of high-dose MTX in combination with infliximab in ERA demonstrated substantial clinical and radiologic benefits compared with monotherapy.¹⁹ These findings are consistent with data in late RA where MTX was combined with etanercept and revealed better

clinical and radiologic outcomes than monotherapy.²⁰ The data in both studies demonstrated that patients in all groups have a clinically significant benefit, but patients in the combination group exhibit greater improvement, as reflected by substantially larger numbers of patients achieving ACR 50 and ACR 70 responses.

Three subset analyses also support the “window of opportunity” concept showing earlier use of TNF antagonists (e.g., etanercept, infliximab, adalimumab) is more effective than later use in the disease. A retrospective analysis of patients with etanercept in early vs. late disease has shown substantial improvement in disability in early vs. late disease.²¹ Moreover, a *post hoc* analysis of the Anti-TNF Therapy in RA with Concomitant Therapy (ATTRACT) data also revealed more profound inhibition of radiographic progression in the infliximab plus MTX groups in ERA, despite the propensity of the MTX control group to progress substantially.²² A more recent subset analysis of data from a trial of adalimumab showed greater improvement in signs and symptoms, disability and radiographic progression in patients with less than two years of disease, relative to those with a longer disease duration.²³

COMPARATIVE EFFICACY OF NEW THERAPEUTIC STRATEGIES

In order to evaluate the efficacy of new therapeutic strategies in ERA, a head-to-head comparison of four treatment strategies was carried out (e.g., combination, step-down, step-up, and sequential regimens).²⁴ The results support that more aggressive strategies, such as initiating infliximab in combination with high-dose MTX, are equivalent to a step-down regimen of high-dose steroids in combination with sulphasalazine and MTX. Both aggressive regimens showed a more rapid clinical response and were superior radiographically to conventional sequential and step-up regimens.

SUMMARY

A general consensus has emerged regarding the following:

1. Joint damage occurs early.
2. Aggressive treatment early in RA has a lasting effect on the prevention of damage and, hence, on long-term function.
3. Barriers to appropriate early treatment may include:
 - Delay in patients seeking medical attention for symptoms;
 - Delay in recognition of the problem by PCPs;



- Delay in referral to rheumatologists;
 - Delay in rheumatologists seeing referred patients;
 - Delay in diagnosis by rheumatologists;
 - Delay in initiation of appropriate treatment by rheumatologists;
 - Lack of acceptance of diagnosis and treatment regimens by the patient;
 - Undertreatment by rheumatologists and other arthritis specialists; and
 - Provincial and private drug plan reimbursement restrictions.
4. An aggressive treatment regimen prior to three months of disease should be restricted to patients with specific risk factors evaluated by highly skilled arthritis specialists. This subcommittee therefore recommends the following:
1. DMARD therapy should be instituted as quickly as possible in patients with ERA, once disease has been established for two to three months, recognizing that not all patients will fulfill the ACR criteria for the diagnosis of RA.
 2. Early referral to an arthritis specialist (usually a rheumatologist) for confirmation of diagnosis, risk stratification and initiation of optimal therapy for new-onset RA is needed.
 3. Patients should be seen frequently by their arthritis specialist with a goal of tightly controlling the extent of inflammation in their joints, although the ideal frequency still remains to be determined.²⁵
 4. Further research concerning the etiology of barriers to early therapy should be undertaken, including the extent of recognition of persistent synovitis by PCPs.
 5. An important strategy to diminish these barriers is to encourage rheumatologists who receive referrals for new-onset RA to accommodate these patients into their clinics quickly. Other strategies may include: lay public education about RA, more training of PCPs to recognize subtle synovitis and the need for early referral and treatment, and public and private drug plan reimbursement criteria that provide appropriate, timely and equitable access to all DMARDs (including biologics) for those with ERA.

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East Coast Tidings: Meet the CRA's New Secretary-Treasurer, James Henderson

Some people would say that the most difficult and arduous task in the Canadian Rheumatology Association (CRA) is that of Secretary-Treasurer. What made you accept the nomination for this post?

I would have to counter that the most difficult position would be that of President, and having watched our last three Presidents operate, I would have to tip my hat to them as making a far more serious commitment to the CRA. I have certainly enjoyed all the time I have spent working with the CRA executive. When Carter Thorne indicated he was stepping down, I was certainly interested in playing a larger role. I think Carter would agree that the role of Secretary-Treasurer is to provide some long-term stability for the executive. Carter served in the position for many years and was a stabilizing force providing a historical perspective as to how the CRA has evolved over the years. I anticipate that I will be contributing in much the same fashion.

The last several Secretary-Treasurers came from independent practices in their communities. Does running the business aspect of a practice have benefits in running the business aspect of a large organization like the Canadian Rheumatology Association (CRA)?

For the past 15 years I have been running the business end of the Fredericton Medical Clinic. This is a medical clinic that houses 80 physicians under one roof. I certainly think that having responsibility for such a large organization has definitely prepared me for the business aspect of the CRA.

Ten years ago, the budget of the Canadian Rheumatology Association (CRA) wouldn't buy a good second-hand car. This situation has changed dramatically. What do you see as the financial challenges of the CRA over the next few years?

We have been trying to acquire sufficient savings in our account which, if our donations were to dry up, would still allow us to finance the CRA Annual Meeting.

We are living in a changing climate and we will never be in a position to always count on sponsorship of the pharmaceutical industry to help pay for our Annual Meeting. We are also finding the CRA is being stretched in many directions as

we try to fulfill our role as the arthritis experts in Canada. We need to make sure that our grasp on challenges does not exceed our financial ability to sustain ourselves.

In addition to running a successful practice in Fredericton, you are known to be an avid sportsman. How would you describe James Henderson without the stethoscope?

When you find me outside the office you will usually find me outdoors. My wife and I both enjoy canoeing and have had opportunities in the past few years to canoe a few rivers in the Northwest Territories and Nunavut. We plan to do another river in Nunavut next summer. We have certainly canoed many of the rivers in New Brunswick. Both of us also enjoy salmon fishing and like nothing better than to stand in the middle of a river searching for the elusive salmon.

My other favorite pastime is getting my fingernails dirty in the garden.

The CRA is a political organization. You have had prior exposure to "real" politics before the current posting with the CRA. Would you please describe some of your experiences?

The closest brush with politics I've had was running for office as a provincial Member of the Legislative Assembly (MLA) in the 1991 provincial election. It was an exhilarating experience, but I am sure I was completely out of my mind at the time. Looking back, I am truly thankful I was unsuccessful in that campaign.

I have been involved for many years with the New Brunswick Medical Society (NBMS) in a variety of roles and am currently chairman of the Negotiating Committee for the NBMS. I have just recently stepped away from the role of Chief of Internal Medicine, which I held for close to 10 years.

If you were suddenly appointed as the new federal Health Minister, what would be your top three suggestions to solve Canada's ongoing healthcare woes? I would begin to take a close look at the fact that most Canadians incur 80% of their healthcare bills during the



last three months of their lives. Many patients like to think that intensive investigations and expensive medications can somehow cheat death. There seems to be a lack of recognition that death is an inevitable part of life and often patients undergo a poor-quality death in an intensive care unit rather than being surrounded by family and loved ones in their own homes. A lot of savings to the healthcare system could be achieved by helping Canadians come to grips with their fear of death.

I certainly feel that the federal government has a role to play in a national pharmacare system and I am disappointed that the current government seems to be stepping away from that challenge.

I also personally feel that there is a role for a private side to our healthcare system. When one looks at how the system functions in Britain, the two seem to work together very well with physicians working on both sides of the system.

Who has most influenced you in your career?

I had the opportunity to spend six months with Dr. Howard Stein at St. Paul's Hospital during my final year of training and I would have to say that he, more than anyone else, showed me how to function as a rheumatologist.

What have been the best (and/or worst) pieces of professional (or personal) advice that you have been given?

I have certainly learned that stockbrokers never seem to have their clients' financial security at the top of their priority list. I can think of several instances when I have been given advice that, in retrospect, made perfect sense for them and their careers, but not for me.

The best piece of advice I was ever given was to "have a look around the Maritimes" as a place that one might want to consider raising a family. Coming to the east coast has made all the difference in my quality of life.

If you could learn three skills instantly, what would they be and why?

The first skill I would like to achieve immediately is the ability to kayak in white water. I am fairly comfortable

canoeing in most white water, but have always thought it would be fun to tackle the waves one on one.

I have often thought having the ability to perform microarthroscopy of some joints would certainly help in the ability to investigate inflammatory arthritis. I can foresee the day when, hopefully, the equipment will be available for this sort of procedure to be done in the office as part of a regular rheumatologic exam.

The third skill I would like to achieve is, of course, to learn to read my wife's mind.

What advice do you have for young rheumatology trainees wanting to someday practice in Fredericton or other similar setting?

As long as the individuals are committed to staying in one location for the duration of their professional lives, I would advise them to own their own office space and be in a position to control the real estate themselves.

I would also tell them not to focus too much on debt accumulated during training, as over a lifetime, the amount of money owed will be miniscule compared to their total lifetime earnings.

I would advise them that their greatest asset during their careers as rheumatologists will be the people they hire to run their offices and that they need to invest a lot of time and energy to make sure they get the right people.

I would also tell them to avoid the thrill of owning a new car and always buy used vehicles. The quality of their professional lives will be directly proportional to the density of rheumatologists in their immediate vicinity.



– James Henderson, MD
Secretary-Treasurer, CRA

Summary of the Frontiers in Inflammatory Joint Diseases Conference

The Frontiers in Inflammatory Joint Diseases conference brought together a wide spectrum of stakeholders to help define a vision for Canadian research in inflammatory joint diseases (IJD). The scope of these diseases includes rheumatoid arthritis (RA) and its variants, juvenile idiopathic arthritis (JIA) and its subtypes, and the spondyloarthropathy (SA) group of disorders, including ankylosing spondylitis, psoriatic arthritis, and reactive arthritis. Together, these disorders affect 2% to 3% of the general population, and they often begin during the most productive stages of the individual's life, or in the case of childhood arthritis, even before this stage begins. The impact on the individual and on society is staggering. Fortunately, there has been considerable progress in the development of effective therapies for IJD, as well as in achieving a better understanding of the pathogenesis of these disorders. The challenge we collectively face is to develop approaches to the early identification of these disorders and to intervene with effective and cost-effective management strategies.

The stakeholders assembled at the Frontiers conference included patient consumer groups, government representatives, industry representatives, clinicians and scientists with expertise in basic science, clinical trials, health services research and population health. A consumer day was the first event of the conference and was organized by consumers. This was followed by a scientific program on the second day, and the third day was devoted to "synthesis." The discussions were frank and open, and were woven around presentations from national and international opinion leaders in these areas. The consensus-building process was guided by a skilled and experienced facilitator who was not a stakeholder. The primary objectives of this conference were as follows:

- To provide an opportunity for the Institute of Musculoskeletal Health and Arthritis, the Canadian Arthritis Network (CAN) and The Arthritis Society (TAS) to consult with consumers, policy makers, public agencies, national/international researchers

and industry regarding priority national research themes which can lead to improved identification, understanding and management of arthritis, particularly of early arthritis.

- To educate multiple stakeholders on the scope of current research in IJD in Canada and globally.
- To develop the Canadian research agenda in IJD.
- To identify the unique qualities, opportunities and resources that offer Canada a strategic niche in the global scene of arthritis research.

On the final day of the conference, a broad-based Forum Recommendations Working Group (FRWG) took the recommendations of the conference discussion groups and condensed these into 10 major strategic research themes:

Adaptive strategies and patient decision making. Research issues from the patient perspective, including patient education and coping, complementary and alternative medicine, innovative therapies, choice, understanding, exercise, team care, pain and fatigue.

Children and youth. FRWG members agreed that children and youth with IJD are a priority area for the Frontiers research agenda. FRWG members concluded that identifying this area as a research priority should not jeopardize the future development of integrated, comprehensive research strategies encompassing IJD across all age groups.

Early inflammatory arthritis. The notion of "early arthritis" as an immediate opportunity and an urgent challenge was a dominant theme during the forum. Research into early arthritis was felt to span the target populations (RA, JIA and SA) and the major research disciplines, and would include early identification and studies of pathogenesis through multiple approaches (e.g., genomics, proteomics, advanced imaging). The need for education around early detection and treatment was also emphasized. Longitudinal observational cohort studies would also provide insight into factors that influence progression. FRWG members noted that this is a broad theme necessitating transdisciplinary research.



Economic and psychosocial dimensions of IJD. Includes human and social issues, as well as challenges related to work and disabilities.

Health services research. Includes research into access issues and models of care.

Measurement of outcomes. Includes the development and implementation of improved measurement tools (e.g., magnetic resonance imaging of inflammatory and structural changes in the joint, and newer functional and occupational instruments).

New drug targets. Includes studies of pathogenesis, development of animal models and investigations into the biological basis of the immune and inflammatory processes in the joints seen in IJD.

Optimizing drug and nondrug therapy. Includes new and existing drug and nondrug therapies, biomarkers, cohort studies, investigator-initiated clinical trials, prognostic factors and post-marketing surveillance.

Preclinical and risk factors for IJD. Includes etiologic studies, bioprofiling of high-risk populations and studies into the genetic-environmental interactions conferring risk for IJD.

Research on knowledge transfer and exchange. Studies of how to get the message out effectively to key target groups (e.g., the public, policy makers, healthcare professionals, consumers).

In addition, a number of priority tools will be required in order to undertake integrated research projects related to the strategic themes identified above. These include:

- Clinical trials and other research networks
- Investigator-initiated studies
- Development of: a) databases that include multiple sites and provide integrated data across pillars (e.g., data on health services, clinical information, biomarkers, and/or genetics) and b) core facilities to support these databases (e.g., developing model platforms for rules on database-related issues, such as biobanking, freedom of information and consent issues).
- Training

OUTCOMES

It was recognized that the number of strategic themes identified through this process need to be distilled into a smaller number of research directions that would form the basis of a broadly funded request for applications. This process proceeded under the auspices of the Alliance—an advisory organization that brings together the spectrum of Canadian arthritis stakeholders. As a result of this process, the strategic themes were distilled as follows:

Theme I. Improved Methods for Early Detection, Diagnosis and Monitoring of IJD

- Registries
- Integrated clinical and bioprofile databases
- Imaging in diagnosis and monitoring
- Identification of at-risk populations

Theme II. Improved Therapeutics in IJD

- Pathogenesis
- Animal models
- New drug targets
- Nondrug therapies

Theme III. Improved outcomes in IJD

- Psychosocial and economic determinants of outcomes
- New tools in measuring outcomes
- Integrated prognostic models: biologic, social, environmental
- The role of knowledge transfer in determining outcomes

It is hoped that there will be a specific commitment of funding for these initiatives from the Canadian Institutes of Health Research (CIHR), CAN, and TAS. Incorporation of industry funding into the initiatives is an important priority.

A second and equally important outcome has been the establishment of an inclusive process for identifying research priorities in arthritis. The networks that were established as a result of this conference will go a long way towards ensuring the relevance of the research, while maintaining the highest levels of scientific excellence.

– Hani El-Gabalawy, MD, FRCPC
Director, Arthritis Centre, University of Manitoba

Provincial News

News from Newfoundland/Labrador

Spring in St. John's may have been wet and cold, but things were undoubtedly brewing here during that period. A Public Service Workers' strike in April—including the Health Sector Support Workers—led to cancellations and delays in appointments and procedures in hospitals. This was particularly frustrating for those of us in rheumatology, as we are already suffering from severe shortages and long waiting lists. After nearly a month of bitter dispute, the workers were eventually legislated back to work. We are still trying to catch up with the cancellations.

We continue in our active search for more rheumatologists to join our group. Newfoundland has a lot to offer for those interested.

On a lighter note, the summer shaped up to be a great time on the Rock. The weather was fine and the great outdoors invited all of us to put our rusty joints back in motion. My latest fishing trip to Labrador was a success (despite the sun burn and mosquito bites).

Dr. Proton Rahman is spending more time with his little girls while still active in his research.

Finally, our condolences to Dr. Sean Hamilton on his mother's recent passing.

– *Majed Khraishi, MD, FRCPC*



Labrador Sunrise




The Devil's Gap (Labrador)

Regional News

Rheumatology Alive and Well in Peterborough

Peterborough, Ontario is about 90 minutes northeast of downtown Toronto and is a picturesque community with a population of approximately 71,000. Peterborough has had a significant rheumatology presence for many years, with up to five rheumatologists present at one time. The last few years have seen many changes. Peterborough has

a larger population of older Canadians compared to the Ontario average, so demand for arthritis care is high. An Arthritis Society physiotherapist is available in the region and she offers assistance to patients both privately as well as in group sessions. We have magnetic resonance imaging with a fairly short waiting time, an infliximab infusion clinic, and dual-energy X-ray absorptiometry (DEXA) machines aplenty but, unfortunately, there is a major shortage of family doctors. Therefore, patients have a hard time accessing the healthcare system. As well, two of



Peterborough's rheumatologists have left arthritis care completely, with no replacements in sight, so we are now reduced to 2.5 practicing rheumatologists. There has been a dramatic increase in the number of significantly ill patients we are now seeing, due to the redistribution of the orphaned patients. Waiting lists for elective joint replacement surgery can exceed 12 months, so many patients travel to Toronto for this. Due to recent changes at our hospital, we are no longer doing regular internal medicine calls, which has allowed for more time to concentrate on arthritis care.

Peterborough rheumatologists are involved in various Phase 3 research studies and have had summer students working with us. We are also participating in the ExpertMD® training program for family physicians.

All in all, Peterborough is facing the same challenges as many other communities in Ontario and, likely, the country. But hopefully our manpower issues, with rheumatologists actually leaving the specialty completely, is not a widespread phenomenon.

– Jane C. Purvis, MD, FRCPC

Rheumatology in the British Columbia Interior

The care of rheumatic disease patients in the British Columbia (BC) interior has faced unique challenges since I opened my practice in 1975 in Penticton, where I was the only rheumatologist living between Vancouver and Calgary. Geographically, the population is scattered along various valleys separated by mountain ranges and long lakes with few connecting highways or airports. Many arthritis patients gravitated to the area, particularly south Okanagan, because of the desert-like climate and low housing costs.

My office opened to a waitlist of three months, which rapidly grew to three-to-five years. The Arthritis Society (TAS) and Penticton Regional Hospital were very helpful in establishing a unique and comprehensive arthritis program, which included an eight-bed rheumatic disease unit (RDU) serving the vast BC interior, and a team of physiotherapists, occupational therapists, social workers and a disease-modifying anti-rheumatic drug (DMARD) clinic nurse. Arthritis patients were treated by the same team whether they were inpatients or outpatients. A DMARD clinic was established in 1975 for monitoring gold and D-penicillamine and has

grown to an average of 450 active patients to date. Orthopedic, fibromyalgia and other programs were added or pioneered. Dr. Kathy Gross established the Interior Children's Arthritis Program which follows approximately 50 children through the Penticton centre.

The major problem for many years was the lack of rheumatology manpower residing in the interior—a void which has been gradually filled by rheumatologists moving to the major communities in the Thompson-Okanagan region. Chronologically, the following rheumatologists have discovered the unique beauty and lifestyle of the area: Dr. Jan Navritil (Kamloops), Dr. Dan McLeod (Kelowna), Dr. Mike Puttick (Kelowna), Dr. Stuart Seigel (Kelowna), Dr. Nancy Hudson (Kamloops), Dr. Barb Blumenauer (Kamloops) and Dr. Jackie Stewart (Penticton).

There are large areas of the BC interior where patients are still a long distance from a rheumatologist. Some of these areas are served by TAS's Travelling Consultation Service from Vancouver, while other areas are covered by internists with special expertise or interest in rheumatic diseases, including Dr. Phil Malpass (Nelson), Dr. Mike Buchanan (Prince George), and Dr. Danny Myers (Salmon Arm).

The whole region has recently been consolidated under the Interior Health Authority and is fairly self-sufficient for orthopedic and diagnostic services, with major joint replacements being done in most centres, hand and spinal surgery being done in Kamloops and Kelowna, and shoulder and ankle replacements being done in Penticton.

The rheumatologists get together for Continuing Medical Education (CME) events several times a year—usually in Kelowna, which is most central—and for the Western Alliance of Rheumatology (WAR) meeting organized annually in Kelowna by Drs. Paul Davis and John Esdaille. The now famous Okanagan wines are a highlight of most meetings.

In the past two years we have established the Interior Osteoporosis Physicians group, which has membership from seven different specialties and family practice, and has representation from most of the major interior communities. The focus has been educational, with the intent of raising the standards of osteoporosis prevention and care, and a consultative role to the health region.

The future of rheumatology in the rapidly developing BC interior appears very bright. I predict that in the next two years there will be a freestanding arthritis treatment centre located in increasingly cosmopolitan Kelowna, rheumatology trainees rotating through the Penticton

Joint Communiqué



Dr. Robert Offer (left) and Dr. Michael Puttick with a view of Penticton, BC in the background.

arthritis program, and more effective outreach programs will link underserved interior communities to the rheumatologists in the Thompson-Okanagan corridor.

All of which is good news for people with arthritis.

– Robert Offer, MD, FRCPC

Rheum with a View in the Greater Toronto Area

I return home, a summerless, soggy Torontonian, after wandering the hollowed (sic) halls of Queen's Park, halogen lantern in hand, searching for an honest politician. Healthcare is again politicians' re-election currency, both on federal and provincial shores. Three successive Ontario governments (I never learned Latin in medical school but am sure the linguistic root for government has nothing to do with the English word "govern") have platted on healthcare reform and have dutifully fixed the system into its current "quackmire."

I ready myself for another long office day tomorrow. Ten extra minutes are added to all scheduled appointments, not because I am slowing down (though I am), but to accommodate for three minutes of complaints about the hospital's new parking fees, five minutes of carping about my waiting list, nearly two minutes of fielding Limited Use Form explanations, and the polite two seconds of greeting. By the time I finish debating

self-diagnosed Internet research and stamping the disabled parking permit, there's nary time for a history and physical (should I bill for counseling I wonder?).

Each patient agonizingly complains about the intolerable delays for imaging tests, in-hospital physiotherapy (discretionary funds being exhausted on chiropractic and shark cartilage), and surgical lotteries (I now ask not only the month of upcoming scheduled joint replacements but also the year). But I inform them that there are actually "no waiting lists," as per Prime Minister Martin's recent election promise. Even in our affluent bedroom community, many patients no longer have a family doctor. They bring all their sundry ills to me for healing. I worry that I could lose my license, if not a finger or two, if forced to do a pap smear. Gone is time for practicing medicine, replaced by the exhausting swim upstream to spawn care in an overloaded system.

The Canadian Rheumatology Association (CRA) publishes guidelines for early treatment in rheumatoid arthritis (RA). Meanwhile, the panacea window expires early on my imaginary waiting list. A guarantee for shorter waiting lists? How many rheumatologists will be required to service an aging population and replace our retiring colleagues? Can we entice more trainees or are the health ministry doyens intent on shopping on eBay?

Are novel solutions in the offing? The federal health minister rails against privatization. The Ontario government plans to unprivatize a den of diagnostic clinics which are billing through the Ontario Health Insurance Program (OHIP) at no extra cost to the provincial coffers. It is a fiscal philosophical nightmare that private interests have dared to save the government capitol equipment costs, all the while providing service to needy patients. People continue to suffer through our "to-tears" system.

My present waiting list stretches past the next American College of Rheumatology (ACR) conference. Most days feel like the final hours at the Alamo. I propose a "single-blind" experiment. Please record your baseline wait times and we'll tally the changes at 12 and 24 months (or just before the next election).

For the academics amongst us, the "single-blind" refers to our politicians.

– Diogenes the Cynic (i.e., frustrated, stand-up rheumatologist in the greater Toronto area)*

*Author prefers to remain anonymous

News from Université de Sherbrooke

It's been busy in Sherbrooke!

Artur de Brum-Fernandes, MD, PhD was appointed President of the Ethics Review Board of the *Centre hospitalier Université de Sherbrooke* (CHUS) in January 2003 as well as Head of the Rheumatology Division in March 2003, promoted to Full Professor at the *Université de Sherbrooke* in June 2003 and awarded a Senior Clinical Scientist award from the *Fonds de la Recherche en Santé du Québec* (FRSQ).

The main research thrust of the Division is on bone metabolism and prostanoid receptors, with the collaborated work efforts of Dr. Fernandes (FRSQ; The Arthritis Society [TAS], Canadian Institutes of Health Research [CIHR]), Jean-Luc Parent, PhD (CIHR investigator; Canadian Foundation for Innovations [CFI], TAS, Kidney Foundation) and Sophie Roux, MD, PhD (FRSQ Junior I Clinical Scientist; TAS).

Following the recruitment of Dr. Roux (July 2002) and David Hercelin, MD, DEA (March 2003)—both trained in France—and the return of Patrick Liang, MD (post-doc at The Cleveland Clinics), multidisciplinary clinics were set up for specialized metabolic bone diseases (Dr. Roux), systemic vasculitis and connective tissue disease (Dr. Liang).

Dr. Julie Beauchemin completed her rheumatology training in June 2004 and joined the staff at *Hôpital Charles-Lemoyne*, a *Université de Sherbrooke*-affiliated teaching hospital close to Montreal. Another rheumatology fellow, Dr. Isabelle Deschênes, is currently completing her training. Expectations are high for admission of new fellows next year.

Gilles Boire, MD, MSc is on sabbatical leave for the full 2004 year. Dr. Boire is spending this year in research on early polyarthritis (TAS-sponsored) and on the molecular biology of the Ro autoantigen (part of a ribonucleic acid-protein interaction; Group of Excellence from the *Université de Sherbrooke*).

Following a significant dedicated gift to the *Université de Sherbrooke* from André Lussier, MD, professor emeritus and former president of the Canadian Rheumatology Association (CRA), three annual awards (\$12,000 in total) have been established: the most meritorious fourth-year medical student, the most meritorious first- or second-year resident rotating in rheumatology and the most meritorious graduate student from the wet labs of the Division.

– Gilles Boire, MD, MSc, FRCPC
Professor of Medicine, *Université de Sherbrooke*

News from Dalhousie University

The Division of Rheumatology at Dalhousie University—one of 15 divisions within the Department of Medicine—has three full-time rheumatologists (Drs. Evelyn Sutton, Volodko Bakowsky and John Hanly), in addition to three community-based rheumatologists (Drs. Dianne Mosher, Siraj Ahmad and Souad Shatshat), who also run a private office practice. For many years there have not been dedicated inpatient beds for rheumatology; the majority of our services are now provided in an ambulatory setting. The Rheumatology Clinic is a provincial and regional referral centre and has approximately 7,000 patient visits per year. The relocation of this ambulatory service to the Nova Scotia Rehabilitation Centre (NSRC) site of the Queen Elizabeth II Health Sciences Centre in July 2002, and the establishment of the Arthritis Centre of Nova Scotia, have provided a more accessible, patient-centred, interdisciplinary model of care for patients with arthritis. One of the unique features of our centre is the inclusion of a satellite office of The Arthritis Society (TAS) of Nova Scotia through which TAS's educational and service-related programs are promoted.

All members of the rheumatology division participate in the undergraduate teaching programs at Dalhousie and the post-graduate rheumatology training program remains active.

Members of the rheumatology division are currently involved in a number of clinical research projects studying the effectiveness of new therapies, the role of genetics and long-term outcomes in different patient groups, including those with rheumatoid arthritis, psoriatic arthritis and systemic lupus erythematosus.

– John Hanly, MD, FRCPC
Professor and Head, Division of Rheumatology,
Director, Arthritis Centre of Nova Scotia,
Dalhousie University and QEII Health Sciences Centre,
Halifax, Nova Scotia