First Anniversary Special

In a family which Birthday / Anniversary is more significant? 1, 10, 25, 50, 75, 100 ... ? Surely, the very First! because this leads to the next, next and so on.

VOICE OF APLAR at 1 needs your blessings to grow in size and stature.... Tell us what you think, what you need, keep writing be it a letter, an event happened or happening, a case report, an anecdote, a caricature ... and of course a thought provoking essay or a story to invigorate Rheumatology and us.

Rheumatology Nonstop
Please download, print for relaxed reading, forward to your colleagues.

Dear APLAR members... Please DO come and join us at the APLAR CONGRESS OCT. 17, DUBAI. APLAR 2017 will present a vital scientific programme of several plenaries, interactive symposia on contemporary trends as well as symposia organized by Special Interest Groups of APLAR, a review course, poster discussion and debates on hot topics.

We are looking forward to meeting you in the global city and business hub at Dubai.

Prof Kazuhiko Yamamoto, President, APLAR, Japan

The International Tsunami of Musculoskeletal Pain: When will it hit and will we cope?

Kevin Pile
APLAR Past President

Continued on Page 2

The tsunami metaphor is apt when considering the threat of an overwhelming burden of musculoskeletal pain flooding our clinics. The impact of a tsunami depends on the lie of the land, its natural vulnerabilities and defences, the preparedness of the population and the resources that can be brought to bear. Similar factors can be considered in our discussion of musculoskeletal pain. The following is a précis of a presentation from the “Controversies in Bone, Muscle, and Joint Disease” held on the Gold Coast, Australia, 2017.
The tsunami of musculoskeletal pain is here already, but the waters are not receding and unfortunately it continues to rain. Rheumatologists will be insufficient to deal with this burden, and are likely to focus on the inflammatory disorders which are difficult for our primary care colleagues to manage. Certainly new management and curative strategies for musculoskeletal pain are needed, but pragmatically the community is going to have to look after itself more.
1958: Nobel prize for Medicine and Physiology was awarded to 32 year old Microbiologist, Joshua Lederberg, USA. His ideas enunciated later are hot topics today. 'Microbiome', then emerged in a collaborative human-microbiome "superorganism" study launched by National Institutes of Health, USA and European MetaHit consortium. What is Microbiome? Lederberg proposed that it was the sum total of all microbes (commensals and pathogenic) residing in human body mostly the gut, out-numbering 100 trillion, weighing approximately 2 Kg. Till recently they were regarded as essentially hostile to human hosts, thought to be perennial enemies, inviting 'rampant' antibiotics. Our understanding has undergone a sea-change as we now know human genome contains 30,000 coding proteins-genes. This composite of microbial genome is 100 times larger. Together with 100 trillion microbes, their composite genes and our 30,000 constitute Metagenome. This emerging science has transformed our notions as we now begin to understand this "ecosystem" within us that profoundly influences our health vis-a-vis disease.

Add to it, dynamic environmental factors and we will appreciate how microbiome can influence predisposition, manifestations of veritable diseases and consequently our treatment strategies and variable response.

**Cause - Effect Phenomena**

To prove, Koch's postulates must be convincingly addressed. A major stumbling block was inability to culture approximately 80% of all bacteria in our microbiome. However, DNA sequencing technology has revolutionized studies in Molecular Biology. Simultaneously, advances in Computational Biology along with Bioinformatic tools have enabled us decipher the complexity of such microbial host-environmental interaction within us. (Fig.1)

**Classic example: HLA B27 predisposition to Ankylosing Spondylitis (AS)**

The association of HLA B27 gene and AS is far too well known. In Caucasians the gene is present in about 95%,
Evidence Based Medicine (EBM) relies on data collection through a variety of studies localized or multicentric in specific, well defined disease subsets of patients with elaborate criteria of inclusion and exclusion. Conclusions if any are then extrapolated into general recommendations presented commonly as ‘guidelines’, or algorithms. Such presumptions and premises are expected to be valid for any patient anywhere by the attending doctor who follows such guidelines to write standardized prescription, that is how most of us are prone to practice medicine daily ... through generalized treatment regimes naturally with highly variable treatment outcome.

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Targeted and Tailored P4 Medicine

Now many hospitals in India offer genetic profiling in an attempt to predict later disease manifestations.

So far our thrust is to diagnose diseases and treat as per their organ involvement, eg. Angioplasty and CABS for episodes of myocardial infarction. About 90% of our investment in medical research and treatment seems towards attacking fully manifested diseases rather than predict, prevent diseases.

In Asians about 70 - 75% of AS patients. The organisms most commonly implicated are gram negative, bacilli, eg.. Klebsiella, Shigella, Salmonella. Near identical mirror image cell surface antigenic structures of these bacilli and HLA B27 gene is a fine example of molecular mimicry. This can incite and signal to activate Th and TREGG pathways of the immune system complex signaling, inducing remote sacroiliitis as in AS, or Reactive Arthritis in HLA B27 patients. (Fig.2)

 Some subsets of HLA B27 are known to be predisposed to AS eg.27:02, 27:04, 27:05 and other subsets protect the host against AS eg. 27:06, 27:09. The Africans seem protected against AS, the Caucasians seem vulnerable.

![Fig 2: HLA B27 positive AS patient with marked bilateral sacroiliitis and hip joint narrowing.](image)

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**P4 Medicine for the masses**

Computational Biology centres with high capability to collate mass data, dissect and analyze mathematically into reproducible observations, treatment outcome is on the anvil. An individual patient and / or his physician can log in symptoms / signs, investigated reports into a Computational Biology centre to generate and transmit prescriptions. Already 15% of Rheumatoid Arthritis patients in the U.S. have gone a step further and asked for prescribed drug delivery at their doorstep online... sparking a debate on the merits and inherent risks.

**Medicine and the telecom revolution**

Taking microbiome, meta-genomics and P4 medicine to the masses allow democratization of Medicine perhaps akin to 'Obamacare'... via mini gadgets such as smart phones. I have had some patients even from remote villages showing before and after pictures of diseases they or their folks suffer from on their cell-phones. Are not laboratory reports shown to us on 'WhatsApp'? Don't increasing number of patients located elsewhere expect "cellular" treatment advice?

Isn't telemedicine eroding and cutting down clinic visits of patients? Aren't 'Dr. Apple' and 'Dr. Google' taking charge of some of our medical practices? Isn't the traditional Holy Grail Doctor-patient relationship in peril?

This relentless march of technology is impacting our patients and us doctors every day. This surely facilitates our daily work. eg. scanned reports are transmitted right away on our gadgets from imaging centres. That's good for us; but what when patients expect our prescriptions and advice to be sent on their tools or download direct from internet without having to visit us? Don't we see abuse, misuse, falsehoods and serious errors in medical practice by gullible patients, as we lose our authority to treat our patients ourselves? Is there still room for patients to visit us for that healing touch? In the era of driverless taxis are 'doctorless' clinics in the offing?

Surely for surgical patients this is inevitable despite robotic surgery. As for physicians we have got to adopt, adapt, be adept and accept these new turns and twists of science if we insist that patients must visit us at our clinics .... in their interest... and ours.

**A missing gap**

Today, such new technologies are invented by a new generation of scientists in their laboratories of physics, mathematics, engineering, bioengineering and computer sciences. Are they alive to the needs of our patients? Are we in a position to open a dialogue with them at the start and not at finish? When will our medical conferences, our textbooks and medical curricula incorporate courses of these nascent sciences heavily influencing our ways of medicine and life? Are we ready for this brave new world of relentless march of science? Will we be swept off our feet or ride the change?

Prakash Pispati, M.D., F.R.S.M. (Lon)
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Director of Rheumatology, Mentor, Jaslok Hospital, Mumbai.
Sr. Consultant Rheumatologist, Saifee Hospital, Mumbai.
Master; Honorary Member and Past President: APLAR
Past President: India Rheumatology Association.
International Fellow Member: ACR.

**Recommended Reading:**
2. ErmannJ. Landmarks & Advances in Understanding HLA-B27. The Rheumatologist 2016; 7: 1, 11-15

**Snippet... Personalized Medicine ?**

Wife: Darling, My swollen knee hurts.
Husband: Lets consult a Rheumatologist, the Internet is down anyway.
• Introduction

To make a movie, one starts with a novel idea on which a storyline is developed. Thereafter one decides on the genre and format in which the story will be told. It is only then that one starts shooting the first scene. Writing a scientific paper is akin to making a movie. You start with a good research idea, choose an appropriate scientific design to carry out the research and select appropriate statistical methods to analyse the data. Now comes the mammoth task of writing it all in form of a scientific paper.

In this article, let us focus our attention on the art of medical writing before identifying the specific challenges facing an amateur or an individual writer.

• The hourglass concept

All of us are familiar with the IMRAD (Introduction, methods, results and discussion) format of scientific writing. It is best visualized as an hourglass (Fig 1), where the top half (funnel) represents the Introduction, the bottom half (reverse funnel) represents the discussion and the narrow waist includes the methods and results section.

The introduction answers just one question; Why was this study planned? It can roughly be divided into 3 parts; a) *What is known?* (Broad inlet that covers the magnitude and importance of the problem), b) *What is the unknown?* (the mid part of funnel that highlights gaps in knowledge) and c) Does the study attempt to bridge the gap?

The Methods section contains details of the study design, study population, data collection, laboratory methods, and statistical analysis. This section is most thoroughly inspected by reviewers before publication and by a few interested readers after publication. It is also the easiest part to write as specific guidelines exist for specific types of studies (eg CONSORT for Randomised controlled studies, STROBE for observational studies etc) It is recommended that the reader visits equator network at http://www.equator-network.org/ that details all these guidelines.

The Results section is the heart of a paper. Enough interpretation is provided to lead the reader from one analysis to the next in a logical, story-like progression that addresses the main study question, The use of subheadings is encouraged. The text of the results should explain but not replicate information contained in the tables and figures. The equator network offers detailed guidelines for this section too. The reason methods and results can be considered as the thin waistline of hourglass in spite of being the most important parts of the manuscript is that the guidelines have standardized these sections to a great extent and one can complete these sections in minimal time with almost no errors by using these templates.

The Discussion section should provide a critical argument for the study objectives and findings by covering most of the following questions: What answer did you get and what does it mean? The discussion starts with the study’s specific findings, expands into weaving the findings into the greater body of literature, and ends with making broad speculations (reverse funnel).

There needs to be a section for the major limitations of the study, their potential impact on interpreting the findings, and ways with which the effect of the limitations was minimized. To end on a positive note, limitations should be followed by strengths. Thought as well as tact are required in explaining differences between the study being presented and previous studies.

It is not necessarily the best thing to write in the sequential format of IMRAD. One effective and nonlinear way is to assemble all vital study materials, including protocols, final analyses, and references. The following reverse technique might actually be helpful (Table 1).
• **Announcing the article**

The title and abstract are the advertisement of the article. A reader who cannot extract the significance of an article from its title is unlikely to read further. Most readers will probably just read the title to skip ahead. If the title appears interesting, some would read the abstract. So the title should be informative and specific to the study and contain key elements that advertise the paper’s design, contents or main findings.

The Abstract section is best written last when it is easiest to summarize all aspects of the study. After the title, the abstract is often the only part of the manuscript read by most readers. Only if the abstract incites curiosity in the reader will they venture to read the full article. Even here, most start with conclusions, then discussion, then results and lastly the most discerning ones will scrutinize the methods section. It is therefore imperative that a lot of effort is devoted to a good title and a concise abstract.

• **The backend work**

The Reference list supporting the methods and claims should be generous, up to date, and thorough in acknowledging previous work. References are read by editors and reviewers. Potential reviewers may get identified from the reference list, which is another reason to be respectful of previous work. It is a good practice to check PubMed a few days before you submit your paper to be sure that there have not been any recent publications related to your work (it is better to be acknowledged by you than by the editor or reviewer).

Typing references and running the risk of misspelling names should be avoided. Specialized reference software, such as Mendeley and Zotero (both free) can alleviate these issues and make referencing a cakewalk.

• **Which journal to send the article?**

The choice of the journal is decided by a knowledge of the paper’s focus and strengths, and the journal's impact factor and readership. The best potential journal is one with a high impact that is widely read by one’s peers. Because authors typically overestimate the value and novelty of their manuscripts, choosing a high-impact journal for the initial submission can be time consuming and disappointing. Ask the question “who should read my paper?” and consult with senior researchers before finalizing a journal. After selecting a journal, check the requirements for submission, proceed with electronic submission, and ensure that you receive a notice of receipt.

• **Challenges to medical writing**

In the typical academic setting, the challenges facing the Medical writer are manifold (Table 2).

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>SUGGESTED STEPS TO WRITING A MANUSCRIPT</th>
</tr>
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<tbody>
<tr>
<td>1. Write Methodology section first (Easiest part, standardized, highest satisfaction for effort)</td>
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<tr>
<td>2. Write the results section next</td>
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<td>3. Construct tables and figures based on the final analyses</td>
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<td>4. Develop an outline with major and minor points in each section</td>
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<td>5. Introduction and discussion next</td>
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<td>6. Abstract should be attempted after article is complete</td>
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<td>7. Title is reserved for the very end and should be catchy and informative</td>
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<td>8. First draft</td>
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<td>a. Share it with the main co-authors</td>
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<td>b. Revise, read again; first for content, then for fluency, clarity, accuracy</td>
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<tr>
<td>c. Authorship should be clearly stated in first draft (number and order of authors)</td>
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<th>TABLE 2</th>
<th>CHALLENGES FACING THE INDIAN PHYSICIAN</th>
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<tr>
<td><strong>External challenges</strong></td>
<td></td>
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<tr>
<td>1. Clinical work: almost everyone is burdened with heavy OPD load with no time in hands for anything else</td>
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<td>2. Teaching responsibilities</td>
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<td>3. Administrative work: committee assignments</td>
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<td>4. Personal time: Need to balance time between work and home</td>
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<td><strong>Intrinsic challenges</strong></td>
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<tr>
<td>1. Inability to begin, sustain and complete a manuscript:</td>
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<tr>
<td>a. Only 10-17% abstracts become full texts</td>
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<td>b. Having multiple revisions, repeated analyses, and changes in the focus</td>
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<tr>
<td>c. Procrastination</td>
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<tr>
<td>2. Not having basic knowledge about</td>
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<tr>
<td>a. How to choose a topic and identify study question</td>
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<td>b. Poor access to specialists to design correct study</td>
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<tr>
<td>c. Poor access to research methodology and Biostatistics</td>
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<tr>
<td>3. Barriers to medical writing skills</td>
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</tr>
<tr>
<td>a. English language and grammar</td>
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<tr>
<td>b. Poor knowledge on literature search</td>
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<tr>
<td>c. Journal access limited</td>
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1. Spontaneous writing
   a. Consistently devote 1 hour daily to write (without feeling ready or fully in control or awaiting inspiration)
   b. Make writing contingent on doing a valuable but recurrent daily delayable activity. For example, schedule writing time before recurrent activities, such as eating, taking a shower, or going home to have dinner with the family.
   c. Set target dates and complete parts of manuscripts

2. Create externality artificially
   a. Soliciting feedback from colleagues, friends, or co-authors on parts of the manuscript across stages for preparation, in form of comments or critique on writing.
   b. Good for collaborative team building because it requires reciprocation and may generate new ideas. It may also build a sense of audience and develop better anticipation of critiques.

### TABLE 3

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**THE STORY OF RHEUMATOLOGY IN UAE**

When I was asked to write an article on the story of rheumatology in the United Arab Emirates (UAE) by my friend Professor Prakash Pispati who is the Editor-in-Chief of the Voice of APLAR, I welcomed the opportunity coinciding with APLAR-ESR Congress October 2017.

UAE is a fantastic country and it is difficult to believe that a country, which was established only in 1971, has achieved so much in such a short time and became one of the international hubs in finance, commerce, tourism, transport, communications and urban development.

I moved to Abu Dhabi in February 2003 leaving my position as a professor of rheumatology at the University of Baghdad to establish the first rheumatology unit in Mafraq hospital, which is a major governmental hospital under the ministry of health (MOH) at that time and later, became under HAAD (Health Authority Abu Dhabi).

The first rheumatology unit in Dubai to open was at the Dubai government hospital under DHA (Dubai Health Authority) which had a small start in 1987 under Dr. Hamdi Afifi, an Egyptian rheumatologist then expanded gradually to become currently the biggest rheumatology unit in the country.

Dr. Ayman AL Mofti established the first UAE rheumatology club in 1999 though it existed few years before under an Ortho & Rheumatology gathering which had few members not exceeding ten from all over the country. The club was holding scientific events on regular basis and its membership built up year after another.

**Suggested Reading**

Dr. Jamal AL Saleh became the head of the UAE Rheumatology club in 2004 then in 2005 it was my turn to take over for the next four years until 2008 when the ESR (Emirates Society of Rheumatology) was founded.

Dr. Waleed Al Shehhi from UAE, the current ESR president and its founder. A highly dynamic ambitious rheumatologist, which I met first time in the winter of 2004 in Paris during a EULAR ultrasound course. We had dinner together in a nice Parisian bistro during which he told me how it was his dream to return back home to UAE and to establish a national society for rheumatology under the name of ESR (similar to the lab test name). At that time, Waleed was a final year rheumatology trainee in Dublin. He came back home next year in 2005 as planned and managed to bring his dream true in 2008 to initiate the ESR which has replaced the UAE rheumatology club and which has now more than seventy rheumatologists member.

The leadership of the ESR transferred in 2010 to Dr. Mustafa Al-Maini, Canadian trained and the current head of the rheumatology service of Mafraq hospital, Abu Dhabi then Dr Jamal Alsaleh in 2013 took over the leadership which turned back again to Dr. Waleed AlShehhi in 2016 all through society elections.

Dr. Humeira Badsha, a highly motivated bright, youthful lady rheumatologist who is American qualified joined the private rheumatology service in Dubai in 2004. She gets the credit for establishing the Emirates Arthritis Foundation (EAF), which holds many patients educational activities in addition to holding the annual celebration event of the World Arthritis Day (WAD).

Under the ESR, dozens of highly esteemed international and regional rheumatology events were held both in Abu Dhabi and in Dubai including the well-known Arab Health Congress, The Pan Arab Rheumatology congress in 2014 which witnessed the emergence of ARLAR (Arab League Against Rheumatism) and the regular annual event of ADARRC (Abu Dhabi Advanced Rheumatology Review Course) which is organized by Dr. Mustafa Al Maini, this year in its seventh cycle.
BANGLADESH

YOUNG NATION : YOUTHFUL RHEUMATOLOGY

Bangladesh acquired nationhood in 1971 overcoming strife and recording strides now with resurgent economy and Healthcare development with four stage Rheumatology initiative:

a) delivery of focused treatment and clinical research (1991 onward)

b) professionals in the Bangladesh Rheumatology Society (BRS) platform (1997)

c) institutionalization of research and education like establishment of Department of Rheumatology at the apex medical university (1999-2012), and

d) formation of and dialogues with patient-support group (2011 onward).

Bangladesh Rheumatology Society was inaugurated on 28 April 1997 (Dhaka) under a very dynamic leadership of Prof. MN Alam and inspired by Dr. Prakash K. Pispati (India) and Dr. Chng Hiok Hee (Singapore). Since inception it is trying to open a new horizon in education, patient care and research in the field of rheumatology. It observes World Arthritis Day, World Lupus Day, World Osteoporosis Day each year.

Landmark events: Due to its relentless efforts, the apex medical university of the country now has a full-fledged rheumatology division with two five-year postgraduate programs founded in the department of Medicine, Bangabandhu Sheikh Mujib Medical University (BSMMU). Specialized rheumatology services started in the BSMMU in 1991.

The Society formed a COPCORD Study Group in 1999. It has completed a series of epidemiological research works including disability, work loss, burden of disease, study of risk factors for common rheumatic morbidities and development of preventive modules incorporating identified behavioral risk factors.

Inspired by the rheumatology professionals and BRS, lupus patients and families of the country “Lupus Foundation of Bangladesh (LFB)” was founded in October 2011. The LFB aims to promote lupus care in the country envisioning ‘a society where people are aware of lupus and feel at ease to manage, control and support lupus cares without any psychosocial tensions and barriers’. The foundation is acting for patient empowerment for holistic self-management. In specific, it arranges periodic patient education programs in Dhaka and other parts of the country, supports for lupus patients from underprivileged segments of the community and is also carrying out several lupus-related psycho-social researches. Over the five years, its membership expanded beyond 1,500 lupus patients / families all over Bangladesh.

Forthcoming event: Biennial Conference 7th & 8th October 2017: Theme “Lupus & Vasculitis” with eight international visitors to enrich proceedings highlighting domestic endeavours.

Authored by: ...

SYED ATIQUL HAQ

Professor of Rheumatology, BSM Medical University, Dhaka
President Elect, APLAR (Asia Pacific League of Associations for Rheumatology)
Vice President, Bangladesh Rheumatology Society
Associate Editor, International Journal of Rheumatic Diseases
Vice President, Lupus Foundation of Bangladesh. (September 14, 2017)

TAILPIECE:

Soon after Bangladesh was on the Atlas (1971), as a member of Indian Medical Assistance team, I spent two weeks in remote areas adjoining Chittagong near Eastern Burma border,…an eye-opening, emotional experience. In late 1990’s it was different addressing medical luminaries on Rheumatology topics at Dhaka Intercontinental Hotel. I spotted a young, handsome, smiling, lively doctor. Following personal interaction I sounded him if he would take up Rheumatology as a challenge. He did. Together with youthful colleagues notably Dr. Nurul and others they set up a tiny group. The outcome? Bangladesh Rheumatology Society which I had the privilege to be its guest at the inaugural CME (1997),

Who was this young man? You guessed it right! Dr. Syed Atiqul Haq, your next APLAR President… Bravo!

Prakash Pispati

Wading through water hyacinths on a journey to the COPCORD villages

2015: Conference of the Bangladesh Rheumatology Society
The 2017 Combined Australian Rheumatology Association and New Zealand Rheumatology Association Annual Scientific Meeting was held in Auckland, New Zealand from May 20-23, 2017. The Australian and New Zealand Associations have a combined meeting in New Zealand every 7-8 years, and in 2017 the NZRA hosted the meeting in the Auckland Convention Centre. The meeting was held in conjunction with the Australian & New Zealand rheumatology allied health professionals. Over 700 delegates attended the meeting.

Meeting themes included new therapeutic targets in arthritis, mechanisms of joint disease, musculoskeletal imaging, and new models of care in rheumatology practice. International guests included Professor Georg Schett (Germany) speaking on osteoimmunology and joint damage in arthritis, Professor Arthur Kavanaugh (US) speaking on psoriatic arthritis and therapeutic targets in rheumatoid arthritis, Dr Peter Balint (Hungary) on musculoskeletal ultrasound in rheumatology practice, Dr Madelaine Rooney (Ireland) on paediatric rheumatology and Dr Kori Dewing (US) on the role of the nurse practitioner in rheumatology practice. Two satellite meetings were held after the Annual Scientific Meeting, for Paediatric Rheumatology and Musculoskeletal Ultrasound.

In addition to national and international speakers, original research presentations were a strong feature of the meeting. Dr Sam Whittle was awarded the Tom Highton prize for best presentation of the meeting, for his study describing the role of the DAS28 as a predictor of response to DMARDs in early RA. We also celebrated Assoc Prof David Champion’s milestone of presenting at Australian Rheumatology Association Annual Scientific Meeting for 50 years! Combined meetings with the New Zealand and Australian Associations are always very collegial, and social events included the conference dinner at the Auckland War Memorial Museum, which included a very impressive Māori welcome. A highlight of this dinner was the presentation of the NZRA Distinguished Service Medal to Dr Sue Rudge, for her services to paediatric rheumatology in New Zealand.

Prof Nicola Dalbeth
Chair, Organizing Committee
2017 combined ARA and NZRA meeting
MALAYSIA

2017 has been an interesting and progressive year for rheumatology in Malaysia. Various educational activities have been conducted to ensure that rheumatology fellows and rheumatologists are updated in their knowledge in rheumatology. Short courses of specific diseases are organised quarterly with the collaboration of various pharmaceutical companies to update rheumatologists and rheumatology fellows on the latest developments. (Figure A)

Figure A: SpA workshop in April and Rheumatoid Arthritis meeting in July.

MSR recognised the importance of musculoskeletal (MSK) ultrasound, as an important tool to aid in the management of patients with inflammatory arthritis. Targeted Ultrasound Initiative (TUI) subcommittee was formed under the MSR umbrella and is responsible for promoting ultrasound among MSR members. This year, TUI-MSR has created a training module with an aim to credential members for MSK ultrasound. (Figure B)

Figure B: Ultrasound workshop in National University of Malaysia.

World Arthritis Day is one of the most celebrated event among rheumatology fraternity. Almost all rheumatology centres, including private hospitals celebrate it by conducting workshops, conferences, fun activities for patients with rheumatologic conditions and their carers, as well as for other healthcare professionals. (Figure C).

Figure C: Public forum held by a rheumatology centre.

To create awareness of common rheumatological diseases among the primary care doctors, roadshows are done regularly in different regions in Malaysia. This year, Practical and Essential Approach to Rheumatological Symptoms (PEARL) workshops highlight the presentation of common rheumatological conditions encountered in primary care settings. (Figure D)

Figure D: PEARL workshop in Muar (South of Malaysia) and Kuala Terengganu (East Coast).

MSR will be organising the 19th MSR-SSR 2018 conference, a collaboration between MSR and Singapore Society of Rheumatology (SSR) which will be held in Kuala Lumpur.

By...
Dr. Mollyza Mohd. Zain, President
Dr. Hazlyna Baharuddin, Assistant Secretary
Malaysian Society of Rheumatology
The smallest Central Asian republic locked in the middle of mountainous range is Tajikistan, where about 8 million people are living. It is bordered by Afghanistan to the south, Uzbekistan to the west, Kyrgyzstan to the north, and China to the east. Pakistan lies to the south, separated by the narrow Wakhan Corridor. Rheumatologic service in this post-soviet country met all ups and downs during the past years.

1978: the First Republican Rheumatologic Center was organized, with main responsibility to provide methodological, clinical and laboratory support to researches in the field of musculoskeletal system diseases.

The following researches were conducted:

- Visceral manifestations of the morphological pattern of the liver in patients with gout
- Study of the hepatotoxic effect of allaparinol
- Studying the features of Cardiovascular lesions in patients with arthropathies
- Study of the female version of Bekhterev's disease features
- Frequency of NSAIDs - gastropathies manifestations in patients with rheumatic diseases
- Frequency and features of metabolic syndrome in patients with gout

Scientific works accomplished during these years were devoted to study:

- Clinico - functional and morphological examination of the liver in patients with gout
- Cardiovascular system disorders in patients with rheumatoid arthritis
- Features of ankylosing spondylitis in women in the population of Tajikistan
- Development of combined "basic" therapy for rheumatoid arthritis in the early stages of the disease
- Tajikistan population screening for joint syndrome prevalence
- Rheumatology service quality and coverage in Tajikistan

The Association organizes Rheumatologic Short Courses for family doctors and young specialists around Tajikistan that upgrades knowledge on the common rheumatic diseases burden, diagnostics and treatment. Communities are getting involved to dynamic issues of the rheumatic diseases.

Nowadays the Rheumatologic Association of Tajikistan is closely collaborating with Maastricht University (Netherlands) on Work Disability Study in patients with rheumatoid arthritis, Eurasian Therapeutic Association with the study on Rheumatic Diseases Spread and Specifications in Population of the country, Russian Rheumatology Society on different rheumatology issues, ISPOR on drugs outcomes in patients with rheumatic diseases, as well as with other regional and international research institutions.
The Japan college of Rheumatology (JCR) has opened the International School since 2013 in Karuizawa, Japan. We had the 5th meeting in August this year. The purpose of the school is to facilitate fellows in training and junior faculty not only from Japan, but also from overseas to exchange their experiences in research and practice for rheumatology in English. Through presenting the topics in the diagnosis, pathogenesis, and treatment for the rheumatic diseases by individual attendee will be discussed in depth by all members in the school including 8 faculties from JCR. We believe the program encourage the attendee interaction one another and with faculty, leading to raise rheumatologists and rheumatology researchers, who can actively work internationally.

The school is held for 3 days in Karuizawa. The town is 130 km away from Tokyo and everybody can concentrate science and can think differently from monotonous usual life (Figure2), inviting approximately 20-25 young rheumatologists including those from foreign countries and 8 senior tutors from Japan. Tutors are member of the faculty in the JCR International School Committee.

Before the school, a lecture on ‘how to make good presentations’ by Mr. Jego is started off which is excellent, interactive and having a lot of take home messages. The school starts with a keynote lecture by a leading and distinguished rheumatologist in the APLAR region. It is followed by 8 parts of oral presentation and discussion. Young rheumatologists and facilitators can freely join in the discussion in each presentation, but younger people are prioritized. Also during the course one lunch time memorial lecture by a rheumatologist selected in Japan is served.

**VOICES OF THE PARTICIPANTS**

“I had the honor to be invited to the JCR International School. What a nice and didactic initiative.

*Sofia Ramiro - The Netherlands (2015)*

“The JCR International School offered a magnificent experience. I have never before experienced such an optimal learning environment.”

*Dr. Rachel Knevel - USA (2016)*
The well-organized courses impressed me deeply. I learned how to give a successful presentation and had enough time to interact with the reporters and tutors. As a researcher in basic immunology, the lecture "Improving our oral presentation" by Mr. E. H. Jego was also very vivid full of passion and very practical for us.

Dr. Haibo Zhou - China (2016)

Intimate, intimidating, innovative, inspiring: these adjectives summarize my experience in the JCR International School. It felt like a highly-charged classroom, with young minds that are so advanced and dynamic.

Dr. Angeline -Therese D. Magbitang - Philippines (2013)

Because of the limited space, I cannot show all the participants’ VOICE, more than 100 participants appear to be satisfied with the school very much and enjoyed science, communications one another and Karuizawa. I deeply appreciate tutors and the staff of the JCR and also would like to send special thanks to 10 key note lectures for visiting Karuizawa to send us educational and wonderful lectures and actively participating the program by the end, which has attracted young rheumatologists and contributed to the success. I believe that such a partnership and friendship will definitely lead to progress in science/rheumatology in the APLAR region near future.

Yashiya Tanaka, MD, PhD
- Vice president, APLAR
- Chairperson, Committee on JCR International School
- A member of the director board, JCR
- Chairperson, Committee on Certification Systems
- Editor-in-Chief, Modern Rheumatology Case Reports
- Professor & Chairman, The First Department of Internal Medicine, School of Medicine
- Dean, Graduate School of Medical Science,
- University of Occupational & Environmental Health, Japan
1-1 Iseigaoka, Yahata-nishi, Kitakyushu 807-8555, Japan
Annotation from Personal Diary

The other day an anxious mother came with her son aged five years with polyarthritis, high fever, vomiting

She : "Doctor, what’s the problem?"
Me : "JIA – Juvenile Idiopathic Arthritis”.
She : "What’s that doctor?"

I fumbled, didn’t have a cogent answer, I still don’t have, am still disturbed. Must we doctors coin words which are so complex leaving the patient perplexed? Lingo which is unclear and alarming to our patients vitiating treatment? I wrote to an international journal that it’s time we did some soul searching. After all, there are two types of people in the world, those who make ‘simple things complex’ and those who make ‘complex things simple’, isn’t it so?

Which category do I belong to...? I introspect.

E-in-C: VOA.........pp

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