Treat-to-target recommendations for spondyloarthritis undergo updating

One of the notable updates being presented at this year’s EULAR congress is the updated recommendations concerning treat-to-target (T2T) for spondyloarthritis (SpA).

“The T2T recommendations are following the principle that you have to define a target you want to reach and adapt management to reach this target. This is independent of the treatment you use to reach the target,” said Prof. Désirée van der Heijde, a professor of rheumatology at Leiden (the Netherlands) University Medical Centre, who will describe the new recommendations this afternoon.

The updated recommendations “enforce that it is important to set a target in shared decision with the patient, monitor the disease and act with adaptation of management if the target has not been reached” in order to improve the outcome of SpA, she added.

The original 2012 EULAR recommendations for SpA were inspired by the T2T reasoning that drove the recommendations for rheumatoid arthritis. Those recommendations separately addressed axial SpA, peripheral SpA, and psoriatic arthritis. The 2017 update from a task force of European and North American rheumatologists, dermatologists, patients, and a health professional developed a single set of recommendations for the three subtypes.

Pain often persists despite biologic treatment in PsA

About one-third of the cohort reported little pain or mild pain, 30% reported moderate pain, and the rest reported severe pain despite biologic drug treatment.

In an interview, Prof. Conaghan said that it’s important for clinicians not to assume that pain in a PsA patient on a biologic means that the drug is not working.

“The main limitation of our study is that we haven’t worked out how well-controlled patients’ psoriatic arthritis is, so, although we know they’re on a biologic for more than 3 months, we don’t know if they were responding well to it.” But, even in the absence of systemic inflammation, he said, there are other potential causes for pain.

Methods for improving care, outreach to ethnic groups and immigrants outlined

The recommendations apply to axial SpA, peripheral SpA, and psoriatic arthritis as a group, Prof. van der Heijde said.

THE CHALLENGES OF TREATING rheumatic and musculoskeletal diseases (RMDs) in patients from different ethnic backgrounds, including those who have recently immigrated, are a central topic of this afternoon’s PARE Session on “Difficult to reach patient groups.”

A combination of poor awareness of RMDs and their causes, dissatisfaction with communication about the nature of a disease and its treatment, and differing beliefs about medicinal use can lead to nonadherence to treatment regimens prescribed by clinicians. These problems play a big part in racial and ethnic disparities that remain in many countries despite the availability of effective treatments for many RMDs.

Two of the presentations during this afternoon’s session will highlight efforts to boost the...
IN RHEUMATOID ARTHRITIS (RA),

AS IL-6 ELEVATES, THE EFFECTS GO BEYOND THE JOINTS

IL-6 = interleukin-6.

LEARN MORE ABOUT THE ROLE OF IL-6 IN RA AT BOOTH 41
FOR MORE INFORMATION, PLEASE VISIT www.arthritis-IL6.es*

*For Spanish healthcare professionals only.

EULAR 2017 poster tours: Thursday, Friday, Saturday

A total of 461 posters will be presented in 45 themed poster tours during Thursday, Friday, and Saturday. EULAR congress attendees who wish to attend a tour need to register for the tour at the poster tours and workshops desk located at the registration area. Tour attendance will be limited to 20 attendees per tour and will be determined on a first come, first served basis. Registration is only possible on the day of the poster tour itself.

THURSDAY, 15 JUNE
11:45 – 13:30
• From top to toe; health professional practice
• A stroll among the crystals
• Clinical features and treatment of orphan diseases
• Economical impact of biosimilars and discussing risks with patients
• Genetic basis, epigenetics, and genomics in disease
• Inflammatory mediators in rheumatic disease
• MTX, GCs, and JAK inhibitors in RA
• Novelty in the clinical approach to SLE, Sjögren’s, and APS I
• Outcomes across all rheumatology
• Paediatric Rheumatology
• Pathomechanism in SLE, SS, APS
• Progress in management of spondyloarthritis
• RA disease course and prognosis
• Rheumatology training and disease burden
• Vasculitides Clinical Aspects I
12:00 – 13:30
• PARE Poster Tour I

FRIDAY, 16 JUNE
11:45 – 13:30
• Imaging advances in arthritis – what is new?
• Indexes and predictors in systemic sclerosis and myositis
• New drivers in RA and SpA pathophysiology
• Novelty in the clinical approach to SLE, Sjögren’s, and APS II
• Osteoporosis risk assessment and treatment: new tools and new strategies
• Outcome in AxSpA: Does it matter?
• RA all over the body
• RA stromal cells – reloaded
• Risk factors for RMDs or comorbid conditions
• Scleroderma and myositis: etiology
• TNF inhibitors in RA – always and again
• Trends in non-TNF alpha biologicals for RA I
• Vasculitides Clinical Aspects II
• What’s new in orphan diseases
12:00 – 13:30
• PARE Poster Tour II

SATURDAY, 17 JUNE
10:15 – 11:45
• Nursing and daily practice
• A walk through PsA progress
• Comorbidities and outcomes in RMDs
• From the heart of rheumatology
• How B and T cells contribute to rheumatic disease
• Imaging advances in vasculitis, crystal, and connective tissue disease
• Infection related rheumatic disease: clinical and epidemiologic aspects
• Innate mediators and autoantibodies in rheumatic disease
• Last news on systemic sclerosis and myositis
• New treatment options in SLE, Sjögren’s, and APS
• RA – risk factors and consequences
• SSC, myositis, and rare diseases: etiology
• Steps forward in osteoarthritis research
• Trends in non-TNF alpha biologicals for RA II
Rheumatologists will hear a rallying cry to implement ultrasound and, in general, more modern imaging techniques at a session detailing recent EULAR projects in musculoskeletal imaging.

Dr. Christian Dejaco of the department of rheumatology at the Medical University of Graz (Austria) will start the session with a discussion of how ultrasound and modern imaging techniques are changing how rheumatologists find signs of giant cell arteritis (GCA).

“The use of ultrasound as a point-of-care tool in early access clinics for GCA provides immediate results and allows rapid diagnosis,” Dr. Dejaco said in an interview. “Ultrasound and, to a lesser extent, high resolution MRI have been extensively studied for the assessment of superficial temporal arteries revealing a high sensitivity and specificity to diagnose GCA.”

Dr. Dejaco will lay out best practices for clinicians who are unfamiliar with using such techniques in place of more widely known, and more frequently used, procedures.

“The most important obstacle to implement imaging as a point-of-care tool for the diagnosis of large- vessel vasculitis is lack of availability and expertise,” Dr. Dejaco said. “Apart from appropriate technical equipment that is required to achieve high-quality results, specific training in imaging of large- vessel vasculitis would be the first step toward a successful implementation of these recommendations in clinical practice.”

Dr. Dejaco hopes this will be a gateway toward a new chapter of diagnostic practices for rheumatologists, moving away from more invasive procedures like temporal artery biopsies.

“Imaging, and particularly ultrasound, lacks invasiveness, is readily available, provides immediate results, and enables the possibility to scan several vessels within the same visit,” Dr. Dejaco explained. “Besides, biopsy of extracranial arteries is usually not feasible, and temporal artery biopsy might be frequently false negative in patients.”

Dr. Dejaco believes these recommendations will be a good first step toward implementation, eventually becoming the gold standard for diagnosing GCA.

After hearing the practicality of ultrasound to test for GCA, attendees will be presented with an updated set of recommendations for the reporting of musculoskeletal ultrasound studies in rheumatology.

A specific focus on ultrasound imaging in pediatric rheumatology will come after, followed by a presentation delving into the specific characteristics of arthritis bone erosion.

The session will end with recommendations for the correct use of ultrasound in clinical practice, as well as standardised procedures in its implementation.

Dr. Dejaco reported receiving grant or research support from Pfizer, Merck Sharp & Dohme, and Esato and serving on the speakers bureau for Pfizer, Merck Sharp & Dohme, AbbVie, Celgene, UCB, Roche, Bristol-Myers Squibb, GlaxoSmithKline, Novartis, and Sandoz.

Imaging recommendations focus on ultrasound

Recommenations gain support Continued from page 1

Pain stymies PsA patients Continued from page 1

pain that should not be overlooked. “There’s no reason why PsA patients wouldn’t have pain due to tendinitis, enthesitis, and osteoarthritis – the same mechanical type joint pain that we see in the whole community of people over 40,” Prof. Conaghan said. “I am concerned that, once we give someone a label of inflammatory arthritis, we stop looking at all the other things that can happen to their musculoskeletal system.”

Moreover, he said, “people who’ve had arthritis severe enough to need a biologic treatment will have muscle deconditioning and weakness. It’s very common that PsA patients have trouble opening jars and getting out of chairs.”

Such weakness “can lead to mechanical joint pain, which fortunately can be improved – along with the pain – through muscle strengthening and rehabilitation.”

For their study, Prof. Conaghan and his colleagues collected information from clinicians on treatment and from patients. The questionnaires incorporated several measures of disability, pain, functional impairment, and health-related quality of life that have been validated for use in PsA patients.

Severe pain was significantly associated with increased use of prescription nonsteroidal anti-inflammatory drugs and opioids, as well as nonprescription pain medication. Patients 65 years and older had a significantly greater likelihood of being unemployed or retired because of PsA, they reported severe pain, compared with those reporting mild or moderate pain.

A number of quality of life and work-related measures were also significantly associated with pain severity.

Prof. Conaghan and his colleagues found that the risk of disability increased with bodily pain, and more severe pain was associated with greater activity impairment, worse social functioning, more work impairment, and work time missed, among other measures.

Prof. Conaghan reported financial relationships with AbbVie, Eli Lilly, Novartis, Pfizer, Bristol-Myers Squibb, and Roche. Some of his study coauthors have similar disclosures. Four coauthors are employees of Novartis.

CLINICAL SCIENCE SESSION
Treat-to-target in axSpA: Reality or utopia?

Thursday 13:30 – 15:00
Hall 8

Psa: A fascinating disease

Thursday 10:15 – 11:45
Hall 7A
Translating the Latest Knowledge in PsA...

...Into Daily Practice

Thursday, 15 June 2017
17:30 - 19:00    Room N101/N102

Description
This symposium will provide the latest insight on the management of the multiple manifestations of PsA, focusing on the therapeutic challenges associated with the heterogeneity of this disease and recent advances in capturing the patient’s perspective. At the conclusion of the symposium, patient case studies representative of the clinical challenges discussed throughout the program will be presented to demonstrate how inhibition of phosphodiesterase-4 can provide value in psoriatic arthritis.

Program Chair
**Dr. Jaime Calvo-Alén**
Head of Rheumatology
Hospital Universitario Araba
Basque Country, Spain

Program Faculty
**Prof. Carlo Selmi**
Head, Rheumatology and Clinical Immunology
Humanitas Research Hospital
University of Milan
Milan, Italy

**Dr. Kurt de Vlam**
Principal Investigator
University Hospital Leuven
Leuven, Belgium

**Prof. Dennis McGonagle**
Professor of Investigative Rheumatology
University of Leeds
Leeds, England

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Early inflammation predicts progression in axial SpA

Structural joint damage progresses moderately in patients with axial spondyloarthritis (SpA) and objective signs of inflammation may predispose these patients to radiographic sacroiliitis, according to a new DESIR cohort data analyses that will be presented in an abstract session this morning.

“We found a relatively low progression in the whole population. We expected 50%-70% of radiographic axial spondyloarthritis after 5 years of follow-up, and we observed only 20%,” Prof. Maxime Dougados, lead author of the two studies, said in an interview. “However, despite the fact that these data are suggesting that the risk of structural progression is low, we confirmed our initial hypothesis of the importance of inflammation observed at MRI of the sacroiliac joints to predict this radiographic progression, meaning that the presence of inflammation at baseline is an important predictor of subsequent structural damage and, consequently, functional disability in axial spondyloarthritis,” he said.

Prof. Dougados of the department of rheumatology at the Cochin Hospital, Paris, and his colleagues collected pelvic x-ray data at baseline and after 2 and 5 years in 416 adults with axial SpA of 3 years’ or less duration. The participants were part of the DESIR cohort, a 10-year longitudinal study conducted in France to follow adults with early inflammatory low back pain.

In a study evaluating changes in structural damage, the researchers measured radiographic structural joint damage progression in these patients by assessing the change in the total continuous score on the modified New York (mNY) grading scale (from 0 = normal to 4 = fusion) with scores from both sacroiliac joints combined. Over 5 years of follow-up, there was a “modest but highly significant” increase in score from 1.41 to 1.60 (P less than or equal to .0001).

The researchers also measured change across three different variables. They found that 5.1% of patients transitioned from nonradiographic to radiographic axial SpA according to the mNY criteria (defined as a change of at least a unilateral grade III or bilateral grade II). Another 13.6% experienced a change of at least one grade in at least one sacroiliac joint. There were also 10.2% of patients who had a change of at least one grade in at least one sacroiliac joint and an absolute final value of at least 2 in the worsened joint.

In addition, a review of these 416 participants in DESIR showed that 15% were considered radiographically positive for axial SpA at baseline, based on mNY criteria, and 6% changed from mNY negative to mNY positive after 5 years.

The factors that predisposed these individuals to radiographic progression at 5 years, according to a multivariate analysis, were the presence of bone marrow oedema on MRI of the sacroiliac joint (odds ratio, 4.85; 95% confidence interval, 2.95-7.97), together with a younger age (OR, 0.97; 95% CI, 0.94-0.99) and longer symptom duration (OR, 1.40; 95% CI, 1.04-1.89).

The key messages from the DESIR cohort are not only that the risk of structural progression in axial SpA is low but also that baseline sacroiliac joint inflammation seen on MRI is “the important predisposing factor of subsequent structural progression suggestion that an MRI of the sacroiliac joints should be performed systematically in patients presenting with a diagnosis of axial spondyloarthritis,” Prof. Dougados emphasised.

Avenues for additional research include a longer follow-up of the DESIR cohort, confirmation of the findings in other cohorts, and “translational research studies to better understand the correlations existing between inflammation and structural damage in axial SpA,” he added.

For more information about the DESIR cohort, visit www.lacohortedesir.fr.

Prof. Dougados had no financial conflicts to disclose.

CBT programme delivered by rheumatology teams can help combat rheumatoid arthritis fatigue

Cognitive behavioural therapy (CBT) delivered by a multidisciplinary clinical team helped patients with rheumatoid arthritis (RA) combat fatigue, according to results from a trial that will be reported in a Thursday morning Health Professionals in Rheumatology abstract session.

Although evidence has shown that biologic treatment can moderately reduce levels of fatigue experienced by people living with RA, it does not completely resolve the issue, Prof. Sarah Hewlett, Arthritis Research UK, Professor of rheumatology nursing at the Bristol (United Kingdom) Royal Infirmary, said in an interview.

Fatigue is common among RA patients and can adversely affect quality of life, as well as produce anxiety and worry because of family, friends, and employers’ poor understanding of its adverse effects.

Prof. Hewlett and her colleagues therefore set out to conduct the Reduction in Arthritis Fatigue – Clinical Teams (RAFT) study to determine if CBT delivered by members of the rheumatology clinical team could have a meaningful impact on RA-related fatigue, just as CBT has proven effective in managing fatigue when delivered by a clinical psychologist.

Prof. Hewlett and her colleagues randomized 308 patients with RA across seven rheumatology centres in the United Kingdom to a CBT programme delivered by a rheumatology nurse and occupational therapist pair or to usual care. The 26-week RAFT programme involved six weekly 2-hour group sessions and a consolidation session at week 14 of the study. It addressed links between thoughts, feelings, and behaviours (pacing, communication, sleep, stress). Patients were required to keep daily diaries of energy expenditure and weekly goal-setting. Usual care involved a 5-minute discussion of the Arthritis Research UK fatigue booklet.

Patients who received CBT had improvements in the impact of living with fatigue based on a Bristol Rheumatoid Arthritis Fatigue Numerical Rating Scales (BRAF-NRS) score at 26 weeks of 5.74, compared with 6.36 for usual care (which served as the trial’s primary outcome).

Regression analysis also revealed secondary outcomes in favour of RAFT, based on significant differences of –3.42 in BRAF Multi-Dimensional Questionnaire total fatigue score, –1.19 for Living with Fatigue score, –0.91 for Emotional Fatigue score, and 3.05 for RA self-efficacy.

“Such interventions have previously only been delivered by clinical psychologists. Therefore, it was very exciting to find that, after some brief training, and supported by a course manual, nurses and occupational therapists can also successfully help patients manage their fatigue,” Prof. Hewlett said.

The programme was also well received by patients: 99% said they would recommend the course to others.

The research team is continuing to follow the cohort to see if the intervention has an impact on RA-related fatigue over the long term.

They are also testing different ways of training teams to deliver the programme, Prof. Hewlett said. For example, the training is likely to be refined to two short online modules that will be completed before attending a 1-day, face-to-face training session.

“We are still refining the training to make it feasible within the current healthcare costs and systems, which are the main barriers to implementation,” she added.

Prof. Hewlett and her coauthors had no relevant disclosures.

HPR Abstract Session

Mind over matter – patients’ perspectives
Thursday 10:15 – 11:45
Room N101/N102
THE PATIENT’S PERSPECTIVE ON PsA

WHAT MORE CAN RHEUMATOLOGISTS DO TO OPTIMISE DISEASE MANAGEMENT?

SESSION 1:
UNDERSTANDING PsA FROM THE PATIENT’S PERSPECTIVE

SESSION 2:
OPTIMISING PsA CARE IN CLINICAL PRACTICE

SESSION 3:
RIsing TO THE CHALLENGE: PATIENT CASE STUDIES

EULAR 2017 | FERIA DE MADRID
FRIDAY, JUNE 16 | 8:15 AM—9:45 AM
ROOMS N117 & N118

JUAN GÓMEZ-REINO, MD, PhD—CHAIR
FUNDACIÓN RAMÓN DOMÍNGUEZ, SPAIN

ANA-MARIA ORBAI, MD, MHS
JOHNS HOPKINS ARTHRITIS CENTER, USA

LAURE GOSSEC, MD, PhD
PIERRE AND MARIE CURIE UNIVERSITY, FRANCE
Understand views, needs of patients from ethnic backgrounds to improve care

Continued from page 1

Care for services for the transition of young patients with rheumatic and musculoskeletal diseases (RMDs) from paediatric to adult care ought to take the unique needs of individual patients into account. Yet, evaluations that seek to identify the best aspects of transition programmes need to be more rigorous in order to improve their effectiveness, according to speakers who will discuss these issues at a joint health professionals, PARE, and paediatric rheumatology session this afternoon.

Wendy Olsder, the chair of Youth-R-Well.com – an organisation for young people with RMDs in the Netherlands – will speak about her own personal experience as a young adult with arthritis. “I was diagnosed with juvenile arthritis when I was 14 years old and transitioned from paediatric to adult care a couple of years ago,” she said. “Many young people feel nervous about this change. Health professionals have the power to ensure a smooth transition. Preparing patients is key to success.”

Both patients and health professionals have perceptions about the transition from paediatric to adult treatment. If these issues are not addressed, it can have a negative impact on the care and wellbeing of patients, Ms. Olsder said in an interview. “My presentation will address some of the main issues in this process using my personal story, as well as the experiences of patients from ethnic backgrounds, we can help improve the health outcomes. This session will provide the audience with insight into some solutions from the UK that might be helpful in order to improve satisfaction with information, disease engagement, and treatment adherence,” Dr. Kumar said. Treatment of RMDs in Sweden has also been challenged by increased immigration. Those fleeing repression and war elsewhere can find a safe haven in countries, including Sweden. But, their freedom does not include freedom from existing medical conditions. One approach is to contact immigrants during their integration into Swedish society to provide information on available medical services and treatments, according to Tidiane Diao, an International Liaison Officer at the Swedish Rheumatism Association (SRA), a nonprofit organisation headquartered in Stockholm. The strategy was first tried about 15 years ago. “In the early 2000s, we noticed an increasing number of immigrants reaching the Swedish shores due to the Iraqi war that affected the whole subregion. Having an RMD is hard enough for anyone. If the person is from another cultural background, this can be a disadvantage on the personal level. Many of these immigrants didn’t know about RMDs and had no clue how to handle it. In many cultures, RMDs are also seen as a divine curse, so people don’t talk about it. This may impair the relation between the individual and the society,” Mr. Diao explained in an interview. The SRA started a project with the aim of reaching out to immigrant women suffering from RMDs. “By informing them and giving them the tools to live their lives to the fullest in Sweden, the SRA participated indirectly to reduce the burden on the welfare system and also increased the number of our members and embraced the diversity in the organisation,” Mr. Diao stated. SRA did not take on these challenges alone. With state funding from a programme tailored for non-profits, SRA established a network of stakeholders, including health providers, employment offices, high schools, and an adult education association.

“The iconoclastic experience enriched the SRA and gave it a great knowledge of how to reach out to minority groups, giving them the tools to be fully part of society despite the burden of the RMDs,” Mr. Diao said. “Today, the SRA is cited as a reference in Sweden when it comes to reaching out to different minorities suffering from RMDs. Many organisations are now lining up to work with the SRA in these matters.” Neither Dr. Kumar nor Mr. Diao had any conflicts of interest to report.
PAH is a progressive disease!
Open the prostacyclin pathway with the only oral selective IP agonist

INDICATION
Uptravi is indicated for the long-term treatment of pulmonary arterial hypertension (PAH) in adult patients with WHO functional class (FC) II–III, either as combination therapy in patients insufficiently controlled with an endothelin receptor antagonist (ERA) and/or a phosphodiesterase type 5 (PDE-5) inhibitor, or as monotherapy in patients who are not candidates for these therapies.

Efficacy has been shown in a PAH population including idiopathic and heritable PAH, PAH associated with connective tissue disorders, and PAH associated with corrected simple congenital heart disease.

References:

To learn more, visit UPTRAVI.info.
Rheumatism Research Centre in Berlin will be discussing the evaluation of diverse transition interventions for patients with childhood-onset RMDs that persist into adulthood. "Transitional care services are complex interventions, which include several interacting components, have variable outcomes, and present problems for evaluators," Dr. Minden said in an interview. "There are also practical and methodological difficulties. "A key question in evaluating complex interventions is whether they are effective in everyday practice," she continued. "Therefore, it is important to understand how transitional care services work, what their active ingredients are, and how they exert their effects. Well-designed studies are needed to build an adequate body of evidence."

Dr. Minden will cover issues regarding questions asked in transition research. "More rigorous study design, dedicated funding, and inclusion of paediatric and adult researchers are needed to demonstrate the impact of transitional care," she explained. "In addition, the effectiveness of transition programmes and their elements has to be demonstrated. There are a variety of challenges, which I will discuss in my talk. "Another major barrier is the lack of a common and validated definition of transition success. Currently, there is no well-substantiated tool that measures transition readiness for transfer to adult care," she added. "Research needs are wide ranging and include both substantive and methodological concerns."

Attendees will learn about the current body of evidence on rheumatologic transitional care services, possible evaluation metrics, and future research needs. The presentation will also offer suggestions for putting transition programmes into practice and provide options for evaluation. "Despite widespread agreement on the importance of transition and need for adequate transition programmes, rigorous research is still limited," Dr. Minden stated. "Given the lack of reliable methodology in transition research, a joint initiative will be essential, ideally by EULAR and PReS, to agree to facilitate a standardised measurement approach, foster future research initiatives, and enable comparative assessment across Europe." Neither Ms. Olsder nor Dr. Minden have disclosures of interest.

"I was diagnosed with juvenile arthritis when I was 14 years old and transitioned from paediatric to adult care a couple of years ago. Many young people feel nervous about this change. Health professionals have the power to ensure a smooth transition. Preparing patients is key to success."
A New Era for Giant Cell Arteritis

Thursday 15 June 2017, 17:30–19:00, Hall 7B, IFEMA – Feria de Madrid

Food and refreshments will be served from 17:00

17:30–17:35 Welcome and introduction
Prof John H. Stone, USA (Chair)

17:35–17:55 Current and future GCA treatment options
Prof John H. Stone, USA

17:55–18:05 Exploring the diagnosis landscape
Dr Yara Banz, Switzerland

18:05–18:20 Harnessing innovation to guide diagnosis and management
Dr Andreas Diamantopoulos, Norway

18:20–18:35 Navigating the route to better outcomes for patients
Prof Georg Schett, Germany

18:35–18:45 Discussion: What do these data mean for clinical practice?

18:45–18:50 Summary: Towards a brighter horizon for GCA
Prof John H. Stone, USA

18:50–19:00 Question and answer session

From Evolution to Revolution in Treatment of RA Patients

Friday 16 June 2017, 08:15–09:45, N101/N102, IFEMA – Feria de Madrid

Food and refreshments will be served from 07:45

08:15–08:20 Welcome and introduction
Dr José María Álvaro-Gracia, Spain (Chair)

08:20–08:40 What can we learn from real-world data approaches with biologics?
Dr José María Álvaro-Gracia, Spain & Prof Leslie Harrold, USA

08:40–09:05 What RA treatment-related challenges do patients still face?
Moderator: Dr José María Álvaro-Gracia, Spain
Prof Andrea Rubbert-Roth, Germany & Prof Ernest Choy, UK

09:05–09:25 Exploring new opportunities for RA treatment
Dr David Lee, Switzerland

09:25–09:30 Summary
Dr José María Álvaro-Gracia, Spain

09:30–09:45 Question and answer session
Exhibitors' List

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EULAR Village Exhibitors’ List

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18th Annual European Congress of Rheumatology  // 14-17 June 2017  // Madrid
Study examines tapering strategy after rheumatoid arthritis remission on tocilizumab

Extending time between doses is a more effective way to taper tocilizumab than a dose reduction strategy for patients with remitted rheumatoid arthritis, according to research that will be presented this morning.

A number of studies have revealed that reduction of biological disease-modifying antirheumatic drugs is possible for some rheumatoid arthritis patients in whom these drugs have induced clinical remission or low disease activity," Dr. Yukitomo Urata of Tsugaru General Hospital in Goshogawara, Japan, said in an interview. "For tocilizumab, while there have been studies concerning tapering, there have been no studies regarding which tapering option is better in rheumatoid arthritis after clinical remission has been achieved. Should we use a dose reduction strategy (DRS) or an interval tapering strategy (ISS)?"

To investigate this issue, Dr. Urata and his colleagues assigned 57 RA patients in remission to the two tapering strategies: dose reduction and interval tapering.

Remission in these patients was classified by a unique twin target method, which Dr. Urata and his colleagues validated in a 2012 study (Ann Rheum Dis. 2012 Apr;71:534-40). The TREATing to Twin Targets (T-T) Study concluded that it was not only feasible, but desirable, to achieve both a disease activity score in 28 joints (DAS28) of less than 2.6 and normalisation of matrix metalloproteinase 3 (MMP-3) in patients for whom augmented therapy was required.

The investigators showed, in the subsequent T-T-4 study presented at last year’s EULAR congress, that dose reduction of either etanercept, abatacept, or tocilizumab proved noninferior to standard care in maintaining rheumatoid arthritis remission as defined by a simplified disease activity index (SDAI) of 3.3 or lower, as well as normalisation of MMP-3.

In the current study that Dr. Urata will present, patients receiving intravenous tocilizumab (n = 42) were assigned to the DRS group, which lowered the dose by 80 mg every 3 months to a minimum dose of 80 mg every 4 weeks.

Patients who received tocilizumab via subcutaneous injections (n = 15) were assigned to the ISS group that involved an increase in the period between injections by 1 week every month, up to a minimum dose of 162 mg every 6 weeks.

In both groups, if the target remission scores on SDAI and MMP-3 were exceeded, the dose reverted to the previous level that maintained remission. After stabilisation, patients attempted the taper again.

The primary outcome was the difference in the number of the times when a patient’s SDAI exceeded 3.3 across the four time points at 3, 6, 9, and 12 months. Over 12 months, 55 patients completed the trial. Results were consistently superior with the interval tapering strategy. Dr. Urata said. Patients on the ISS exceeded their SDAI scores significantly fewer times than did those using the DRS (0.9 vs. 2.4).

They also had a longer total duration of time in remission (7.4 vs. 3.9 months). The DRS group used a lower total tocilizumab dose than did the ISS group by the end of the study period (1,367 mg vs. 1,626 mg), but this was not statistically significant.

"Tocilizumab tapering with the ISS and using the twin targets as defined by the rT-4 study is an excellent strategy that is both safe and cost effective for RA patients who are both being treated with tocilizumab and have reached these targets," Dr. Urata said.

He had no financial disclosures.

Adding ultrasound is not associated with improved treat-to-target outcomes in rheumatoid arthritis

Subclinical, ultrasound-detectable synovitis has been shown to be predictive of disease flare in people with rheumatoid arthritis (RA), suggesting that ultrasound may have a role in defining treatment strategies, but recent trials integrating musculoskeletal ultrasound assessments into a treat-to-target protocol have not shown better outcomes than when standard clinical definitions of remission are used.

This afternoon, Dr. Alexandre Sepriano of Leiden (the Netherlands) University Medical Centre will add to the growing body of evidence that ultrasound remission may not be a helpful measure in establishing treat-to-target (T2T) strategies.

Dr. Sepriano and his colleagues set out to learn whether using ultrasound data in T2T would result in better outcomes by creating a combined new strategy using both ultrasound and clinical measures than does use of the established T2T strategy that uses only clinical data.

To do this, they looked at a subgroup of 130 patients from six countries treated at the BIODAM centers that had expertise in ultrasound. Patients’ clinical and ultrasound data were collected every 3 months through 2 years (for 963 visits in total) and were managed by rheumatologists under established T2T protocols.

As in the broader BIODAM study, the researchers used multiple clinical definitions of remission, including 28-joint and 44-joint Disease Activity Scores and the EULAR/American College of Rheumatology–Boolean criteria. For the ultrasound measure, they used the previously validated US-7, which looks at seven joints for signs of synovitis. Dr. Sepriano and his colleagues found that the combined clinical and ultrasound benchmark for T2T decreased the likelihood of clinical remission after 3 months by 61% when compared with the conventional strategy of T2T using clinical remission measures.

The reasons for this finding are difficult to discern, Dr. Sepriano said, and are complicated by the fact that this study was not a randomized, controlled trial but a longitudinal cohort in real-world practice settings.

Given the many variables involved, Dr. Sepriano said, "it may be not entirely linear to have an explanation as to why, when we used ultrasound, we actually got worse results."

But, he noted, results from two randomized trials in more restricted populations of RA patients have also shown no benefit from adding ultrasound.

"What the data is telling us is that the clinician should be encouraged to use clinical data in his or her decisions – so we stress the importance of following a T2T strategy according to clinical data," Dr. Sepriano said. "Adding ultrasound may not be an advantage in this scenario."

Dr. Sepriano and his associates had no conflicts of interest to declare.
Young RMD patients need employment support

College graduates and young working professionals with rheumatic and musculoskeletal diseases (RMDs) are ready to work. They just need some help, according to speakers at a PARE session this afternoon.

The session will feature speakers deeply involved in creating programs to help young people with RMDs navigate through the complex nature of being in the workforce with an RMD.

Attendees will first hear from Leili Kullamaa, a patient advocate, as she opens a window into RMD patient advocacy, specifically a meeting she recently helped organise.

“The workshop came together as a common idea of the European Patients' Forum Youth Group and European Multiple Sclerosis Platform Youth Group,” Ms. Kullamaa said in an interview. “We felt that the topic of young people with chronic conditions in the labour market is not often addressed.”

Along with a recount of her workshop, Ms. Kullamaa will also touch on some of the challenges facing young people with RMDs while trying to secure a job.

“I hope that the audience will take away ideas on how to help solve the situation on the national and international level within their own field and generally,” Ms. Kullamaa said.

Next, Jeanette Andersen, a youth leader and advocate, will delve deeper into the stigmas of young professionals with RMDs and the hurdles these patients must overcome.

“It is often a problem for young people with RMDs that they have to take off time from work for doctor appointments, blood tests, or disease activity, which makes them ‘bad’ or ‘unstable’ workers in the eyes of their coworkers and employer,” Ms. Andersen said in an interview. “I hope to bring attention to a problem that means a lot to most young people with RMDs.”

Ms. Andersen will also explore the strengths and shortcomings of some of the current legislation that has been enacted to curb discrimination against those with an RMD.

Maureen McAllister, manager of the Joint Working Service at Arthritis Care Scotland, will speak about some of the support systems in place that are already helping young RMD patients and the importance of both medical and nonmedical therapy.

“The Joint Working Service offers employability guidance, support, information, and signposting and is funded within Arthritis Care,” Ms. McAllister said in an interview. “Complementing medical treatments with access to condition-specific services, which have a good understanding of the impact of the condition, can help people with arthritis to increase their capacity, confidence, and resilience in managing everyday life and work issues.”

The speakers hope those who attend the session will gather insight into the help that patients need beyond just medical intervention and how the effects of RMDs are not just medical.

“With a partnership approach, organisations such as Arthritis Care can complement the work of health professionals, thus improving the prospects of people with RMDs to work well with arthritis,” Ms. McAllister said.

None of the speakers had conflicts of interest to declare.

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EULAR Live Courses 2017/18

- EULAR Ultrasound Courses - Basic, Intermediate, Advanced levels plus Paediatric US course
- EULAR Course for Ultrasound Trainers in Rheumatology
- EULAR Course on Epidemiology
- EULAR Postgraduate Course
- EULAR Course on Immunology
- EULAR Course on Capillaroscopy
- EULAR Imaging Course
- EULAR Course on Health Economics on Rheumatology
- EULAR Seminar on Teaching and Learning

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Tailored exercise can produce positive effects on patients’ comorbidities

A Health Professionals session this afternoon aims to impart the importance of exercise in combating the comorbidities that often accompany patients with rheumatic diseases despite treatment with disease-modifying antirheumatic drugs. Three presentations will focus on the positive effects of exercise on patients with comorbidities.

Arja Helena Häkkinen, PhD, of the University of Jyväskylä in Finland will speak about why there is still comorbidity in patients despite new drugs. “Nowadays, treatment and prevention in the healthcare system is too often concentrated on single diseases,” Dr. Häkkinen said. However, people are living longer and may have sedentary lifestyles and obesity. Comorbidity is reported in 35%-80% of all ill people.

“Given that the resources of the healthcare system and society are limited, we need new strategies to encourage people with comorbidities toward proper self-management and physical activity,” she continued. “There are many barriers and beliefs that may prevent people from exercising. People with rheumatoid arthritis may think that exercise will make the disease worse and add to flares. People with heart disease may think they should take it easy.”

In an interview, Dr. Häkkinen said the goal of her presentation is to highlight the importance of exercise in patients with comorbidities and demonstrate the beneficial effects that a properly designed exercise intervention can have on a specific population. “Physical activity in its different forms has numerous preventive and curative effects in most diseases as a supplement to medication,” Dr. Häkkinen explained. “Thus, it should be an integral part of the comprehensive and multidisciplinary treatment.

“Usually higher intensity training is more effective, so patients need professional help, at least in the beginning of their exercise programme,” she added. “However, the target is that patients will learn to modify their programme according to changes in their disease activity and symptoms.”

Prof. Hanne Dagfinrud of Diakonhjemmet Hospital in Oslo will speak about how to prevent and treat cardiovascular comorbidity with exercise. “Patients with inflammatory rheumatic diseases have an increased risk for cardiovascular disease, compared with the healthy population,” she said. “Therefore, it is particularly important that these patients benefit from the risk-reducing effect of exercise. Cardiovascular disease is a serious comorbidity in inflammatory rheumatic diseases. Thus, it is worthwhile to focus on reducing risk factors.”

Prof. Dagfinrud explained in an interview. “Exercise has well-known positive effects on cardiovascular health in the general population, and it is likely that also patients with rheumatic diseases can benefit from these effects.”

Prof. Dagfinrud will focus on the possible untapped potential of exercise as treatment for patients with rheumatic diseases. “I am hopeful that people will leave the session with the knowledge that exercise is important in the management of these patients.”

Mariëtte de Rooij, PhD, of the Reade Centre for Rehabilitation and Rheumatology in Amsterdam will discuss comorbidity-adapted exercise for patients with knee osteoarthritis. “Comorbidity in patients with knee osteoarthritis (OA) is highly prevalent. Studies have reported comorbidity rates of 68%-85%, which may interfere with application of exercise therapy, contribute to nonadherence, and affect the outcome of exercise therapy,” Dr. de Rooij said in an interview.

“Dr. de Rooij will offer a strategy (i-5 strategy) on how to develop comorbidity-related adaptations to exercise therapy on an index disease. “We have developed a tailored exercise programme for patients with knee OA and comorbidity,” she said. “I will be discussing the results of a randomised, controlled trial in which we tested the efficacy on physical functioning and the safety of tailored exercise therapy on such patients. I will also briefly cover how to implement the protocol in primary care. “Patients should be viewed in their entirety, with consideration of integrated body structures, functions, and activities as a whole, rather than as separate elements,” she continued.

“Their results should encourage clinicians to consider exercise therapy as a treatment option for patients with knee OA, even in the presence of severe comorbidity,” she said.

Dr. Häkkinen, Prof. Dagfinrud, and Dr. de Rooij have no disclosures of interest.

Variability in juvenile idiopathic arthritis clarified in EPOCA study

The epidemiology of juvenile idiopathic arthritis (JIA) varies worldwide, with a wide disparity in the prevalence of the diverse disease subtypes and variability in treatment across different geographic areas, according to findings from the cross-sectional, multinational Epide-
New strategies for remission induction take shape

Researchers who are testing some of the newest approaches to inducing long-lasting remission and potentially curative treatment for autoimmune diseases will discuss the rationale and experience behind the new methods and the questions they have raised in a basic and translational science session this afternoon. Two of the strategies in particular have garnered attention: targeting pathogenic memory cells for elimination and turning antigen-presenting cells into tolerogenic cells.

Hyun-Dong Chang, PhD, of the German Rheumatism Research Centre in Berlin will speak about the role of pathogenic memory cells as roadblocks to tolerance induction. “During my presentation,” Dr. Chang said, “I will discuss why conventional immunosuppressive therapies, in most cases, do not lead to therapy-free remission.” These therapies can lead to significant improvement in patients suffering from rheumatic diseases but are rarely curative.

“Current therapies mostly aim at blocking secreted products, activation of immune cells, or cell proliferation,” he explained. “But, many memory cells do not divide or require activation for function, so they are not affected. As a result, they can drive inflammation despite therapy or cause relapse if therapy is stopped.”

The presentation will provide evidence that it may be essential to eliminate these pathogenic memory cells in order to restore immunological tolerance for rheumatic disease patients. “Our proof of principle comes from clinical trials where the immune systems of patients are completed ablated followed by restoration of the immune system with autologous hematopoietic stem cells,” Dr. Chang stated. “The result is that the entire immunological memory is lost, and many patients achieve long-term therapy-free remission.”

In an interview, Dr. Chang said that he will cover current approach es and plans to address the selective targeting of the pathogenic memory cells, based on current knowledge of these cells’ lifestyles. “I hope my talk will raise awareness about the shortcomings of current therapies,” he said. “I also expect that it will increase knowledge about novel developments for therapies, especially those aimed at cure and long-term restoration of immunological tolerance against autoantigens by considering the presence of existing immunological memory for the inflammation.”

Another talk will focus on how antigen-presenting cells can be turned into tolerogenic cells. John D. Isaacs, PhD, of the Institute of Cellular Medicine at Newcastle (United Kingdom) University will share the experience of his team in creating and testing tolerogenic antigen presenting cells in the clinic.

The team has developed a therapeutic approach based on autologous tolerogenic dendritic cells, which they derive from circulating peripheral blood monocytes. “I will be discussing several key issues that have been raised as part of our work,” Dr. Isaacs said. “These include, How do we ensure the cells’ stability and safety? Which autoantigen(s) should we choose? What route should be used to administer them? And, how should we monitor their effectiveness?”

The presentation will raise awareness of the potential of tolerogenic therapies in general and tolerogenic presenting cell therapies in particular. “These treatments can lead to the concept of prevention, or even cure, of arthritis,” he said in an interview.

Dr. Isaacs further noted, “There remains a need for therapies that can regulate the disordered immune response in rheumatoid arthritis and other immunological diseases.” He continued, “Targeting the antigen-presenting cell, T cell interaction using cellular therapies, is one way to tackle this problem.”

Neither Dr. Chang nor Dr. Isaacs has disclosures of interest.
B- and T-cell receptor clones contribute to rheumatoid arthritis development and progression

B- AND T-CELL RECEPTOR clones are playing a key role in the initiation and progression of rheumatoid arthritis, according to a pair of studies that will be presented this morning. In one study, B-cell receptor (BCR) clonal changes were significantly associated with RA development. In a second study, T-cell receptor (TCR) clones present in early RA also were present at the preclinical stage.

The presence of specific autoantibodies in the absence of synovial inflammation generally occurs before the onset of seropositive RA, noted Marieke Doorenspleet, MD, of the Amsterdam (the Netherlands) Rheumatology and Immunology Centre.

Previous research has shown that “rheumatoid arthritis is not only taking place once a patient develops arthritis but that it is preceded by a phase of systemic autoimmunity in which antibodies can already be present,” Dr. Doorenspleet said in an interview. “It was acknowledged that this is a very favorable period to start treatment, in an effort to prevent irreparable damage to the joints, shorten the treatment time, and potentially provide cure. Unfortunately, there was not a single marker to identify individuals that will develop RA in this at-risk stage,” she said. “Therefore, we set out to study the [BCR] repertoire in these at-risk individuals and follow them over time, in order to learn more about the pathogenesis of RA and develop a marker for early detection of those patients who will eventually develop RA. This will hopefully fuel further studies and clinical trials to improve the treatment of RA patients in this at-risk phase,” she explained.

Dr. Doorenspleet and her colleagues conducted a prospective cohort study of 21 adults at increased risk for RA and 10 healthy individuals. The presence of five or more dominant BCR clones in paired peripheral blood and synovial tissue samples was associated with the development of arthritis. This risk factor was also validated in the peripheral blood of an independent set of 50 at-risk individuals. Both cohorts together showed that the presence of five or more dominant BCR clones in peripheral blood was associated with a sixfold increased risk of arthritis development (relative risk, 6.3). The test proved to be accurate in predicting arthritis in at-risk individuals even after adjustment for the results of a recently described clinical prediction rule (RR, 5.0; P = .024).

“We found that, if our test is positive in an at-risk individual with positive antibodies and either positive family history or arthralgia, there is an 83% chance of developing RA within 3 years,” Dr. Doorenspleet said. “We hope that we and others can build on these findings to unravel the exact pathogenesis of RA and ultimately be able to cure the disease,” Dr. Doorenspleet said. “Obvious next steps are to study the effect of differ-
RA, first author Giulia Balzaretti, are at increased risk of contracting arthritis if they developed arthritis within 27 months of their baseline sample. Four of the participants had seropositive samples from the synovial biopsy. The researchers identified T-cell clones using RNA-based sequencing. The T-cell repertoire was already present in the blood during the at-risk phase and may help to discover novel early disease markers.

The researchers examined whether the same research findings apply to patients who developed arthritis. Ms. Balzaretti, who presented the study, was surprised by some of the results. In contrast to previous findings on B cells, TCR repertoire in the seropositive at-risk stage was relatively constant. This finding might indicate that changes in the TCR repertoire happen earlier, even before the seropositive arthralgia stage. Ms. Balzaretti said. Furthermore, our findings suggest these synovial T cells might have a regulatory role. These observations put in the spotlight T-cell clones that could have a direct role in the pathophysiology of RA. These clones need further characterisation regarding their potential regulatory activity, phenotype, and genomic makeup.

The researchers conducted a prospective study of 55 adults with arthritis who were seropositive for immunoglobulin M rheumatoid factor and/or anticitrullinated peptide antibody. They identified TCR clones using RNA-based sequencing. The researchers compared blood samples from the synovial biopsies of four of the participants at baseline and after development of arthritis. The average time to the development of arthritis was 27 months.

"Patients with arthralgia and anti-CCP and/or IgM-RF autoantibodies are at increased risk of contracting RA," first author Giulia Balzaretti, a PhD candidate at the Amsterdam Rheumatology and Immunology Centre, said in an interview. "Investigation in this at-risk phase has the potential to gain more insight into the immunological changes that accompany onset of arthritis and may help to discover novel early disease markers," she said. Just as the results in the other study from the researchers showed that dominant B-cell receptor (BCR) clones circulate in the peripheral blood during the at-risk phase and can predict the onset of arthritis, "we assumed that – given the pivotal role of T cells in the immune response – also the [TCR] repertoire would undergo drastic changes during the clinical onset of arthritis," she said. Ms. Balzaretti, who will present the study, said she was surprised by some of the results. "In contrast to previous findings on B cells, a TCR repertoire was already present in the at-risk phase of RA suggest that, at the time of onset of arthritis, evident changes in the synovium in the B-cells influx and/or differentiation are observed, whereas the T-cell receptor repertoire is relatively constant. This finding might indicate that pathogenic changes in the TCR repertoire happen earlier, even before the seropositive arthralgia stage," she added.

Dr. Doorenspleet and Ms. Balzaretti and most of their colleagues had no financial conflicts to disclose. Two authors on both studies are employees of GlaxoSmithKline.

**ABSTRACT SESSION**

**Cellular drivers of inflammation in rheumatic disease**

**Thursday 10:15 – 11:45**

**Room N107/N108**
Satellite Symposia Programme // Thursday, 15 June

08:15-09:45 // Hall 6 // AbbVie

**Non-infectious uveitis: Beyond the joints – a vision for all**

Chairperson: James T. Rosenbaum (United States)

08:15 James T. Rosenbaum (United States)

Welcome and introduction: how do we create a vision for all?

08:25 Andrew D. Dick (United Kingdom)

A dual perspective, from fundamental science to the clinic: the uveitis specialist’s view

08:40 Athimalaipet V. Ramanan (United Kingdom)

Keeping an eye on our paediatric patients: the rheumatologist’s view

08:55 Antoine P. Brézin (France)

Near and distant vision: treatment goals in adult non-infectious uveitis

09:10 James T. Rosenbaum (United States)

Establishing the evidence base for the management of non-infectious uveitis: the importance of co-management

09:25 All

Roundtable discussion: optimizing the care of rheumatologic patients with ocular manifestations

08:15-09:45 // Hall 8 // Novartis Pharmaceuticals

**IL-17A Inhibition: a paradigm shift in the management of axial spondyloarthritis**

Chairperson: Denis Poddubny (Germany)

08:15 Denis Poddubny (Germany)

Welcome and introductions

08:20 Denis Poddubny (Germany)

Marco Garrido-Cumbra (Spain)

Axial spondyloarthritis: the physician versus patient perspective

08:35 Dirk Elewaut (Belgium)

Pathophysiology of axial spondyloarthritis: the role of IL-17A in inflammation, enthesisitis, and new bone formation

08:55 Xenofon Baraliakos (Germany)

An update on IL-17A inhibitors in clinical trials: latest data

09:15 Atul Deodhar (United States)

Remission in axial spondyloarthritis: a realistic treatment target?

09:35 All

Panel discussion: what does this mean for our patients?

08:15-09:45 // Hall 7A // Lilly

**Redefining expectations for patients living with rheumatoid arthritis: the role of JAKs inhibition and baricitinib**

Chairperson: José M. Álvaro-Gracia Álvaro (Spain)

08:15 José M. Álvaro-Gracia Álvaro (Spain)

Welcome and introduction

08:20 Paul Emery (United Kingdom)

Perceptions of the burden for a rheumatoid arthritis patient: is it really all about inflammation?

08:35 Peter Taylor (United Kingdom)

An unconventional journey to the center of the cell

08:50 Maxime Dougdados (France)

The current evidence of the efficacy/safety profile of baricitinib in rheumatoid arthritis

09:05 Josef S. Smolen (Austria)

EULAR updated rheumatoid arthritis management recommendations: what’s new?

09:20 José M. Álvaro-Gracia Álvaro (Spain)

Panel discussion and Q&A

09:45 Symposium close

08:15-09:45 // Hall 7B // Bristol-Myers Squibb

**Role of co-stimulation in adaptive immunity and autoimmune diseases**

Chairperson: Juan Gómez-Reino (Spain)

08:15 Juan Gómez-Reino (Spain)

Welcome and introduction

08:17 Tom Huizinga (Netherlands)

Co-stimulation and pathophysiologic drivers of clinical outcomes in RA

08:42 Georg Schett (Germany)

The molecular pathophysiologies underlying erosive arthritis

09:07 Gregg Silverman (United States)

The impact of co-stimulation in autoimmune diseases with unmet needs

09:32 All

Panel discussion and Q&A

08:15-09:45 // N103/N104 // Pfizer

**The biologic conversation: talking originators and biosimilars**

Chairperson: Robert J. Moots (United Kingdom)

Panel: Eduardo Mylser (Argentina)

Mark Genovese (United States)

Ronald Van Vollenhoven (the Netherlands)

08:15 Robert J. Moots (United Kingdom)

Welcome and introduction

08:30 Talking originator biologics and biosimilars

• How can the critical roles of the physician and patient as treatment decision makers be maintained?

• What do physicians need to know with respect to biologic and biosimilar clinical data?

• How can real-world data support decision making?

• What factors need to be considered when making switching decisions?

09:30 Unanswered questions

09:40 Robert J. Moots (United Kingdom)

Summary and close

08:15-09:45 // N101/N102 // medac

**Current trends and future perspectives of MTX – Do you really know it all?**

08:15 Ulf Müller-Ladner (Germany)

Welcome and introduction

08:20 Ulf Müller-Ladner (Germany)

Optimizing the current RA treatment paradigm and the benefit in daily practice

08:40 Carter Thorne (Canada)

Implementing clinical guidelines and optimizing outcomes in RA - learning from CATCH

09:00 Pavla Dolezalova (Czech Republic)

Is there a place for conventional disease modifying drugs in the treatment of paediatric rheumatic diseases in biologic era?

09:20 Jaime Calvo-Alén (Spain)

New recommendations for the optimal use of parenteral MTX

08:15-09:45 // N105/N106 // Amgen

**Biosimilars in rheumatology: Are we comfortable or cautious?**

Chairperson: Thomas Dörner (Germany)

Welcome and introduction

Ferdinand Breedveld (the Netherlands)

Are we reassured by the current regulatory approval approach to biosimilars?

Tore K. Kvien (Norway)

Are we confident about switching to biosimilars in our patients?

Jonathan Kay (United States)

Are we comfortable with indication extrapolation of biosimilars in clinical practice?

Thomas Dörner (Germany)

Concluding comments and close

08:15-09:45 // N117/N118 // GSK

**Optimising SLE disease management: a patient-centric case-based workshop**

Chairperson: Roger Levy (Brazil)

08:15 Roger Levy (Brazil)

Chairman’s welcome

08:20 Roger Levy (Brazil)

Introduction

08:40 Ioannis Parodis (Sweden)

Detailed examination of case study

09:40 Roger Levy (Brazil)

Summing up and concluding remarks

08:15-09:45 // N111/N112 // Grunenthal

**Time to control gout and make it crystal clear**

Chairpersons: Fernando Perez Ruiz (Spain)

Thomas Bardin (France)

Alexander So (Switzerland)

Do you think you know gout? Time to rethink

Chairperson: Fernando Perez Ruiz (Spain)

08:15 Tillman Uhlig (Norway)

Epidemiology and pathogenesis: a common disease with genetic predisposition

08:25 Thomas Bardin (France)

Disease burden and comorbidities: a chronic disease with serious consequences

Treating to target? Challenges galore

Chairperson: Thomas Bardin (France)

08:40 Pascal Richette (France)
Current treatment guidelines and clinical practice

08:50 Alexander So (Switzerland)
Unmet medical needs and limitations of current treatments
Lesinurad: the start of a new era
Chairperson: Alexander So (Switzerland)
09:05 Fernando Perez Ruiz (Spain)
Lesinurad - a novel, selective uric acid reabsorption inhibitor
09:15 Thomas Bardin (France)
Lesinurad clinical development programme
09:35 All
Q&A

17:30-19:00 // Hall 8
Sanofi Genzyme & Regeneron
Moving past first biologic failure in rheumatoid arthritis: the great switch/cycle debate
Chairperson: Ronald van Vollenhoven (the Netherlands)
17:30 Ronald van Vollenhoven (the Netherlands)
Welcome and introductions
17:35 Juan J. Gómez-Reino (Spain)
Understanding the clinical question
17:45 Andrea Rubbert-Roth (Germany)
The case for cycling to another anti-TNF agent
18:00 Jacques-Eric Gottenberg (France)
The case for switching to an agent with an alternative MOA
18:15 Andrea Rubbert-Roth (Germany)
Cycling to another anti-TNF: the rebuttal
18:20 Jacques-Eric Gottenberg (France)
Switching to an alternative MOA: the rebuttal
18:25 All moderated by Ronald van Vollenhoven (the Netherlands)
Moderated discussion with faculty and audience Q&A
18:50 Ronald van Vollenhoven (the Netherlands)
Close

17:30-19:00 // Hall 7A
AbbVie
Deep dive into SpA: the way to an integrative approach
Chairperson: Walter P. Maksymowycz (Canada)
17:30 Walter P. Maksymowycz (Canada)
Welcome and introduction - the many faces of SpA
17:40 Ernest Seidman (Canada)
Gut inflammation in SpA: significance and treatment implications
17:55 Miguel Cordero-Coma (Spain)
Integrative management of anterior uveitis in the patient with SpA
18:10 Wolf-Henning Boehncke (Switzerland)
The dermatologist’s perspective on collaborative care in patients with PsA
18:25 Walter P. Maksymowycz (Canada)
How can integrative management enhance the care of patients with SpA?
18:40 All
Participant engagement and panel response
17:30-19:00 // Hall 7B
Roche
A new era for giant cell arteritis
Chairperson: John H. Stone (United States)
17:30 Opening patient video ‘Living with GCA’
John H. Stone (United States)
17:35 Introduction
17:40 John H. Stone (United States)
Future GCA treatment options
18:00 All faculty address key topics, using slides where necessary to back up opinion
Discussion: What do these data mean for clinical practice?
18:10 Yara Banz (Switzerland)
Exploring the diagnosis landscape
18:19 Andreas Diamantopoulos (Norway)
Harnessing innovation to guide diagnosis and management
18:32 Georg Schett (Germany)
Navigating the route to better outcomes for patients
18:45 John H. Stone (United States)
Summary: Towards a brighter horizon for GCA
18:50 All
Moderated by John H. Stone (United States)
Question and answer session

Continued on following page
Continued from previous page

17:30-19:00 // N103/N104
Celtrion Healthcare

Expanding the horizon of rheumatic disease treatment through compelling biosimilars
Chairperson: Tore K. Kvien (Norway)
17:30 Tore K. Kvien (Norway)
Evolution of biosimilar perception
17:40 Tore K. Kvien (Norway)
Another step towards evidence based switching_NOR-SWITCH
18:00 DaeHyun Yoo (Korea)
Taking the first step with the 1st biosimilar rituximab
18:20 Balsa Alejandro (Spain)
A new level of evidence seen through therapeutic drug monitoring
18:40 All
Panel discussion

17:30-19:00 // N101/N102
Celgene

Translating the latest knowledge in PsA into daily practice
Chairperson: Jaime Calvo-Alén (Spain)
17:30 Jaime Calvo-Alén (Spain)
Introduction to the complexity of PsA
17:35 Carlo Selmi (Italy)
Clinical challenges of PsA in daily practice
18:00 Kurt de Vlam (Belgium)
Partnering with patients to guide therapy decisions
18:25 Dennis McGonagle (England)
Real-world clinical experience
18:45 Question-and-answer panel

17:30-19:00 // N105/N106
MSD

Shaping long-term outcomes: how to ensure durable disease control in rheumatic diseases
Chairperson: Josef S. Smolen (Austria)
17:30 Josef S. Smolen (Austria)
Welcome and Introductions
17:35 Josef S. Smolen (Austria)
Long-term management of patients with rheumatic diseases: achievements from the past and lookout for the future
17:55 Roberto Caporali (Italy)
Choosing the right treatment for our patients: making our first choice count
18:15 Xenofon Baraliakos (Germany)
Integrating patients’ needs and therapeutic strategies
18:35 Faculty
Panel discussion & Question-and-answer session

17:30-19:00 // N111/N112
UCB

Breaking the fragility fracture cycle: Can we step up to the challenge?
17:30 Serge Ferrari (Switzerland)
Welcome and introduction
17:35 Piet Geusens (Belgium)
Who manages patients with a recent fragility fracture?
18:00 Bente Langdahl (Denmark)
How can we do better to heed the warning of the first fragility fracture?
18:30 Peter Taylor (United Kingdom)
Stepping up to the challenge - are there learnings from rheumatoid arthritis?
18:50 Serge Ferrari (Switzerland)
Questions, summary and close

17:30-19:00 // N117/N118
GSK

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Chairperson: Roger Levy (Brazil)
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Detailed examination of case study
18:55 Roger Levy (Brazil)
Summing up and concluding remarks

EULAR Congress Dinner at the Castle of Viñuelas

Friday, 16 June 2017 20:30-24:00
Price: EUR 95 per person (not included in the registration fee)

Over the years, the EULAR Annual European Congress of Rheumatology has set the Congress Dinner as a traditional event offering a unique opportunity to meet and network with friends and colleagues from around the world in a relaxed atmosphere, enjoying the unmatched charm of the different venues and artistic performances selected.

In this special anniversary year, the EULAR Congress Dinner will take place in a special location, the historical Castle of Viñuelas, located in the north of the city of Madrid.

You will enjoy a wonderful experience full of local flavours in this incredible venue surrounded by meadow-oak forest within a protected natural area, allowing the observation of wild animals and birds at close range.

Come and celebrate EULAR’s 70th anniversary with us and enjoy the impressive grounds of this property taking you back to the 17th century.

Don’t miss this exceptional chance to experience the culture of Madrid and Spain and get to know other attendees!

Tickets are available in the registration area.

EULAR Congress News // Thursday Edition
An authorised publication of the European League Against Rheumatism

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18th Annual European Congress of Rheumatology // 14-17 June 2017 // Madrid
PRESCRIBING INFORMATION MabThera® (rituximab) in rheumatoid arthritis (RA), granulomatosis with polyangiitis (GPA), and microscopic polyangiitis (MPA):

Please refer to MabThera 100mg & 500mg concentrate for solution for infusion SPC for full prescribing information

Indications: RA: MabThera, in combination with methotrexate, is indicated for the treatment of adult patients with severe active rheumatoid arthritis who have had an inadequate response or intolerance to other DMARDs including one or more TNF inhibitor therapies. MabThera has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve functional status, when given in combination with methotrexate. GPA and MPA: MabThera, in combination with glucocorticoids, is indicated for the induction of remission in adult patients with severe, active Granulomatosis with Polyangiitis (Wegener’s) (GPA) and Microscopic Polyangiitis (MPA)

Dosage and administration: Patients must be given the patient alert card with each infusion. Administer through a dedicated line, with full resuscitation facilities immediately available in case of severe infusion related reactions (IRRs). Monitor for cytokine release syndrome. Interrupt infusion if severe reactions occur. Premedicate with analgesics/antipyretic and anti-histamine before each infusion. RA: Recommended dose is 1000 mg iv infusion on day zero and a second 1000 mg iv infusion two weeks later. Premedication with 100 mg methylprednisolone should be completed 30 minutes prior to each infusion. First Infusion: Initial rate 50mg/hour, after 30 minutes this can be escalated by 50 mg/hour increments every 30 minutes to a maximum of 400 mg/hour. Second and subsequent Infusion: Initial rate 100mg/hour, with 100 mg/hour increments every 30 minutes to a maximum of 400 mg/hour. Alternative faster infusion option (4mg/mL in 250mL infusion volume) for increments every 30 minutes to a maximum of 400 mg/hour. Pneumocystis jiroveci pneumonia (PCP) prophylaxis recommended during and following MabThera as appropriate. In RA, concomitant use of MabThera and antirheumatic therapies other than those specified is not recommended. Limited data suggest the rate of clinically relevant infection is unchanged following sequential use of DMARDs including biologics after MabThera.

Pregnancy and Lactation: Avoid pregnancy or breastfeeding and use effective contraception during and for 12 months following treatment.

Undesirable effects: Consult SPC for full details of Adverse Drug Reactions (ADRs). Cases of posterior reversible encephalopathy syndrome (PRES) / reversible posterior leukoencephalopathy syndrome (RPLS) and toxic epidermal necrolysis (Lyell’s Syndrome), Stevens-Johnson Syndrome reported. RA: Very common: infusion related reactions (hypertension, nausea, rash, pyrexia, pruritus, urticaria, rhinitis, throat irritation, hot flush, hypertension, rigors, tachycardia, fatigue, oropharyngeal pain, peripheral oedema, erythema), upper respiratory tract infection, urinary tract infections, headache, decreased IgM levels. Common: Bronchitis, sinusitis, gastroenteritis, tinea pedis, hypercholesterolemia, parasthesia, migraine, dizziness, sciatia, alopecia, depression, anxiety, dyspnea, diarrhoea, gastro-oesophageal reflux, mouth ulceration, upper abdominal pain, arthralgia/musculoskeletal pain, osteoarthritis, bursitis, neutropenia, decreased IgG levels. Uncommon: IRRs (generalised oedema, bronchospasm, wheezing, laryngeal oedema, angioneurotic oedema, generalised pruritus, anaphylaxis, anaphylactoid reaction) Rare: Angina pectoris, atrial fibrillation, heart failure, myocardial infarction, late neutropenia. Very rare: PML, reactivation of hepatitis B, serum sickness-like reaction, atrial flutter. GPA and MPA: ADRs occurring in ≥ 25% of patients receiving MabThera in a clinical study: thrombocytopenia, diarrhoea, dyspepsia, constipation, peripheral oedema, cytokine release syndrome, urinary tract infection, bronchitis, herpes zoster, nasopharyngitis, decreased haemoglobin, hyperkalaemia, muscle spasms, arthralgia, back pain, muscle weakness, musculoskeletal pain, pain in extremities, dizziness, tremor, insomnia, cough, dyspnoea, epistaxis, nasal congestion, acne, hypertension, flushing. Also reported: IRRs, infections (including pneumonia), tachycardia, atrial fibrillation, hepatitis B reactivation (some fatal), hypogammaglobulinemia, neutropenia.

Legal category: POM

Marketing Authorisation Numbers: EU/1/98/067/001 (100mg), EU/1/98/067/002 (500mg)

Marketing Authorisation Holder: Roche Registration Limited, 6 Falcon Way, Welwyn Garden City, Herts AL7 1TW. MabThera is a Registered trademark.

Date of Preparation: May 2017 PR/MABR/1704/0001

Reporting of suspected adverse reactions: Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via their corresponding national reporting system.
MabThera has a reliable, proven safety profile, with almost 9000 patient-years of exposure\textsuperscript{1-3}

References