There’s a New Name in Rheumatology Research Funding in Europe

Can EULAR do something to stimulate funding of small-to-medium-scale rheumatology research in Europe? This was a question that the EULAR Executive Committee pondered some 2 years ago. The question was a strategic one: Should EULAR keep walking its path of funding major projects it had started in 2008 with its orphan disease programme on systemic sclerosis, followed by patient-reported outcomes, and pain? Could this be a sustainable strategy for EULAR in view of the increasing need for research on every scale to alleviate the burden of rheumatic and musculoskeletal diseases? Or would it not be better to try to tap financial sources that are out of EULAR’s realm by offering them a viable vehicle? A potential solution was not far away: Under the leadership of President Maxime Douagos, EULAR started developing the idea of establishing a Foundation dedicated to funding rheumatology research and based in Switzerland.

Now, the European Rheumatology Research Foundation (ERRF) is a fact. The Foundation is recognised by the Swiss authorities as an independent fund-raising and research funding institution with not-for-profit status. The ERRF seeks to initiate research of the highest quality, oriented towards a broad range of rheumatic and musculoskeletal diseases. Only peer-reviewed research proposals that fulfill this ambition shall be considered for funding. Whereas the ERRF will define its strategic goals and operations independently, the intention is that it will coordinate its research activities with EULAR in order to avoid unnecessary overlap or otherwise ineffective research.

Exercise Programme

Improved Strength, Walking in AS

Patients with ankylosing spondylitis who participated in a progressive muscle strengthening programme gained significant improvements in muscle strength and walking performance after 4 months, compared with those who did not participate, results from a randomised, controlled study suggest.

The exercise programme, which involved resistance training with the Swiss ball, was also well tolerated and was not associated with negative effects on disease activity, reports one of the investigators, Marcelo Cardoso de Souza, a physiotherapist and member of a multidisciplinary rehabilitation team in the rheumatology division at the Federal University of Sao Paulo, Brazil. Exercise is recommended for people with AS, but the benefits of a specific exercise programme have not been established.

‘More Inclusive’ Scleroderma Classification Criteria to Be Unveiled

More patients could be correctly identified as having scleroderma and potentially be included in epidemiological studies and clinical trials if existing classification criteria were replaced with a more inclusive system. This system currently still is a proposal and is under review by the European League Against Rheumatism and the American College of Rheumatology.

This morning, Dr. Frank van den Hoogen will present the proposed new classification criteria for systemic sclerosis developed by EULAR in collaboration with ACR. Dr. van den Hoogen, who is the director of the Rheumatology Centre at Sint Maartenskliniek and head of the department of Rheumatology.
Osteoarthritis to Be First Topic

Research from page 1

cient deployment of precious re-
search resources.

A Unique Opportunity for Donors
Clearly, effective fundraising will be

management of rhematic and

musculoskeletal disorders and,
hence, the living, working, and so-

cioeconomic conditions of the

more than 120 million people in

Europe variously afflicted by RMDs.

While the ERRF will independently
develop its research strategy and
grant agenda, it is nevertheless in-

terested in engaging with and learn-
ing from various stakeholders,

including European centres of

excellence in rheumatology research

and other stakeholders active in

rheumatology research.

Equipped with starting capital do-

nated by EULAR, the ERRF is ready
to launch its first call for research
proposals, which will presently be an-
nounced on the Foundation’s web-
site: www.errf.net. Osteoarthritis,
affecting a substantial proportion of
the European population, has been
chosen by ERRF as a first topic.

In consultation with a group of OA ex-

perts, research priorities have been
identified that define the scope of
the call for proposals. For more infor-
mation and application procedures,
please visit the ERRF website.

An Expert Leadership Group
The ERRF is directed and supervised
by an international Board of Trustees
comprising renowned researchers and
scientific experts in rheumatology in
Europe. An international Executive
Committee will define the strategic
agenda for the Foundation, coordinate
the Foundation’s operational aspects,
and evaluate and decide on funding of
peer-reviewed research proposals.

An international Scientific Com-

mittee of experts from relevant fields
of rheumatology will act as an advis-
ory body for all scientific and
methodologic aspects. Patients and
health professionals are represented
in both committees.

Thus, the organisational structure of
the ERRF will ensure that the ERRF
fulfills a need in rheumatology re-
search and acts according to the high-
est standards and ethics of scientific
research.

www.errf.net

New Criteria Are Highly Sensitive, Specific
Scleroderma from page 1

rheumatology at Radboud University
in Nijmegen, the Netherlands, will high-
light how these joint ACR-EULAR criteria perform
better than did the preliminary criteria for
the diagnosis of systemic sclerosis developed
by the Arthritis and Rheumatism Association
(ARA) more than 30 years ago (Arthritis Rheum.

Indeed, the ACR-EULAR criteria had a sen-
sitivity of 91% and a specificity of 92%
to correctly identify patients with systemic sclero-

sis. By comparison, the 1980 Preliminary
ARA Criteria had a sensitivity of 75% and a
specificity of 72%.

The whole process of developing the ACR-
EULAR criteria has taken about 5 years, Dr.
van den Hoogen explained in an interview.

“The ARA criteria were not as sensitive as we
wanted because they excluded some patients
with limited disease and also patients with
newly diagnosed disease,” he said.

“Classification criteria are not exactly the
same as diagnostic criteria,” Dr. van den
Hoogen was keen to point out. “[They] are
generally more standardised and less in-
cclusive,” he observed. This is because physicians will see
patients with multiple symptoms and it would
not be possible to include every symptom seen
in routine practice in a set of classification
criteria.

The process of determiningwhich items to
include was driven by both data and consen-
sus. Delphi exercises and a nominal group
technique were used to create a set of poten-
tial items for the classification of systemic
sclerosis.

Several patient cases were then reviewed by
leading scleroderma experts based in Europe
and North America. The cases represented
the full spectrum of systemic sclerosis,
including those with a low and those with a
high probability of having the disease. Ex-

erts ranked the importance of the symp-
toms exhibited by each of these cases, and a
whittled down list with a scoring system was

gained. Systemic sclerosis was present if a
score of 9 or more out of a possible 19 was
achieved.

Skin thickening of the fingers of both
hands extending past the metacarpophal-
goal (MCP) joints was considered to be
indicative of scleroderma, and was given
a score of 9. Conversely, patients with skin in-
volvement likely to be due to another sclero-
derma-like disorder or skin thickening
sparing the fingers were not likely to have
systemic sclerosis.

Other items included skin thickening of the
fingers, with sub-items of puffy fingers (score = 2) and
whole finger skin thickening, distal to the
MCP (4); finger tip lesions, with sub-items of
digital tip ulcers (2) and pitting scars (3),
telangiectasia (2), abnormal nailfold capillaries
(2); pulmonary arterial hypertension, intersti-
tial lung disease, or both (2); Raynaud’s pne-

moniomen (3); and the presence of any
scleroderma-related autoantibodies (3).

The ability of these criteria to correctly iden-
tify patients with and without systemic sclero-
sis was then prospectively tested in a random
sample of 200 individuals and further validated
in a cohort of 405 individuals that included
both early and prevalent cases of scleroderma
and its mimics who had been collected from
several European and North American sclero-
derma centres.

“The proposed ACR-EULAR criteria for the
classification of systemic sclerosis should allow
more patients to be classified correctly as sys-
temic scleroderma,” Dr. van den Hoogen said.
This includes those with early (less than 3 years) and
limited disease.

Dr. van den Hoogen said that he had no
disclosures, except that this work was funded
jointly by EULAR and the ACR.

Abatacept, Adalimumab Showed Equivalent in
Rheumatoid Arthritis in 2-Year Head-to-Head Trial

A 2-year head-to-head com-
parison of abatacept and
adalimumab in rheumatoid
arthritis patients who were on
background methotrexate has
found equal im-
provement with both biologics,
according to data to be
presented by
Dr. Michael H.
Schiff this morn-
ing.

The ran-
domised, investigator-blind-
ed AMPLExe trial is the first
2-year comparator study of
biologics done in biologic-
naive rheumatoid arthritis
patients.

“Through 2 years of
treatment, in this first ac-
tive comparator study be-
tween biologic agents in
rheumatoid arthritis pa-
tients with an inadequate
response to methotrexate, this
robust data set demonstrates
that subcutaneous abatacept and adalimumab
were equally efficacious in
clinical, functional, and ra-
diographic outcomes,” the
researchers reported.

Researchers recruited 646
patients with active
rheumatoid arthritis and an
inadequate response to
methotrexate, and ran-
domised them either to 125
mg of abatacept weekly
(without an IV
load) or 40 mg of
adalimumab bi-
weekly, with a stable dose of
methotrexate.

“We will pre-
sent the data to show that both
agents have an ex-
cellent retention rate; similar ef-
cacy for ACR 20, 50, 70, and 90; DAS remission is
the same at 50%; and x-ray
nonprogression is also the
same,” said Dr. Schiff, who
is the medical director of
the Denver Arthritis Clinic
Research Unit and on the
faculty of the University of
Colorado School of Medi-
cine in Denver.

The study found similar
numbers of adverse events
in both arms, although there
were fewer discontinuations
in the abatacept arm, and
patients given abatecept also
had fewer injection site reac-
tions (4.1% vs. 10.4%).

“Fewer infections (3.8% vs.
5.8%) and opportunistic
infections (3 vs. 5) occurred
with abatacept, including
two cases of tuberculosis in

continued on page 8
Treating early for long-term success: The PRIZE in RA

Wednesday 12th June, 13:00–14:30
Hall 7
Chair: Tore Kvien

Treatment targets in rheumatoid arthritis

Thursday 13th June, 08:15–09:45
Plenary Hall 6
Chair: Juan Gómez-Reino

The mosaic of RA: Assembling the pieces for optimal treatment outcomes

Thursday 13th June, 17:30–19:00
Hall 8
Chair: Bernard Combe
Hand OA Linked to Increased Heart Disease Risk

Symptomatic hand osteoarthritis is associated with a significant increase in the risk of coronary heart disease events, although the association was not significant for asymptomatic hand osteoarthritis.

This morning Dr. Ida K. Haugen will present findings from a population-based cohort study of 1,348 participants from the Framingham Heart Study, which found more than double the incidence of coronary heart disease among individuals with symptomatic hand osteoarthritis (OA) (hazard ratio, 2.26; 95% confidence interval 1.22-4.18), compared with those without hand OA.

The study defined symptomatic hand OA as one or more hand joints with Kellgren-Lawrence grade of 2 or above and pain in the same joint.

The definition excluded individuals with rheumatoid arthritis (RA).

The association persisted even after adjustment for lower limb pain (HR, 2.06; 95% CI 0.96-4.15), to account for the physical inactivity potentially associated with OA in lower limb joints, according to Dr. Haugen from Diakonhjemmet Hospital in Oslo, and her associates.

However, individuals with radiographic but not symptomatic hand OA showed a nonsignificant increase in the risk of coronary heart disease (HR, 1.60: 95% CI 0.96-2.66).

The study set out to examine a possible association between hand OA and cardiovascular disease, based on the premise that hand OA is especially likely to be related to metabolic rather than mechanical causes.

“We hypothesized that the association between hand OA and coronary heart disease could be mediated through metabolic factors, such as hyperlipidaemia and diabetes, or a more sedentary lifestyle due to generalised OA,” Dr. Haugen said in an interview.

“Radiographic hand OA is very prevalent in the general population, and only a proportion of those with radiographic hand OA may experience symptoms,” she said. “We believe that symptomatic hand OA represents more severe hand OA and, further, the association between hand OA and coronary heart disease may be mediated through factors associated to pain, such as synovitis.”

Synovitis has been shown in other diseases such as RA to increase the risk of cardiovascular disease due to the development of atherosclerosis, Dr. Haugen said.

The study failed to find any significant associations between hand OA – either symptomatic or radiographic – and other unspecified reasons (2%).

Adalimumab an Effective First-, Second-Line Biologic in JIA

Adalimumab is safe and effective as both a first- and second-line biologic agent in patients with juvenile idiopathic arthritis, according to data to be presented at this morning’s paediatric rheumatology abstract session by Prof. Gerd Horneff.

Prof. Horneff from the Asklepios Klinik, St. Augustin, Germany, and Dr. Heinrike Schmeling from the Albert Children’s Hospital analysed data from the German Biologics Register for 329 children aged 4-18 years with juvenile idiopathic arthritis (JIA), finding that a high proportion of patients showed a significant response to treatment with adalimumab.

“The results of this study indicate that adalimumab is highly effective as a first and also as a second introduced biological agent resulting in substantial improvements in clinical signs and symptoms in children with juvenile idiopathic arthritis,” Dr. Schmeling said in an interview.

Even patients who were using adalimumab as a second or third biologic gained an additional response to adalimumab on top of their responses to previous biologics. “The percentage of patients who met the criteria of 30%/50%/70% improvement at last documentation when adalimumab was the first introduced biological agent was 65%/61%/46%, compared to 73%/65%/48% when adalimumab was initiated after other biologics,” the researchers report.

Around one-third of patients had rheumatoid factor–negative polyarticular juvenile idiopathic arthritis, 22.9% had extended oligoarticular juvenile idiopathic arthritis, and 22% of patients had a history of uveitis.

The median age of onset of disease was 6.7 years, and median age at treatment initiation was 13.8 years, with a median disease duration of 5.1 years. ANA positivity was found in 51% of patients and HLA-B27 positivity in 19.8%. Most patients had been previously treated with methotrexate (92.4%), approximately one-third had received other disease-modifying antirheumatic drugs, and two-thirds had been treated with biologics, mostly etanercept.

Many were also receiving concomitant treatment with nonsteroidal anti-inflammatory drugs (55.3%), steroids (38%), methotrexate (57.8%), and other disease-modifying antirheumatic drugs (13%).

However, Dr. Schmeling emphasised that this study was not an attempt to compare adalimumab to other biologic treatments.

While no malignancies were observed during adalimumab treatment, 96 patients reported 220 adverse events, 14 of which were serious. There were also more autoimmune adverse events among patients treated with adalimumab, but Dr. Schmeling said the numbers were too small to draw any conclusions.

Uveitis developed in 18 children while on treatment, 13 of them had a history of uveitis prior to Adalimumab initiation. Treatment was discontinued in 61 patients because of inefficacy (9%), adverse events (5%), remission (3%), patient request (9%), and other unspecified reasons (2%).

Congress Dinner at the Palacio del Negralejo

The Congress Dinner is a great opportunity to see and experience an historic building while enjoying a relaxed evening with dinner among colleagues from around the world. In 1780, on the ruins of the “Negrales” castle, a family from Madrid’s nobility built their country palace. Later, well into the 19th century, the Marquis of Villamejor founded his famous stables, home to the renowned “Figueroa” stud. In 1982 the owners decided to turn this fabulous complex into a venue for events and functions, keeping the original style but introducing all the modern functionality required for events. Such was the determination and perfectionism put into the restoration that Palacio del Negralejo can today be considered an ethnological museum where one can find countless antique farm implements, household, and decorative items. Join this evening and taste the Spanish flavour of the place!
Will doing these activities be challenging for your digital ulcer patients?

Come to Stand 57 and let’s talk

Digital ulcers (DUs) are a frequent and persistent problem for patients with systemic sclerosis (SSc)\(^1,2\) and can significantly impact their quality of life.\(^3,11\)

Here on stand 57, hall 10 we’re talking not only about a clinical management approach to help reduce the burden of this debilitating condition, but also about earlier detection via capillaroscopy.

To find out more and get some hands on experience with capillaroscopy, come and join us during exhibition times.
Tracleer® (bosentan) Abbreviated Prescribing Information (Please refer to the full SmPC before prescribing)

Tracleer 62.5 mg and 125 mg delayed-release tablets: 32 mg bosentan (as monohydrate)

Uses
Treatment of pulmonary arterial hypertension (PAH) to improve exercise capacity and symptoms in patients with WHO functional class II-IV. Tracleer has also been shown to improve exercise capacity in patients with skeletal muscle hypoxia.

Dosage and administration
Treatment should only be initiated and monitored by a physician experienced in the treatment of PAH or systemic sclerosis. Tablets are to be taken orally with food, with or without milk, and the dispersible tablets are to be dissolved in water. The dispersible tablets are not recommended for children under 6 years of age.

Tracleer has been associated with decreases in haemoglobin concentration (section 4.4, Special warnings and precautions for use).

Inhibitions and interactions
Tracleer has been associated with dose-dependent decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Drug interactions
Tracleer has been associated with dose-dependent decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Drug metabolising enzymes
Tracleer has been associated with dose-dependent decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Special warnings and precautions for use
The efficacy of Tracleer has not been established in patients with severe pulmonary arterial hypertension. In addition, the safety of Tracleer is untested in patients with WHO functional class IV and PAH associated with congenital systemic-to-pulmonary shunts and Eisenmenger's physiology. Some improvements have also been shown in patients with PAH WHO functional class II.

Tracleer is also indicated to reduce the number of new digital ulcers in patients with systemic sclerosis (scleroderma) and to improve their quality of life.

Drug stability
Tracleer is stable at controlled room temperature and in light for at least 5 years. After opening, the vial should be used within 4 weeks. After reconstitution, the solution is stable for at least 5 years. The contents of the vial should be used within 2 hours of reconstitution.

Product information
Tracleer is available in the following strengths and pack sizes:
- Tracleer 32 mg: 56 dispersible tablets.
- Tracleer 62.5 mg: 14, 56 or 112 film-coated tablets.
- Tracleer 125 mg: 56 or 112 film-coated tablets.

Haemoglobin concentration
Tracleer has been associated with dose-related decreases in haemoglobin concentration. In placebo-controlled clinical trials, decreases were not progressive, and stabilised after the first 4-6 weeks of treatment. It is recommended that haemoglobin concentrations be checked prior to initiation of treatment, monthly for the first 4 months and subsequently at 3-monthly intervals. The presence of anaemia is not a contraindication to the use of Tracleer. In the long-term, haemoglobin levels may fall further and it may be necessary to adjust the dose, if indicated. It is recommended that haemoglobin concentration is monitored at regular intervals, especially before treatment is re-initiated, and it is recommended to check haemoglobin concentration at 2-4 week intervals following re-initiation of treatment. Before Tracleer treatment, haemoglobin concentration should be close to 12.5 g/dL.

Blood pressure
Tracleer has been associated with dose-related decreases in haemoglobin concentration. In placebo-controlled clinical trials, decreases were not progressive, and stabilised after the first 4-6 weeks of treatment.

Blood pressure
Tracleer has been associated with dose-related decreases in haemoglobin concentration. In placebo-controlled clinical trials, decreases were not progressive, and stabilised after the first 4-6 weeks of treatment. It is recommended that blood pressure is measured prior to initiation of treatment, monthly for the first 4 months and subsequently at 3-monthly intervals. It is recommended that blood pressure is measured at regular intervals, especially before treatment is re-initiated, and it is recommended to check blood pressure at 2-4 week intervals following re-initiation of treatment.

Aminotransferase elevations
Tracleer has been associated with dose-related decreases in haemoglobin concentration. In placebo-controlled clinical trials, decreases were not progressive, and stabilised after the first 4-6 weeks of treatment.

Liver function tests
Tracleer has been associated with dose-related decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Other liver function tests
Tracleer has been associated with dose-related decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Adverse events
Tracleer has been associated with dose-related decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Digital ulcers
Tracleer has been associated with dose-related decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.

Tracleer has been associated with dose-related decreases in liver function tests. An increased long-term risk of hepatic toxicity and haematological adverse events cannot be excluded. These adverse events have been associated with concomitant use of antiretroviral agents.
High Protein, Low Fat, Sugar Diet Might Help in OA

Anti-inflammatory diets – ones low in fat and sugar but high in protein – might slow the progression of osteoarthritis, according to data to be presented this afternoon by Dr. Marian Hannan of the department of medicine at Harvard Medical School, Boston.

When it comes to diet and OA (osteoarthritis), “there are two components. The first component is weight loss. The other is dietary factors that address inflammation. Even though OA isn’t known as an inflammatory condition, one does have inflamed joints. And there are a lot of inflammatory cytokines that are affected by diet. If you want to minimise the possibility of the onset or progression of OA, we should be looking more at nutrition as a modifiable factor. Currently, I don’t think anybody thinks about it,” said Dr. Hannan, also the editor of Arthritis Care & Research.

There has not been much study of the topic, and past investigations tended to focus on single nutrients, such as the spice turmeric, which is known to have anti-inflammatory properties. Although some “very interesting ideas were looked at,” none panned out with further investigation, she said.

So the field’s shifted away from single nutrient studies to take a broader look at diet and inflammation. The idea of anti-inflammatory diets was borrowed from diabetes and cardiovascular research. “We know there are diets that lower your inflammation,” and they’ve been shown to help in both conditions, she said.

“Just about any heart-related diet you can think of is an anti-inflammatory diet. [They are] akin to the Mediterranean diet but with more protein in addition to the nuts, fruits, and other foods. “Those are the diets you want to model your intake after. It’s not so much about caloric restriction. You can eat a lot of things; it’s not like your limited to grapefruits or tomatoes, which makes it appealing to people,” Dr. Hannan said.

In her talk, she plans to review the literature for anti-inflammatory diets in chronic disease, and highlight findings of particular interest in OA. She’ll also touch on two randomised clinical trials investigating the role of nutrition, as well as exercise, on OA progression. Despite the lack of hard data to support with any certainty the benefit of putting OA patients on anti-inflammatory diets, “I think we’ve got pretty good evidence that [these diets] lower metabolic loads and help people lose pounds. And from those perspectives’ efforts to modify diets should be encouraged, even while their possible anti-inflammatory benefits in OA are investigated.”
Patients Like Training

Exercise from page 1

Marcelo Cardoso de Souza found that training with the Swiss ball strengthened key muscle groups.

Atacicept Improved Disease Markers, Delayed Flares in Patients With Nonrenal SLE

Atacicept was associated with favorable pharmacodynamic effects and changes in disease-related markers in an efficacy trial of patients with nonrenal systemic lupus erythematosus.

Two different doses of atacicept were compared against placebo in 461 patients with active nonrenal systemic lupus erythematosus (SLE) in the phase II/III study. “There were declines in antibodies to DNA, immunoglobulins, as well as in the number of mature B cells and plasma cells” in patients who received atacicept, compared with those on placebo, said trial investigator Prof. David Isenberg, who will be presenting the pharmacodynamic findings of the study this morning.

And in subjects with abnormal values at screening, atacicept was also associated with favorable effects on the complement C3 and C4 levels,” he said in an interview in advance of the presentation. In the study, atacicept was associated with a significant beneficial effect in preventing and delaying the onset of flares; the efficacy results are being presented in today’s poster session.

Atacicept is a fusion protein that blocks the B cell-stimulating factors BLyS and APRIL. Belimumab (Benlysta), the monoclonal antibody approved in the United States, EU, and other countries for the treatment of active, autoantibody-positive SLE, blocks BLyS only. After a corticosteroid taper for 10 weeks, patients in the study were randomised to treatment with 75 mg or 150 mg of atacicept (administered subcutaneously twice a week for 4 weeks, then weekly for 48 weeks), or placebo. The 150-mg arm was terminated prematurely after two patients died of pulmonary infections. A total of 285 patients completed the study (111 on placebo, 112 on 75 mg of atacicept, and 62 on 150 mg).

Treatment was associated with the following changes in pharmacodynamic and disease-related markers at 52 weeks: Total IgG dropped by a median of 30% among those on 75 mg and by 38% on 150 mg, and total IgA dropped by a median of 53% and 58%, respectively, compared with increases of 2%-3% among those on placebo. Total IgM dropped by a median of 66% and 69% among those on the 75-mg and 150-mg doses, respectively, compared with a drop of almost 1.5% among those on placebo.

Patients who tested positive for anti-dsDNA antibodies had their levels drop by 32% on 75 mg and by 38% on 150 mg, compared with an increase of 14% on placebo, reported Prof. Isenberg, academic director of rheumatology at University College London. C3 and C4 complement levels increased in association with both doses of atacicept, but not with placebo. Mature B cell and plasma cell levels declined significantly in the two treatment groups, compared with levels in those on placebo.

The muscle strengthening programme improved AS patients’ results in the 6-minute walk test, and measures of disease activity did not worsen during the training.

Continued from page 2

the adalimumab arm that led to discontinuations,” the researchers reported. Abatacept also resulted in more autoimmune adverse events than adalimumab (3.8% vs. 1.8%), although most were clinically unimportant and none were described as serious. “EULAR/ACR guidelines recommend starting a patient on methotrexate and then optimising the dose over 3-6 months, and if a patient has an incomplete response to methotrexate, then to add a biological agent,” said Dr. Schiff in an interview.

Dr. Schiff said anti-TNF agents have been the first choice of most rheumatologists, and adalimumab is the most chosen anti-TNF agent worldwide, which is why it was selected as one of the agents for the head-to-head trial. Abatacept employs another method of action: T-cell inhibition. “This paper has important clinical significance because a patient and his or her rheumatologist want to have data to make an informed choice of a biologic agent to add when an incomplete response to methotrexate occurs.”

Abstract Session HPR
Building blocks for better care
Thursday 10:15 – 11:45
Room N113/114

Abstract Session HPR
New targets beyond TNF inhibition
Thursday 10:15 – 11:45
Hall 4
Roche-sponsored satellite symposia at EULAR 2013

**Tailoring choice of therapy to meet patients’ needs:**

*What are the differences between available treatment options in RA?*

Friday 14 June 2013, 08:15–09:45, Hall 8, IFEMA Madrid

This educational programme features an eminent panel of rheumatology experts, who will be sharing insights and data behind the key considerations underlying treatment choice in current clinical practice – with a view to both meeting individual patients’ needs and optimising outcomes in RA

**Chair:** Maxime Dougados, France

**Evolving choices in RA treatment: What are the important differences between the mechanisms of action?**

Ernest Choy, UK

**Translating the evidence into clinical context: What are the considerations for tailoring treatments to optimise outcomes in RA?**

Paul Emery, UK

**Insights into the safety profiles of RA treatments: What does the long-term evidence tell us?**

Andrea Rubbert-Roth, Germany

**Summary**

Maxime Dougados, France

**Question and answer session**

*This presentation is not intended for physicians practicing in the USA*

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**Different needs, different options:**

*Clinical challenges and considerations in tailoring RA treatments to patients*

Friday 14 June 2013, 17:30–19:00, N101 + N102, IFEMA Madrid

**Chair/Moderator:** John Isaacs, UK

**Panel**

Maya Buch, UK
Andrew Östör, UK
Cem Gabay, Switzerland

Please join us for an interactive panel discussion featuring the latest clinical trial and registry data, real-time audience opinion polls and live audience Q&A. Our distinguished faculty will be discussing their clinical insights and experience on topics that include:

- The growing range of treatment options in RA
- The importance of considering patient factors in therapeutic decision-making
- Medication non-adherence in RA, including data on prevalence and clinical impact

*This presentation is not intended for physicians practicing in the USA*
### Exhibitors’ List

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Convention Centre Floor Plan

North Convention Centre
ACHIEVE BALANCE FROM YOUR RA* BIOLOGIC THERAPY¹⁻²

Efficacy
Safety

The first and only selective T-cell co-stimulation modulator approved for the treatment of RA*¹⁻⁷

Now available in both IV and SC formulations¹

* RA: Rheumatoid arthritis.

**ORENCIA® (abatacept) PRESCRIBING INFORMATION**

See Summary of Product Characteristics before prescribing.

**PRESENTATION**: 250 mg powder for concentrate for solution for IV infusion containing 250 mg abatacept per vial. Each ml contains 25 mg of abatacept, after reconstitution; 125 mg pre-filled syringe for SC injection. Each pre-filled syringe contains 125 mg of abatacept in 1 ml.

**INDICATION**: Rheumatoid arthritis (IV infusion and SC pre-filled syringe) Treatment of moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, in adult patients who have responded inadequately to previous therapy with one or more disease-modifying anti- rheumatic drugs (DMARDs) including methotrexate (MTX) or a Tumour Necrosis Factor (TNF)-alpha inhibitor. A reduction in the progression of joint damage and improvement of physical function have been demonstrated during combination treatment with abatacept and methotrexate. See SmPC. Polyarticular Juvenile Idiopathic Arthritis (pJIA) (IV infusion only): Orencia 250 mg powder for concentrate for solution for IV infusion for the treatment of moderate to severe active pJIA in paediatric patients 6 years of age and older who have had an insufficient response to other DMARDs including at least one TNF inhibitor. DOSEAGE and ADMINISTRATION: Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA. Orencia 250 mg powder for concentrate for solution for IV infusion is indicated for treatment of moderate to severe active pJIA in paediatric patients 6 years of age and older who have had an insufficient response to other DMARDs including at least one TNF inhibitor. DOSEAGE and ADMINISTRATION: Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA. Orencia 250 mg powder for concentrate for solution for IV infusion is indicated for treatment of moderate to severe active pJIA in paediatric patients 6 years of age and older who have had an insufficient response to other DMARDs including at least one TNF inhibitor.

### PARE Session

**Patient rights to crossborder healthcare and other entitlements**

**Room N101/102**

**15:30 – 17:00**

**What Is New (WIN)**

**WIN Session 4**

**Room N110/111**

**Clinical Science Sessions**

**Modern assessment of disease activity in inflammatory arthritis**

**Room N103/104**

**Impact of imaging on clinical practice**

**Room N111/112**

**Challenges in Clinical Practice Session**

**Peripheral neuropathy in rheumatic diseases**

**Room N101/102**

**How to Treat/Manage (HOT)**

**HOT Session 5**

**Room N113**

**Outcomes Science Session**

**Investigating in a world of confounders**

**Room N109/110**

**PRES Session**

**Still's disease**

**Room N105/106**

**Primary Care Session**

**Hot topics for primary care**

**Room Retiro**

**Fellows in Training Session**

**ABC of science**

**Room N11/112**

**Health Professionals Session**

**The foot health needs of people with inflammatory arthritis in the era of biologic therapies**

**Room N113/114**

**Practical Skills Sessions**

**MRI Basic 2**

**Room N117**

**Dealing with journalists: Media training by media professionals**

**Room N118**

**Crystals in synovial fluid 2**

**Room N115**

**How to Treat / Manage (HOT)**

**HOT Session 4**

**Room N107/108**

**Bone: A tale of cells and hormones**

**Room N109/110**

**Tissue repair by DMOADs: The proof of the pudding**

**Room N107/108**

**ORENCIA® (abatacept)**

- **DOSAGE**
  - **ORENCIA® (abatacept)**
  - **250 mg concentrate for solution for infusion (IV infusion)**
  - **Adults and elderly**: Treatment should be initiated with a loading dose using an intravenous infusion. After initial administration, Orencia should be given at 2 and 4 weeks, then every 4 weeks thereafter. Patients who are unable to receive an infusion may initiate weekly injections of subcutaneous Orencia without an intravenous loading dose. Patients transitioning from infliximab or adalimumab to Orencia should be initiated with weekly subcutaneous injections of Orencia without an intravenous loading dose. Patients transitioning from TNF antagonists to Orencia should have a washout period of at least 14 days. Concomitant therapy of Orencia with a TNF-inhibitor is not recommended. Concomitant therapy may be associated with progressive multifocal leukoencephalopathy (PML). Orencia treatment should be discontinued if neurological symptoms suggestive of PML occur, and appropriate diagnostic measures initiated. Malignancies: The potential role of Orencia in the development of malignancies is unknown, see SmPC. Elderly: Caution should be used when treating elderly patients due to a higher incidence of infections and malignancies in this patient group. Autoimmune processes: Theoretical risk of deterioration in autoimmune disease. Immunisation: Live vaccines should not be given simultaneously or within 2 months of administration of Orencia. See SmPC. **DRUG INTERACTIONS**: Concomitant therapy of Orencia with a TNF inhibitor is not recommended. No major safety issues were identified with the use of Orencia in combination with sulfasalazine, hydroxychloroquine or leflunomide. PREGNANCY AND LACTATION: Do not use in pregnancy unless clearly necessary. Women should use contraception and avoid pregnancy during treatment and for up to 1 month after last dose treatment. UNDESIRABLE EFFECTS: In adult placebo-controlled trials the following adverse drug reactions were reported. **Very Common (≥1/10)**
  - Upper respiratory tract infection including bronchitis, urticaria
  - Gastrointestinal disorders:
    - Inflamed, abdominal pain, diarrhoea, nausea, vomiting, mouth ulceration, aphthous stomatitis, dyspepsia
    - Hole, dry eye, skin irritation, headache, dizziness, paraesthesia, conjunctivitis, hypertension, flushing, blood pressure increased, cough, abdominal pain, diarrhoea, nausea, dyspepsia, mouth ulceration, aphthous stomatitis, vomiting, liver function test abnormal (including transaminases increased), rash including dermatitis, alopecia, purpura, pruritus in extremity, fatigue, anaemia, injection site reactions. **Common (≥1/100 to <1/10)**
    - Tooth infection, orofacial pain, toothache, herpes zoster, herpes, molluscum contagiosum infections, skin abscess, papulonecrotic tissue, exacerbation of the disease, urticaria, oedema, hyperpyrexia, hyperpyrexia, depression, anxiety, sleep disorder, migraine, dizziness, dry eye, acuity reduced, vertigo, palpitations, tachycardia, headache, hypotension, hot flush, vasculitis, blood pressure decreased, bronchospasm, wheeze, dyspepsia, gastritis, increased tendency to bruise, dry skin, urticaria, oedema, arthralgia, amnesia, menacalia, influenza-like illness, weight increased. **Uncommon (≥1/1000 to <1/100)**
    - Bacteremia, gastritis, gastrointestinal infection, pyrexia, lung neoplasms malignant, chest pain. **Rare (≥1/10,000 to <1/1000)**
    - Asthenia, oral candidiasis, pneumonia, dysphagia, botulism, toxic epidermal necrolysis, pancreatitis, meningitis, visual disturbances, hepatitis, skin necrosis, angioedema, respiratory failure, myocardial infarction, pulmonary disease, death. **Very Rare (≥1/100,000 to <1/10,000)**
    - Necrotising fasciitis, urticaria, anaphylaxis, angioneurotic oedema, vasculitis, hyperpyrexia, severe anaemia, haematological disorder, liver failure, angioedema, anaphylactic shock, anaphylactoid reaction, angioneurotic oedema, thrombocytopenia, lymphadenopathy, tissue oedema, pancreatitis, angioedema, urticaria, angioedema, cutaneous adverse reaction, anaphylactic shock, angioneurotic oedema, abdominal pain, diarrhoea, nausea, vomiting, mouth ulceration, aphthous stomatitis, dyspepsia, hole, dry eye, skin irritation, headache, dizziness, paraesthesia, conjunctivitis, hypertension, flushing, blood pressure increased, cough, abdominal pain, diarrhoea, nausea, dyspepsia, mouth ulceration, aphthous stomatitis, vomiting, liver function test abnormal (including transaminases increased), rash including dermatitis, alopecia, purpura, pruritus in extremity, fatigue, anaemia, injection site reactions. **Other adverse reactions**: Miscellaneous: **Very Common (≥1/10)**
  - **Adverse reactions**: Miscellaneous: **Common (≥1/100 to <1/10)**
  - **Adverse reactions**: Miscellaneous: **Uncommon (≥1/1000 to <1/100)**
  - **Adverse reactions**: Miscellaneous: **Rare (≥1/10,000 to <1/1000)**
  - **Adverse reactions**: Miscellaneous: **Very Rare (≥1/100,000 to <1/10,000)**
  - **Adverse reactions**: Miscellaneous: **Other adverse reactions**.
A majority of patients with inflammatory arthritis have one or more additional chronic diseases at the onset of the disease, according to a study to be presented this afternoon.

The results argue for close cooperation among primary care physicians and specialists, both of whom care for inflammatory arthritis (IA) patients, says Jennie Ursum, Ph.D., who will present the research on behalf of colleagues at the Netherlands Institute for Health Services Research, Utrecht; and the VU University Medical Centre and the Jan van Breemen Research Institute, both in Amsterdam.

"Despite the fact that IA patients are mainly treated in specialised care, the general practitioner plays an important role in the management of other chronic diseases," said Dr. Ursum, a researcher with the Netherlands Institute for Health Services Research.

If the primary care physician and specialist are not coordinating care, there is the potential for drug misadventures, and noncompatible treatment regimens, she said.

The study used data from the Netherlands Information Network of General Practice. The LINH is a longitudinal database that began in its present form in 2001. Physicians who participate record data on all patient contacts, including diagnoses, referrals and prescriptions; patient sex and age; type of health insurance; and place of residence. Some 83 practices and 337,000 patients are registered.

For Dr. Ursum’s nested-case control study, data – including information on consultations, morbidity, prescriptions, and referrals to other health professionals – were extracted from electronic medical records.

The data included 3,354 patients with newly diagnosed IA who were seen from 2001 to 2010. Each patient was matched for age, sex, and general practice with two control patients, making for 6,708 controls. The researchers compared the presence of 121 different chronic diseases between patients and controls with logistic regression analyses.

They found that 70% of inflammatory arthritis patients had at least one other chronic disease at the onset of IA, compared with 59% of control patients. Cardiovascular disease was the most prevalent condition, affecting some 35% of the IA patients.

Twenty-seven percent of IA patients had musculoskeletal diseases and 22% had neurological diseases. The IA patients had the highest increased risk for musculoskeletal and neurological diseases.

While it might not be surprising that IA patients had a high risk of musculoskeletal conditions, that grouping does not just include inflammation of the joints, said Dr. Ursum.

The authors studied diagnosis codes and found a prevalence of 2% or higher for shoulder syndrome, spinal cord diseases, tennis elbow, and osteoporosis. The highest risk was for a diagnosis of carpal tunnel syndrome.

Although the study did not delve into why these conditions might be present in IA patients, “there might be a shared etiology for some diseases,” said Dr. Ursum. “However, based on the results of this study we can only hypothesise about this,” she said.

One hopes that the physicians who attend her presentation will learn to stay alert for the presence of these other conditions in their IA patients, Dr. Ursum said. “Co-operation between different physicians is important to gain the best treatment for patients,” she said.

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**Other Diseases Present at Inflammatory Arthritis Onset**

**Satellite Programme Thursday 13 June 2013**

**08:15 – 08:45** Pfizer Hall 6
*Treatment Targets in Rheumatoid Arthritis*
*Chair: J. Gómez Reino, Spain*
- **08:15 – 08:20** Introduction
- **08:20 – 08:45** Targeting the inflammatory cascade: Mechanism of action of oral cytokine signalling inhibitors
  - G. Firestein, USA
- **08:45 – 09:10** Targeting new agents: Balancing the clinical profile with safety considerations and management in clinical practice
  - R. van Vollenhoven, Sweden
- **09:10 – 09:35** Targeting the future: Interpreting the EULAR treatment recommendations
  - R. Landewé, Netherlands
- **09:35 – 09:45** Panel discussion
- **09:45** Summary and close
  - J. Gómez Reino, Spain

**08:15 – 08:45** AbbVie Hall 7
*Understanding the Synergy Between Methotrexate and Biologics in Rheumatoid Arthritis*
*Chair: G.R. Burmester, Germany*
- **08:15 – 08:30** Methotrexate is the anchor drug in rheumatoid arthritis management
  - D. Aletaha, Austria

**08:30 – 09:00** Understanding the synergy between methotrexate and biologics
  - G.R. Burmester, Germany
- **09:00 – 09:15** Through the eyes of the patient: Patient-reported outcomes
  - R. Fleischmann, USA
- **09:15 – 09:35** Methotrexate-related tolerability: Is it really of concern?
  - J. Kremer, USA
- **09:35 – 09:45** Panel discussion
  - All

**08:15 – 09:45** MSD N103/N104
*Current and Future Strategies for the Management of Osteoporosis: Igniting a Change in the Conversation*
*Chair: N. Guanabens, Spain*
- **08:15 – 08:20** Welcome & opening
  - N. Guanabens, Spain
- **08:20 – 08:40** Optimising current osteoporosis management with a focus on vitamin D
  - E. Jodar, Spain
- **08:40 – 09:00** Looking to the future: The impact of selective cathepsin K inhibition on bone homeostasis
  - R. Baron, USA
- **09:00 – 09:15** Odanacatib: A novel approach to the treatment of osteoporosis
  - D. Hosking, UK
- **09:15 – 09:45** Questions & answers

**08:15 – 09:45** Bristol-Myers Squibb & Company Hall 8
*Confirming the Path to Optimum Long-Term Patient Benefit*
*Chairs: P. Emery, UK & E. Martin-Mola, Spain*
- **08:15 – 08:20** Welcome and introduction
  - P. Emery, UK & E. Martin-Mola, Spain
- **08:20 – 08:35** Revisiting the concept of remission: Impact on long-term treatment goals
  - J. Smolen, Austria
- **08:35 – 08:55** Investigating long-term treatment benefit: The value of head-to-head biologic trials in RA
  - M. Schiff, USA
- **08:55 – 09:10** Demonstrating long-term structural benefit: New insights in joint damage assessment
  - D. van der Heijde, Netherlands
- **09:10 – 09:25** Considering long-term benefit-risk balance: How to make the right choice of biologic
  - R. Alten, Germany
- **09:25 – 09:40** Panel discussion and Q&A
  - All
- **09:40 – 09:45** Summary and close
  - E. Martin-Mola, Spain & P. Emery, UK

**08:15 – 09:45** IBSA/Laboratoires Genévrier Retro
*The Real Story of SLE: Understanding the Spectrum of the Disease*
*Chair: M. Petri, USA*
- **08:15 – 08:25** Introduction: Re-evaluating the natural history of SLE
  - M. Petri, USA
- **08:25 – 08:40** Managing early lupus
  - D. Isenberg, UK
- **08:40 – 08:55** Severe SLE: Latest advancements and innovation
  - F. Houssiau, Belgium
- **08:55 – 09:10** Moderate lupus: The unmet needs of an underserved majority
  - M. Petri, USA
- **09:10 – 09:25** Updates in SLE pathogenesis and emerging therapeutic targets: Impact on clinical practice
  - R. Furté, USA
- **09:25 – 09:45** Audience Q&A and panel discussion
  - All

An application has been made to the EACCME® for CME accreditation for this event. This event has been funded by an unrestricted educational grant from UCB Pharma.

**08:15 – 09:45** Sudler Medical Communications N105/N106
*Panel discussion and Q&A*

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Continued on page 17
The **JAK pathways** play an important role in the inflammatory process that leads to joint destruction.\(^1\)–\(^5\)

**Discover the intracellular world of Janus kinase (JAK) pathways in RA**

1. Activated immune cells infiltrate the joint and produce pro-inflammatory cytokines\(^1\).
2. The cytokines bind to cell surface receptors\(^1\).
3. This activates intracellular signalling pathways such as JAK pathways\(^4\).
4. The activated JAK proteins activate STATS\(^4\).
5. STATS translocate to the nucleus and act as transcription factors\(^4\).
6. The pro-inflammatory protein production triggers the recruitment and activation of additional immune cells. These cells infiltrate the synovium where they cause inflammation and joint destruction, continuing the loop of inflammatory signalling.\(^1\)–\(^5\)

**References:**

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April 2013, Pfizer EU-JAK 2 0413
A modern approach to an old disease: Glycosaminoglycans (GAGs) therapy in OA

Chair: P. Richette, France
Welcome and introduction
Y. Hendon, Belgium

Novel discoveries on the mechanism of action of GAGs in OA
Y. Henrotin, Belgium

From clinical studies to real life: recent data on the clinical efficacy of chondroitin sulphate in OA and its potential to reduce the consumption of NSAIDs
P. Richette, France

Ultrasound applications in rheumatology
T. Tamborrini, Switzerland

Tailoring the viscoinduction/viscosupplementation treatment to the joint affected by OA and its effects on the disease stage
A. Migliore, Italy

Discussion and conclusion
P. Richette, France

08:15 – 09:45 Celgene Corporation N107/N108
Advancing the Understanding of Psoriatic Arthritis: Burden, Pathogenesis and Management
Chair: P. Helliwell, UK

Welcome, introductions & opening remarks
P. Helliwell, UK

The burden of psoriatic arthritis
P. Helliwell, UK

The role of extra-and intracellular signaling pathways in the pathophysiology of psoriatic arthritis
G. Schett, Germany

New therapeutic approaches to the management of psoriatic arthritis
A. Kavanaugh, USA

17:30 – 19:00 Pfizer Hall 8
The Mosaic of RA: Assembling the Pieces for Optimal Treatment Outcomes
Chair: B. Combe, France

17:30 – 17:35
Welcome and introduction
B. Combe, France

17:35 – 18:00
Why aren’t we starting biologics earlier?
M. Dougados, France

18:00 – 18:25
How do you treat the methotrexate-intolerant patient?
P. Nash, Australia

18:25 – 18:50
What do we do when TNF inhibitors fail?
B. Combe, France

18:50 – 18:55
Panel discussion
All

18:55 – 19:00
Summary and close
B. Combe, France

17:30 – 19:00 AbbVie Hall 7
Unravelling Immunogenicity: What Do
17:30 – 19:00 MSD
Moving Beyond the Joint: What Does Rheumatoid Arthritis Mean to the Patient?

Chair: E. Martin-Mola, Spain

17:30 – 17:40
Chair’s welcome and opening remarks  E. Martin-Mola, Spain

17:40 – 18:05
Management of disease symptoms: Relief for our patients now
H. Schulze-Koops, Germany

18:05 – 18:25
Remission as the primary goal of treatment in RA
J. Smolen, Austria

18:25 – 18:45
Treating the individual: Reclaiming quality of life for the RA patient
P. Taylor, UK

18:45 – 19:00
Question-And-Answer Session  Faculty

17:30 – 19:00 UCB Pharma Hall 4
Long-Term Treatment Outcomes in RA: Early Decision for Sustained Success

Chair: G. Burmester, Germany

17:30 – 17:35
Introduction and welcome  G. Burmester, Germany

17:35 – 17:50
Early treatment decisions: Current guidelines vs. clinical practice  G. Burmester, Germany

17:50 – 18:10
Early response and sustained treatment outcomes  B. Haraoui, Canada

18:10 – 18:30
Treatments for sustained outcomes: Physician choice vs. patient preference  J.-M. Alvaro-Gracia, Spain

18:30 – 18:50
Induction-maintenance in rheumatoid arthritis: Is it possible?  R. van Vollenhoven, Sweden

18:50 – 19:00
Question and answer session  Faculty

17:30 – 19:00 Servier Osteoarthritis: State of the Art

Chairs: F. Berenbaum, France & M. Cutolo, Italy

17:30 – 17:35
Welcome and introduction  M. Cutolo, Italy

17:35 – 17:55
A major health burden in Europe  M. Cutolo, Italy

17:55 – 18:15
What’s new in our understanding of the physiopathology of osteoarthritis?  F. Berenbaum, France

18:15 – 18:35
Diagnosis of osteoarthritis: beyond the symptoms  P. Conaghan, UK

18:35 – 18:55
Joint degradation in osteoarthritis: can we prevent the inevitable?  T. Spector, UK

18:55 – 19:00
Conclusion  F. Berenbaum, France

17:30 – 19:00 Novartis IL-17 Pathway: From Pathogenesis to Potential Treatment in Arthritis

Chair: J. Sieper, Germany

17:30 – 17:35
Chairman’s welcome  J. Sieper, Germany

17:35 – 18:05
Biologics of IL-17 in inflammatory arthritis  D. Baeten, Netherlands

18:05 – 18:25
IL-17-driven pathogenesis of rheumatoid arthritis and psoriatic arthritis and therapeutic inhibition of IL-17  I. McInnes, UK

18:25 – 18:45
IL-17-Driven pathogenesis of ankylosing spondylitis and therapeutic inhibition of IL-17  J. Sieper, Germany

18:45 – 19:00
Questions and Answers  Faculty panel

17:30 – 18:00 Celltrion Healthcare Retiro
The Rise of Biosimilar mAbs: The New Era of Biologic Therapy in Rheumatology

Chair: M. Cutolo, Italy

17:30 – 17:55
Welcome  M. Cutolo, Italy

17:33 – 17:45
Opening: Why biosimilar mAbs?  M. Cutolo, Italy

17:45 – 17:55
Strategy and capability for global biosimilar mAbs development  S. Hong, South Korea

18:00 – 18:20
Stretching your expectation with next generation treatment in ankylosing spondylitis  J. Braun, Germany

18:20 – 18:45
Brand new biologic candidate in rheumatoid arthritis  U. Müller-Ladner, Germany

18:45 – 18:55
Q&A  Faculty panel

18:55 – 19:00
Summary and closing remarks  Faculty

17:30 – 19:00 Biologische Heilmittel Heel N107/N108
The Inflammation Continuum From Acute to Chronic: Optimising Patient Outcomes by a Multi-Targeted Approach

Chairs: B. Wolfarth, Germany & C. Gonzales de Vega, Spain

17:30 – 17:35
Welcome & introduction  B. Wolfarth, Germany & C. Gonzales de Vega, Spain

17:35 – 17:50
New insights in the pathophysiology of inflammation in musculoskeletal disorders  A. Scott, Canada

17:50 – 18:05
Management of acute exacerbation of chronic Injuries  C. Speed, UK

18:05 – 18:25
The range of musculoskeletal disorders and the place for a multi-target medication  B. Wolfarth, Germany

18:25 – 18:45
Ongoing and future research  L. Van den Bossche, Belgium

18:45 – 18:55
Questions & Answers  B. Wolfarth, Germany & C. Gonzalez de Vega, Spain

18:55 – 19:00
Summary and close  B. Wolfarth, Germany

17:30 – 19:00 Fidia Osteoarthritis and Intra-Articular Hyaluronic Acid Therapy: A Successful Challenge

Chair: L. Punzi, Italy

Welcome and introduction  L. Punzi, Italy

The multiple biological and clinical facets of osteoarthritis  J.M. Dayer, Switzerland

The biological role of HA and its amide derivative  G. Abatangelo, Italy

Updated intra-articular therapy  T. Bardin, France

The unmet needs in i.a. treatments for knee OA: The reasons for a new HA?  F. Benazzo, Italy

Discussion and Conclusion  Faculty
**Important Treatment Considerations**

**Indications**
- **Rheumatoid Arthritis (RA)**: HUMIRA, in combination with methotrexate, is indicated for:
  - The treatment of moderate to severe active RA in adult patients when the response to disease-modifying antirheumatic drugs (DMARDs), including methotrexate, is inadequate.
  - The treatment of severe active and progressive RA in adults not previously treated with methotrexate.
  - HUMIRA can be given as monotherapy in cases of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate.
- **Psoriatic Arthritis (PsA)**: HUMIRA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to systemic therapy, including cyclosporine, methotrexate, or PUVA.
- **Crohn's Disease (CD)**: HUMIRA is indicated for the treatment of moderate to severely active Crohn's disease in adult patients who have not responded despite a full and adequate course of therapy with a corticosteroid and an immunosuppressant, or who are intolerant or have medical contraindications for such therapies.

**Contraindications**
- Hyperчувствивність до активного субстрату або до компонентів препарата.
- Туберкульоз або інші системні інфекції, таких як спізум, інфекційно-восковий хвороба або бактеріально- інфекційна хвороба.
- Малюнкові поховання.
- Септичний синдром.
- Серцева недостатність.
- Недостатність кровообігу.
- Нестабільність серцево-судинної системи.
- Нерівномірність серцевого ритму.
- Повторні інфекції сечевого тракту.
- Нехроматинна гематоплазія.
- Туберкульоз.
- Гепатит.
- Вибіркови пороки серця.
- Нестабільність серцево-судинної системи.
- Нехроматинна гематоплазія.
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- Нестабільність серцево-судинної системи.
TRUST in HUMIRA
An unmatched legacy.

10 YEARS OF EFFICACY DATA FOR RA IN LABEL

9 INDICATIONS

15 YEARS OF CLINICAL TRIAL EXPERIENCE, BEGINNING WITH RHEUMATOID ARTHRITIS (RA)

MORE THAN 23,000 PATIENTS IN GLOBAL CLINICAL STUDIES

71 CLINICAL TRIALS IN THE LARGEST PUBLISHED ANTI-TUMOUR NECROSIS FACTOR (TNF) CROSS-INDICATION SAFETY DATABASE

*Rheumatoid Arthritis (RA)

HUMIRA, in combination with methotrexate, is indicated for:
- The treatment of moderate to severe active RA in adult patients when the response to disease-modifying antirheumatic drugs (DMARDs), including methotrexate, has been inadequate.
- The treatment of severe active and progressive RA in adults not previously treated with methotrexate.
HUMIRA can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate.
HUMIRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with methotrexate.

†First person dosed in April 1997.


Please note: Not all indications are approved in all countries.

Please see Important Treatment Considerations on reverse.

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