EULAR Congress News

#EULAR2016

EUROPEAN LEAGUE AGAINST RHEUMATISM

17th Annual European Congress of Rheumatology // 8-11 June 2016 // London

FRIDAY/SATURDAY EDITION

Friday/Saturday, 10-11 June

At a Glance

Friday, 10 June

08:00 – 17:15 Exhibition
08:15 – 09:45 Satellite symposia
10:15 – 17:00 Scientific sessions
17:30 – 19:00 Satellite symposia
20:30 – 24:00 EULAR congress dinner

08:15 – 09:45

Basic and Translational Science Sessions
News from kinase inhibitors
Crystal arthritis

Educational Session
The Lancet – Meet the Editor
Room S20

10:15 – 11:45

What is New (WIN)
WIN Session 5 ICC Auditorium
Axial and Peripheral Spondyloarthritis
Psoriatic arthritis

How to Treat / Manage (HOT)
HOT Session 7 Hall E
Myositis
Vasculitis

Abstract Sessions
Abstract Session: Expanding therapeutic options in spondyloarthritis
Abstract Session: Developments in the treatment of RA
Abstract Session: Epidemiology of RMDs
Abstract Session: SLE, SJögren’s and APS: Clinical aspects (other than treatment)

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Award winners for best research honoured

At Wednesday’s Opening Plenary Session, Prof. Gerd R. Burmester presented awards to the winners of the top clinical (top left), basic science (top middle; top right, five awardees on right), and undergraduate abstracts (top right, first three on left). Awards were also given for best PARE (bottom left) and Health Professionals in Rheumatology abstracts (bottom right three).

EULAR School of Rheumatology opens new chapter in learning

This year’s congress marks the launch of the EULAR School of Rheumatology, a new initiative that is geared to help connect healthcare providers, scientists, and students to foster communication and joint learning across the field of rheumatology and its associated subspecialties.

In a series of talks on Friday afternoon, EULAR President Prof. Gerd R. Burmester, President-Elect Prof. Johannes W.J. Bijlsma, and chair of the Standing Committee on Education and Training Prof. Annamaria Iagnocco will lay out the organisation’s offerings in 2016, its School of Rheumatology continued on page 2

Task forces devise new recommendations; at-risk arthralgia defined

During a Saturday afternoon session, several EULAR task forces will report updated recommendations and also issue a new definition for clinically suspect arthralgia.

An update on recommendations for the management of axial spondyloarthritis (SpA) is “very timely,” said the convenor of the recommendations task force, Prof. Désirée van der Heijde, “as sufficient new evidence has become available recently on new treatment options, the treatment of nonradiographic axial SpA, and the tapering of biologic agents.”

Recommendations continued on page 3
Recommendations aim to optimise paediatric to adult transition

How should young people with rheumatic diseases be prepared for the handover to adult rheumatology care? What needs to be done and when, and how can the transition be made consistent across rheumatology practises throughout Europe to ensure continuity of quality clinical care? These are questions that the first joint EULAR and Paediatric Rheumatology European Society (PReS) Working Party Recommendations for Transitional Care Management for Adolescents and Young People aim to answer.

On Saturday morning, Prof. Helen E. Foster of Newcastle University (England) will share these new EULAR/PReS guidelines ahead of them being published later in the year in the Annals of the Rheumatic Diseases.

“There is evidence that there has been a long-standing problem of young people growing up with their condition moving to adult care and either falling between the services or losing to follow-up, or there has not been continuity of care. All in all, that’s translated into poorer health outcomes for young people,” Prof. Foster explained in an interview.

One of the aims of the Working Party is practical recommendations for clinicians that can be used to help young people from the age of 11 years as they get ready for the transfer to adult services that could occur anywhere from 16 to 19 years of age.

“The idea is that young people are supported to be in control of their condition, that they can cope with being seen on their own in clinic, that they are getting on with their lives, and ultimately that they have a better outcome, which includes becoming healthy, getting a job, living independently, and having a family,” Prof. Foster said. The age at transfer is flexible and needs to fit with the young person’s home and school life. Ideally, it occurs at a time when their disease and medication are stable, they are attending routine appointments, and generally able to be independent and cope with their condition.

Together with Prof. Kirsten Minden of the German Rheumatism Research Centre Berlin (DRFZ), Prof. Foster chaired an international, multidisciplinary Working Party to review existing national and international guidelines, consensus statements, and other supporting evidence on transitional care management in childhood-onset rheumatic illness. The remit was to develop recommendations to facilitate optimal transitional care management in rheumatology across different European countries. As such, the recommendations cover both the ideal situation as well as the bare minimum requirements to hopefully allow widespread adoption.

In many countries, there is a natural break between paediatric and adult care, with young people often moving from one centre to another, perhaps in another part of the country. An important part of the transition process is therefore ensuring that there are appropriately trained staff members and good communication between centres to ensure that young people don’t get lost during the move.

The recommendations aim to be flexible so that they can be widely implemented. “It is not ‘one size fits all,’” Prof. Foster acknowledged, noting the importance of being realistic and recognising the differences between health systems, resources, and access across Europe.

During the session, Prof. Foster, who trained in adult rheumatology before turning to paediatric rheumatology, will go through the proposed transition process before focusing on how to implement the recommendations. She will also give some practical advice on what can be done to help transition young people right now, as there are existing resources that can be used.

“We don’t want to reinvent the wheel. We want to share best practice and resources,” she said. Indeed, one of the recommendations is that all the guidelines and all the resources used to develop them are made publicly available via an electronic platform so that anybody involved in the care of a young person with rheumatic disease, as well as the young person and their family, can access them.

She had no relevant financial disclosures.
RECOMMENDATIONS

Axial SpA teamwork ensures wide representation

In another presentation during the session, Prof. Annette H.M. van der Helm-van Mil will describe how the development of a new definition for arthralgia in patients at risk for developing rheumatoid arthritis should make research study results more easily compared and interpreted.

Prof. Josef S. Smolen will discuss new recommendations for the use of disease-modifying antirheumatic drugs (DMARDs) in the treatment of rheumatoid arthritis (RA).

Recommendations that update 2007 early-arthritis management advice will be presented by Prof. Bernard Combe, who said that they take advantage of much more evidence that supports diagnosing and managing early-stage inflammatory arthritis as early as possible.

Axial spondyloarthritis

A task force assembled jointly by the Assessment of Spondyloarthritis International Society (ASAS) and EULAR has updated the recommendations for managing patients with axial SpA that the two groups published in 2011 (Ann Rheum Dis. 2011 June;70(6):896-904), as well as recommendations for using tumour necrosis factor inhibitors on these patients published by ASAS (Ann Rheum Dis. 2011 June;70(6):905-8). These recommendations are now combined, and the new update also broadens the disease spectrum from ankylosing spondylitis to axial spondyloarthritis (SpA).

The 2016 update includes five overarching principles, and 13 specific recommendations that cover the definition of a treatment target, disease monitoring, and a wide range of aspects of pharmacologic and nonpharmacologic treatment. Among the new features are combined recommendations for using biological agents in patients with both nonradiographic and radiographic axial SpA, guidance on tapering biologic drugs, and addition of the Ankylosing Spondylitis Disease Activity Score (ASDAS) as an alternative to the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) when assessing SpA patients for possible treatment with a biological drug, said Prof. van der Heijde, professor of rheumatology at Leiden University Medical Centre in the Netherlands.

The new recommendations also include a new biologic-drug class, the interleukin-17A inhibitors. The interleukin-17A inhibitor class includes secukinumab, which has been approved for treating ankylosing spondylitis by both the European Medicines Agency and the U.S. Food and Drug Administration.

The collaboration by both EULAR and ASAS “ensures a worldwide representation,” in the development of these recommendations, she said.

Defining clinically suspect arthralgia

A EULAR task force has taken the first step toward developing a definition of patients with arthralgia who are at risk for progression to rheumatoid arthritis. This consensus definition should help better unify selection of patients with “arthralgia” by various investigators for studies and help make the results of their research more easily compared and interpreted, said Prof. van der Helm-van Mil, convenor of the task force.

“The EULAR task force set out to derive a definition of arthralgia in patients at risk for developing rheumatoid arthritis with the aim of selecting homogeneous patients for scientific studies,” she said. The definition the task force produced consists of seven clinical parameters that identify patients with symptoms that constitute arthralgia prior to the appearance of identifiable rheumatoid arthritis, said Prof. van der Helm-van Mil, professor of rheumatology at Leiden University Medical Centre in the Netherlands.

Until now, investigators had not defined nor agreed upon symptoms of the arthralgia phase that are specific precursors to rheumatoid arthritis. As a result, different research groups have used different definitions, which has made results from different studies hard to compare and interpret, she said.

“Further studies are now needed to determine the predictive accuracy of the new clinical criteria by themselves, and when used in combination with serology and imaging.” Ideally all this information will identify with high accuracy patients with arthralgia who are on the verge of developing rheumatoid arthritis, she said.

The task force included 18 rheumatologists, 2 patients, 3 health professionals, and 1 fellow, who work in 15 European countries.

Use of DMARDs in RA

A 50-member Task Force that included patients and health professionals updated the 2013 EULAR recommendations for the treatment of RA with DMARDs. According to Prof. Smolen, who will present the recommendations, the update includes recommendations on the use of glucocorticoids in the treatment algorithm; conventional synthetic DMARD monotherapy vs. conventional synthetic DMARD combination therapy; the similarities and potential differences of biologic DMARDs; bio-similar DMARDs; targeted synthetic DMARDs (JAK inhibitors); and treatment targets and general approaches to therapy.

The new recommendations include “4 overarching principles and 12 recommendations, in contrast with 3 overarching principles and 14 recommendations in 2013 and 15 recommendations in 2010. We will again provide a table with the recommendations and an algorithm, adapted according to the changes decided on,” said Prof. Smolen of the Department of Rheumatology, Internal Medicine III, at the Medical University of Vienna (Austria). He noted that a research agenda will complement the recommendations.

For the first time, the convenors invited rheumatologists from all over the world, from Asia and Australia to Latin America and North America, in addition to experts from all across Europe. The recommendations were developed in line with the EULAR standardised operating procedures. Rheumatologists Jackie Nam, Katerini Chatzidionysiou, and Sofia Ramiro performed three systematic literature reviews to inform the Task Force on the available evidence. The Task Force carefully worded each recommendation, and each underwent one or more rounds of voting at a meeting in April in Vienna until a large majority accepted the individual proposals.

Eight of the recommendations had the highest level of evidence. After the meeting, there was an anonymous ballot on the level of agreement, and on a 0-10 scale, most recommendations attained a mean of 9 to 10, and none had a level lower than 8.4. Prof. Robert Landewé served as the epidemiologist organising the meeting with Prof. Smolen, and others in the steering committee included Prof. Johannes Bijlsma, Gerd Burmester, Maxime Dougdos, Désirée van der Heijde, Ronald van Vollenhoven, and Marieke Schute-Voshaar.

Announcements

The deadline to apply for the EULAR/ACR Exchange Programme has been extended from 15 June to 21 June at noon. You still have time!

On Wednesday, #EULAR2016 was the No. 4 trending topic on Twitter in the United Kingdom! Great job spreading the word, everyone!
Top honours for distinguished careers in rheumatology

The 2016 EULAR Meritorious Service Awards in Rheumatology go to two devoted clinician-researcher-educators who have served the field of rheumatology for many years: Prof. Eliseo Pascual and Dr. Jackie Hill.

Since 2000, EULAR has awarded rheumatologists and health professionals in rheumatology who have been judged by the EULAR Executive Committee to have served rheumatology in an outstanding way through scientific research, clinical science, or their activities in EULAR, national, or international organisations.

Prof. Pascual is Emeritus Professor and Chair of the Department of Clinical Medicine at University Miguel Hernández of Elche (Spain) and Head of the Rheumatology Section at Hospital General Universitario de Alicante. He is an authority on the diagnosis and treatment of gout and calcium pyrophosphate deposition disease, as well as the analysis of synovial fluid. Prof. Pascual has organised a EULAR course on synovial fluid analysis since 2002 and is a member of this year’s Scientific Programme Committee. He was President of the Spanish Society of Rheumatology in 1992-1994 and is the author of more than 110 original articles, a rheumatology textbook, and numerous presentations at national and international congresses.

Jackie Hill, Ph.D., was one of the first rheumatology nurses in the United Kingdom. She was Senior Lecturer and Co-Director of the Academic and Clinical Unit of Musculoskeletal Nursing in the Department of Medicine at the University of Leeds (United Kingdom) for 30 years. In 2012, Dr. Hill was awarded the first Lifetime Achievement Award by the British Health Professionals in Rheumatology. She has organised and has been invited to speak at many national and international conferences. Dr. Hill has conducted research leading to over 100 papers published in peer-reviewed journals and was co-convenor of the EULAR Nursing Task Force to produce “Recommendations for the role of the nurse in the management of chronic inflammatory arthritis.” She is also the author of a rheumatology nursing textbook.

Stene Prize: Taking action despite life’s challenges

Simon Stones of the United Kingdom is the 2016 Edgar Stene Prize winner for his essay on the topic “Living with a rheumatic or musculoskeletal disease (RMD): How I take action to enjoy life to the full.”

Mr. Stones, a 22-year-old student and patient research ambassador who has lived with juvenile idiopathic arthritis, hypermobility, and fibromyalgia since 3 years of age, decided to take part in the contest after learning about it at last year’s congress in Rome. “I wanted to share my story of living with arthritis to help inspire other young people to realise that they are capable of achieving their dreams,” he said.

In his essay, Mr. Stones describes his struggles with arthritis and medication side effects from an early age and his will to succeed academically despite absences from school and ongoing medical struggles.

Mr. Stones’s subsequent academic success and personal experiences have inspired him to advocate for patients living with RMDs. Today, he serves as a consumer health advocate with the United Kingdom’s National Institute for Health Research and Arthritis Research on their paediatric rheumatology research agendas. He has also advised on the development of mobile app technology to promote self-management in young people with juvenile idiopathic arthritis and supported the development of EULAR/ReS recommendations for transitional care in young people with RMDs. He currently serves as a member of the EULAR Young PARE working group.

He is also currently studying for a bachelor’s degree in biomedical sciences at the University of Manchester (England) and hopes to do postgraduate research in child health. He lives in Bolton in the Greater Manchester area with his two parents, both of whom have multiple rheumatic and musculoskeletal diseases.

For his winning essay, Mr. Stones received a prize of 1,000 euros, paid travel to London, hotel accommodations, and an invitation to Friday night’s congress dinner at the Natural History Museum.

The Stene Prize was established in honour of the memory of the late Edgar Stene who himself had severe ankylosing spondylitis. Mr. Stene was a great promoter of cooperation among doctors, patients, and community workers.

A jury elected by the PARE (People with Arthritis/Rheumatism in Europe) Standing Committee chose Mr. Stones’s essay from those selected by each national PARE organisation as its best entry. The essay can be read at www.eular.org/pare_stene_prize.cfm. Judges for the award represent the three pillars of EULAR (patients, health professionals, and rheumatologists) and come from a several different countries across Europe.

The 2016 Prize Jury was led by Nele Caeyers, PARE board member from Belgium and CEO of ReumaNet. Other jury members included Prof. Tadej Avicin from Slovenia, Chair of the EULAR Standing Committee on Paediatric Rheumatology; Kjerstin Fjeldstad from Norway, board member of the Norwegian League Against Rheumatism; Wendy Oldier from the Netherlands, board member of Youth-R-Well.com and representative of Young PARE; Costas Ioulianos from Cyprus, President of Cosmos-Rheuma Plus, representing the EULAR Health Professionals in Rheumatology; Marios Kouloumas, Vice President, EULAR, representing PARE; and Dieter Wick, Chair of the EULAR Standing Committee of PARE.
Seven honorary EULAR memberships awarded

EULAR recognised the hard work and dedication of seven individuals for their long-standing service to the organisation in a variety of positions and roles. EULAR President Gerd R. Burmester presented each person with an honorary EULAR membership at Wednesday evening’s Opening Plenary Session.

Daniel Aletaha is an Associate Professor of Medicine and a consultant physician in the division of rheumatology at the Medical University of Vienna (Austria). He has served as EULAR liaison officer to the American College of Rheumatology and was a founding member of the Emerging EULAR Network (EMEUNET) in 2009. He has also served as chairman of the EULAR Standing Committee on Clinical Affairs.

Ingrid Lundberg is Professor and Chair of the Rheumatology Unit at the Karolinska Institute in Stockholm. She is the past Chair of the Standing Committee on Education and Training.

Deborah Symmons is Professor of Rheumatology and Musculoskeletal Epidemiology at the University of Manchester (England). She is the past Chair of the Standing Committee on Epidemiology and Health Services Research.

Alberto Martini is Professor of Paediatrics at the University of Genova (Italy) and Director of the Department of Paediatrics Pediatria II in the Istituto Giannina Gaslini at the University of Genova. He is the past Chair of the Standing Committee on Paediatric Rheumatology.

Susan Oliver is an independent nurse consultant in rheumatology who is based in North Devon, England. She is the past Chair of the Standing Committee on Health Professionals in Rheumatology.

B-cell clusters in synovial tissue predict joint damage in early RA

The presence of clusters of B cells in synovial tissue can predict which patients with early rheumatoid arthritis are most at risk of developing joint damage, according to research that will be presented Friday morning.

The results of the study, which examined synovial biopsies at baseline from 135 patients with early RA who had not taken disease-modifying antirheumatic drugs previously, are clinically significant because they suggest that integration of synovial molecular markers into clinical algorithms might significantly improve patient outcomes, lead author Dr. Frances Humby said in an interview.

“Although outcomes for patients with RA have improved dramatically in the past decade, we are still unable to reliably predict disease prognosis at baseline,” said Dr. Humby, Senior Lecturer and Honorary Consultant Rheumatologist in the Department of Experimental Medicine and Rheumatology at Queen Mary University in London. “If we can use synovial tissue to stratify patients according to best drug, we can move towards an era of personalised medicine for patients with RA.”

Based on the biopsies, Dr. Humby and her associates classified patients into lymphoid, myeloid, or fibroid synovial pathotypes according to the degree of synovial infiltration of CD20+ B cells, CD3+ T cells, CD68+ macrophages, and CD138+ plasma cells. The patients were in the Pathobiology of Early Arthritis Cohort at Barts Health NHS Trust in London.

At 12 months of follow-up, the researchers discovered that baseline lymphoid pathotypes were significantly associated with anticitrullinated protein antibody (ACPAb) positivity (P = .017) and highly active disease as measured by the 28-joint Disease Activity Score, C-reactive protein, erythrocyte sedimentation rate, and swollen joint count (P < .01). Furthermore, a significantly higher number of patients with a baseline lymphoid pathotype developed radiographic progression, compared with those who were stratified as myeloid or fibroid pathotypes (9 of 26 vs. 5 of 53; P = .026).

“The significant association observed between a lymphoid pathotype and a severe clinical phenotype seropositivity for ACPA supports a direct role for synovial lymphoid structures in disease pathogenesis,” the researchers said.

“The results strongly support the concept that B-cell activation and proliferation within the synovial tissue equate to poorer outcomes and drive ongoing joint damage,” Dr. Humby explained.
Study identifies postgraduate education shortcomings

With the notable exception of nurses, postgraduate rheumatology education for health professionals in most European countries is lacking, results from a new study suggest.

“There is a considerable need for postgraduate rheumatology education for health professionals in Europe,” Prof. Theodora Vliet Vlieland said in an interview in advance of her presentation on Friday afternoon. “As time and financial constraints were identified as important barriers, educational offerings in people’s home countries and online education were very much desired. The English language was found to be an important barrier to take part in educational offerings for health professionals in many countries, indicating a need for innovative solutions.”

In a project that received financial support from EULAR, Prof. Vliet Vlieland, of the department of Orthopaedics, Rehabilitation and Physical Therapy at Leiden University Medical Centre, the Netherlands, and her associates from the EULAR Standing Committee of Health Professionals in Rheumatology set out to assess the availability of postgraduate education for rheumatology health professionals in Europe, to define their education-al needs, and to identify potential barriers. There were two components to the study: in-person and telephone interviews with representatives of rheumatology health professional organisations, plus an online survey for individual health professionals. On a scale of 0-10, respondents were asked to answer questions on availability of postgraduate education, familiarity with EULAR and its educational offerings, needs regarding contents and mode of education delivery, and potential barriers to education.

The researchers conducted interviews with representatives from 17 countries. Of these, the number of countries where postgraduate rheumatology education was reported to be available was highest for nurses (13 countries), followed by physical therapists (8 countries), occupational therapists (7 countries), and professionals in other disciplines (3 or fewer countries).

Prof. Vliet Vlieland went on to report that 1,041 respondents from 19 countries completed the online survey, which was translated into eight different languages. “The number of respondents was overwhelming, indicating that the topic is extremely relevant,” she said. Their mean age was 41 years, 86% were female, 56% reported being familiar with EULAR, 21% had attended one or more EULAR annual conferences, and 14% were familiar with EULAR’s online course offerings. Educational need scores related to content were highest for “inflammatory arthritis” and “connective tissue diseases,” while scores related to desired mode of delivery were highest for “courses in English organised in own country” and “EULAR online course.” The most commonly cited perceived barriers to participate in educational offerings were “lack of resources,” “lack of time,” and “lack of mastery of the English language” (the latter limited to participants who completed the translated survey).

Prof. Vliet Vlieland acknowledged certain limitations of the study, including the fact that, since a link to the survey was distributed by national presidents of rheumatology health professional organisations, “we do not exactly know how large our target population of health professionals was, and thus, to what extent the respondents were representative of all health professionals in Europe. In particular from Eastern European countries, the response was relatively low.”

Prof. Vliet Vlieland reported having no financial disclosures.
People with rheumatoid arthritis are more likely to receive an early diagnosis and treatment when healthcare professionals across all settings work together, including general practitioners, rheumatologists, and physiotherapists.

Although progress has been made in identifying and treating people with inflammatory arthritis earlier, there is room for improvement across all aspects of the jig saw puzzle of musculoskeletal care, congress delegates will learn in a Saturday morning Clinical Science Session titled “Time Is Joint: Early recognition and treatment of arthritis.”

Prof. Annette H.M. van der Helm-van Mil, a rheumatologist at Leiden University Medical Centre in the Netherlands, said that barriers to diagnosis and treatment exist at different levels of patient care. In many countries, patients need to seek medical attention through their general practitioner, who then has to refer them.

This is difficult, however, as general practitioners see many people with a wide range of musculoskeletal symptoms, Prof. van der Helm-van Mil said. She will address the logistical issues involved in gaining early access to rheumatologic care, as well as the evidence around the benefits of early treatment and how to identify patients with arthralgia who are at high risk of rheumatoid arthritis.

Prof. Christian Mallen, the National Institute for Health Research Professor of General Practice Research at Keele University (United Kingdom), agreed that it is sometimes hard for busy general practitioners to distinguish people with potentially serious pathology, particularly if they do not present with classical symptoms.

He said the absence of diagnostic tests that are useful in community settings adds to the challenge. “With GPs under increasing pressure not to refer, we need help from our consultant colleagues to help us know who to refer and when,” Prof. Mallen said in an interview. “While some areas have superb ‘fast track’ pathways, these are not the norm and as such we need appropriate care pathways to support and promote diagnosis.

“Being critical of GPs is commonplace but not productive … We need to work together to improve care and support earlier diagnosis,” he said.

According to Prof. Mallen, most examples of successful rapid-access clinics that had improved time to diagnosis always seem to have one thing in common: ‘A high-quality educational programme underpinned by strong relationships between primary and secondary care.’

Working together is a sentiment that physiotherapist Paul Kirwan agrees with. “Whether you are a rheumatologist, orthopaedic surgeon, GP, physiotherapist, nurse, or any other allied health professional dealing with patients with joint pain, it is important we all try to identify these patients as early as possible to minimise joint damage and get the optimal treatment for these patients,” he said in an interview.

According to Mr. Kirwan of Connolly Hospital, Dublin, Ireland, physiotherapists are well placed to identify patients with inflammatory arthritis as they are often the first point of contact for patients complaining of joint pain. They also see patients who, over a course of visits, may have presented initially with a single painful joint or tendon that has evolved into multiple joints.

“It is of utmost importance [that physiotherapists be] able to recognise joint pain that is non-mechanical,” he stressed, because “physiotherapists need to arrange for these patients to be assessed promptly by rheumatologist.”

Mr. Kirwan will take delegates through some simple strategies and clinical tools that physiotherapists can use in their clinical assessment.

The role of the patient also is important in fostering rapid diagnosis, and this could be achieved by raising public awareness around the signs and symptoms of rheumatoid arthritis and the importance of early diagnosis, according to Ailsa Bosworth, Chief Executive and founder of the National Rheumatoid Arthritis Society in the United Kingdom.

This is, however, easier said than done when there are no signs of government funding. “We do what we can … but we do not have the funds to run TV adverts as the government has done, for example, to raise awareness of stroke,” she said in an interview.

Early arthritis clinics (EACs) are also instrumental in ensuring patients are seen earlier because evidence shows they prioritise patients more effectively.

“We wish to encourage all rheumatology units where an EAC does not exist, to set one up. … It is possible to do this without a lot of extra funding,” said Ms. Bosworth, who also will be taking delegates through the impact that rheumatoid arthritis has on people’s lives, with particular reference to the prevalence of depression and anxiety in early rheumatoid arthritis.

## Smoking, excess weight hinder sustained remission in early RA

Tobacco use and excess weight can make it harder to achieve sustained remission in the treatment of early rheumatoid arthritis. Research to be presented on Friday morning will describe how the two potentially modifiable lifestyle factors act independently and in a combined way to blunt therapy geared toward sustained remission.

Aggressive treatment that starts soon after diagnosis of rheumatoid arthritis (RA) is important for the absence of disease activity, which is the hallmark of sustained remission. But the reality is a success rate of less than 50% in the first 3 years with physical deterioration continuing thereafter. “Excess weight and smoking are two risk factors for developing RA. We were interested in seeing if they might also affect how well people responded to treatment,” said lead investigator Susan Bartlett, Ph.D., an Associate Professor in the Faculty of Medicine at McGill University in Montreal, Canada.

Dr. Bartlett and colleagues examined a cohort of 1,008 early RA patients enrolled in the Canadian Early Arthritis Cohort (CATCH) multicentre, prospective study. The patients were followed from around the time of diagnosis through the first 3 years of treatment to estimate the time it took until they achieved sustained remission, defined as being in remission for two consecutive visits.

The patients (72% female, 81% white) had a mean age in the early 50s. Overall, 30% of females and 47% of males were overweight, one-third of both genders were obese, and 15%-20% smoked. Treatment at entry included methotrexate in mono- or combination therapy in about three-quarters of the patients, with steroids used in about half and biologics used sparingly.

The proportion of patients in sustained remission was only 38% at 3 years, with a median time to remission of 11.3 months. “That finding wasn’t surprising because that is generally what is found in most studies of early RA. However, when we looked more closely at who was...”
Improved outlook for people with giant cell arteritis

Giant cell arteritis is associated with substantial mortality, but the results of a population-based study being presented Friday afternoon show that survival over the past 20 years has significantly improved.

Comparing two cohorts of patients with giant cell arteritis (GCA) – one diagnosed between 1997 and 2004 and the other between 2005 and 2012 – researchers supported by Arthritis Research Canada found that the adjusted relative risks for death over the two time periods were 4.58 and 1.48, respectively, when compared against individuals in the general population. While the adjusted relative risk of death was significantly greater for men with GCA than in the general population during the first period, this was not true for the second period. However, the increased risk of death did not completely go away for women in the second period, although the risk was diminished.

“The risk of death from GCA over time has decreased,” noted principal study investigator Dr. J. Antonio Aviña-Zubieta in an interview. Dr. Aviña-Zubieta, who is Assistant Professor of Medicine at the University of British Columbia in Vancouver, Canada, and a scientist at Arthritis Research Canada, noted that improved mortality also was seen in individuals without GCA over the two time periods, but this was not as dramatic as in the GCA cohorts. “This suggests that at least some of the improvement in the GCA cohort is likely related to better care in general.”

Improved survival over time has been noted recently in several rheumatic diseases, such as systemic lupus erythematosus and rheumatoid arthritis, and Dr. Aviña-Zubieta’s research group wondered if the same might be true in systemic vasculitis.

“Given that GCA is the most frequent adult systemic vasculitis, we decided to test this question. Furthermore, given that our cohort is a population-based study, we thought that our result could be generalizable to the general population,” he said.

While the adjusted relative risk of death did not completely go away for people who smoked and those who were overweight or obese were much less likely than their non-smoking, normal-weight peers to be in sustained remission,” Dr. Bartlett said in an interview.

After adjusting for factors that could affect response to treatment – including age, race, disability status, pain, and early medications used – smoking (P = .046) and excess weight (P = .003) were associated with a poorer likelihood of achieving sustained remission. While more men were overweight or obese than women, the effects of weight and smoking appeared to be more problematic for women (P = .02).

An average nonsmoking male with a healthy body mass index (BMI; 25 kg/m² or less) had about a 41% probability of achieving sustained remission within 3 years, compared with only 15% for an obese male smoker. A nonsmoking female with a healthy BMI had a 27% probability of achieving sustained remission within 3 years, compared with only 10% for an obese female smoker. Probabilities of sustained remission were also lower for overweight men and women.

Smoking and obesity have already being linked with an increased likelihood of developing RA, which in turn increases the risk of cardiovascular disease and premature death. The latest data suggest that both smoking and extra weight – including overweight and obese as defined by BMI – may also independently influence the success of treatment. “Our data suggest that if you have RA, it’s important to take the medications that your doctor has prescribed. If you smoke, you need to stop. And if you’re carrying extra weight, not only is that placing a greater demand on already vulnerable joints, it may also be making your RA treatment less effective,” Dr. Bartlett said. These lifestyle modifications can be challenging for some people with RA. Dr. Bartlett suggested that clinicians may be better able to help by considering lifestyle behaviours that lead to chronic diseases and poorer outcomes in addition to their more traditional view of diagnosis and treatment.

Well-controlled clinical trials will be needed to better understand the benefits of weight control and smoking cessation on response to RA treatment. Further, why women who smoke and are overweight are at more of a disadvantage than their male counterparts is unknown.

“As we begin putting these pieces together, we may learn valuable information that helps us to better control and ultimately cure RA,” Dr. Bartlett said.

The researchers had no conflicts of interest to declare.
Annual European Congress of Rheumatology EULAR 2017
Madrid, Spain, 14-17 June 2017

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FDG-PET/CT useful for fever, inflammation of unknown origin

The use of combined modality imaging with $^{18}$F-fluorodeoxyglucose-PET/CT may provide enough information to make a definitive diagnosis in patients with fever or inflammation of unknown origin, particularly in those who are aged 50 years or older, have elevated C-reactive protein, and have no fever, according to findings from a single-centre study of 240 cases that will be presented on Friday afternoon.

The retrospective study of patients seen at the University Clinic of Erlangen (Germany) during 2007-2015 found that $^{18}$F-FDG-PET/CT was useful in identifying a diagnosis in a majority of patients with fever of unknown origin (FUO) and inflammation of unknown origin (IUO). By implementing a single $^{18}$F-FDG-PET/CT scan in a structured diagnostic approach for patients with FUO or IUO we were able to catch the underlying disease in the majority (79%) of the 240 patients studied. In the FUO group the leading diagnosis was adult-onset Still’s disease, and in the IUO group it was large-vessel vasculitis and polymyalgia rheumatica, the study’s lead investigator, Prof. Georg Schett, said in an interview.

FUO was defined about 50 years ago as several episodes of temperature exceeding 38.3°C that accompany an illness lasting more than 3 weeks, with no diagnosis after a week of testing following hospital admittance. If inflammation but no fever is involved, the condition is termed IUO.

FUO and IUO are severe, sometimes even life-threatening, conditions, in which the cause of fever and inflammation, respectively, has not been defined using standard diagnostic approaches. This makes diagnosis challenging and requires a costly and complicated work-up. A delayed diagnosis can be serious, resulting in severe organ damage in patients with FUO and IUO due to the underlying, and uncontrolled, inflammatory disease.

The current diagnostic approaches for FUO and IUO include a thorough medical history, physical examination, laboratory testing, and imaging. $^{18}$F-FDG-PET/CT imaging could be potentially useful for the diagnosis of FUO/IUO because of its high-resolution detection of inflammation and malignancy. Prof. Schett and his colleagues explored this potential and examined clinical markers that would increase the likelihood of accurate $^{18}$F-FDG-PET/CT-based diagnosis in patients presenting with FUO or IUO.

The 240 patients in the study included 72 with FUO and 142 with IUO, with the remaining 26 not fulfilling the criteria for either condition. The diagnostic work-up included $^{18}$F-FDG-PET/CT scans. Scans were considered to be positive when uptake of the tracer occurred at foci in addition to the other expected locations. The investigators explored whether the scans aided the final diagnosis, with multivariable regression analysis clarifying clinical parameters that aided the success of the scans in patients with and without FUO or IUO.

$^{18}$F-FDG-PET/CT was helpful in finding the diagnosis in 57% of all patients and 72% of the patients with a later diagnosis. A definitive diagnosis was not reached in 29% of patients with FUO and 17% of patients with IUO. Predictive markers for a diagnostic $^{18}$F-FDG-PET/CT for FUO and IUO were age over 50 years ($P = .002$ and $P = .005$, respectively), elevated C-reactive protein (CRP), and IUO. Other patients could benefit as well. It may be important to investigate also those patients who were referred for FUO or IUO but do not show fever or inflammation at time of admission. Several of these ‘ex-FUO/IUO’ patients were diagnosed with IgG4-related disease by applying $^{18}$F-FDG-PET/CT,” Prof. Schett said.

The research will support establishing recommendations for the use of $^{18}$F-FDG-PET/CT in FUO and IUO patients. Other patients could benefit as well. It may be important to investigate also those patients who were referred for FUO or IUO but do not show fever or inflammation at time of admission. Several of these ‘ex-FUO/IUO’ patients were diagnosed with IgG4-related disease by applying $^{18}$F-FDG-PET/CT,” Prof. Schett said.

False-positive results with $^{18}$F-FDG-PET/CT could occur in interstitial lung disease (ILD), the result is often death. One reason may be its frequent lack of detection until organ function or damage is sufficient to be apparent by routine diagnostic approaches like computed tomography (CT) and pulmonary function tests. "Currently, in the diagnosis of SSc-ILD, there is a lack of sensitive and disease-specific diagnostic tools. ... We proposed that targeting pathophysiologic key players of early inflammation-dependent fibrosis like the integrin alpha beta, [integrin alpha beta], might be a novel, sensitive diagnostic approach for the early detection of SSc lung involvement,” Ms. Schniering said in an interview.

Scc is an autoimmune disease of the connective tissue. When the lungs are involved, as occurs in interstitial lung disease (ILD), the result is often death. One reason may be its frequent lack of detection until organ function or damage is sufficient to be apparent by routine diagnostic approaches like computed tomography (CT) and pulmonary function tests. “Currently, in the diagnosis of SSc-ILD, there is a lack of sensitive and disease-specific diagnostic tools. ... We proposed that targeting pathophysiologic key players of early inflammation-dependent fibrosis like the integrin alpha beta, [integrin alpha beta], might be a novel, sensitive diagnostic approach for the early detection of SSc lung involvement,” Ms. Schniering said in an interview.

Ideally, diagnosis of SSc-ILD should occur early in the course of the disease, when SSc-ILD can be more effectively treated and the damage that has occurred so far could perhaps be reversed. The researchers explored this issue in two ways. The first was an immunohistochemistry study aimed at detecting the expression of integrin alpha beta, a pathophysiologic key player of inflammation-dependent fibrosis. The integrin was significantly upregulated in lung sections from patients with SSc-ILD and idiopathic pulmonary fibrosis, compared with tissues from healthy controls ($P < .009$ and $P < .02$, respectively). The same pulmonary expression levels were evident in lung tissue from bleomycin-induced and transgenic mouse models of SSc (both $P < .05$).
Despite the effort that’s gone into developing them, none of the recently devised rheumatoid arthritis-specific cardiovascular risk calculators offer an advantage over the tried-and-true models created for general populations. When tested on about 1,800 patients with rheumatoid arthritis (RA), the Expanded Cardiovascular Risk Prediction Score for Rheumatoid Arthritis (ERS-RA) calculated a 10-year cardiovascular disease risk of about 9%, which is similar to the risks found by the simpler general risk calculators, according to Cynthia Crowson, a medical statistician at the Mayo Clinic, Rochester, Minn.

The EULAR 1.5 multiplier, another RA-specific tool, only reclassified six patients above the 7.5% treatment threshold for the calculator created by the American College of Cardiology/American Heart Association (ACC/AHA). It reclassified just three patients above the 20% treatment threshold for the Framingham Adult Treatment Panel III (FRS-ATP), said Ms. Crowson, who will present these findings on Friday morning.

“These calculators that are specifically aimed at RA patients are more complicated and take longer to complete, and don’t perform as well as those validated for the general patient population, she said in an interview. “While I do advocate screening our patients for cardiovascular disease, I don’t think these specially focused tools are worth the extra effort. We can use one that has been developed for the general population for now."

She and her colleagues compared three RA-specific cardiovascular risk tools to three designed for the general population: the FRS-ATP, the ACC/AHA cardiovascular risk calculator, and the Reynolds Risk Score.

The study comprised 1,796 patients with RA, who were drawn from cohorts in the United Kingdom, Norway, the Netherlands, the United States, South Africa, Canada, and Mexico. None of the patients had prior cardiovascular disease. They were a mean of 54 years old and most (74%) were women.

The mean follow-up on these subjects was about 7 years, which accounted for 12,430 person-years. Over that time, 100 patients (8% event rate by 10 years) experienced a cardiovascular event.

The ERS-RA estimated a 10-year cardiovascular disease risk of 8.8%, which was very similar to the FRS-ATP and Reynolds calculators (9% each) and the ACC/AHA calculator (9.8%). The QRISK2 10-year risk was 15.5%.

Ms. Crowson also examined the net reclassification index (NRI) between the specialised and general calculators.

“The net reclassification index is an aggregate measure of what proportion of patients was correctly reclassified from a low-risk to a high-risk category and from a high-risk to a low-risk category. So the higher the NRI, the better. An NRI less than zero would indicate the new score is worse than the old score. Small NRI values indicate very little improvement in predicted risks,” she said.

The NRI for the ERS-RA calculator was low, compared with both the ACC/AHA (~0.8%) and FRS-ATP (2.3%). It was also low for the QRISK2, compared with the ACC/AHA (~2.4%). When the QRISK2 was compared against FRS-ATP, the NRI was higher, but still not significantly so.

Next, Ms. Crowson applied the EULAR 1.5 multiplier rule to each assessment. This incorporates increased cardiovascular risk for patients who have two out of three criteria: At least 10 years’ disease duration, positive for rheumatoid factor or anti-CCP, and extra-articular manifestations of RA. This adjustment only reclassified three patients higher than the FRS-ATP threshold (i.e., greater than 20%) and six patients higher than the ACC/AHA threshold (i.e., greater than 7.5%).

She suggested that any risk calculator, no matter how detailed and specific, will probably have a hard time predicting long-term outcomes in such a complicated and multifaceted disease process.

Patients with RA not only face the familiar general cardiovascular risks of diet, exercise, and family history, but the complex interaction of chronic inflammation over time with all of these.

“Many medical centers in the U.S. and Europe are starting to have their own cardiovascular rheumatology clinics that combine the disciplines. At Mayo, for example, special imaging is performed to look for subclinical markers of heart disease, such as carotid artery plaque presence, along with measurements of arterial stiffness and endothelial dysfunction to supplement information from a risk calculator.”

And while predicting the future is important, she said, managing the present is even more so.

“We really should be raising awareness about treating cardiovascular risk factors. A lot of our patients are not getting their hypertension and hyperlipidaemia treated as often as are people without RA. We have clear evidence of under-treatment."

Ms. Crowson’s study was funded in part by a grant from the National Institutes of Health.

She had no financial disclosures, but she is part of the ATACC-RA (A TransAtlantic Cardiovascular Risk Calculator for Rheumatoid Arthritis) consortium, which receives some financial support from Eli Lilly.

“Given these promising ex vivo results, we decided to perform first in vivo proof-of-concept SPECT/CT imaging studies,” Ms. Schniering explained. The examinations were done in the mouse models of SSC as well as in healthy mice to see whether the approach was suitable. The researchers deliberately focused early in the disease, using established pulmonary inflammation and incipient fibrosis landmarks to guide the timing. Consistent with what had been found in the lungs of SSC and idiopathic pulmonary fibrosis patients, the investigators observed increased uptake of an integrin $\alpha_{\beta_3}$-targeting radiotracer in the lungs of the mice. Other studies confirmed that the radiotracer was accumulating only in the lungs and only at sites of integrin $\alpha_{\beta_3}$ deposition.

“From these findings, we conclude that targeting the integrin $\alpha_{\beta_3}$ by nuclear imaging might be a novel diagnostic approach for the early detection of lung involvement in SSC,” Ms. Schniering said.

The radioactivity exposure from the tracer is minuscule and no pharmacologic effect of the tracer has been found. The risks from the radiation are comparable with conventional CT scans. In the future, the researchers plans to assess the use of PET imaging in combination with MRI to reduce the radiation dose of repeated CT scans.

The ultimate goal is the clinical application of the diagnostic tool. Much remains to be done including exploring the utility of PET/CT, which offers better resolution and detection sensitivity than SPECT/CT; and further animal model-based experiments to confirm the superiority of the radiotracer target imaging approach over conventional CT and the current gold standard $^{18}$F-FDG-PET/CT. However, given the careful approach of target confirmation and coverage in human biosamples prior to the performance of animal experiments, there is a great chance that we will successfully identify promising targeted radiotracers for nuclear imaging in patients with systemic sclerosis,” Ms. Schniering said.

Ms. Schniering and her coauthors reported receiving a grant from the Swiss National Science Foundation or their respective institutions. One coauthor disclosed consultancy remuneration from many pharmaceutical companies and research support from some of the same companies.
The biggest developments in the treatment of Paget’s disease of bone (PDB) take advantage of new knowledge about predisposing mutations that may give presymptomatic individuals a chance to prevent the disease from arising through early treatment, according to Prof. Stuart H. Ralston, who will present the latest insights into the pathogenesis and treatment of the disease on Saturday afternoon.

‘Attendees will learn about advances in knowledge of the causes of PDB, the latest news on treatment, and prospects for how the disease might be prevented in presymptomatic individuals,’ said Prof. Ralston of the University of Edinburgh (United Kingdom).

PDB is a skeletal disorder characterised by osteoclastic and osteoblastic overactivity that results in structurally disorganised and weaker bone tissue. About 80% of afflicted patients experience complications and symptoms such as bone pain, deformity, nerve compression syndrome, and fragility fractures. The genetic and environmental causes of Paget’s disease and the prevention of disease complications are two areas of focus in recently published and ongoing research.

In his presentation, Prof. Ralston will review the clinical presentation, genetic causes, and new treatments of PDB. “Most notably, I will be mentioning the results of the PRISM-EZ trial, which looked at long-term effects of bisphosphonate therapy in PDB,” he said in an interview.

The PRISM-EZ trial was an extension of the 2010 PRISM trial that aimed to address secondary diseases and complications (deafness, progression of arthritis, bone fractures, and reduced quality of life) of bisphosphonates, which are commonly prescribed to treat Paget’s disease and work to decrease alkaline phosphatase (ALP), the primary biomarker.
Lupus may confer higher risk for cervical cancer

Women with systemic lupus erythematosus have more than twice the risk of developing cervical neoplasia than do women in the general population, according to the results of a large Swedish registry study to be presented during an abstract session Friday morning.

The study results indicated that the highest risk for cervical dysplasia or invasive cancer occurred among women with systemic lupus erythematosus (SLE) who were using immunosuppressive agents, compared with those on antimalarial medication.

The results highlight the importance of women with SLE attending cervical screening appointments, say the study’s authors, who are from the Karolinska Institute in Stockholm, Linköping University in Linköping, Sweden, and Stanford University in Stanford, U.S.A.

“At this time, we cannot comment on whether changes to screening programmes are necessary, especially given there are considerable differences in cervical screening between countries,” study author Mr. Hjalmar Wadström said in a pre-congress interview.

Mr. Wadström, who is a PhD student at the Karolinska Institute, explained that SLE is associated with various immunological aberrations and is typically treated with immunomodulatory regimens. These regimens, however, have been linked to an increased risk of cervical neoplasia.

“Therefore, determining the risk among women with SLE is of direct clinical relevance,” he said. “Cervical cancer screening is important in the prevention of cervical cancer.”

To date, there have been few studies looking at the topic, and, as SLE is a relatively rare disease and the development of cancer is a relatively rare outcome, the study aimed to better estimate the risk.

Data from national Swedish patient and pharmacy registers were used to assemble a cohort of almost 5,000 women with SLE and a matched cohort of women from the general Swedish population. The average age at the start of follow-up was 51 years, and about 40% of women were taking oral corticosteroids.

The hazard ratio (HR) for cervical neoplasia comparing women with SLE versus those without was 2.12. The analysis was adjusted for multiple confounding factors, including family history of cervical cancer and prior cervical screening in the 5 years before the start of follow-up.

Within the SLE cohort, two subcohorts of women also were identified: those taking Plaquenil (n = 1,783) and those taking immunosuppressive drugs (n = 1,981). One of the reasons for looking at this is that treatment may serve as a proxy for the severity of disease, Mr. Wadström explained.

“SLE is a heterogeneous disease with numerous phenotypes that span from mild to life-threatening systemic disease,” he said. “Patients treated with an antimalarial with or without oral steroids exclusively tend to represent less severe cases, while more severe manifestations and organ involvement may necessitate potent cytotoxic immunosuppressive therapy.”

Adjusted HRs for cervical neoplasia in women with SLE were 1.52 for those taking antimalarial therapy and 2.72 for those taking immunosuppressive drugs, compared with women in the general population. The HR for cervical neoplasia comparing women with SLE taking immunosuppressive drugs versus those taking antimalarial medication was 1.83.

So what does this mean for clinical practise? “We think it’s important that women with SLE, especially those with severe disease who are being treated with systemic immunosuppressants, attend cervical screening,” Mr. Wadström said.

None of the authors had financial disclosures to report.
EULAR 2016 poster tours: Friday and Saturday

On the last two days of the congress, nearly 300 posters will be presented in 30 themed poster tours. 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.

Friday, 10 June
11:45–13:30  Poster tours, poster viewing

- HPR – Poster Tour: Focus on rehabilitation
- PARE – Poster Tour II

**Poster Tours**
- Biology of RA I
- Comorbidities update 2016, part II
- Education
- Epidemiology of RMDs
- From research to biomarkers and targeting SSc
- Imaging in RMD – Adding value
- RA treatment: Predictors, tapering, and biosimilars
- Safety and efficacy of non-TNFa blockers in the treatment of RA I
- Scleroderma, myositis, and related syndromes I
- SLE and APS – Clinical aspects
- SPA – Clinical
- Time for some fun with molecules
- Vasculitis I

Saturday, 11 June
10:15–11:45  Poster tours, poster viewing

- HPR – Poster Tour: Getting around rheumatic disease

**Poster Tours**
- Basic research in systemic sclerosis
- Biology of RA II
- Genetic basis and genomics of disease
- Imaging RMD – What else?
- Infection-related rheumatic diseases
- Innate immune cells coming to play
- New approaches to back pain – Soft tissue problems
- New insights in osteoarthritis
- Optimising treatment of axial SpA
- Safety and efficacy of non-TNFa blockers in the treatment of RA II
- Scleroderma, myositis, and related syndromes II
- SLE and Sjögren’s – Clinical aspects
- Vasculitis II
- PReS – Poster Tour: Juvenile-onset connective tissue diseases

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Session to spotlight patient empowerment strategies

With a nod to the power of tapping into the intangible traits of patient empowerment and self-responsibility, a session titled “It’s in Your Hands” is sure to inspire attendees.

Prof. Wilfried Mau will kick off the session by presenting a talk entitled ‘A self-determined life with rheumatic disease: How can social participation be preserved or obtained and how can barriers be overcome?’ In an interview, Prof. Mau, Director of the Institute for Rehabilitation Medicine at the Martin Luther University of Halle-Wittenberg, Halle, Germany, said that social participation is often at risk for persons with rheumatic and musculoskeletal diseases (RMDs) because of numerous health problems. “We know from our own research that at least every ninth person with RMDs reports severe limitations of social participation due to multiple health problems and reduced resources,” he said. “In a rheumatic disease, the symptoms frequently occur in the third to fifth decades of life when family, employment, social, and leisure roles are prominent. Social consequences may be of even more concern to the patients than impairments or specific activity limitations. To date, published research has focused primarily on the communication between patients and doctors. Several studies could show that the patient’s communication competence has a positive impact on the doctor’s communication behavior, including more detailed and individually adjusted information, which ideally leads to better disease-related decisions.”

Prof. Mau plans to discuss results from an online survey funded by the German League Against Rheumatism that aimed to identify difficulties in everyday disease-related conversations among people with RMDs. “It was surprising that affected persons primarily have difficulties asserting their interests and objectives in their conversations with staff members of public authorities [e.g., health insurance providers, pension insurance, etc.], followed by difficulties in the work environment,” he said of the results. “These are important areas of social participation which are under threat for patients with arthritis. According to the social skills and communication competence the greatest uncertainties occur in situations which require saying ‘no.’ In addition, the patients reported most difficulties in conversations with their doctors concerning personal circumstances.”

He noted that strengthening the communication skills of persons with RMDs in everyday situations “can promote a self-determined life and contribute to the maintenance of social participation. Based on the results, a communication skills training for persons with RMDs for adequate social participation is underway.”

In a separate presentation titled “Learning to control – When knowledge becomes power over the day-to-day setbacks,” Margarida Fonseca Santos will share how mental training can empower patients to think differently about their perceptions of pain and emotional feelings related to their disease.

“Once, a doctor said to me that I could deal with pain by training my mind,” Ms. Santos, a resident of Lisbon, Portugal, who has had spondyloarthritis since 2000, said in an interview. “I then started an adventure, learning, testing, teaching in groups, [and] talking about this. There is a significant part of suffering that can be put aside if we practise it mentally. It really is in our hands – not only the day-to-day pain relief but also the energy to put behind the fatigue.”

To relieve pain, for example, patients can employ techniques such as distraction, mindfulness, and emotion-al writing. “Words written (where our eyes can read them, observing rather than feeling) will let our minds think about them and decide what to do next,” she explained. “Doing this in a group session can be the beginning of a different way of feeling. Most people live alone with their suffering. Hearing what others say and write about this, and how each one cope is with their illness, can make this loneliness disappear, giving space to a new way to live beyond this illness.”

Dr. Mau and Ms. Santos reported having no financial disclosures.

Let’s talk about sex: challenges of intimacy in RA patients’ lives

Approximately one-third of rheumatoid arthritis patients suffer from impaired sex drive, but despite this significant impact on patient quality of life, the topic of sexual disorders in RA has not been well studied, according to Dr. Pedro Santos-Moreno. On Saturday afternoon, Dr. Santos-Moreno will discuss his study surveying the problem, along with a panel of other speakers who will present research and share their experiences of helping RA patients identify and manage sexual health issues.

Dr. Santos-Moreno’s recent research includes a cross-sectional study including 1,298 adults (1,048 women and 250 men). Of these, 36% of women and 34% of men reported sexual problems including lack of desire, dissatisfaction with sexual life, dyspareunia, orgasmic dysfunction, and premature ejaculation. Although the current study showed no statistically significant relationship between precipitating, predisposing, or maintenance factors and disease activity, “there was statistical significance between patients reporting no sexual activity and higher disease activity in patients with RA,” he said in an interview.

Possible avenues for additional research include establishing specific psychotherapeutic interventions for sexual disorders and testing their effectiveness in real life, said Dr. Santos-Moreno of the Center for Rheumatoid Arthritis in Bogota, Colombia. “We consider essential the presence of a psychologist with orientation toward sexuality issues in a clinical centre with high volume of patients with RA,” he added.

“This session provides information and practical recommendations on how to approach and assist in promoting sexual health for persons with RA,” Dr. Areskoug-Josefsson, Ph.D. said in an interview. The often-neglected area of sexual health and function is important to patients, she added, and physiotherapists can play a role in promoting sexual health as part of a patient’s treatment team to achieve the best results for that patient.

“Pain and fatigue are the main reasons for reduced sexual health, but there also other factors influencing the experience of sexual health, such as body image, physical function, reduced self-esteem, and anxiety,” said Dr. Areskoug-Josefsson of Jönköping University in Jönköping, Sweden. Declines in sexual desire and satisfaction, and less frequent sexual activity also can contribute to sexual health issues, she said.

Dr. Areskoug-Josefsson advised clinicians who treat RA patients to have working knowledge of how RA may impact their patients’ sexual health. She also emphasised the need for competent communication about sexual health, “because this is the key to finding out what the individual patient wants assistance with,” she said. “For the physiotherapist, it is important to understand how regular physiotherapy interventions such as coaching of physical activity also can assist in promoting sexual health.”

A team approach with a clear strategy is the most effective way to promote sexual health together with the patient, she noted.

“The importance of communication...
Website provides guides to keep people with RMDs working

An Irish website with a comprehensive suite of guides and a brand new e-learning program will help individuals with rheumatic and musculoskeletal diseases remain in the workforce, while also helping their employers and healthcare providers.

Fit for Work Ireland, launched in 2011 by Arthritis Ireland, offers a comprehensive suite of guidelines and trainings for those affected by rheumatic and musculoskeletal diseases (RMDs). This offering helps address a huge unmet need, according to Gráinne O’Leary of Arthritis Ireland, who will talk about the impact the website has had in a PARE session on Saturday morning.

In Ireland, approximately 7 million workdays per year are lost because of RMDs, according to a 2009 report by the Work Foundation. This represents about half of the total lost workdays in this small country of 4.5 million people, and means that the disease burden brings a huge personal and national cost, she said.

In her role as head of education and support services, said Ms. O’Leary, “My whole remit is developing and providing services and programs for people to enable them to live with the best quality of life that they can.”

Part of that remit was accomplished in 2011, when Ms. O’Leary and her Arthritis Ireland colleagues launched Fit for Work Ireland (www.arthritisireland.ie/go/fit_for_work), described as “a coalition of stakeholders including employer and employee representatives and health professionals with the key goal of improving employees’ ability to work with RMDs and reducing the impact of RMDs on workplace absenteeism.”

Fit for Work Ireland, said Ms. O’Leary, pulled together the employers’ representatives, one of the largest unions, and various medical associations, including the Irish Society for Rheumatology, representatives from physiotherapy and occupational therapy, and insurers.

The tripartite approach that underpins Fit for Work Ireland provides information and tools for employees, employers, and healthcare professionals. This comprehensive mind-set is the only way to adequately address the difficulties faced by those with RMDs, Ms. O’Leary said.

“Many people with RMDs are struggling to maintain and retain their work,” and work is not only an economic necessity, but a key component of personal identity for many, she said.

“One of the things that we did is we put together two guides,” Ms. O’Leary said; one for the employee and one for the employer. Although the employee with an RMD may know that he or she is struggling at work, or that frequent appointments may require an altered work schedule, that individual may not know what creative solutions may be feasible, or even what accommodations are legally available.

Similarly, an employer may not understand that accommodations could help a valued employee retain a position. “Employers are in a very difficult position, and very often they don’t understand what RMDs are … and they’re unsure about the type of support that their workers need.” Ms. O’Leary said that the employer guide outlines specific aspects of the support that an employer might consider for an individual with an RMD.

The accommodations required may actually be quite simple, such as a flexible schedule, or ergonomic adaptations, but they can be key in enabling workers to stay employed, she said.

The general practitioner is an important player in helping individuals with RMDs maintain employment and receive reasonable accommodations. “If an individual goes to them with a complaint, and may be signed out of work for a period of time, what does that interaction consist of? Is there a dialogue about the person’s ability to do their job … is there any kind of solution proposed? Very often there isn’t, so we began to look at these interrelationships,” Ms. O’Leary said.

Ms. O’Leary said that Arthritis Ireland is just finalising a Fit for Work online program that provides video training and scenarios for employers, employees, and health professionals, and she expects to be able to share the website at her presentation. “I hope to give people a flavour of the e-learning program at EULAR,” she said. “It provides a comprehensive package not only to employees, but to employers and healthcare professionals.”

Ms. O’Leary reported no conflicts of interest. Fit for Work Ireland is supported by AbbVie and by Irish Life, an Ireland-based insurance company.

Continued from previous page
The many new treatment options that have become available over the past two decades for blunting the severity of rheumatologic diseases have given clinicians powerful tools for controlling disease severity and for placing many patients in remission. They have also made treatment decisions much more complex, said Prof. Ronald F. van Vollenhoven, who will describe evidence for potential use of biomarkers in clinical practice in a Friday afternoon session.

Prof. Josef S. Smolen will join him in the session but will contest the current value of biomarkers in clinical practice. Biomarkers are all currently no better than clinical disease activity at predicting outcomes, according to Prof. Smolen, but they will undoubtedly come of age when the right ones are found.

Using new biomarkers to predict response to therapy

When treatment options were limited, decisions on which drugs to use on which patients could largely depend on an empiric approach. But in an era with many options to choose among that work very effectively on some patients but less effectively on others, choosing the best drugs and the order in which to try them is difficult and has enormous implications for a patient’s quality of life and prognosis. Biomarkers offer some of the best solutions to this dilemma, said Prof. van Vollenhoven, Professor of Rheumatology and Director of the Amsterdam Rheumatology and Immunology Center.

Recent experience also shows that older biomarkers, such as rheumatoid factor, anticitrullinated-protein antibody, C-reactive protein, and erythrocyte sedimentation rate – are not totally sufficient. Newer options of next-generation biomarkers and biomarker panels are advancing the field, allowing clinicians to be more proactive and evidence based in routine practise and to apply a precision-medicine approach to patient care.

For example, a study published last year by Prof. van Vollenhoven and his associates show that higher serum levels of survivin, a tumor-associated cytokine found in about a third of rheumatoid arthritis patients, linked with a poor response to methotrexate monotherapy (BCM Medicine. 2015 Sept;30:13:247-56). This post hoc analysis used data collected from 302 patients with early rheumatoid arthritis enrolled in the Swedish PharmacoTherapy (SWEFOT) trial. Patients with a serum survivin level of more than 0.45 ng/mL had the best outcomes when treated with a combination of methotrexate, sulfasalazine, and hydroxychloroquine; this triple regimen worked even better than monotherapy with an agent that targets tumour necrosis factor. The researchers concluded that measuring survivin levels can help in selecting the best treatment option for patients with early rheumatoid arthritis.

Another example he cited is a commercially marketed, multibiomarker disease activity panel that assays levels of 12 biomarkers. The multibiomarker disease activity panel showed prognostic value in a post hoc analysis of 235 patients with early rheumatoid arthritis enrolled in SWEFOT. The analysis results showed that 21% of patients with high scores on this multibiomarker disease activity panel at baseline had radiographic progression of their rheumatoid arthritis during the following year, compared with no progressors among those with a low multibiomarker disease activity panel score at baseline and a 3% rate of progression among those with a moderate score at baseline (Ann Rheum Dis. 2015 June;74[6]:1102-9). These results suggest that assessing patients with early rheumatoid arthritis with the multibiomarker disease activity panel could identify patients at low risk for radiographic progression and thereby help guide treatment decisions, Prof. van Vollenhoven said.

Biomarkers that predict individual response to therapy don’t yet exist

Prof. Smolen of the Department of Rheumatology, Internal Medicine III, at the Medical University of Vienna (Austria) will describe in his talk how presumptions of the value of certain biomarkers have not panned out over time and not surpassed the value of early clinical response, clinical disease activity, and longstanding biomarkers C-reactive protein and autoantibodies.

Many molecules or cells predicted to be good targets in RA ultimately made it to the clinic, such as TNF-alpha inhibition, IL-6 inhibition, B-cell depletion, or interference with T-cell costimulation. However, many of these predictions did not fulfil expectations, foremost the recent dogma that Th17 cells would be pivotal in RA. While the levels of the presumed all doses of infliximab are similarly efficacious, while patients with high TNF levels will only respond to high infliximab doses. And it is well established that rituximab, the B-cell depleting agent, has better efficacy in seropositive than seronegative patients.

The question of which patients respond best to individual treatments is still unanswered. A recent Belgian study revealed that changes in gene expression are very similar upon use of disease-modifying antirheumatic drugs targeting different molecules.
Outcome Measures Library sees success in its first 2 years

The first 2 years of the EULAR Outcome Measures Library’s existence has demonstrated its value to many users, including a network of individuals who have used it to increase awareness of and interest in patient-reported outcomes in the rheumatology community, according to Dr. Isabel Castrejón.

In a presentation on Friday afternoon, Dr. Castrejón, Assistant Professor in the Division of Rheumatology at Rush University Medical Centre in Chicago, U.S.A., will update attendees on the Outcome Measures Library (OML), which was created in November 2013 in direct response to the increasing importance placed on rheumatology patients’ perceptions of health and their priorities and preferences in making therapeutic decisions.

Patient-reported outcomes (PROs) can distinguish active from control treatment as efficiently as other conventional measures, such as swollen joint counts or laboratory tests, and they “allow patients to get involved in their own care,” Dr. Castrejón said in an interview. “But despite being increasingly recognised as important measures, there is great heterogeneity in their use.”

In response to this situation, EULAR sought to develop the OML as a database that standardised and enhanced validated PROs in rheumatic and musculoskeletal diseases. The OML includes 138 generic and disease-specific PROs for some of the most common rheumatological diseases such as rheumatoid arthritis, osteoarthritis, spondyloarthritis, fibromyalgia, systemic lupus erythematosus, low back pain, osteoporosis, and gout.

It includes a detailed description of each instrument as well as recommendations and rules for use, information about its validation and the instrument itself, and versions in several EU languages.

In its first 2 years, the OML has received over 41,000 page views and almost 26,000 visits. The PROs that are downloaded most frequently are the Evaluation of Ankylosing Spondylitis Quality of Life (EASI-QOL), the Multidimensional Health Assessment Questionnaire (MDHAQ), the RA Quality of Life scale (RAQoL), and the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC).

Interestingly, users tend to prefer accessing the library through mobile devices such as iPad, Android, and iPhone. France and Germany top the list of most frequent users, followed by the United Kingdom, Ukraine, and Spain.

The library is also popular with non-European countries, with the United States making up almost 20% of total users.

According to Dr. Castrejón, perhaps the OML’s biggest success to date is the creation of a network of PROs users who have ultimately improved the rheumatology community’s knowledge and interest in PROs and validation.

Terms like “patient-reported outcomes” and “validation” are often thought to be the domain of researchers only. However, the library was created with both rheumatic and musculoskeletal disease researchers and clinicians in mind.

“We are convinced that this dynamic library with a structured access to a growing database of validated PROs is going to be a useful tool for many researchers and clinicians,” Dr. Castrejón said.

“In the era of ‘treat to target,’ clinicians need to get familiarised with measurement tools, and PROs are the ones more feasible for routine care,” she said.

The library is freely available online (oml.eular.org) and EULAR encourages anyone with an interest in PROs to collaborate and get involved.

Success in health technology development requires collaboration

The creation of health technology apps must involve the collaboration of developers with end users on their design if improved patient outcomes are to be achieved, according to three speakers at a Friday afternoon Health Professionals Session.

The speakers will take delegates through their experience collaborating to develop technology designed to improve patient outcomes.

Involving the end user in the design of a physical activity self-management app for people with rheumatoid arthritis (RA) called tRAppen not only improved its effectiveness and usability, said Dr. Asa Revenäs of the Department of Neurobiology at the Karolinska Institute in Stockholm, but it also gave it more credibility.

“People living with a chronic disease have expert knowledge important for healthcare to use in the development and improvement of healthcare services,” she said in an interview.

By collaborating with future users, Dr. Revenäs and her colleagues were able to refine the service, as well as learn what was important for people with RA when it came to maintaining a physically active lifestyle.

Speaker Karin Håkansson of Stocklund, Sweden, who gave input into the development of tRAppen from the perspective of a user with RA, agreed that to produce an app, the developer needs to truly understand what it is like to live with the condition.

By sharing their experiences, people living with the disease can provide a greater insight into what will, and will not, be successful and useful as an end product.

“Working alongside the scientists and developers, I believe we create a more patient-friendly outcome empowering the patients in the process,” Ms. Håkansson said in an interview.

However, collaboration involving many different perspectives can also throw up unique challenges, such as finding the time and resources to incorporate the opinion of end users during the development stage.

Dr. Sanne van der Weegen, an eHealth researcher from Maastricht University in the Netherlands, will discuss how developers could engage the perspectives of different end users in the various stages of development.

Dr. van der Weegen said that because end users sometimes find it difficult to come up with ideas on the spot, one solution is to use probe kits that allow end users to take their time in coming up with answers.

Ms. Håkansson suggested managing the end-user input session by using a moderator who is able to encourage and bring out the best from the group.

“When I participated, I was happy to do so and share my experience, but it took time to form trust within the group and create a good environment,” she said.

It was also a good idea for developers to limit the target group to those patients whose symptoms have a large impact on their daily lives, she added.
Scenes from EULAR Wednesday and Thursday

Early arthritis
A task force developed the first update to the EULAR recommendations for managing early arthritis since 2007 (Ann Rheum Dis. 2007 Jan;66[1]:34-45). The new recommendations apply to patients with an identifiable inflammatory joint disease prior to its progression to rheumatoid arthritis, psoriatic arthritis, or SpA.

The update contains three overarching principles that are new and were not included in the original 2007 recommendations; four specific recommendations that deal with diagnosis, referral, and prognosis; three recommendations that cover first-line drug treatment with nonsteroidal anti-inflammatory drugs, disease-modifying antirheumatic drugs, and glucocorticoids; two recommendations that cover management strategy; one recommendation that covers prevention including the importance of smoking cessation, weight loss, and controlling comorbidities; and a final recommendation that deals with patient information and education, said Prof. Combe, convener of the task force and professor of rheumatology and head of the bone and joint diseases department at Montpellier University in France.

Since 2007, additional EULAR task forces developed specific drug-management recommendations for rheumatoid arthritis, psoriatic arthritis, and SpA. However, the recommendations for diagnosis, treatment and management, and prevention and education for patients with early arthritis remain relevant because they deal with aspects of early rheumatologic disease that are common to all three subtypes, he said.

This includes assessing patients with early disease with blood tests, imaging, and biomarkers. The 10-year gap between the prior edition of early arthritis recommendations and the new update largely resulted from the release during the intervening years of recommendations covering more specific forms of arthritis, but none of the recommendations covering rheumatoid arthritis, psoriatic arthritis, and SpA dealt with the issues that are intrinsic to early arthritis, he said.

“Our recommendations deal especially with early-stage inflammatory arthritis,” and are universal for all rheumatologic arthritis conditions when diagnosed early, before they differentiate into a more specific disease, he said.

The importance of diagnosing and managing inflammatory arthritis at the earliest possible time as the best opportunity for producing remission had been appreciated as long as a decade ago, when the first early-arthritis recommendations came out, but today much more evidence supports this strategy and creates an overwhelming case in favor of early-arthritis diagnosis and treatment, Prof. Combe said.
Estrogen: a role in decreasing scleroderma fibrosis?

The profibrotic effects of estrogen inhibition in two scleroderma mouse models and the antifibrotic effects of estrogen in dermal fibroblasts from systemic sclerosis patients provide evidence of the potential role that the hormone may have in pathogenesis and as a potential treatment, according to research findings to be presented Saturday afternoon.

Observations regarding the fact that women generally develop systemic sclerosis after menopause and that the disease is usually more severe in men than in women, as noted recently in the EULAR Scleroderma Trials and Research (EUSTAR) registry (Ann Rheum Dis. 2014 Oct 23. doi: 10.1136/annrheumdis-2014-206386), have suggested that estrogen could play a role in its pathogenesis, lead investigator Dr. Jérôme Avouac said in an interview.

Dr. Avouac of the Rheumatology A Department at Paris Descartes University and Cochin Hospital in Paris noted that clinicians have been cautious in giving hormone replacement therapy to women with systemic sclerosis because of a lack of data on its effects on the disease, “but our data are quite reassuring because it seems that estrogens have protective effects on the fibrotic process.”

The investigators used two of the most widely used mouse models in scleroderma research to examine the effect of estrogen inhibition: the mouse model of bleomycin-induced dermal fibrosis, which mimics early inflammatory stages of scleroderma, and the tight skin (Tsk-1) mouse model, which mimics later, less inflammatory stages of the disease and skin fibrosis. When the investigators inhibited the effect of estrogen by inactivating the estrogen receptor-alpha via knockout in the mouse models, they found increased activation of dermal fibroblasts and increased expression of transforming growth factor-beta (TGF-beta) and a corresponding worsening of skin fibrosis. TGF-beta is the main activator of fibroblasts in systemic sclerosis; it differentiates dermal fibroblasts into myofibroblasts that produce extracellular matrix proteins such as collagen. Treatment with the selective estrogen receptor modulator tamoxifen in estrogen receptor knockout mice (after they received bleomycin injections) resulted in significant, 17%-20% increases in dermal thickness, 16%-36% increases in hydroxyproline content, and 20%-22% more myofibroblasts vs. control mice. Treatment of Tsk-1 mice with tamoxifen led to a 31% increase in hypodermal thickening and a 17% increase in hydroxyproline content vs. control mice.

Separate experiments on dermal fibroblasts from patients with systemic sclerosis showed that 17-beta-estradiol significantly decreased the stimulatory effects of TGF-beta on collagen synthesis and myofibroblast differentiation, decreased activation of canonical TGF-beta signalling, and markedly reduced the expression of TGF-beta target genes. Tamoxifen reversed the inhibitory effects of estrogens by restoring the activation of the TGF-beta pathway and TGF-beta-induced collagen synthesis.

Although the research examined only the effects of estrogen on skin fibrosis, Dr. Avouac noted that the extent of skin fibrosis in humans is correlated with severity and progression. The researchers have plans to investigate the effects of estrogens on mouse models of lung fibrosis and pulmonary hypertension, Dr. Avouac said. If the group goes on to obtain convincing results on protective effects of estrogens on organ involvement, therapeutic options involving estrogen could arise. One potential next step would be to look at the use of estrogen therapy in observational cohorts of systemic sclerosis patients to determine its effects, he said.

Dr. Avouac said that he received funding for the study from the French Society of Rheumatology and a French patient association, ISF. He had no other disclosures.
EULAR congress dinner at the Natural History Museum

Friday, 10 June 20:30 – 24:00
Price: GBP 85 per person (not included in the registration fee)

This year, the EULAR congress dinner will take place in the beautiful Natural History Museum near South Kensington Underground station. Surrounded by the unique historic collections and attractions, you will wine and dine in the theme of “The British Invasion.” Experience an unforgettable evening surrounded by dinosaurs, birds, butterflies, Neander-thals, and many other species. Enjoy good food, music, and dancing around the famous Diplodocus dinosaur.

The congress dinner is a great opportunity to network with friends and colleagues from around the world in a relaxed atmosphere and enjoy the unmatched charm and fascination of the Natural History Museum in London. Those who have shared in the congress dinner experience of previous years would not want to miss it, so come and join in!

Tickets are available in the registration area.
Satellite Symposia Programme Friday, 10 June

**Satellite Symposia as of 1 May**

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**Advancing quality of care in SpA**

Chairperson(s): Josef S. Smolen (Austria)

08:15 Josef S. Smolen (Austria)

Treat-to-target strategy: Learning from RA?

08:30 William Tillett (United Kingdom)

Assessment tools and targets for tailored treatment in PsA.

08:50 Joachim Sieper (Germany)

Treat-to-target in axSpA: Implications for clinical practice.

09:05 Maria A. D’Agostino (France)

Is the use of imaging techniques to detect the subclinical inflammation in SpA a worthwhile approach?

09:20 Dafna Gladman (Canada)

So that is the evidence – Can we translate it into PsA and axSpA clinical practice?

09:35 All

Panel discussion

08:15 – 09:45 Hall E

UCB

Optimising patient outcomes throughout the rheumatoid arthritis (RA) patient journey: The exception, the standard, and the rule

Chairperson(s): Peter Taylor (United Kingdom)

08:15 Peter Taylor (United Kingdom)

Welcome and introduction

08:25 Ronald F. van Volkenhoven (Netherlands)

The role of biomarkers for DMARD-naive RA patients: The exception

08:45 Peter Taylor (United Kingdom)

When to start biologics: The standard RA patient

09:05 Daniel Aletaha (Austria)

How to optimise biologics: The rule

09:25 Peter Taylor (United Kingdom)

Wrap-up and conclusion

09:30 All

08:15 – 09:45 Hall A

Pfizer

Clinical and patient perspectives: A “joint” approach for improving the management of psoriatic arthritis

Chairperson(s): Douglas Veale (Ireland)

08:15 Douglas Veale (Ireland)

Welcome and introductions

08:20 Laura Coates (United Kingdom)

Jo Lambert (Belgium)

Douglas Veale (Ireland)

Exploring challenges in the diagnosis and assessment of psoriatic arthritis

08:50 Laura Coates (United Kingdom)

Jo Lambert (Belgium)

Douglas Veale (Ireland)

Shared decision-making strategies for optimizing management of psoriatic arthritides

09:15 Laura Coates (United Kingdom)

Jo Lambert (Belgium)

Douglas Veale (Ireland)

Taking action: Integrating our learnings into future clinical practice

09:40 Douglas Veale (Ireland)

Summary and close

08:15 – 09:45 Capital Suite 07

Samsung Bioepis

Biosimilars: Your questions answered

Chairperson(s): Paul Emery (United Kingdom)

08:15 Paul Emery (United Kingdom)

What do you think about biosimilars?

08:25 Brian Min (Republic of Korea)

How does Samsung Bioepis rapidly develop and manufacture high-quality biosimilars?

08:40 Michael Rawlins (United Kingdom)

How are biosimilars regulated and monitored?

08:55 Thomas Dörner (Germany)

How can clinicians interpret biosimilar studies?

09:15 Paul Emery (United Kingdom)

What if biologics were readily monitored?

09:35 Paul Emery (United Kingdom)

Q&A

08:15 – 09:45 Capital Suite 02

BIOIBERICA

New facts on osteoarthritis treatment: Building the mosaic

Chairperson(s): Philip Conaghan (United Kingdom)

Jean-Pierre Pelletier (Canada)

08:15 Philip Conaghan (United Kingdom)

Jean-Pierre Pelletier (Canada)

Welcome and introduction

08:18 Weiya Zhang (United Kingdom)

Overall treatment effect and contextual effect of osteoarthritis treatments: Meta-analysis of RCTs

08:30 Philip Conaghan (United Kingdom)

Drug use and risk of comorbidities in osteoarthritis

08:42 George Peat (United Kingdom)

Chondroitin sulphate for hand osteoarthritis: A randomized, placebo-controlled trial in primary care: The FACTUAL study

08:54 Jean-Pierre Pelletier (Canada)

MOSAIC: 24 MOnth study on Structural progression in Psoriatic arthritis

09:18 Ali Guermazi (United States)

Long-term use of analgesics and risk of osteoarthritis progression and knee replacement from the Osteoarthritis Initiative cohort

09:30 Q&A

09:40 Concluding remarks

08:15 – 09:45 Capital Suite 09

Biosimilar Medicines Group, Medicines for Europe

Biosimilar Medicines for Rheumatologists: Understanding the science of extrapolation

08:20 Fernando de Mora (Spain)

Welcome and introduction

08:50 Elena Wolff-Holz (Germany)

Biosimilars: The science of extrapolation and interchangeability

09:10 Ferdinand Breedveld (Netherlands)

The EULAR position in the making

09:45 All

Faculty members plus Tore Kvien (Norway)

Panel discussion, Q&A

17:30 – 19:00 Capital Suite 02

Chugai and Roche

Rheumatology TODAY Highlights of EULAR 2016

Symposium in German language

Chairperson(s): Matthias Schneider (Germany)

17:30 Christof Iking-Konert (Germany)

Biologica monotherapy

17:45 Torsten Witte (Germany)

Novelties in RA treatment

18:00 Christof Spoecker (Germany)

Collagenosas

18:15 Peer M. Aries (Germany)

Vasculitis

18:30 Frank Bебrens (Germany)

Psoriatic arthritis

18:45 Xenofon Baraliakos (Germany)

Axial spondylarthritides

17:30 – 19:00 Capital Suite 09

Oxford Immunotec

Ask the experts: Tuberculosis testing in patients with rheumatic diseases - A case-based, interactive session

17:30 Roy Chemaly (United States)

Welcome & introductions

17:35 Roy Chemaly (United States)

Overview of TB and diagnosis: What rheumatologists need to know

18:05 Jean Tayar (United States)

Roy Chemaly (United States)

Case presentations & discussion with audience participation

18:55 Roy Chemaly (United States)

Concluding remarks

19:00 Conclusion of program

**EULAR Congress News Friday/Saturday Edition**

An authorised publication of the European League Against Rheumatism

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