Welcome to the 2015 Congress and to Rome, the Eternal City

The doors of Rome are opened wide to welcome all of you for the start of the 16th Annual EULAR European Congress of Rheumatology. As in 2010, the "Eternal City" is hosting a significant number of participants from nearly 120 countries.

More than 2,000 years ago the city of Rome would welcome you with a Latin sentence like this:

"Salvete, medici totius Europae totiusque orbis terrarum! Urbs Roma benigne vos excipit, affluens urbs liberalissimis studiis doctrinae scientiae, quae omnibus temporibus viros ingentis ingenii ad se trahere voluit."

(Welcome, doctors from across Europe and around the world! The city of Rome welcomes you with joy, city of liberal studies, centre of doctrine and science, which at all times wanted to attract to itself men of great talent.)

Today, we are grateful and thank all who are taking part in what EULAR offers in order to spark scientific and clinical progress in the broad field of the rheumatic and musculoskeletal diseases. Contributions from both People with Arthritis/Rheumatism in Europe (PARE) and Health Professionals in Rheumatology will add further matters of interest to the scientific contents of the Congress. In addition, this year features a joint congress of Prof. Maurizio Cutolo, President of EULAR

Recommendations Focus on Comorbidity Management

The management of comorbidities associated with chronic inflammatory rheumatic diseases will be the focus of new recommendation updates that will be presented at a How to Treat/Manage session this afternoon.

Specifically, the management of cardiovascular disease in patients with rheumatoid arthritis will be discussed at length, along with new recommendations for the management of three other major comorbidities associated with chronic inflammatory rheumatic diseases: cancer, infection, and osteoporosis.

"The main objective of the EULAR initiative is to see whether there is the possibility of a standardisation and homogenisation of what all health professionals working in this area are doing," Prof. Maxime Dougados, professor in the department of rheumatology at Hôpital Cochin in Paris, explained in an interview. "Our task

Survey Finds Young Rheumatologists Confident in Training

Young rheumatologists believe they are receiving adequate training in most core competencies, according to a survey of trainees in rheumatology and recently certified rheumatologists.

This afternoon, lead author Dr. Francisca Sivera will present the results based on responses from 1,243 survey participants, which was 28% of the target population consisting of trainees (58% of respondents) and those certified within 5 years of the survey period of June-December 2014. Respondents were from 41 EULAR countries with rheumatology training. A total of 30% of the respondents were male. Although the rheumatologists were confident with
Welcome to Rome

Welcome continued from page 1

EULAR and PReS, the Paediatric Rheumatology European Society – as is the case every 3 years – with an extended programme for paediatric rheumatology.

Looking at the programme, you may discover an impressive growth in quantity and quality of abstracts and sessions ready for some 14,000 physicians, health professionals, scientific researchers, patients and patient group members, and industry representatives who together form a unique platform in the world to discuss and debate rheumatic and musculoskeletal diseases.

A record number of over 4,300 abstracts has been submitted, of which 82% were accepted. Over 300 were accepted as oral presentations. The EULAR Scientific Programme will provide 160 sessions and 35 symposia with over 350 speakers. A greater number of poster tours than ever before (more than 40 tours with 10 selected posters on each tour) will offer a much-appreciated guided commentary to high-scoring posters. The poster area, accessible throughout the day, will host more than 2,000 presentations, which constitute the heart of our Congress.

Unquestionably, rheumatologic research in Europe is productive, but still restricted for economic reasons. However, it is my pleasure to confirm that a progressive availability of European Union research funds for rheumatic and musculoskeletal diseases has been achieved as a result of several years of intensive promotion in Brussels at the EU Parliament. In addition, the formation of the FOREUM Foundation for Research in Rheumatology in September 2013 has lent support to European research in rheumatology through EULAR; several projects have already been funded.

Don’t worry if you can attend only a limited number of sessions at the Congress – most delegates can attend only 20% – because all the sessions in Rome will again be recorded and be available for registered participants through the new EULAR website right after the Congress ends.

For your free time between sessions, pleasant outdoor areas will be available to sit, rest, get a drink, but more importantly to meet and talk with fellow and young rheumatologists, health professionals, as well as with patients from all over the world. Free Internet access has become a standard at EULAR congresses, serving to help you make your stay at and around EULAR 2015 outstanding and a memorable one.

Transportation is a delicate issue for very old European cities like Rome, but at this year’s Congress it will be improved because of the availability of the train connection to and from the airport and the city. Please refer to the Congress reception desks for information.

Last but not least, it is good news – especially for dinner time – that large areas in the city centre have recently been transformed into pedestrian zones, such as around the Coliseum, the Fori Imperiali, the Piazza Navona, the Pantheon, or the Piazza di Spagna. The atmosphere is irresistible.

All of the above highlights have only been possible and realised thanks to the untiring effort and support of all the EULAR members, including the Steering Group, the Scientific and Executive Committees, the whole EULAR Secretariat, as well as the MCI staff.

The bottom line is that there are indeed countless attractive reasons to enjoy yourself in Rome during the 16th Annual EULAR Congress. Or, as Cicero (born 106 BC) used to say: “res ipsa loquitur” (the matter speaks for itself).

Prof. Maurizio Cutolo
EULAR President

Recommendation Updates

Updates continued from page 1

as EULAR health professionals is to improve the reporting, screening, and prevention of these associated comorbidities.”

Prof. Dougados, a past EULAR President, will be speaking on the recommendation updates regarding management of comorbidities across rheumatic diseases. He will be joined during the session by Dr. Laure Gossec of the Hôpitaux Universitaires La Pitié Salpêtrière in Paris, who will speak on the EULAR recommendation updates on management of psoriatic arthritis (PsA), and Dr. Mike Nurmohamed of the VU University Medical Centre in Amsterdam, who will discuss the EULAR recommendation updates on cardiovascular disease related to rheumatoid arthritis.

“Cardiovascular comorbidity in inflammatory arthritis patients is one of the most important comorbidities for which cardiovascular risk management is necessary [but] the implementation of cardiovascular risk management differs among the European countries due to the lack of consensus of the practical implications of existing guidelines,” Dr. Nurmohamed said in an interview.

“This update of the previous EULAR guidelines aims at a pan-European, evidence-based consensus about optimal CV-RM [cardiovascular risk management] strategies.”

Dr. Nurmohamed stated that the updated recommendations are expected to yield an international, multicenter collaboration that will ultimately result in a decreased cardiovascular burden on patients with inflammatory rheumatic diseases.

Dr. Dougados echoed this, saying that, despite the vast number of current health care initiatives in the field of chronic inflammatory rheumatic diseases, there is a great need for consensus among health care providers.

Among the updates that will be announced is that more evidence now exists for advanced cardiovascular risk in ankylosing spondylitis and psoriatic arthritis. According to Dr. Nurmohamed, the EULAR recommendations will now advise physicians to assess patients’ risk every 5 years rather than every year.

“Rheumatoid arthritis itself is enough for risk multiplication and an RA-specific risk model is not yet advocated,” Dr. Nurmohamed said. “The use of certain antihypertensives is not recommended anymore, and there is more evidence that antihypertensives and cholesterol-lowering agents are at least as effective as in the general population.”

Dr. Gossec will discuss recommendation updates pertaining to treatment and management of PsA; more specifically, she will discuss how the results of randomised, controlled trials for ustekinumab, secukinumab, and apremilast should influence how rheumatologists treat patients with PsA.

“We now have 5 overarching [treatment] principles and 10 recommendations, with a worldwide scope for any rheumatologist, general practitioner, or dermatologist who treats PsA,” Dr. Gossec said in an interview, adding that health authorities and medical reimbursement agencies also would find the update recommendations to be of significant value.

Dr. Gossec explained that the algorithm of treating PsA patients was amended to take into account not only the aforementioned new drugs, but new data on existing drugs and treatments that have come to light since the last EULAR recommendation updates were made. Dr. Gossec stressed the urgency of recommendation updates, saying that EULAR health care providers responsible for crafting these updates came to “quite a high level of consensus” on just about every point.

“We knew that we would need these updates because PsA is very much a changing field,” Dr. Gossec said. “In fact, GRAPPA [Group for Research and Assessment of Psoriasis and Psoriatic Arthritis] is also doing an update of its own recommendations that will be published at about the same time as the EULAR ones, so we are not alone in updating our recommendations.”

“The recommendations to be presented are based on evidence, consensus, and expert opinion,” said Prof. Dougados, adding that “the information will be available on the EULAR website and downloadable for anybody in the world to have this information.”

Prof. Dougados, Dr. Nurmohamed, and Dr. Gossec did not report any relevant financial disclosures related to the content of their presentations at EULAR 2015.
IN RHEUMATOID ARTHRITIS (RA),

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

ATTENDING EULAR? LEARN MORE ABOUT THE ROLE OF IL-6 IN RA.
VISIT REGENERON AND SANOFI AT BOOTH 5.17 IN HALL 5


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EULAR Honours the 2015 Abstract Award Winners

First authors from six basic science and six clinical research abstracts will each receive awards at tonight’s Opening Plenary Session. The abstracts in each category received the best overall scoring from a panel of four reviewers. Each winner will receive 1,000 euros.

Basic Science Abstract Winners

Mojca Frank-Bertoncelj, M.D., Ph.D., is a senior postdoctoral scientist at the Center of Experimental Rheumatology at University Hospital Zurich (Switzerland). She is receiving her award for research (abstract OP0071) on how the transcriptomes of synovial fibroblasts differ according to their positional identity within an anatomical joint location rather than by primary disease such as rheumatoid arthritis or osteoarthritis.

Mohit Kapoor, Ph.D., is head of Cartilage Biology Research in the Arthritis Program at Toronto Western Research Institute, University Health Network, and is an Associate Professor in the Department of Surgery at the University of Toronto (Canada). He is being honoured for his work (abstract OP0209) in identifying ephrin-B2 as a novel mediator of fibrogenesis and a potential therapeutic target in systemic sclerosis.

Simon Mastbergen, Ph.D., is an Associate Professor of Tissue Regeneration in the Department of Rheumatology & Clinical Immunology at University Medical Center Utrecht (the Netherlands). Tonight he will be awarded for his research (abstract OP0147) describing the regenerative transcriptional response that triggers intrinsic cartilage repair during joint distraction in an experimental model of osteoarthritis.

Clinical Research Abstract Winners

Pilar Brito-Zerón, M.D., Ph.D., is a member of the Laboratory of Autoimmune Diseases “Josep Font” at the Institut d’Investigacions Biomèdiques August Pi i Sunyer in Barcelona. Last year she won a clinical abstract award for identifying predictive factors for lymphoproliferative disease in patients with primary Sjögren’s syndrome, and this year she will present another award-winning study (abstract OP0088) characterising what baseline systemic activity at the time of primary Sjögren’s syndrome will predict a high risk of poor outcomes.

Kateric Lévesque, M.D., is an obstetrician with a subspecialty in autoimmune diseases at Sainte-Justine Hospital, Montreal, Canada. She is receiving her award for research (abstract OP090) conducted during her fellowship at St-Antoine Hospital in Paris, in which she and her colleagues describe how the factors associated with late-onset dilated cardiomyopathy (DCM) in fetuses and neonates with congenital heart block differ completely from those associated with neonatal DCM.

Joost F. Swart, M.D., is a pediatric rheumatologist/immunologist in the Department of Pediatric Immunology and Rheumatology in the Wilhelmina Children’s Hospital at University Medical Centre Utrecht. Dr. Swart is receiving his prize tonight for a multicentre registry study (abstract OP0062) of patients with juvenile idiopathic arthritis showing an increase in the rate of serious adverse events and infection for the sequential addition of one or more biologics to methotrexate alone.

Elke Theander, M.D., Ph.D., is an Associate Professor in the Department of Rheumatology at Malmö University Hospital, Lund (Sweden) University. She is being honoured this evening for work with her colleagues on a study (abstract OP0087) that confirms their previous research demonstrating that smoking cessation increases the risk of being diagnosed with primary Sjögren’s syndrome, while being a current smoker seems to lower it.

William Tillett, M.B.Ch.B., Ph.D., is a consultant rheumatologist at the Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom. He is being recognised tonight for a study (abstract OP0001) describing a clinically significant improvement in presenteeism, productivity loss, and disease activity after initiation of disease-modifying antirheumatic drug and anti-tumour necrosis factor treatment, with greater and more rapid improvement in worker disability among those taking anti-TNF agents.
AN EXCLUSIVE PHASE 3 JAK PROGRAM IS IN THE WORKS.

Exciting opportunities are on the horizon for RA research. And AbbVie is inviting you to be a part of it all. Learn more about our planned Phase 3 clinical trials for an investigational oral selective JAK-1 inhibitor, and other ongoing RA and OA research. Join us in our pursuit to help patients lead healthier lives.

Visit Booth 6.7
Top Health Professional, PARE Abstracts Awarded

Edzard U. E. Ulbricht 2015 marks the fourth year in which awards have been given to the lead authors of the top three Health Professionals in Rheumatology abstracts and the second year for the lead author of the top People with Arthritis/Rheumatism in Europe (PARE) abstract. The winners will be recognized at tonight’s Opening Plenary Session and each will receive a prize of 1,000 euros.

Health Professionals

Linda Kwakkenbos, Ph.D., is a post-doctoral fellow at McGill University and Jewish General Hospital, Montreal, Canada. She is receiving her award for a study (OP0224-HPR) on whether a Cancer-Related Fatigue case definition could be applied to patients with rheumatic diseases, using women with systemic sclerosis as model for defining Chronic-Illness-Related Fatigue. In the study, which will be presented in an abstract session on Thursday morning.

Friday morning, the omission of two cognitive fatigue symptoms from the Cancer-Related Fatigue case definition gave an equivalent ability to detect Chronic-Illness-Related Fatigue in women with systemic sclerosis, compared with women successfully treated for breast cancer.

Dr. Ericsson

Linda Kwakkenbos

Dr. Kwakkenbos

Undergraduates Receive Awards for Clinical Abstracts

This evening, EULAR President Maurizio Cutolo will present undergraduate research abstract awards worth 1,000 euros each to three students who were the lead authors on clinical or basic research studies in rheumatology that were conducted while they were medical students. This is the third time that the awards have been presented at the Congress. The winners are the following:

Daniele Ferrari is a medical student at the University of Padua (Italy) who is completing his thesis to graduate in July 2015. He will present the results of a registry study (abstract OP0066) that examined the safety of anti-tumour necrosis factor–alpha agents for the treatment of juvenile idiopathic arthritis-related chronic anterior uveitis (JIA-CAU) in a PReS Session on Thursday morning. CAU is the most common extra-articular complication of JIA. In 209 patients with JIA-CAU who had been treated with either infliximab or adalimumab during 2007-2013 at the 24 Italian centres in the ORCHIDEA registry, Mr. Ferrari and his colleagues found that the two anti-TNF agents were relatively safe for over a medium-term period of at least 2 years in 126 patients and for up to 5 years in 39 patients. No major adverse events occurred, and 72 minor adverse events took place, which were mainly infections, headaches, and infusion reactions.

Camelia Frantz, a rheumatology fellow at Cochin Hospital, Paris Descartes University, will present the results of a study (abstract OP0060) that aimed to improve knowledge about the health-related quality of life of patients with systemic sclerosis and their perceptions of the disease in an abstract session on Thursday morning. She and her colleagues conducted a large, international, cross-sectional survey of 1,902 patients with diffuse cutaneous, limited cutaneous, and systemic sclerosis (SSc) sine scleroderma during December 2013 to April 2014 in which patients responded online to a standardized questionnaire.

They found that patients reported significant impairments in physical and mental health and viewed the chronicity and consequences of the disease negatively. Patients with diffuse cutaneous disease expressed the worst quality of life and had more negative perceptions. Although patients with late SSc viewed their disease as more chronic and less controllable, they had a better understanding of it and had fewer negative emotions; non-European patients had worse physical quality of life and more negative illness perception but felt that they had a better understanding of the disease and fewer negative emotions than did European patients.

Dr. Frantz

Ms. van Zanten

Mr. Rickmann

Dr. Kwakkenbos

Mr. Ferrari

Ms. Arends

Mr. Rickmann

Mr. Ferrari

Ms. van Zanten

Dr. Kwakkenbos

In a study (OP0097-HPR) described three courses of adaptation that remained stable during the course of a year: “Moderate engagement” (44%), “Broad goal management repertoire” (35%), and “Holding on” (21%), with each having different patterns of goal management (goal maintenance, goal adjustment, goal disengagement, and goal re-engagement). Ms. Arends will present the results at an abstract session on Thursday morning.

Linda Kwakkenbos

Health Professionals

Roos Arends is a PhD candidate in the Faculty of Behavioral Sciences, Psychology, Health & Technology at the University of Twente, Enschede, the Netherlands, whose study identified the adaptive ability of different subgroups of arthritis patients to meet personal goals over time. She and her colleagues in the study (OP0097-HPR) described three courses of adaptation that remained stable during the course of a year: “Moderate engagement” (44%), “Broad goal management repertoire” (35%), and “Holding on” (21%), with each having different patterns of goal management (goal maintenance, goal adjustment, goal disengagement, and goal re-engagement). Ms. Arends will present the results at an abstract session on Thursday morning.

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Welcome and introduction
Chair, Professor Gianfranco Ferraccioli, Italy

Recommendations for the treatment of RA: can we predict how patients will respond to treatment?
Professor Michael Schiff, USA

Defining patient types in real-world clinical practice: what prognostic factors have been identified?
Professor Jacques-Eric Gottenberg, France

Joint destruction and autoantibodies: unique mechanisms and opportunities for intervention
Professor Georg Schett, Germany

Autoantibody maturation as a biomarker for RA development – is there a place for targeted therapies?
Professor Tom Huizinga, The Netherlands

Panel discussion and Q&A
All
Guiding Disease Treatment During Pregnancy

Effective new therapies over the past 15 years have vastly improved the lives of patients with rheumatic diseases but are also creating complex treatment decisions as more female patients consider pregnancy.

This afternoon, Prof. Monika Østensen will discuss present and future treatment options for rheumatoid arthritis (RA) and spondyloarthritis in pregnancy.

She will be joined by Dr. Anja Strangfeld, who will present reassessing new data from the German biologics registry RABBIT indicating that exposure to biologic therapies around the time of conception does not increase the risk of malformations or other harmful neonatal consequences.

Conventional disease-modifying antirheumatic drugs (DMARDs) such as sulfasalazine, cyclosporine, and azathioprine, as well as prednisone and nonsteroidal anti-inflammatory drugs, remain valid treatment options for pregnant patients because their safety profile with regard to the fetus is known, according to Prof. Østensen of the Norwegian National Advisory Unit on Pregnancy and Rheumatic Diseases, St. Olavs Hospital–Trondheim University Hospital in Norway.

Methotrexate and cyclophosphamide are teratogenic and must be discontinued before a planned pregnancy. In spite of no indication for teratogenicity in humans, child safety still has not been established for leflunomide, so a washout procedure should be completed before conception, she said.

In contrast to conventional DMARDs, child safety is a concern for the new biologic therapies and combination therapies that include methotrexate or leflunomide because there is no or little pregnancy experience, Prof. Østensen said.

Tumour necrosis factor-alpha inhibitors (TNFi), the best-studied biologic DMARDs, can be given before conception and during the first and early second trimester. Use in late pregnancy is a different matter because transplacental passage varies based on differences related to their structure. Some TNFi have small affinity to the fetal Fc receptor or no Fc part and show low transplacental passage to the child. TNFi that possess an Fc part of immunoglobulin G1, however, allow high amounts of transfer and should be avoided in the third trimester whenever possible, she said.

Data are scarce on human pregnancy exposure and fetal side effects and outcomes for most other biologics, so decisions to use biologics targeting B-cells, T-cell activation, or cytokines like interleukin-6, IL-23, IL-17, or IL-1beta must be based on the severity of maternal disease and reserved for cases in which no other safe options are available, Prof. Østensen cautioned.

It is in the context of this knowledge gap that Dr. Strangfeld will present data from an analysis of 95 pregnancies in 78 women and their outcomes reported to the German biologics registry RABBIT from 2001 to 2011.

Observational studies suggest that biologic DMARDs are safe to use in patients with RA until conception, but questions remain about their influence on birth outcomes, the course of RA during pregnancy in women who stopped biologic therapy in the first trimester, and how to treat high disease activity, including use of glucocorticoids, Dr. Strangfeld of the German Rheumatism Research Center, Berlin, said in an interview.

The study identified 4 spontaneous abortions in 35 pregnancies (11%) in which biologic DMARD infusions or injections were stopped at least 4 weeks before conception and 10 spontaneous abortions among 51 pregnancies (20%) exposed to biologic DMARDs at conception. Nine patients were biologic naive.

Reassuringly, rates of spontaneous abortions were similar across treatment regimens and within the range of about 15% to 20% observed in the general public, she noted.

Among the 35 women who stopped biologics before conception, therapies named rituximab (n = 13), etanercept (n = 10), adalimumab (n = 9), tocilizumab (n = 2), and infliximab (n = 1). Etanercept and adalimumab were the most common therapies among those using biologics at conception, administered in 26 and 10 patients, respectively.

More than a third of women (37%) exposed to biologics at conception went on to require biologics and/or at least 10 mg/day of glucocorticoids later in pregnancy. Notably, all four preterm births in the study occurred in patients receiving at least 10 mg/day of glucocorticoids, Dr. Strangfeld said.

Induced abortions were decided on in 4 of the 95 pregnancies. Three occurred in the 35 women who stopped biologic therapy before conception, including one abortion due to trisomy 21 with a cardiac defect.

Three congenital defects were reported in live-born children: one anal atresia with urogenital malformation (last adalimumab injection 4 weeks before conception), one congenital nystagmus (last adalimumab injection 6 months before conception), and one talipes in a child whose mother reported also having talipes (adalimumab exposure at time of conception), Dr. Strangfeld said.

Although the analysis includes a limited sample of pregnancies, the data confirm previous reports and show no increased risk of major malformations or other harmful consequences in patients exposed to biologic therapy around conception, she said.

Dr. Østensen and Dr. Strangfeld reported having no disclosures. The German Biologics Registry RABBIT is supported by grants from AbbVie, Bristol-Myers Squibb, Merck Sharp & Dohme, Pfizer, Roche, and UCB.

Clinical Science Session

Pregnancy in rheumatic disease

Wednesday 17:00-18:30

Hall 2

Confident in Training

Survey continued from page 1

most areas of their training, Dr. Sivera noted in an interview that she and her colleagues were “surprised to find a significant proportion of the trainees across Europe (less than 10%) managed 10 or fewer patients with specific RMDs during their training period. We believe that managing 10 or fewer patients in most RMDs, given the heterogeneity in clinical presentation many of our diseases have, provides you with very limited practical experience.”

In the survey, the rheumatologists rated their confidence in their ability to perform the tasks outlined in 21 core competencies from the European Union of Medical Specialists European Board of Rheumatology’s Curriculum Framework, based on a scale of 0-10. The surveys did not evaluate actual training. Most scored themselves in the 7-9 range on each competency. For any given competency, mean confidence was higher when a survey respondent received formal education, compared with those who did not. Both greater patient exposure (more than 10 patients) and longer training periods (internal medicine plus rheumatology) also resulted in higher mean scores.

The two exceptions in which survey respondents had lower confidence were crystal identifications and ultrasounds, scoring on average 5.98 and 5.89, respectively.

“More than a quarter of the respondents had very low confidence in their ability to identify crystals, and less than half had performed a ‘sufficient’ number of procedures during their training (less than 10). This is relevant for the management of patients with gout or other crystal arthritis,” said Dr. Sivera of the Hospital General Universitario de Elda (Spain).

Dr. Sivera was less concerned about the lower confidence in performing ultrasounds. “Even though ultrasound is a very useful technique, it is still debated whether every trainee should be expected to master it.”

In the area of specific disease management, “the management of patients with connective tissue disease and vasculitis shows the lowest confidence across most countries,” she said. “This could be due to any number of causes – other specialties taking over the management of these patients, a lesser prevalence and therefore experience with these diseases, or the higher complexity of these diseases. If possible, these causes should be analysed and addressed.”
TRANSLATING SCIENCE INTO PATIENT CARE

Join us for these three symposia
FIERA ROMA | Room F-G

BENEFIT-RISK IN CONTROLLED TRIALS AND REAL WORLD
WHAT DOES IT REALLY MEAN?

AN INTEGRATED APPROACH TO RA MANAGEMENT
HOW TO COMBINE INNOVATION, PATIENT PERSPECTIVES AND COST CONSIDERATIONS

CLINICAL ADVANCEMENTS IN AXIAL SPA
A JOURNEY OF SCIENTIFIC EVOLUTION

WEDNESDAY
10 JUNE 2015
13:00-14:30

THURSDAY
11 JUNE 2015
17:45-19:15

FRIDAY
12 JUNE 2015
08:30-10:00

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THE EUROPEAN LEAGUE AGAINST RHEUMATISM (EULAR) 2015
10-13 JUNE 2015 | ROME | ITALY
Date of preparation: May 2015    EU-ENB-114-0215
New RA Physical Activity Programmes Tested

Programmes that employ direct coaching and text messages to rheumatoid arthritis patients may be effective in motivating them toward increased physical activity and decreased sedentary behavior, according to studies in Sweden and Denmark. Researchers leading the studies will share their results this afternoon in the “Get on the Move with Rheumatic and Musculoskeletal Disease” session.

Most people with rheumatoid arthritis (RA) do not perform health-enhancing physical activity, said Dr. Birgitta Nordgren, a physiotherapist for the Karolinska Institute in Solna, Sweden. Session attendees will gain some insight into how to run intervention studies and the use of objective methods to measure activity, she said in an interview. They also will learn more about coaching and guidance of RA patients.

Dr. Nordgren and her colleagues directed a 2-year intervention program for 220 RA patients in which participants were coached by physical therapists to exercise on their own. The study aimed for 30 minutes of moderate-intensity activity a day, with 45-minute circuit training sessions for muscle strength twice a week; therapists conducted biweekly support group sessions to facilitate adoption and maintenance of physical activity. Participants initially were instructed in circuit training and physical activity by the physical therapists but could complete the program at any gym they liked; they also were sent text messages twice a week asking them how many days per week they were doing the physical activities.

“Ninety-five percent of participants had never been to a public gym, but they really enjoyed exercising in a place with other people,” Dr. Nordgren said. “Outsourced physical activity is feasible for a lot of people with RA and should be encouraged.”

Participants’ overall physical activity level increased substantially during the study but their exercise capacity was quite modest, Dr. Nordgren said: “It’s something we have to consider for other studies.” In addition, physical therapists had an adjustment period of learning to coach without supervising exercise, and it wasn’t easy to meet participants’ individual needs during the group sessions. Physical therapists and other care providers should learn more about behavior change and become more skilled in coaching RA patients, she said.

Still, the program was “highly appreciated by a subgroup of the RA population,” Dr. Nordgren said: “It’s perfect to run an exercise intervention in a real-life environment and not a clinical setting, because that’s where patients are living.”

The use of similar principles appears to be succeeding in Denmark, where researchers have been working to reduce daily sitting time among sedentary RA patients, said Bente Appel Esbensen, research manager and associate professor at Glostrup Hospital and the University of Copenhagen.

In an ongoing study, 150 patients with RA who had at least 5 hours of daily sitting time were randomised either to a control group or to an intervention group that participated in three personal motivational-counseling sessions and periodic text message reminders to stand up at work, or walk to the television to change the channel, etc., over a 16-week period. Participants wore an activity monitor, and researchers are tabulating outcomes including change in daily sitting time, fatigue, pain, physical function, health-related quality of life, self-efficacy, costs, and cost-effectiveness, as well as changes in participants’ body size, blood pressure, and serum lipids.

There has been a lot of interest in how to sustain physical activity in RA patients, Ms. Esbensen said, because usually after an intervention, patients return to their pre-study low activity levels. Their study aims to interrupt bad habits to reduce sedentary behavior. Participants in the intervention arm were actively involved in deciding how to reduce their daily sitting times, like vowsing to stand at their workstations or to take short walking breaks throughout the day. Some inspired others to join them.

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“Some of the messages have been passed on not only to the participants but also to their work colleagues and family members,” Ms. Esbensen said. “There should be a broad view of physical activity and physical exercise,” she said. “It’s important to measure objectively the actual physical activity that people do. Sometimes we have a feeling patients are not moving, but we don’t really know how much they are doing.”

Programs like these are simple and could easily be replicated at other centers, she said.

Anti-TNFs Help Psoriatic Arthritis Patients Get Back to Work

Anti-tumour necrosis factor agents have a slight edge on conventional disease-modifying antirheumatic drugs when it comes to helping psoriatic arthritis patients with work issues, according to a large British observational study to be presented this afternoon.

“We observed a clinically significant improvement in presenteeism, productivity loss, and disease activity after initiation of DMARD and anti-TNF treatment. Improvement in work disability and disease activity was greater and more rapid among those commenced on anti-TNF. This study suggests that work disability is reversible in the real-world setting,” said the investigators, led by Dr. William Tillett of the Royal National Hospital for Rheumatic Diseases in Bath, United Kingdom. He and his colleagues will receive a clinical abstract award for their research this evening at the Opening Plenary Session.

The study is from the Long-term Outcomes in Psoriatic Arthritis (LOPAS II) working group, a 2-year, multicentre, observational cohort study of work disability in psoriatic arthritis.

The study, to be discussed Wednesday afternoon, sought to see how treatment affects work performance. At baseline, before treatment with anti-TNFs or DMARDs, the LOPAS II team found that 164 (41%) of their 400 subjects were unemployed. Unemployed patients tended to be older (median of 59 years vs. 49 years) and have worse physical function (a median score of 1.4 on the Health Assessment Questionnaire vs. 1.0). Subsequent treatment with anti-TNFs or DMARDs didn’t change overall employment levels.

However, among the 236 subjects working at baseline, presenteeism improved from 40% to 10% and productivity loss improved from 45% to 10% among patients who started taking anti-TNFs. Gains were more modest when patients were started on DMARDs, with presenteeism improving from 30% to 20% and productivity loss from 40% to 25%. The difference in change of presenteeism between the two treatment groups became statistically significant at 2 weeks and remained so at 24 weeks.

Patients started on anti-TNFs tended to have longer disease duration (median of 11 vs. 5 years) and a greater median number of tender (16 vs. 11) and swollen (7 vs. 5) joints, but otherwise there were no significant differences in demographic or clinical measures between the two treatment groups. Median scores on the Disease Activity Index for Psoriatic Arthritis (DAPSA) improved over 24 weeks from 53 to 14 among anti-TNF patients, which is considered a good response, but only improved from 39 to 30 in the DMARD group, which is considered a poor response. All of the findings were statistically significant.

The results revealed a “surprisingly poor clinical response to synthetic DMARDs on clinical outcomes … as opposed to good response amongst patients commenced on TNF inhibitors,” Dr. Tillett said. Dr. Tillett reported receiving grant/research support from AbbVie. The other authors said they have no disclosures.
Roche-sponsored satellite symposium at EULAR 2015

One disease, many impacts: How do I treat my RA patient?

Thursday 11 June 2015, 17:45–19:15
Hall 8, Fiera Roma, Rome, Italy

Food and refreshments will be served from 17:15

Chairs:
Prof. Paul Emery, UK and Prof. Marcello Govoni, Italy

Welcome and introduction
Prof. Marcello Govoni, Italy

RA: More than just a joint disease
Prof. Paul Emery, UK

Exploring real-world methotrexate use and treatment adherence
Prof. Tom Huizinga, The Netherlands

Question and answer session

How patient–nurse interactions drive comprehensive RA management
Alison Kent, UK

Aligning physician goals and patient expectations in RA management
Prof. Laure Gossec, France

Summary
Prof. Paul Emery, UK

Question and answer session

A webcast of this symposium will be available after the congress. Please visit the medical information booth on the Roche exhibition stand (5.5) in Hall 5 for more information

Based on US rules, this symposium is only intended for physicians practicing outside the USA
### EXHIBITORS’ LIST

**List of Exhibitors status as of 5 April 2015**

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**LEGEND**
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Fiera Roma

WEDNESDAY, 10 JUNE
AT A GLANCE

Schedule continued from page 1

**PReS Session**
Autoinflammatory diseases  Room 10 B
Basic and Translational Science Session  Room 10 I
Co-stimulation: towards genuine immune modulation  Room 10 D-E
Estrogens: critical regulator of the immune response; implication for sex bias in the development of autoimmunity  Room 10 D-E
The Young Rheumatologist  Room 10 C
Training of rheumatology across Europe  Room 10 C
Health Professionals Session  Room 10 A
Get on the move with rheumatic and musculoskeletal disease  Room 10 A
EULAR Projects in Education and Training  Room 10 H
A master class in constructing reliable assessment questions  Room 10 H
PARE Session  SC.2 Room A
Building sustainable relationships between patients and researchers

**Practical Skills Session**
Laboratory I  Room 8 A
Improving your graphs and tables for publication and presentation I  Room 9 A

**Clinical Science Session**
What is the impact of imaging on the management of rheumatoid arthritis?  Hall 8
Pregnancy in rheumatic disease  Hall 2

**Challenges in Clinical Practice Session**
Calcinosis  Hall 3
How to Treat / Manage (HOT)  Room 10 F-G

**Outcome Science Session**
Searching for evidence to support clinical practice – using non-steroidals as an example  Hall 1

**PReS Session**
From children to adults  Room 10 B
Basic and Translational Science Session  Room 10 I
Computers in rheumatology – friends or foes?  Room 10 D-E
Food and the immune system  Room 10 D-E
The Young Rheumatologist  Room 10 C
Science bites: 10 Arthritis abstracts + 10 Systemic inflammation abstracts selected by score  Room 10 C
Health Professionals Session  Room 10 A
Ethnicity - a blind spot within rheumatology?  Room 10 A
PARE Session  SC.2 Room A
Measuring success - How to evaluate the impact of your campaign
Practical Skills Session  SC.2 Room A
Capillaroscopy
Crystals  Room 8 A
Room 9 A
FUTURE.FORWARD.GEOCHALLENGE.

TEST YOUR KNOWLEDGE AND CHALLENGE YOUR COLLEAGUES

VISIT ACTELION
EXHIBITION HALL 6 / LOCATION 6.3A
Conducting a Successful Political Campaign

To succeed, campaigns by patient organisations must define the scope of the problem, clearly state what is needed to change, and band with other organisations if possible for added resources, according to speakers for this afternoon’s PARE Session, “Measuring Success – How to evaluate the impact of your campaign.” Too often groups forge ahead without taking these steps, they said in interviews in advance of their presentations.

“There are three common mistakes that seriously diminish the potential impact of campaigning,” said Jaan Aps, chair of the management board for the Estonian Social Enterprise Network. First, the societal need related to patients’ well-being is not defined clearly enough. Second, the full explanation of what needs to change to benefit patients is not designed. As a result of those first two mistakes, he said, “organising a campaign becomes a goal in itself, and the full theory of change is not backed up by enough resources or cooperation needed to bring about the intended change.”

Patient organisations should clearly define societal need, Mr. Aps said. Start by asking strategic questions: What is the main issue? Are there legislative changes that are needed? Is the implementation of current regulations not good enough?

“Often, patient organisations define the need far too broadly, e.g., ‘Politicians have to become more supportive,’ or ‘The general public needs to be more tolerant,’” Mr. Aps said. These organisations can identify groups or individuals who have influence in meeting campaign objectives, but only if they first single out what is needed.

Next, patient groups should define how the patient need should disappear, decrease, or change, he said. This must be done before brainstorming about the activities to achieve results. While keeping in mind desired patient outcomes, build relationships with stakeholders such as donors, politicians, or medical staff to gain their buy-in to the change.

In addition, Mr. Aps said, advocacy activities for campaigning should be undertaken collectively with other groups. Some campaigns may be too large for one organisation to tackle alone.

The Danish Rheumatism Association has had good success following steps like this, said Jacob Andreas Holch, a consultant for the organisation. Political campaigning is one of the most effective ways of directly improving the lives and conditions of people with musculoskeletal diseases, he said in an interview.

Mr. Holch will share two case studies of successful campaigns. After learning that rheumatoid arthritis patients had a strong need for foot care by therapists because hand and foot deformities made it difficult to handle this task alone, the Danish Rheumatism Association suggested policy changes that could improve foot care for affected patients. In 2007, after years of campaigning, a new law gave RA patients with strong symptoms and hand and foot deformities the right to 50% coverage of the treatment cost.

In a second campaign, the group, along with other organisations, was able to get a new policy enacted in 2006 to provide financial aid toward dental treatment for patients with Sjögren’s syndrome and oral cancer patients. This was after hearing that Sjögren’s patients had difficulties paying for expensive treatments for dental problems related to their illness.

Succeeding in effecting a policy change, however, is “not a guarantee that the actual problem is solved,” Mr. Holch said, “as the practical implementation of the policy is at least as important.”

>PARE Session
Measuring Success – How to evaluate the impact of your campaign
Wednesday 17:00–18:30
SC.2 Room A

Looks easy enough?
Not when you have digital ulcers.

Come and see us in hall 6 at stand 6.3a and let’s talk.
Transitioning From Paediatric to Adult Care

EULAR Congress delegates will for the first time be presented with best practice recommendations for the care of young people with Juvenile Idiopathic Arthritis (JIA) who are transitioning from paediatric to adult care.

In a PReS session this afternoon, paediatric rheumatologist Prof. Helen Foster of Newcastle University, Newcastle upon Tyne, United Kingdom, will describe the importance of transitional care as well as bring people up to date with the evidence on why we need to do things better.

“The be increasing evidence that up to now we haven’t really got transitional care right and the impact on patients is enormous in terms of worse clinical outcomes like high dropout rates or poor adherence to medications,” Prof. Foster said in an interview.

“These patients have to move from paediatric to adolescent to young adult care, and a seamless pathway of care is clearly not there,” she said.

The really great thing, Prof. Foster said, is that EULAR and PReS are working together to address this.

Prof. Foster is the chair of a multi-disciplinary group of experts across Europe charged with the task of developing best practice recommen-
dations that countries can use as a guideline for developing services that meet the needs of young adults transitioning from the paediatric system.

The recommendations encompass clinical care, health care service provision, training, and research and will contain some “essential” and “ideal” criteria in order to cater to the varying socioeconomic situations across Europe.

The guidelines are aimed at the care of young people aged 11 to 25, but it’s the 16- to 25-year-olds that are clearly a group that rheumatologists find difficult to manage for a whole host of reasons, she said.

“It’s a case of when does the adult rheumatologist get involved – there are many different models and one size doesn’t necessarily fit all … one of the key messages is there has to be flexibility,” she said.

For instance, in certain parts of the United Kingdom adolescent rheumatologists specialize in young people and run clinics with a paediatric rheumatologist. In other places, there are paediatric rheumatologists who specialize in adolescent health.

“It just depends on a whole lot of factors, but the important thing is you can’t stop seeing a paediatric rheumatologist one day and see an adult rheumatologist the next. It just doesn’t work that way.”

“Transition is a process, and the focus changes the older a patient gets,” Prof. Foster said.

One challenge the group has is how to benchmark the success of a service, as there currently aren’t any good measures of patient experience.

One of its recommendations is that more research needs to be done into what constitutes outcomes for young people.

The working group is using the Delphi Process, and all EULAR and PReS members have the opportunity to comment on the draft recommendations. The final ones will be published later in the year.

Addressing JIA dropout rates

In the same session, Dr. Philomine A. van Pelt of the University Medical Center, Utrecht, the Netherlands, will present the results of her study on the dropout rates of young people with JIA.

The observational study followed 176 patients aged 10 to 24 years for 3 years. The dropout rate – defined as a clinic non-attendance – was 20% across the entire cohort.

Dropout rates were significantly higher in patients aged 14 to 17 years who were in the process of transitioning (34%), compared with patients aged 10 to 13 years (11%) and 18 to 24 years (12%).

Patients who dropped out had significantly lower disease activity at baseline (JADAS 27, median 1.7, IQR 5.2 vs. 4.3, IQR 6.5; P = .01) and 28-joint Disease Activity Score (median 1.5, IQR 1.4 vs. 2.3, IQR 1.3; P < .00), but did not differ regarding subtype or uveitis or ANA, RF, and HLA-B27 status.

“In contrast to what is currently thought, the process of transition is not associated with an increase in disease activity. However, this period carries a risk for dropout, especially in patients with low disease activity,” the researchers concluded.

Study Finds New Autoinflammatory Disease Genetic Variants

Next generation sequencing discovered many genetic variants that could be linked to disease susceptibility in paediatric autoinflammatory diseases in children in a study that will be presented in a PReS session this afternoon.

However, there are challenges in identifying the clinical relevance of the genetic variants, according to study presenter and coauthor Dr. Elisa Pisaneschi of Bambino Gesu Ospedale Pediatrico in Rome.

Dr. Pisaneschi will share her centre’s experiences in using an emerging diagnostic tool called next generation sequencing (NGS) to genetically diagnose autoinflammatory disorders.

Mutations in more than 15 genes affecting several distinct pathways have been associated with autoinflammatory recessive/dominant syndromes. The molecular genetic analysis of these diseases based just on the candidate gene has low efficiency and is time consuming and expensive, Dr. Pisaneschi and her colleagues said.

Their study enrolled 145 patients who attended their centre from 2010 to 2014 who had an undefined autoinflammatory disorder.

As a way of reducing diagnosis time, the researchers started with 11 genes already known to be involved in autoinflammatory disorders. The genes were divided into two panels; panel one consisted of MVK, MEFV, NLRP12, NLRP3, NOD2, TNFRSF1A, and PSTPIP1 and panel two consisted of IL1RN, LPIN2, IL36RN, and PSMB8.

The researchers identified 61 patients with different variants in the genes of panel one with a detection rate of 42%.

Overall, 36% of the patients showed variants in the NLRP3 gene, 19% in NOD2, 31% in NLRP12, 23% in MEFV, 8% in MVK and TNFRSF1A, and 6% in PSTPIP1.

Some of the variants identified by the researchers were novel and others were already known polymorphisms. A combination of variants in two different genes was found in just under a third of the patients.

Several variants were of unknown pathogenic significance, while some of them were known risk factors.

NGS leads to the identification of many genetic variants that could be associated with disease susceptibility, but the major challenge is in the interpretation of the clinical relevance of identified variants, the researchers said.

Variants that are found at low but more than 1% frequency in various populations are particularly challenging as these may function as susceptibility alleles to inflammation rather than disease-associated mutations.

Because some patients show variants in multiple analysed genes, it can be assumed that different variants in different genes may cooperate to determine a pathological phenotype, the study authors noted.

Large-scale population studies, in vitro functional assay, and careful correlation of genetic information with phenotypic data are needed, they said.

Dr. Pisaneschi and her associates had no conflicts of interest to disclose.
Cultural Awareness Key to Treating RMDs in Ethnic Minority Patients

Being aware of patients’ cultural beliefs plays an important role in managing those with rheumatic and musculoskeletal diseases (RMDs) who come from ethnic or minority backgrounds. Indeed, patients’ ethnicity has been shown to not only affect their overall access to care but also the outcomes of the care that they receive. During the “Ethnicity – a blind spot in rheumatology?” session being held this afternoon, an expert panel of speakers will address some of the everyday challenges surrounding the management of RMDs in patients from an ethnic minority background.

Understanding barriers to health care
Dr. Heidi Zangi, nurse researcher at the National Advisory Unit on Rehabilitation in Rheumatology at the Diakonhjemmet Hospital in Oslo will open the session with a general discussion of the barriers to health care that can be experienced by patients and health professionals.

These barriers occur on a system level, a provider level, and on an individual/patient level. Dr. Zangi will explain. On a system level, access to care may be restricted for ethnic minority patients due to a lack of understanding or knowledge about a country’s health care system or a lack of health insurance, or both. Immigrants from ethnic minorities may also not be entitled to access mainstream health services.

One of the obvious barriers on a provider level is communication. “When you ask clinicians about barriers, I think the first they will mention are the language barriers,” Dr. Zangi observed in a pre-Congress interview. It may be challenging for patients to talk to doctors and conversely for doctors to help patients understand their condition and need for treatment, which does not just include drug therapy.

Health beliefs and health literacy among patients can also be highly variable, with patients perhaps not understanding the importance of seeking medical help early or appreciating the severity or chronicity of their disease and the consequent need for long-term, continuous treatment.

Patients who have migrated from non-European countries may not be familiar with the multidisciplinary approach to treating RMDs and so it’s important for all health professionals to increase their cultural competency, she suggested.

“It is important not to generalise, however, because there is great variability between different ethnic groups and between individual patients,” Dr. Zangi emphasised.

The ethnic minority patient’s journey
Dr. Kanta Kumar of the University of Manchester (United Kingdom) will then discuss what happens to someone from an ethnic minority background when first diagnosed with rheumatoid arthritis (RA) and their journey through the health care system.

Her presentation will first look at what causes patients with RA from a South Asian background to delay seeking medical help. “South Asian patients with RA can delay seeking treatment for up to 4-5 years,” Dr. Kumar explained ahead of the Congress. “This means that by the time patients are seen in clinic they might present with joint damage.”

Dr. Kumar’s talk will include discussion around patients’ health beliefs and how this affects their subsequent adherence to treatment. For example, South Asian patients may not fully appreciate that there are different types of arthritis, she noted, or the fact that RA can be treated.

Culturally related health beliefs can significantly influence medication adherence and outcomes. Indeed, her own research conducted in the United Kingdom has shown that patients with RA from a South Asian background have different beliefs about medication than white British patients (Rheumatology 2008;47:690-7).

Dr. Kumar is working with the U.K. National Rheumatoid Arthritis Society to help raise awareness of RA within Asian communities. Her current research is looking at how to communicate disease- and treatment-related information to patients more effectively. Her PhD work revealed that visual representation may help patients to better understand the RA disease process and why there is a need for long-term treatments, as well as be better informed regarding their health beliefs.

“Hopefully this approach will engage patients in their disease management,” she said.

“We need to fully engage patients from minority ethnic backgrounds in RA management. It is important to determine how health beliefs interact with perceptions about the disease and medicines used to treat it.”

The patient’s perspective
Patient representative Ms. Homaira Khan will then give a more personal perspective of how ethnicity can affect the management of RMDs.

Her talk will focus on why patients’ ethnic, religious, and cultural backgrounds are important to consider when deciding upon rheumatological treatment. Ms. Khan told EULAR Congress News that it could take time, even a few years, to fully appreciate what it means to have a chronic illness and the need to take medication “for the rest of your life.” It can be overwhelming to take in information about an unrelenting disease and all the various treatment options that may not be completely understood initially. If you then consider patients who are not native language speakers, she said, you can see how challenging it becomes to communicate with your doctor, let alone discuss your cultural beliefs or sensitivities even with an interpreter present.

“Ethnicity is quite a broad term and I think it builds up a fear in some people about asking questions,” Ms. Khan suggested. For instance, some RA medications contain gelatin and while some people may have no problem in asking for a vegetarian-appropriate alternative, some may not dare to question their doctor and health professionals may not consider that a patient might not be able or willing to take a medication because of their cultural or religious beliefs.

Health professionals need to be culturally competent and confident to ask patients questions first, “so that patients do not feel that the onus is necessarily on them,” Ms. Khan proposed.

There is no need to be apologetic when asking a potentially culturally sensitive question, she advised. “Don’t be afraid to ask questions,” Ms. Khan said. “I would much rather have a doctor ask me a question than treat me based on an assumption about my ethnicity,” she said.

“Understanding who the patients are in your clinic is important, and [while] collecting ethnicity data is being done, it is perhaps not being done enough,” Ms. Khan said.

Improving health literacy
Prof. Ade Adebajo, who is professor of rheumatology and health services research at the University of Sheffield (United Kingdom), will give the final presentation in the session on overcoming barriers to health literacy in ethnic populations.

Health literacy can be thought of as consisting of two parts, Prof. Adebajo explained in an interview. First, it is about patients being able to understand or process health information, and second, it is about them being able to use or apply that information to their own health care.

One challenge for health professionals treating patients with RMDs from minority backgrounds is finding a way to help those who may have low literacy skills in general or perhaps don’t speak English as a first language to get access to high-quality educational materials on their conditions.

Prof. Adebajo and his colleagues have developed a multilingual, interactive “mind-map,” delivered via a CD or online, that presents health information in a very visual way, giving layered information that is colour coded based on its increasing complexity.
THE SCIENCE OF IL-6 IN PAIN
and Its Impact on the Rheumatoid Arthritis Patient

THURSDAY, 11 JUNE 2015 | 8:30-10:00 AM

Opening Remarks
GIANFRANCO FERRACCIOLI, MD
Symposium Chair
Catholic University of the Sacred Heart

What Scientists Have Discovered About IL-6 and What Clinicians Need to Know
CEM GABAY, MD
University of Geneva

The Role of IL-6 in Persistent Pain in RA
STEPHEN McMAHON, PhD
King’s College London

Utilizing Patient-Reported Outcomes (PROs) in the Treatment Decision-Making Process
BERNARD COMBE, MD, PhD
Montpellier University

Panel Discussion
ALL

Closing Remarks
GIANFRANCO FERRACCIOLI, MD
Data Suggest OX40 Role in SLE Autoimmunity

OX40, a T cell receptor that regulates T cell activity via its interaction with the OX40 ligand, appears to play an important role in amplifying generation of autoantibodies in patients with systemic lupus erythematosus (SLE) could reduce autoantibody production and improve patients’ clinical status, Prof. Patrick Blanco will say during his report this afternoon. The OX40-OX40L signal contributes to aberrant responses by T follicular helper cells in SLE patients.

“The potential utility of controlling OX40 as a way to control T cell and antibody responses is pretty strong,” according to Michael Croft, Ph.D., who will present a review during the same session on what is known about OX40’s role in both autoimmune diseases and in cancer. Animal models have suggested a role for the OX40-OX40L axis in inflammatory bowel disease, type 1 diabetes, atherosclerosis, rheumatoid arthritis, and multiple sclerosis, as well as allergic conditions such as asthma. But so far, much less evidence exists that directly implicates OX40 as having a central role in clinical autoimmune or inflammatory disease. Until now, most of this evidence has come from genetic association studies, said Dr. Croft, professor and head of the division of immune regulation at the La Jolla (California, U.S.A.) Institute for Allergy and Immunology.

The series of studies that Prof. Blanco will report starts with examination of inflamed tonsil tissue taken from children with SLE. Having used immunofluorescent staining to assess OX40L and CD11c expression, he and his associates will report that the inflammatory environment induces upregulation of OX40L expression on several different types of immune cells found in tonsils.

A second set of studies examined OX40L expression on cells from other inflammatory tissues in SLE adult patients. This identified OX40L in inflammatory renal tissue and in skin biopsies from SLE patients but not in control adults, according to Prof. Blanco, a professor of immunology at the University of Bordeaux (France).

He and his associates also explored several of the effects that OX40-OX40L interactions have in vitro. OX40 signals increased the activity of memory T helper cells and induced T helper cells to express T follicular helper molecules and allow these cells to become functional B-cell helpers. Myeloid antigen-presenting cells isolated from SLE patients that expressed OX40L helped to promote T follicular helper cells’ development or activation (or both).

A final set of studies by Prof. Blanco and his associates found that sera from SLE patients containing ribonuclear protein immune complexes acts along with toll-like receptor 7 to promote OX40L expression.

Now that they have made these findings, Prof. Blanco and his associates plan to examine whether SLE patients harbour other cells that express OX40L and are not B cells, and whether these additional cells also play a role in the differentiation of T follicular helper cells. They also hope to explore whether OX40L activation of T follicular helper cells occurs at the tissue level.

Regarding clinical implications of their work, they have developed a humanised monoclonal antibody that blocks the action of OX40L, which may eventually provide a way to intervene in patients to block OX40L-mediated immune activation. Agents like this will be important to address whether blocking the OX40-OX40L interaction can play a useful role in managing clinical autoimmune disease, noted Dr. Croft. This approach works in animal models, but its relevance to patients remains unclear for now.

The OX40-OX40L axis also could be important for human cancers. OX40L is generally not expressed by cancer cells or available in the tumour environment, which could limit the activity of T cells that can target tumour cells. If research identified a way to induce OX40L on tumour cells, this could be a way to generate a T cell response against the cancer cells. Another approach to cancer treatment currently being tested in clinical trials is to use agonist reagents to OX40 in combination with checkpoint inhibitors to create a combined anticancer intervention, Dr. Croft said.

Cultural Awareness

Arthritis UK has funded the research, which to date has been “road tested” in a South Asian population of patients with osteomalacia. Qualitative studies suggest that the mind-mapping tool is effective and easy to use, and semi-quantitative analyses suggest that there is a correlation between using the tool and patients taking vitamin D supplements.

“One of the things that we hope to achieve is to improve patients’ concordance with their medication,” Prof. Adebajo said. “That includes not only taking medicines regularly, but also taking them correctly,” he added.

The team also hopes to broaden the tool’s use to include other RMDs. “We’ve already done some qualitative research in rheumatoid arthritis, and again, the use of the tool has been very well received,” he noted.

“As health professionals, it’s all of our responsibility to help all our patients understand issues relating to their health and to empower them to be able to take action relating to their health.”

EULAR Congress Dinner at the Villa Miani in Rome

Friday, 12 June 2015 20:30–24:00
Price: EUR 95 per person
(not included in the registration fee)

The 2015 Congress dinner will take place at the Villa Miani. Built in 1873 on Monte Mario, the Villa Miani is an elegant, neoclassical building surrounded by a very well cured parc, offering an absolutely spectacular view over Rome.

The Congress dinner is a great opportunity to dine and meet with friends and colleagues from around the world in a relaxed atmosphere, enjoying the unmatched charm and fascination of Rome. Those who have shared this evening with us in previous years would not want to miss it.

Come and join us as well! Tickets are available in the registration area.
EULAR in association with BMJ has launched a new journal, *RMD Open*, to help publish the large volume of scientific and clinical information that is being generated in rheumatic and musculoskeletal diseases (RMDs) and is not suitable for publication in the *Annals of the Rheumatic Diseases*.

According to the World Health Organization, there are more than 150 RMDs. Not surprisingly, there is an increasing amount of research being conducted to better understand and manage these diseases that needs to be shared with the wider rheumatological community.

"*Annals of the Rheumatic Diseases* is the number one scientific journal in rheumatology in the world and consequently receives a high number of papers for publication," Prof. Bernard Combe of Montpellier (France) University Hospital and Editor-in-Chief of *RMD Open* explained in an interview.

"However, 85% of the papers submitted to the *Annals of the Rheumatic Diseases* cannot be accepted for publication," Prof. Combe added. This means that many potentially important and often good quality papers are not being published, and preliminary findings or results of negative or smaller-scale studies are remaining unavailable.

"*RMD Open* will enable more research on RMDs to be published and will also cover a broader range of topics," Prof. Combe observed. Existing journals such as the *Annals of the Rheumatic Diseases* tend to focus more on the major RMDs, such as inflammatory arthritis and osteoarthritis. *RMD Open* will have a wider remit and will include papers on the whole gamut of rheumatism and connective tissue diseases, as well as osteoporosis, disorders of the spine, pain, and rehabilitation.

"*RMD Open* will also aim to offer more education than *Annals of the Rheumatic Diseases*," Prof. Combe said. This includes publishing more review articles and clinical case studies.

As its title suggests, another unique feature of the new EULAR/BMJ journal is that it is open access, providing free content that is published online only. The advantage of online-only publication means that articles can be published quickly as soon as they are accepted. Submitted articles will undergo the high standard of peer review expected by EULAR and BMJ, and the aim will be to publish within 20 days of their acceptance.

"*RMD Open* is the sister journal of *Annals of the Rheumatic Diseases*, so the two journals are linked," Prof. Combe said. Papers that are not accepted for the latter but are considered to be of good quality may be recommended for publication in *RMD Open*.

During the interactive lecture, Prof. Boers was starting his career in rheumatology, making a good graph involved finding an artist to draw one. Now, he said, there are numerous computer programmes available.

While standard computer programmes may work well for tables, he added, it is worth investing in and learning to use dedicated graphing software for graphs and charts because they make it easy to change any elements. There are about 15 good programmes available for purchase, Prof. Boers said. To learn more, do an online search for scientific graphing software. Many offer a free demo so you can try it first. Prof. Boers said he likes Deltagraph (redrocksw.com) and Graphpad Prism (graphpad.com). Keep in mind, he said, that designing a graph is not a one-shot thing but an iterative process: "The best graphs and tables usually evolve over multiple tries."

To make graphs really great, use symbols that are visually prominent while making relevant data stand out using colour palette wisely. The *Annals of the Rheumatic Diseases* now offers this option for free. Choose scale carefully and have your data fill as much of the frame as possible. In addition, use symbols that are easily discerned such as +, S, <, and O. And make sure graphs are truthful.

For publishing, he said, proofreading is exceptionally important, not only to correct errors but also to ensure that figures are reproduced in the way you want. For presenting, it’s generally best to use dark letters on a light background, in a sans serif font, with letters large enough to read in a conference room. Tables and graphs initially designed for publication should be redrawn for use during presentations to accommodate the low resolution of LCD projectors.

Don’t forget that graphing knowledge also should be applied to peer review, Prof. Boers said. If you review a manuscript, study the graphs just as critically as the text to see if the message requires a graph, if the message is clearly conveyed, and if it is truthful. The lecture will offer some hands-on experience in peer reviewing graphs.

"People reading this and then coming to my lecture will likely already have an initial inclining that they’re not doing everything they can with graphs and tables. I hope to move them to a point where they know what to do and where to turn for tools to improve," he said.

Prof. Boers is now graphic advisory editor for *Annals of the Rheumatic Diseases*. Together with the journal, he has updated the information for authors and prepared a set of short online videos with more information and tips, available at [http://bit.ly/1AStIXS](http://bit.ly/1AStIXS).
Satellite Symposia Programme Wednesday, 10 June

List of Satellite Symposia as of 5 April 2015

13:00-14:30 Hall 3
The value of inhibiting progression in RA: recent aspects of treat to target
Chairperson(s): Josef Smolen (Austria)
13:00 Josef Smolen (Austria)
Targeting remission to stop progression of RA
13:15 Paul Emery (United Kingdom)
Targeting early remission - How can we do better?
13:35 Arthur Kavanaugh (United States)
From early remission to long-term disease control
13:55 Philip Conaghan (United Kingdom)
Dose tapering after achieving sustained remission - Can we predict disease progression?
14:15 All
Questions and answers

13:00-14:30 Room 10 F-G
Benefit-risk in controlled trials and real world: What does it really mean?
Chairperson(s): Gianfranco Ferraccioli (Italy)
13:00 Gianfranco Ferraccioli (Italy)
Welcome and introduction
13:05 Ronald van Vollenhoven (Sweden)
Establishing a foundation for the benefit-risk profile: the role of clinical trials
13:25 Xavier Mariette (France)
From clinical trials to clinical practice: using registry data to further characterise the benefit-risk profile
13:45 Stanley B. Cohen (USA)
Completing the benefit-risk profile: insights from real-world experience
14:05 Gianfranco Ferraccioli (Italy)
The road from clinical trials to the real world: translating clinical and observational data and the benefit-risk profile into treatment decisions for patient care
14:15 All
Panel discussion and wrap-up

13:00-14:30 Hall 2
What is the place for biosimilars in rheumatology?
Chairperson(s): Peter Taylor (United Kingdom)
13:00 Peter Taylor (United Kingdom)
Welcome and introduction
13:05 Joao Goncalves (Portugal)
Biosimilarity: overcoming myths and misconceptions
13:30 Ulf Mueller-Ladner (Germany)
The importance of confirmatory clinical studies for regulatory approval of biosimilars
13:50 Tore K. Kvien (Norway)
The real value of biosimilars: what is the experience in Norway?
14:10 All
Discussion and meeting close

13:00-14:30 Room 10 H
Novartis Pharmaceuticals
IL-17 Inhibition in spondyloarthritis: a targeted approach in psoriatic arthritis
Chairperson(s): Philip Mease (United States)
13:00 Philip Mease (United States)
Welcome and introduction
13:15 Erik Lubberts (Netherlands)
Understanding the pathophysiology of psoriatic arthritis: the role of IL-17
13:35 Iain B. McInnes (United Kingdom)
IL-17 inhibition in psoriatic arthritis: current evidence and future perspectives
14:00 Desirée van der Heijde (Netherlands)
Recent advances in joint structural damage assessment in psoriatic arthritis
14:20 Philip Mease (United States)
Summary and meeting close
13:00-14:30 Room 10 B
International Medical Press
Overcoming barriers in SLE management: the patient at the heart of decision-making
Chairperson(s): David Isenberg (United Kingdom)
13:00 David Isenberg (United Kingdom)
Chairperson's introduction and welcome
13:05 David Isenberg (United Kingdom) and Charlotte Franks (United Kingdom)
What matters to people with SLE?
13:30 Marta Mosca (Italy)
Sharing best practice in early and moderate SLE
13:55 Ian Bruce (United Kingdom)
How can we improve care in severe SLE?
14:20 David Isenberg (United Kingdom)
Summary and conclusions
An application has been made to the EACME® for CME accreditation of this symposium. This symposium is supported by an educational grant from UCB Biopharma SPRL.

13:00-14:30 Room 10 I
Biogen
What rheumatologists need to know about biosimilars of complex biologics
Chairperson(s): Thomas Dörner (Germany)
13:00 Thomas Dörner (Germany)
The roadmap to development: biosimilars of complex biologics in rheumatology
13:10 Till Uhlig (Norway)
The promise and the questions
13:25 Mourad Rezk (Switzerland)
The road from development to approval
13:40 Thomas Dörner (Germany)
The merging role of biosimilars of complex biologics in rheumatology
13:55 Thomas Ryll (United States)
Manufacturing matters: the science behind...
14:10 Allan Struthers (United Kingdom)
The emerging role of biosimilars of complex biologics in rheumatology

13:00-14:30 Room 10 D-E
Sanofi and Regeneron Pharmaceuticals
New frontiers and treatment advances in Rheumatoid Arthritis (RA)
Chairperson(s): Mark C. Genovese (United States)
13:00 Mark C. Genovese (United States)
The evolving scientific and clinical landscape for rheumatoid arthritis (RA): paradigms for RA: the foundational role of biologic therapy - what do we know? What do we still need to know?
13:10 Roy M. Fleischmann (United States)
13:30 Ernest Choy (United Kingdom)
The immunobiology of IL-6 signaling systems and their role in the inflammatory cascade and disease progression in RA: the scientific and mechanistic rationale for IL-6 targeted therapy in RA
13:50 Mark C. Genovese (United States)
Evidence and experience-based therapeutic profiles for IL-6 inhibition - a review of landmark trials, clinical experience, and improvements in disease activity resulting from targeted inhibition of the IL-6-signaling system in patients with RA
14:10 Eric Ruderman (United States)
From science, mechanisms and data to real-world clinical approaches: aligning IL-6 and other biologic therapies to optimize RA management in special patient populations with RA - poor responders, elderly, obese, and men with RA
14:20 Mark C. Genovese (United States)
Chairperson’s summary and near-future vision statement
14:25 All
Interactive Questions & Answers

13:00-14:30 Room 10 C
AstraZeneca
Uric acid: Another side to the story
Chairperson(s): Davide Grassi (Italy)
13:00 Davide Grassi (Italy)
Prologue
13:10 Thomas Bardin (France)
The protagonist: Hyperuricaemia under the spotlight
13:25 Pascal Richette (France)
The plot thickens: uric acid and disease pathogenesis beyond gout
13:45 Allan Struthers (United Kingdom)
An unexpected twist: the potential ofurate-lowering therapy
14:05 Panel discussion
Evaluating the evidence: When should hyperuricaemia be treated?
14:25 Davide Grassi (Italy)
Epilogue
13:00-14:30 Room 10 H
SHARE satellite on patient participation in pediatric rheumatic diseases
Chairperson(s): Nico. M. Wolffaart (Netherlands)
13:00 Nico. M. Wolffaart (Netherlands)
Welcome and introduction
13:10 S. Vaster (Netherlands)
Treatment recommendations and best practices in pediatric rheumatology: an update of the SHARE project
13:30 Karen Durrant (United States)
Increasing awareness for rare paediatric rheumatic diseases, the experience of the autoinflammatory alliance
13:45 Marijn Sikken (Netherlands)
The patient's perspective. Implications for building meaningful patient participation
14:05 Vicky Seyfert-Margolis (United States)
Digital technology and active patient participation - the way forward
Dear colleagues,

Welcome to Rome and to EULAR 2015. I would like to invite you to attend our symposium, “Mapping the Impact of Chronic Inflammation in Rheumatoid Arthritis (RA): From Molecular Triggers and Disease Pathophysiology to Patient Quality of Life.” This symposium is sponsored by Lilly.

During this symposium we will explore the integrated approach to better understand the impact of chronic inflammation in RA on everyday life for our patients. The presenters will review the current and emerging understanding of the molecular mechanisms and signaling pathways underlying chronic inflammation in RA. Additionally, implications will be discussed, with particular focus on RA disease progression and the emergence of associated comorbidities. The impact of the chronic inflammatory disease on patients’ health-related quality of life and practical impact in the day-to-day clinical practice will be stressed.

I invite you to join us for this symposium and hope that you find it a valuable forum for discussing the impact of chronic inflammation in RA.

Kind regards,

Prof. Gianfranco Ferraccioli, MD

UPON COMPLETION OF THIS SYMPOSIUM, ATTENDEES WILL:

- Have gained additional insight on current understanding of the molecular mechanisms/signaling pathways underlying the emergence of chronic inflammation in RA
- Be able to better discuss the implications of targeting dysregulated proinflammatory pathways as far as RA disease progression and emergence of associated comorbidities are concerned
- Better appreciate the impact of chronic inflammation on everyday life from the patients’ perspective

FRIDAY, 12 JUNE 2015
08:30 – 10:00
FIERA ROMA, ROOM B, HALL 10

08:30
WELCOME AND INTRODUCTION
Prof. Gianfranco Ferraccioli, MD
Rome, Italy

08:35
BIOLOGY OF SIGNALING PATHWAYS IN INFLAMMATORY ARTHRITIS
Prof. Peter Taylor
Oxford, United Kingdom

08:55
IMPACT OF CHRONIC INFLAMMATION OF COMORBIDITIES
Prof. Dr. T.W.J. Huizinga
Leiden, The Netherlands

09:15
LIVING WITH CHRONIC INFLAMMATORY DISEASE: THE PATIENTS’ PERSPECTIVE
Prof. Bruno Faurel
Paris, France

09:35
PANEL DISCUSSION, Q&A
All Faculty

10:00
CONCLUDING REMARKS
Prof. Gianfranco Ferraccioli, MD
Rome, Italy