EULAR Congress News

#EULAR2016

EUROPEAN LEAGUE AGAINST RHEUMATISM

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

THURSDAY EDITION

Thursday, 9 June
At a Glance

07:45 – 19:15	Registration
08:00 – 17:15	Exhibition
08:15 – 09:45	Satellite symposia
10:15 – 17:00	Scientific sessions
17:30 – 19:00	Satellite symposia

08:15 – 09:45
Basic and Translational Science Session
Plasma cells as key players and therapeutic target in rheumatic diseases — Capital Suite 11
Global Year against Joint Pain — Capital Suite 14

10:15 – 11:45
What is New (WIN)
WIN Session 2 — ICC Auditorium

Abstract Sessions
Abstract Session: Prognosis and outcome in RA — Hall B
Abstract Session: Advances in SLE Therapeutics — Hall D
Abstract Session: Diagnosis and management of SSc — Hall C
Abstract Session: Vasculitis — Hall A
HPR Abstract Session: Developing evidence-based non-pharmacological care — Capital Suite 07
Abstract Session: SpA and PsA clinical — Capital Suite 11
Abstract Session: New horizons in osteoarthritis — Capital Suite 14
Abstract Session: Clinical Osteoporosis: new insights — Capital Suite 02
Abstract Session: SpA and PsA basic and translational research — Capital Suite 01
Abstract Session: Cartilage, Bone, Synovium — Capital Suite 06
Abstract Session: New pathways to treatment — Capital Suite 13

Schedule continued on page 21

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Stepped approach, multiple targets put forth in fibromyalgia recommendations

This year, EULAR unveils its first new recommendations on fibromyalgia since 2007.

Although the 2016 guidelines do not reflect a novel understanding of the pathophysiology of fibromyalgia or a radically different approach to managing the disease, compared with those published in 2007, they differ vastly in the level and quality of supporting evidence behind them, says guideline lead author Prof. Gary Macfarlane of the University of Aberdeen (United Kingdom).

Prof. Macfarlane, who will present the new recommendations this afternoon, said that the past decade has seen "an explosion of evidence from randomised trials" around the management of fibromyalgia. "I think this will be one of the first EULAR guidelines in which all the recommendations are going to be based on systematic reviews or meta-analysis" – 107 altogether, Prof. Macfarlane said.

COURTESY PROF. GARY MACFARLANE

Participants of the EULAR working group on fibromyalgia, including lead author Prof. Gary Macfarlane (back row, first on left).

Fibromyalgia, a heterogeneous pain condition that involves abnormal pain processing and can affect sleep, function, and quality of life, can be complex to diagnose and treat. Pain is a signature feature of fibromyalgia, but it is not the only

Fibromyalgia *continued on page 3*

Anti-TNF treatments may prevent progression of erosive hand OA

Tumour necrosis factor may play a role in erosive hand osteoarthritis, and anti–tumour necrosis factor (TNF) treatments such as etanercept may help to prevent progression of the condition, according to results of a trio of studies to be presented this morning as part of the abstract session "New Horizons in Osteoarthritis."

"Although erosive hand OA is a condition with a high disease burden, no disease-modifying treatments are available yet," said Dr. Féline Kroon, a PhD student in the Department of Rheumatology at Leiden University Medical Centre in the Netherlands and a coauthor on two of the studies. "Research to find a new form of

Anti-TNF *continued on page 15*

New EULAR imaging guidelines focus on OA clinical management

New EULAR guidelines will assist clinicians in deciding if and how to use imaging in the day-to-day management of their patients with osteoarthritis.

Previously, imaging guidelines in osteoarthritis (OA) have focused on the use of imaging modalities in clinical trials. However, EULAR imaging task force member Dr. Garifallia Sakellariou of the Fondazione I.R.C.C.S. Policlinico San Matteo, Pavia, Italy, said that guidelines for the use of imaging in routine clinical management of patients with OA were now needed because of the rapid growth in imaging technology over the last decade, particularly in the use of MRI and ultrasonography.

Imaging *continued on page 4*

IN RHEUMATOID ARTHRITIS (RA),

AS IL-6 ELEVATES, THE EFFECTS GO BEYOND THE JOINTS[1-3]

IL-6=interleukin-6.

LEARN MORE ABOUT THE ROLE OF IL-6 IN RA AT BOOTH 410

FOR MORE INFORMATION, PLEASE VISIT www.RAandIL6.co.uk*

*For UK healthcare professionals only.

References: 1. Choy E. Understanding the dynamics: pathways involved in the pathogenesis of rheumatoid arthritis. *Rheumatology (Oxford)*. 2012;51(suppl 5):v3-v11. **2.** Crofford LJ, Kalogeras KT, Mastorakos G, et al. Circadian relationships between interleukin (IL)-6 and hypothalamic-pituitary-adrenal axis hormones: failure of IL-6 to cause sustained hypercortisolism in patients with early untreated rheumatoid arthritis. *J Clin Endocrinol Metab*. 1997;82(4):1279-1283. **3.** Madhok R, Crilly A, Watson J, Capell HA. Serum interleukin 6 levels in rheumatoid arthritis: correlations with clinical and laboratory indices of disease activity. *Ann Rheum Dis*. 1993;52(3):232-234.

SANOFI GENZYME REGENERON

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FIBROMYALGIA View symptoms in context

continued from page 1

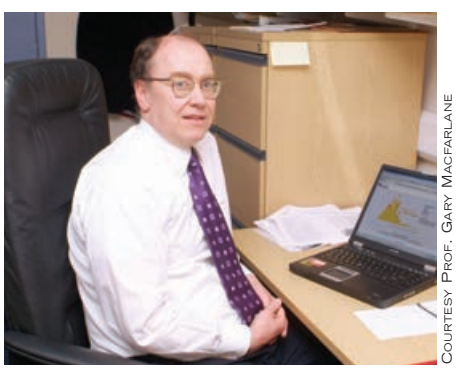
treatment target: sleep, ability to function, and quality of life are all important, Prof. Macfarlane said.

The guidelines emphasise that optimal management of fibromyalgia requires not just a prompt diagnosis but "a comprehensive assessment of the patient's ability to function and about the psychosocial context in which symptoms occur," he said.

Patient education, including written information, is key. Initial management should focus on non-pharmacological interventions, specifically exercise.

If there is insufficient response, the dominant features of the patient's complaints should be characterised before proceeding with second-line strategies, including drug treatment, according to the guidelines. If symptoms are characterised by pain-related depression and anxiety, or behaviour indicating abnormal coping strategies, the guidelines recommend cognitive behavioural therapy (CBT) and, for more severe psychological manifestations, psychopharmacological treatments.

If severe pain and/or sleep disturbance are the predominant features, several medications, including tramadol, duloxetine, and pregabalin, are presented as options. No medication, however, is licensed specifically for fibromyalgia in Europe, in contrast to the United States.



COURTESY PROF. GARY MACFARLANE

Prof. Gary Macfarlane

"We made the decision to consider all therapies whether they were licensed in Europe or not because we felt that helps to contribute to the debate," Prof. Macfarlane said.

Prof. Macfarlane noted that, despite a decade's worth of findings, many questions still hover over the ideal management of fibromyalgia. Although the guidelines strongly promote exercise, "we still don't have enough information about what specific type of exercise would be most beneficial."

And while studies show overwhelmingly that CBT is effective, the size of the benefit is modest. Prof. Macfarlane said that it will be important to learn whether combined pharmacological and non-pharmacological approaches might be more effective from the get-go for certain patients – in contrast to the stepped approach outlined in the guidelines – and whether there is a way to identify patients for whom interventions like CBT are most likely to be effective.

Another question still unanswered is whether fibromyalgia should remain primarily the domain of rheumatologists. While this was not a question addressed in the guidelines, the writing committee comprised not only rheumatologists but specialists in pain, internal medicine, occupational health, and nursing – underscoring the multidisciplinary direction that fibromyalgia treatment is taking.

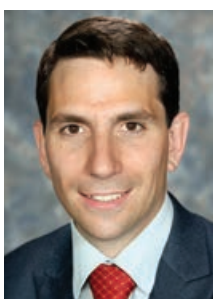
"I think rheumatologists have an important role to play because pain is a dominant feature, and because fibromyalgia is often comorbid with inflammatory rheumatic conditions," Prof. Macfarlane said. "But I think we should be looking at other models of care for these patients as well."

Because patients are referred in and out of various specialties, "there is no one really looking at the overall management, thinking about them holistically," he said. "There's a need for us to organise healthcare services better, so when we have a patient with fibromyalgia-like symptoms, we manage their journey through the system effectively instead of ping-ponging them around."

EULAR Projects in Clinical Affairs
Revised EULAR recommendations for the management of fibromyalgia
Thursday 13:30 – 15:00
Room S20

ANCA-associated vasculitis recommendations get first makeover

Updated recommendations for the management of patients with anti-neutrophil cytoplasmic antibodies (ANCA)–associated vasculitis (AAV) will be the focus of a presentation this morning that outlines treatment for the conditions. "The previous guidelines were published in 2009 and importantly had a wider remit, covering small- and medium-vessel vasculitis and not just AAV," said Dr. Max Yates, clinical fellow of the recommendation task force, who will present the update. "These updated recommendations provide a framework of practise and should apply to the majority of patients with AAV."



DR. MAX YATES

The update, written in conjunction with the European Renal Association–European Dialysis and Transplant Association (ERA-EDTA), reassessed items in the 2009 recommendations for the management of primary systemic vasculitis, focusing on the management of AAV, updating treatment recommendations, and incorporating new items that arose from the changing knowledge base in the interim years. "In the past 5 years, 1,691 papers have been published on primary systemic vasculitis in internal medicine, rheumatology, and nephrology journals. Together with the licensing of rituximab for AAV, it was an opportune time to update the guidelines with an AAV focus," Dr. Yates explained in an interview.

Both the former and updated versions contain 15 recommendations, with some changed and others combined; for example, the updated version reflects the use of glucocorticoids together with other immunosuppressive agents. Specific reassessments include the standard therapy for AAV including the use of biologic agents, as well as the prognostic relevance of histopathology and management of complications over time, said Dr. Yates of Norwich Medical School at the University of East Anglia and the department of rheumatology at Norfolk and Norwich (United Kingdom) University Hospital.

The 21-member task force included rheumatologists, internists, nephrologists, a clinical immunologist, an otorhinolaryngologist, a chest physician, an ophthalmologist, a vasculitis nurse, and a patient with vasculitis from 12 countries in Europe as well as the United States. The task force was convened by Dr. Chetan Mukhtyar on behalf of EULAR and Dr. David Jayne on behalf of ERA-EDTA. The investigators performed systematic literature searches from January 2007 to February 2015 for items in the 2009 recommendations with an open-ended search period for newly identified items. A nonexhaustive list of items identified for updating included the importance of ANCA and biopsy in diagnosis and follow-up, disease staging at diagnosis, the choice of remission-induction and remission-maintenance therapies, and the drug choices for relapsing and refractory disease. Newly considered were the choice of immunosuppressive drugs and biologic agents (principally rituximab), and immunological monitoring. Patient education was identified as another priority.

The task force's 15 recommendations are all important for clinicians to consider and Dr. Yates' presentation will give a full description of their strengths of evidence. Highlights include recommendations for the locality of AAV management (i.e., centre of expertise versus local clinic); the importance of biopsy findings in diagnosis and in cases of suspected relapsing vasculitis; treatment recommendations for induction and maintenance of remission, and major relapse; considerations for plasma exchange; options following failure of remission-induction therapy; treatment changes; assessment for comorbidities and cardiovascular risk; and patient awareness of the nature, benefits, and risks of therapy.

The recommendations should provide clinicians with reliable guidance on the best approach to treating AAV, according to Dr. Yates. "From the patients' point of view these recommendations should provide useful insight into which treatments they are likely to be offered and when. They also emphasise that as a patient, you should have a voice in your treatment and if you have any questions or concerns, be sure to speak with your specialist."

Abstract Session
Vasculitis
Thursday 10:15 – 11:45
Hall A

IMAGING Save for atypical, changing cases

continued from page 1

The EULAR group tasked with developing these guidelines included rheumatologists, radiologists, generalists, methodologists, and patients from nine countries.

The recommendations were developed with a focus on patients with symptomatic OA involving the knee, hip, hand, or foot. In particular, the group sought to address the role of imaging in making a diagnosis of OA and identifying OA features, detecting alternative diagnoses, managing the disease, defining prognosis such as the natural history of the disease and response to treatment, and providing follow-up to guide treatment.

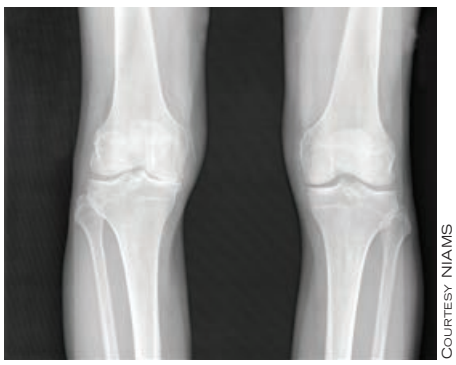
DR. GARIFALLIA SAKELLARIOU

After reviewing 1,317 papers in the literature, the task force included 380 studies in the final analysis that involved the use of conventional radiography, ultrasonography, MRI, CT, and nuclear medicine in OA.

The final recommendations, however, include only conventional radiography, MRI, and ultrasound, noted Dr. Sakellariou, who will present the recommendations during the "New insights into imaging" Abstract Session this morning.

"A greater emphasis is given to conventional radiography, while the use of other imaging can be considered depending on the tissue of interest," she explained in an interview.

One of the key recommendations included in the guidelines is that imaging is not required in patients with OA who have a typical presentation and natural history.



COURTESY NIAMS

"Greater emphasis is given to conventional radiography," Dr. Sakellariou said.

"It might be helpful in case of atypical features or when symptoms change unexpectedly," Dr. Sakellariou said.

The guidelines also recommend that the use of imaging to guide procedures such as intra-articular joint injections should not be routinely used in patients.

Instead, imaging should be reserved for specific conditions, for example, in joints that are difficult to access because of anatomical reasons or for patients with particular characteristics, Dr. Sakellariou said.

The task force noted that, through the process of reviewing the evidence, it had uncovered several gaps in the literature. For example, the group found a lack of diagnostic studies on the added value of imaging over clinical findings to diagnose OA.

Studies that examined the overall cost effectiveness of imaging also were lacking, as were solid prognostic studies and methods to predict and monitor response to treatment.

"A greater attention should also be given to less-studied sites and imaging-guided interventions," Dr. Sakellariou added.

Abstract Session
New insights into imaging
Thursday 10:15 – 11:45
Room S20

New Behçet's recommendations emphasise tailoring treatment

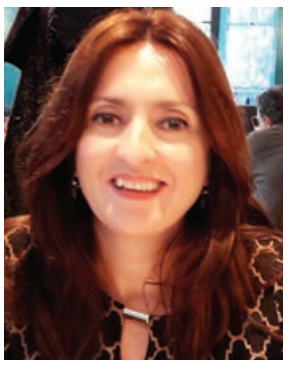
Basing treatment of Behçet's disease on areas of inflammatory involvement will be the focus of new recommendation updates to be presented at a EULAR Projects in Clinical Affairs session this afternoon.

When published in 2008, the first EULAR recommendations on Behçet's disease "generated a lot of interest and helped physicians from different disciplines manage their patients," Dr. Gülen Hatemi of Istanbul University Cerrahpasa Medical School, Turkey, said in an interview. "Since then, there have been several new publications, and data about new agents have accumulated," she noted. For example, biologics such as infliximab, etanercept, and apremilast are increasingly used in Behçet's disease, and more evidence is available to guide the management of gastrointestinal and vascular involvement, she said.

AHMET ALTINER MD, RAJNI MANDAL MD/WIKIMEDIA COMMONS/CC

Oral ulcer in a patient with Behçet's disease.

Behçet's disease (or Behçet's syndrome) is a multisystem vasculitis that classically affects the skin, eyes, and genitals, but also causes oral and gastrointestinal ulcers, pulmonary artery aneurysm, arthritis, thrombophlebitis, and aseptic meningitis. Session attendees will learn about several important changes in the updated recommendations, said Dr. Hatemi, who convened the task force that drafted them. "In the previous version of the recommendations, we suggested the use of anti–tumour necrosis factor [anti-TNF] drugs in patients who are refractory to conventional treatment," she said. "In the 2016 update, we were able to recommend specific anti-TNFs for patients with different types of involvement, based on the currently available evidence."



DR. GÜLEN HATEMI

The recommendation update also will clarify the role of glucocorticoids for each type of involvement in Behçet's disease, recommend when to use apremilast for cases of mucocutaneous involvement, and incorporate new evidence on anticoagulation, "one of the most controversial issues in the management of Behçet's syndrome," Dr. Hatemi said. In addition, it will offer more detailed guidance on managing gastrointestinal involvement according to severity, she added. "We also added new items regarding surgical and interventional treatment options for major vascular involvement," she said. "Finally, the role of newer biologics, such as IL-1 and IL-6 blockers, is discussed."

The task force plans to publish the recommendation update in Annals of the Rheumatic Diseases before the end of 2016, according to Dr. Hatemi. The publication will include two papers summarising results of the systematic literature that backs the guidance. "We think that it is important to submit these papers at the same time, since it is vital to provide the evidence behind the recommendations," she said.

Rheumatologists have come a long way in managing Behçet's disease, but available treatments do not adequately control disease in all patients, Dr. Hatemi noted. "There is definitely a need for newer agents that are safe and effective to improve management," she said. Ongoing trials of various biologics and immunomodulatory agents that target distinct cytokines and inflammatory pathways are showing promise, she noted. "The lack of standardised outcome measures to be used across trials is another important issue that we are trying to address in order to improve our ability to compare different drugs and guide our treatment decisions."

EULAR Projects in Clinical Affairs
Update of the EULAR Recommendations for the Management of Behçet's Disease
Thursday 13:30 – 15:00
Room S20

FRIDAY, 10 JUNE 2016
08.15–09.45

EULAR, Capital Suite 07, London

BIOSIMILARS:
Your questions answered

Addressing key questions regarding biosimilars and their potential impact on the management of Rheumatoid Arthritis

AGENDA

Chairperson: Paul Emery

08.15–08.25 Paul Emery (United Kingdom)
What do you think about biosimilars?

08.25–08.40 Brian Min (Republic of Korea)
How does Samsung Bioepis rapidly develop and manufacture high-quality biosimilars?

08.40–08.55 Michael Rawlins (United Kingdom)
How are biosimilars regulated and monitored?

08.55–09.15 Thomas Dörner (Germany)
How can clinicians interpret biosimilar studies?

09.15–09.35 Paul Emery (United Kingdom)
What if biologics were readily available?

09.35–09.45 Paul Emery (United Kingdom)
Questions & Answers

SAMSUNG BIOEPIS

This symposium is sponsored and organised by Samsung Bioepis

BIOEPIS

Digital health interventions boost self-care in chronically ill

Innovative technology interventions can improve self-care for long-term conditions and keep patients healthier, as well as improve the doctor-patient relationship, according to speakers who will discuss the technology this afternoon.

PROF. ELIZABETH MURRAY

"Long-term conditions and chronic disease [are] increasingly common, and certainly in countries like America and the U.K., they account for a very high proportion of the overall illness burden," said Prof. Elizabeth Murray, head of the research department and director of the eHealth unit at University College London. "It's quite a burden on the patient. They have to learn how to manage their condition."

During her presentation, Prof. Murray will discuss how digital health interventions (DHI) can help patients manage their conditions physically and emotionally, as well as help them to accept changes to their role or biographical narrative.

DHI are defined as health tools delivered digitally, including over the web to a PC, tablet, or phone, or via an app. The interventions combine information with interactive components, and often deliver treatments previously offered face to face. Such offerings could include cognitive behavioural therapy, behaviour change support, mindfulness training, or medication changes according to predefined algorithms that respond to self-monitoring data entered by patients.

MR. SIMON STONES

"The flexibility of the Web allows you to develop interventions that are well suited to helping manage patients," Prof. Murray said. "Examples of that will be discussed, including examples of interventions that help promote behaviour change and help [patients] come to terms with emotional challenges they are facing."

During the session, attendees will hear from Mr. Simon Stones, a final-year biomedical sciences student at the University of Manchester (United Kingdom), who will speak on how technology can enhance the doctor-patient relationship, increase communication, and enable patients to take control of their health.

"Our world is driven by technology, and we all rely on technology," Mr. Stones said.

Mr. Stones will discuss the pace at which industry is moving, and the need for healthcare to be receptive, embracive, and flexible to change for the benefit of patients with health conditions.

Also to be highlighted is how technology can improve communication and relationships among healthcare professionals and patients and inspire stakeholders to support the evolution of technology in the healthcare setting.

"Technology has the potential to revolutionise the way that individuals are treated and monitored in the future, as long as patients, carers, healthcare professionals, and industry colleagues are involved in the development, evaluation, and implementation of such technologies as equal partners," said Mr. Stones, who is a member of the Young PARE (People with Arthritis/Rheumatism in Europe) working group and is the winner of the 2016 Edgar Stene Prize.

Audience members will leave the session with a greater understanding of the advantages and disadvantages of using digital health interventions in clinical care, Prof. Murray said. They will learn how using such tools can help doctors' practises run more smoothly, reduce frustrations, and enhance the ability to focus on quality.

"In the long run, it makes practise easier because your patients are better informed, and so they need less of your time," Prof. Murray said.

Neither Prof. Murray nor Mr. Stones had any relevant disclosures.

PARE Session
Digital applications for the benefit of the patient
Thursday 13:30 – 15:00
Room S19

Behavioural approaches shift paradigm for managing chronic pain

Cures for chronic pain remain elusive, but switching foci can improve outcomes in affected patients, according to Pernilla Åsenlöf, Ph.D., who will speak on the topic this afternoon in a session on the Health Professionals' approach to pain management in inflammatory arthritis and osteoarthritis.

"Of course it is important to decrease suffering from pain, since that is the most important thing for the patient," said Dr. Åsenlöf, a professor specialising in physiotherapy in the Department of Neuroscience, Uppsala University, Sweden. "However, we have not been successful enough in physiotherapy and multidisciplinary rehabilitation with this focus. On the contrary, we may have reinforced pain behaviours and the assumption that when you are in pain, it is necessary to decrease pain to engage in activities."

Instead, studies support learning new thoughts and behaviours in order to keep engaging in life, even when in pain, according to Dr. Åsenlöf. That takes effort, but developing individualised goals can help patients stay motivated. To support the learning process, healthcare providers can shift from identifying problems to attaining goals, from measuring pain intensity to considering how it impedes activities, and from eliminating pain to teaching coping skills through behavioural skills training, she said.

PERNILLA ÅSENLÖF, PH.D.

Providers also can perform functional behavioural analyses to help identify avoidance behaviours and underlying beliefs, Dr. Åsenlöf noted.

"Thereafter, treatments should be based on what is needed to alter these mechanisms." For example, if patients in pain are afraid to engage in daily activities, research supports addressing the emotion by using exposure-based approaches, rather than trying to eliminate pain. Behavioural skills training also can help patients in pain relearn how to move their bodies instead of remaining or becoming sedentary, Dr. Åsenlöf added.

Some individuals might also be genetically predisposed to persistent pain signalling from the nervous system – even after their injuries have healed, Dr. Åsenlöf said. Affected patients could be at risk for irreversible nervous system changes culminating in chronic pain.

Perspectives in chronic pain management continue to evolve. For example, the EULAR task force on managing chronic pain in osteoarthritis and inflammatory diseases continues to focus primarily on pain and pain relief, according to Dr. Åsenlöf. In this traditional view, pain mainly originates from inflammation, "and once the inflammation is treated and reduced, pain will be no problem any longer," she noted. "However, this is too shortsighted. Persons with inflammatory diseases do not differ, in general, from persons with chronic pain." Thus, concepts of nervous system plasticity, persistent pain signalling, and psychological and behavioural prognostic factors for pain-related outcomes apply to inflammatory diseases, and rheumatologists can learn from the expanded focus of other specialists in chronic, noncancer pain, she said.

"Of course," Dr. Åsenlöf said, "I most of all hope for a breakthrough when it comes to curing chronic pain – new ways to understand the role of genetic disposition, and new treatments to either prevent pain sensitisation and restructuring of the plastic nervous system, or to rehabilitate it." But in the meantime, she foresees a transition toward using behavioural assessments to help patients change their thoughts and health behaviours and live meaningful lives, despite pain.

Dr. Åsenlöf has no disclosures.

EULAR Projects in Health Professionals
The Health Professionals' approach to pain management in inflammatory arthritis and osteoarthritis
Thursday 15:30 – 17:00
Room S20

Studies explore physical activity tools

Cost, access, and lack of knowledge remain barriers to measuring physical activity in patients with rheumatic diseases, according to international surveys of patients and health providers. Researchers will share their findings and discuss how best to evaluate these tools this afternoon in a Health Professionals Session.

"From our clinical practise, we know that assessing physical activity and aerobic capacity is important to managing inflammatory arthritis," said Bente Appel Esbensen, Ph.D., research manager and associate professor at Glostrup Hospital and the University of Copenhagen. She and her associates conducted an online survey of approximately 300 nurses, physiotherapists, and occupational therapists from Sweden, Denmark, Belgium, and Ireland. They also surveyed nearly 800 patients from these countries who had rheumatoid arthritis, ankylosing spondylitis, or psoriatic arthritis.

Most health professionals agreed that measuring physical activity is important, in keeping with current

BENTE APPEL ESBENSEN, PH.D.

BIRGITTA NORDGREN, PH.D.

THIJS SWINNEN

practise recommendations. "But the use of physical activity tools in clinics was low, as was confidence in using them," said Birgitta Nordgren, Ph.D., a physiotherapist with the Karolinska Institute in Solna, Sweden. Health professionals need to support and encourage each other to use physical activity tools in practise, and also need more education about these tools, she added.

Likewise, the investigators found that patients understood the value of objectively measuring physical activity, but usually were unfamiliar with options for doing so.

Some providers and patients are already using wearable sensors and smartphone applications to measure physical activity, noted Thijs Swinnen, a physiotherapist and researcher at University Hospitals Leuven in Belgium. "But it is important to scrutinise these novel tools in the same way as any other outcome measure in rheumatology," he emphasised. He will discuss how to use Outcome Measures in Rheumatology, or OMERACT, to determine which physical activity tools are most reliable, responsive, and feasible for clinical use.

It is also unclear how best to translate scientific evidence on physical activity into rheumatology practise, Mr. Swinnen said. Physical activity needs to be considered alongside other lifestyle factors, and simple tools that pass the OMERACT filter and motivate patients to live healthily, despite their challenges, are very much needed, he added.

Even if they are reliable in clinical trials, self-reported measures of physical activity tend to be unreliable and inaccurate when used in clinical settings, Mr. Swinnen noted. On the other hand, "the most sophisticated devices to measure physical activity are too expensive and require too much data for easy clinical use," he said. "For patients, single-sensor devices are affordable, best known, and most easily adopted. But because they are only valid for certain physical activities, such as counting steps during walking, a skilled health professional needs to guide the choice of device in combination with the best physical activity for that particular patient."

The researchers had no disclosures.

Health Professionals Session
Physical activity assessment – what do we know, what do we do, how does it work?
Thursday 15:30 – 17:00
Capital Suite 07

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Nonradiographic axSpA treatment: a continental divide

While it is widely accepted that people with nonradiographic axial spondyloarthritis share many of the same pain symptoms, and laboratory and imaging features as those with radiographically visible disease – and will in many, if not most, cases progress to active ankylosing spondylitis – the approved treatment picture remains quite different in the United States and Europe.

In the past several years, the European Medicines Agency has approved extending indications for a handful of biological medications to treat patients with nonradiographic axial spondyloarthritis, or nr-axSpA. In these patients, inflammation is visible on MRI, or C-reactive protein (CRP) is elevated, but sacroiliitis is not seen on radiography. The U.S. Food and Drug Administration has yet to approve a single therapy for this patient group, citing lack of evidence.

This afternoon, Prof. Joachim Sieper of Charité Universitätsmedizin in Berlin, Germany, will discuss the context of the agencies' different views on indications for nr-axSpA, "which also reflect to some degree the views of rheumatologists on the different continents," said Prof. Sieper, who has worked extensively in nr-axSpA since the mid-1990s.

"Rheumatologists in Europe have been quite aware of nr-axSpA for a long time," Prof. Sieper said in an interview. He said the increased use of MRI as an imaging method in the mid-1990s was what first alerted rheumatologists to the importance of nonradiographic disease. "We were among the first to publish an MRI study in early AS [ankylosing spondylitis] – that's what we called it at the time," he said. "MRI made it clear that patients had inflammation in the beginning, and we have been working in Europe to make sure patients with suspected [axSpA] be referred to rheumatologists."

PROF. JOACHIM SIEPER

The significance of elevated CRP as a risk factor is also a somewhat recent development, he said. "If you look in old textbooks, you'll find that CRP is not of major relevance for AS," he said. "But we now know that if you are CRP positive you are much more likely to show good response to TNF blockage, so we've learned to value CRP in managing the nr-axSpA patient over the last couple years."

The trend in both Europe and the United States is to view nr-axSpA as part of the broader spectrum of AS (the term axial SpA covers both nr-axSpA and AS) and to treat it with biological agents after first-line nonsteroidal anti-inflammatory drugs have failed. It's a similar approach to what's happening in rheumatoid arthritis: "You treat RA also if you don't yet have erosions," Prof. Sieper noted.

Guidelines published in 2015 by the American College of Rheumatology recommend off-label treatment with TNF inhibitors that have been approved for patients with AS. New EULAR guidelines on AS and nr-axSpA, to be presented in London, will likely reflect a similarly proactive approach but with an array of approved therapeutic options.

U.S. regulators are concerned that not all patients will progress to AS within a defined period of time; studies suggest that as many as 60% will develop AS within a decade of onset of symptoms. In the United States, Prof. Sieper said, there is a strong urge to define the early disease and identify who is likely to progress. "Everybody wants to know if you run the risk of overtreating if you identify and treat the patients early. We all want to get a better sense of the natural course of the disease."

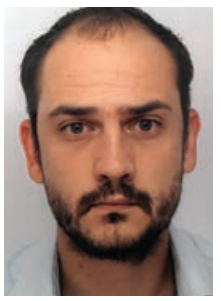
However, he said he disagreed with the way the FDA is attempting to answer these questions, insisting on randomised, placebo-controlled trials in patients with nr-axSpA with 1-year follow-up, whereas the studies used to attain drug approval in Europe lasted only a few months. "The FDA thinks there is a high rate of spontaneous remission – which I doubt – and they want to see what happens if the patients are followed up for 1 year of standard care plus placebo," he said. "I think many will become symptomatic over the course of a year and drop out. I don't think this is ethically acceptable."

Clinical Science Session
EULAR – EMA Session
Thursday 15:30 – 17:00
Capital Suite 02

Predictors of nonresponse to viscosupplementation in knee OA

Higher body mass index and radiologic severity were associated with lack of response to viscosupplementation in patients with knee osteoarthritis, according to a post hoc analysis of a multicentre, double-blind trial that will be presented at the congress on Thursday afternoon.

"This finding may impact our daily practise and help in considering viscosupplementation in future international recommendations. A more stringent selection of patients who are eligible for hyaluronic acid injection could optimise the effectiveness of treatment and limit injections in patients with risk factors for poor outcomes," said Dr. Florent Eymard, who led the study and will present the findings.



DR. FLORENT EYMARD

Intra-articular hyaluronic acid injections are used worldwide to improve pain and function in patients with mild to moderate knee osteoarthritis (OA), but response rates in most viscosupplementation trials have been 60%-70% at best, and predictors of treatment success are unclear, said Dr. Eymard, a rheumatologist at AP-HP Henri Mondor Hospital in Créteil, France.

To explore risk factors for lack of response, he and his associates studied 166 patients with complete clinical and radiologic data who had participated in a trial of 205 patients with symptomatic knee OA. The trial compared HANOX-M (HAppyVisc, LABRHA SAS, Lyon, France) – which combines sodium hyaluronate (1-1.5 megadaltons, 31 mg/2 mL) and mannitol 3.5% – with BioHA (Euflexxa, Ferring Pharmaceuticals, Parsippany, New Jersey, USA, 2.4-3.6 megadaltons, 20 mg/2 mL). Patients received three weekly intra-articular injections, and those who fulfilled the OMERACT-OARSI criteria 6 months later were classified as responders. The two study arms resembled each another clinically and demographically, enabling the data to be pooled for the secondary analysis, Dr. Eymard and his associates noted.

The average age of the patients in the subgroup was 65 years. They had about a 49-month history of knee OA, and were typically overweight, with a mean body mass index (BMI) of nearly 28 kg/m^2. At month 6, 68% of patients were considered responders, and average pain and total scores on the Western Ontario and McMaster Universities Arthritis Index had fallen by more than 40%. High BMI and severe radiographic narrowing of the tibiofemoral joint predicted lack of response in both the univariate and multivariate analyses. Older age and history of viscosupplementation or intra-articular corticosteroid injections showed the same trend, but did not reach statistical significance. However, when combined, these four risk factors showed "a strong cumulative impact" on lack of response, the researchers reported. Notably, patients who lacked these risk factors all met the criteria for response to viscosupplementation, but those with two risk factors had less than a 70% response rate, and those with all four risk factors had less than a 30% response rate.

Deciding whether to use viscosupplementation in obese patients and patients whose OA is severe enough to merit total knee replacement can be difficult, "but we can reasonably propose that patients older than 65 years, with severe radiological and symptomatic osteoarthritis, and no contraindication for surgery or anaesthesia, could be referred to a surgeon without prior viscosupplementation," Dr. Eymard said. "However, we can continue to consider viscosupplementation in patients with severe radiological osteoarthritis if they are young, have many comorbidities, or refuse surgery."

Dr. Eymard had no disclosures.

Basic and Translational Science Session
Lubricants: potential as osteoarthritis treatment?
Thursday 13:30 – 15:00
Capital Suite 14

SANDOZ
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THE EVOLVING LANDSCAPE OF RHEUMATOLOGY: BIOSIMILARITY & EXTRAPOLATION

17:30–19:00, THURSDAY 9 JUNE 2016

Capital Suite 11, ExCel London, UK

Chair: Peter Taylor

17:30–17:40 **Welcome and introductions**
Peter Taylor *(University of Oxford, Oxford, UK)*

17:40–18:00 **Laying the foundation: analytical and functional characterisation of protein products and the demonstration of molecular similarity**
Emily Shacter *(ThinkFDA, Maryland, US)*

18:00–18:20 **Building the totality-of-the-evidence: confirming biosimilarity and supporting extrapolation**
Craig Leonardi *(Central Dermatology, St. Louis, Missouri, US)*

18:20–18:40 **Impacting the clinical landscape: the role of biosimilar therapies in rheumatology**
Peter Taylor

18:40–19:00 **Panel discussion and summary**
Led by Peter Taylor, joined by all

SAN/Immunol/EULAR/Apr2016ad

Online tools seek to engage young RMD patients

As more young patients are getting diagnosed with rheumatic and musculoskeletal diseases (RMDs), the need to engage them with online resources has become more important.

Speakers at a Thursday morning session will describe some of the online tools that are available or being designed in order to address this need.

IRENE MURPHY

This is about "empowering young people with RMDs to find their voice and claim their space," Irene Murphy, who works at the Galway Branch of Arthritis Ireland, said in an interview. She will be presenting information about what Arthritis Ireland is doing to help build a community for young people to help empower them as well as help improve their influence.

She noted that in Ireland, "we can be quite good at giving space to young people and letting them have their voice," but more work needs to be done in terms of getting them involved in patient organisations so that their voices can be heard.

"We're falling behind a little bit in facilitating their influence, particularly in the area of use of resources," Ms. Murphy continued. "So for example, in organisations where you might have a youth branch or a youth committee, they are there, they have a right to be there, they have plenty of opportunities to meet and to talk to each other, maybe even talk to the more senior or the older committee or board, but often they won't be able to influence change or create change. ... It's worthwhile taking that extra step for young people."

To help engage youths, online tools are vital, she said. "I am coming at it from the perspective of somebody who developed arthritis in my teens and felt incredibly isolated and didn't meet somebody for a very long time with the same condition as me. So arthritis became this secret or silent part of my life almost. I think if young people are involved with peers who can understand where they are coming from and where they are going to, arthritis becomes another part of your life, but it's not an isolating or hidden away part of your life, and you are doing something positive about it."

The value of online forums are noted by other speakers during the panel session.

"Youth are online as much as possible," said Wendy Olsder of Youth-R-Well.com of Schiedam, the Netherlands. "I think for youth it works better to have an online youth platform. They want to chat more online instead of meetings. For example, in the Netherlands, we have meetings with older people and I think for youth, they are really boring. It's also really easy to go online. For some people, it's hard to talk about their disease and go to certain meetings, and [with] the online platform, you can just read things about your disease and [it becomes easier to relate]."

WENDY OLSDER

Ms. Olsder will present information on the guide that Youth-R-Well.com developed with a decade of experience in the Netherlands to help other countries establish online communities to serve youth with RMDs. The organisation is in the early stages of testing its guide in three participating countries (Romania, Poland, and Italy) and early results show a promising start.

"On the forum, people can ask questions and others can answer them," Ms. Olsder said in an interview. "It is really an interactive site" that also features cartoons, photos, monthly columns, and relevant information about diseases.

Similarly, Petra Balazova of Young PARE and the Slovak League Against Rheumatism will be presenting the EULAR Young PARE network's new online resource that launched in March 2016, the Virtual Knowledge Centre, which provides tools to youth groups to help build online resources.

PETRA BALAZOVA

"We created this toolbox because we wanted to establish a database with information," Ms. Balazova said. "We would like to create a European network of RMD youth groups."

The goal of this network ultimately would be to establish a database about national youth organisations; create a European network of RMD youth groups to exchange best practises; provide support to national youth organisations; and ensure that these organisations remain in contact to allow for knowledge to continually transfer.

There is a role for physicians to play, even though these tools and resources are primarily designed for patients and are not necessarily clinical in nature but are more about peer support and lifestyle, according to all three presenters. They noted the importance of alerting physicians about these resources so that they may be able to tell their patients about them.

"This specific subgroup of patients is often not recognised as having specific priorities compared to other patients," said Dr. Alessia Alunno of the University of Perugia, Italy. "So the effort should be first to build strong relationships with patients and make them believe that any concern they have should be raised so they should feel free to discuss any problems they may have, any questions regarding treatment, regarding the disease, regarding any information they may need."

DR. ALESSIA ALUNNO

Dr. Alunno will be discussing the role of health professionals in improving shared decision making with young RMD patients.

She noted that there is a lot of misinformation about diseases on the Internet, and she encourages doctors to learn about trustworthy resources to guide their patients to.

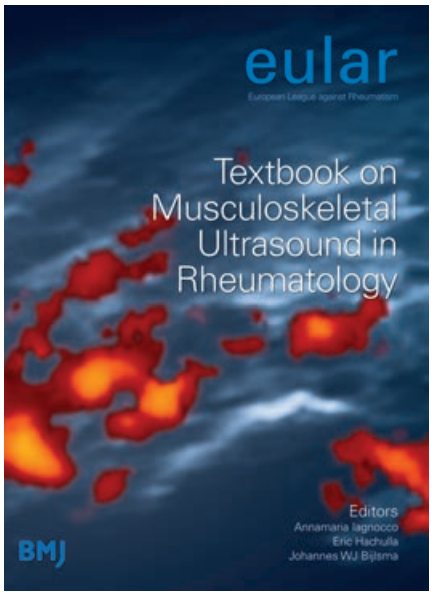
"We should provide them with the tools to access the information. The same for social media or for other platforms. We need to be sure that patients can have access to a wide range of information that may be beyond the hospital or the outpatient clinic," Dr. Alunno said.

None of the presenters have relevant financial disclosures.

PARE Session
Designing solutions to support young people to address the challenges of living with a rheumatic or musculoskeletal disease
Thursday 10:15 – 11:45
Room S19

NEW: EULAR Textbook on Musculoskeletal Ultrasound

This new textbook, designed to complement the EULAR Online Ultrasound Course, aims to assist rheumatologists in the use of ultrasound to facilitate important diagnostic and therapeutic decisions. Written by eminent experts in the field, it includes seven modules with highly illustrative images presented with explanations about the most relevant ultrasound findings.



Visit the BMJ exhibition stand (#810) on Friday, 10 June, at 3:00 p.m. to help us celebrate the book's launch, meet the editors, and buy a copy for them to sign!

Take advantage of the opportunity to buy the book during the congress for just GBP 34.00 and take it home with you.

If you miss your chance, you can still order later at eular.bmj.com (delivery charges apply).

CLINICAL AND PATIENT PERSPECTIVES

A "Joint" Approach for Improving the Management of Psoriatic Arthritis

Friday, 10 June 2016 • 8:15-9:45 • ExCeL London, UK, Hall A

Exploring Challenges in the Diagnosis and Assessment of Psoriatic Arthritis

Shared Decision-Making Strategies for Optimising the Management of Psoriatic Arthritis

Taking Action: Integrating Our Learnings Into Future Clinical Practice

Douglas Veale, MD—Chair
University College Dublin, Ireland

Laura Coates, MBChB, MRCP, PhD
University of Leeds, UK

Jo Lambert, MD, PhD
Ghent University Hospital, Belgium

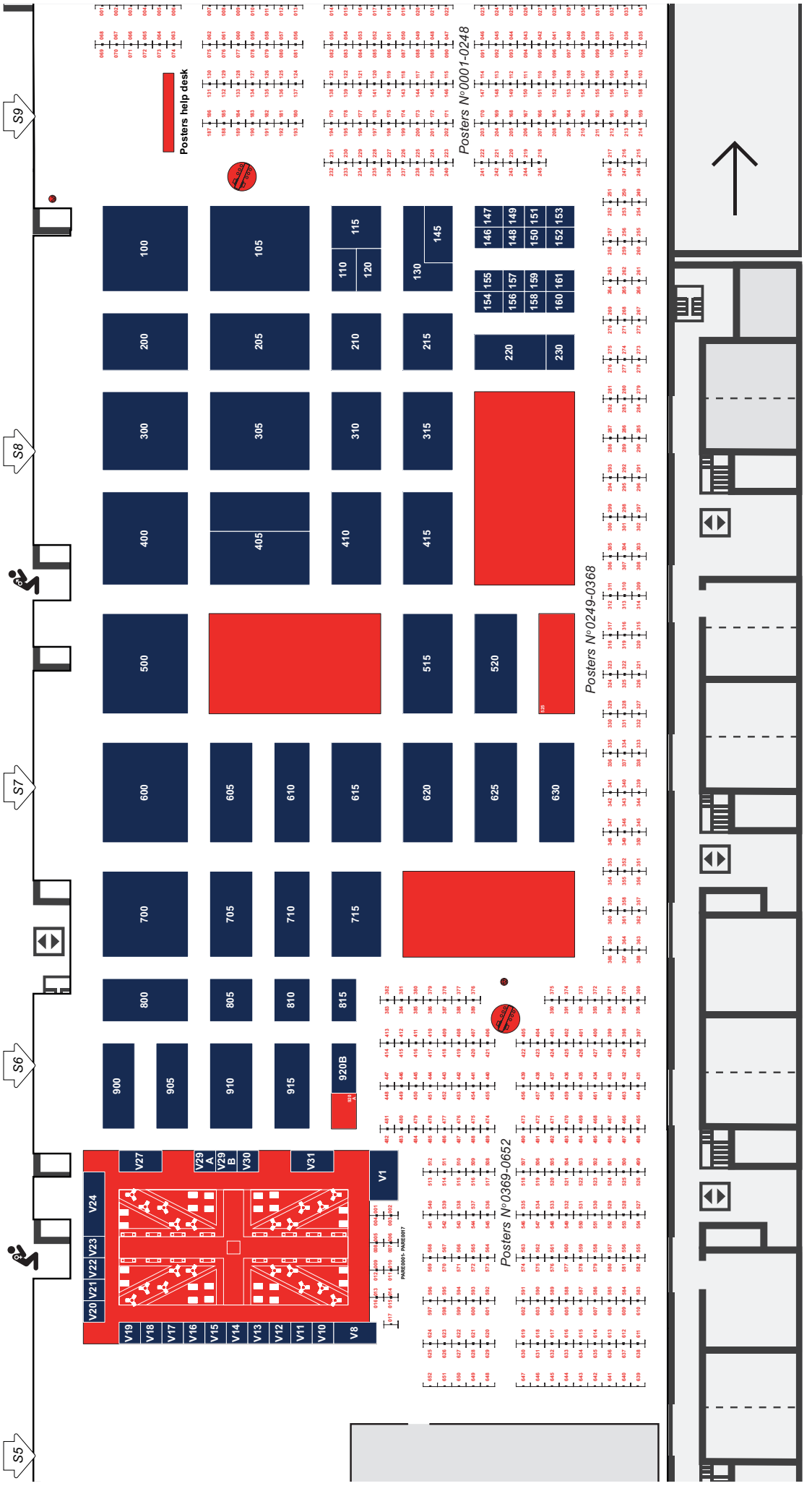
Scan this QR code to discover PsA through the eyes of the patient!

PP-GIP-EUR-0057, PP-GIP-GBR-0043 Date of preparation April 2016

Meeting organized and funded by Pfizer

Exhibition Plan

Status as of 1 May 2016



Exhibitors' List

As of May 1, 2016

ABBVIE	600+605+915
AMGEN	305
ASTRAZENECA	715
BAYER PHARMA AG	800
BIOGEN INTERNATIONAL GMBH	620
BIOIBERICA, S.A	805
BMJ	810
BOEHRINGER INGELHEIM	115
BRISTOL-MYERS SQUIBB	610+615+705
CELGENE CORPORATION	105
CELLTRION HEALTHCARE	630
CLINICAL CARE OPTIONS, LLC	150
CRESCENDO BIOSCIENCE	151
DNALYTICS	148
ELI LILLY AND COMPANY	210+310
ESAOTE	920B
EULAR	910
FIDIA FARMACEUTICI	905
FUTURE EVENTS	157
GE HEALTHCARE	130
GLAXOSMITHKLINE	100
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IBSA INSTITUT BIOCHIMIQUE SA	900
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MSD	700
NOVARTIS PHARMACEUTICAL	415+515+520
OXFORD IMMUNOTEC	153
OXFORD UNIVERSITY PRESS	161
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ROCHE	300
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SANDOZ	520
SANOFI GENZYME	410
SOBI	815
TAYLOR & FRANCIS	149
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UCB BIOPHARMA SPRL	500
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APLAR	V19
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EULAR PARE	V1
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WORLD SCLERODERMA FOUNDATION	V17

Wnt signalling plays crucial role in OA pathology

Researchers have added another piece to the puzzle of how to treat osteoarthritis by confirming that the Wnt signalling pathway has a crucial role to play in the development of the disease.

Martijn van den Bosch from the Radboud Medical Centre in the Netherlands will be presenting his latest findings on the role of the Wnt signalling pathway in osteoarthritis (OA) this morning at the Cartilage, Bone, and Synovium Abstract Session. Mr. van den Bosch received a basic science abstract award for the study at Wednesday evening's Opening Plenary Session.

MARTIJN VAN DEN BOSCH

Mr. van den Bosch and his colleagues had previously discovered that the Wnt signalling pathway played an important role in the development of osteoarthritis.

However, as Mr. van den Bosch explained in an interview, Wnt signalling is a complex signalling pathway with many ligands, receptors, and inhibitors.

In the current study, he and his colleagues performed a microarray analysis of synovial tissue from patients in the CHECK cohort. OA progressors had significantly increased expression of the protein WISP1 – whose expression is induced by the canonical Wnt signalling pathway – at baseline, compared with nonprogressors. They further confirmed the association by discovering that the absence of the protein WISP1 resulted in significantly decreased degeneration of the articular cartilage in three different animal models of osteoarthritis.

The findings suggest that Wnt signalling is highly likely to play a crucial role in the pathology that is found in osteoarthritis, Mr. van den Bosch said.

"More specifically, WISP1 seems to be an important mediator of canonical Wnt signalling in the osteoarthritic joint," he said.

Uncertainty remains, however, about the involvement of WISP1 in other pathologies found in osteoarthritis such as inflammation of the synovium and osteophyte formation.

According to Mr. van den Bosch, the research team now needs to extend its findings in additional studies as well as translate its findings to humans.

Abstract Session
Cartilage, Bone, Synovium
Thursday 10:15 – 11:45
Capital Suite 06

EULAR 2016 poster tours: Thursday, Friday, Saturday

Nearly 500 posters will be presented in 45 themed poster tours during Thursday, Friday, and Saturday. EULAR congress attendees who wish to attend a tour need to register for the tour at the poster tours and workshops desk located at the registration area. Tour attendance will be limited to 20 attendees per tour and will be determined on a first-come, first-served basis. Registration is only possible on the day of the poster tour itself.

Thursday, 9 June

11:45–13:30 Poster tours, poster viewing

- PARE – Poster Tour I

Poster Tours

- Axial SpA – Clinical aspects
- Cartilage, bone, synovium
- Clinical aspects of fibromyalgia
- Comorbidities update 2016, part I
- Crystal and metabolic bone diseases; bone diseases other than osteoporosis
- How to treat osteoporosis in patients with elevated disease
- Immunity in rheumatic diseases
- Outcome measures of RMDs
- Prognosis and outcome in RA
- Psoriatic arthritis
- RA treatments – non-biological, small molecules
- SpA and PsA basic and translational research
- Walk through new pathways, biomarkers, and potential treatments in SLE and Sjögren's
- PReS – Poster Tour: Arthritis in childhood

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

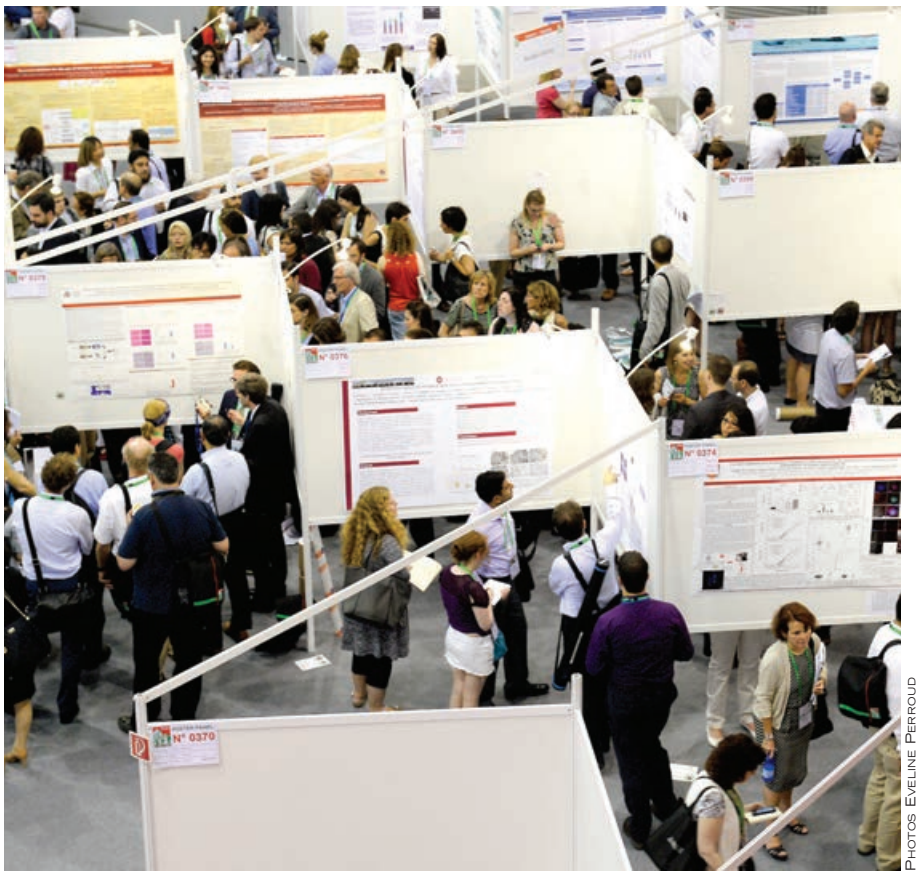
Saturday, 11 June

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



Photos Eveline Perroud

ANTI-TNF TREATMENTS Cytokine-directed therapies for erosive hand osteoarthritis

continued from page 1

therapy is partly hindered by our limited knowledge on the pathophysiology of the disease."

"We previously had the idea that TNF is an important cytokine in the pathogenesis of erosive osteoarthritis, but because there have been no animal studies and it's very difficult to take biopsies or fluid aspiration from these small finger joints, we needed to look for other possibilities to really identify the presence of TNF in those affected joints," added Dr. Ruth Wittoek, a staff rheumatologist at Ghent University Hospital in Belgium and a coauthor of all three studies.

In a small study led by Dr. Wittoek, researchers used immunoscintigraphy to identify the presence of TNF in swollen finger joints. They took static images of both hands of five patients with erosive OA immediately following administration of radiolabeled certolizumab pegol (early phase) and 4-6 hours following the injection (late phase). Patients had erosive OA for a median of 8.4 years and their median age was 55.6 years. All 18 interphalangeal (IP) finger joints were scored according to the anatomical phase scoring system on x-ray. All patients underwent clinical examination for presence of tenderness and palpable swelling of the joints and ultrasound 1 day prior to scintigraphy.

Ninety IP finger joints were studied in total. Active tracer uptake was seen in 7 joints in early phase (7.8%; all weak) and in at least 24 joints in late phase (26.7%; 19 weak, 5 strong). No uptake was seen in metacarpophalangeal joints. Early and late uptake were present in 5 (15.2%) and 12 (36.4%) of 33 tender joints and in 2 (3.5%) and 12 (21.1%) of 57 nontender joints (likelihood ratio/LR = 2.2; *P* = NS). The relationship was most pronounced with palpable joint swelling: early and late uptake were present in 5 (21.7%) and 14 (61%) of 23 swollen joints and 2 (3%) and 10 (14.9%) of 67 nonswollen joints (LR = 8.9; *P* less than .001). Early and late uptake were present in 6 (9.7%) and 18 (29.1%) of 62 sonographic active joints (with any presence of effusion or synovial proliferation) but just 1 (3.6%) and 6 (21.4%) of noninflammatory joints (LR = 1.5; *P* = NS). Uptake was observed in all anatomical phases, but the strongest association was found with R-phase.

"Soft-tissue swelling strongly correlated with uptake of certolizumab, meaning in these joints a lot of TNF was present," Dr. Wittoek said. "These data further solidify the rationale for cytokine-directed therapies in erosive OA."

Two other studies to be presented during the session looked at administration of etanercept in patients with erosive hand OA. In a multicenter, randomized, placebo-controlled trial, 90 patients were randomized to receive either 50 mg of subcutaneous etanercept weekly for 24 weeks, then 25 mg weekly for the remainder of a year, or placebo. Participants were a mean age of 60 years, 81% were women, and 96% fulfilled the ACR hand OA criteria.

"Synovial inflammation is often present in erosive hand OA; moreover, synovitis is associated with pain and with structural damage after around two and a half years," said lead study author Prof. Margreet Kloppenburg, a professor of rheumatology at Leiden University Medical Centre in the Netherlands. "Therefore, we wanted to know whether blocking of synovial inflammation by a well-known drug such as etanercept would also have a positive effect on outcomes in erosive hand OA."

Researchers assessed visual analogue scale (VAS) pain; hand function; quality of life; number of tender joints; and grip strength after 4, 8, 12, 24, and 36 weeks and after 1 year. Radiographic progression of IP joints was scored blindly at baseline, 24 weeks, and 1 year following the quantitative Ghent University Scoring System (GUSS). VAS pain was compared between treatment groups at 24 weeks and 1 year in intention-to-treat analyses.

Etanercept was not superior to placebo on VAS pain at 24 weeks, but it was superior to placebo both on pain and structural damage assessed by GUSS in the symptomatic and inflammatory patients who completed the study. The drug was especially effective in joints with signs of inflammation.

Overall, VAS pain in all patients decreased 24.8 mm (95% confidence interval, –29.2 to –20.5; *P* less than .001) at 24 weeks. In intention-to-treat analysis, differences in pain between the groups were in favor of etanercept but did not reach statistical significance. The per-protocol analysis of GUSS showed a mean difference in favour of etanercept, indicating more remodeling in the etanercept group. Additional analyses showed an interaction between soft swelling/erythema and etanercept treatment on GUSS, resulting in a statistically significant (*P* less than .05) mean difference between the two treatment groups. More patients dropped out on placebo than on etanercept (6 vs. 3) because of ineffi-cacy, whereas more dropped out on etanercept than on placebo (6 vs. 1) because of adverse effects.

"Synovial inflammation is an interesting target for treatment in OA patients with an inflammatory hand osteoarthritis phenotype," Prof. Kloppenburg said.

In a third study led by Dr. Kroon, investigators looked at a subset of patients participating in the clinical trial. The work suggests that etanercept is effective in inhibiting bone marrow lesions in patients with erosive hand OA.

The researchers pulled 20 participants with symptomatic erosive OA with clinical and ultrasonographic signs of inflammation in at least one IP joint. The subjects underwent contrast-enhanced MRI of the eight distal and proximal IP joints of one hand at baseline and 1 year. Images were scored for synovitis and bone marrow lesions (0-3 per joint, total score 0-24), blinded for patient characteristics. Radiographs of the same hand were scored according to the Verbruggen-Veys system. Logistic regression was used to associate the presence of an MRI feature in a joint with being in an erosive versus nonerosive anatomical phase.

"New imaging modalities like MRI enable us to study the pathophysiology of erosive OA more closely," Dr. Kroon said. "This study also gave us the unique opportunity to investigate whether anti-TNF, which is known to lead to clinical improvement and improvement of inflammatory lesions on MRI in other rheumatic diseases like rheumatoid arthritis, might also be effective in erosive OA."

The presence of bone marrow lesions, but not synovitis, was associated with the presence of an erosive anatomical phase in a joint, and treatment with etanercept appeared effective in inhibiting these lesions, suggesting a role for TNF in the pathophysiology of erosive OA. The inhibitory effect of etanercept on bone marrow lesions was more pronounced in IP joints with severe synovitis at baseline, suggesting that inflamed synovial tissue could be a source of TNF production in erosive OA.

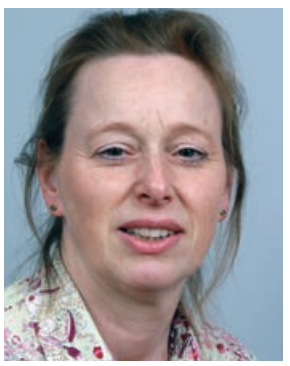
"We think that TNF-alpha plays a role in the pathophysiology of erosive OA via an effect on the subchondral bone," Dr. Kroon said. "Since we saw that the beneficial effect of etanercept on [bone marrow lesions] was more pronounced in joints with synovitis at baseline, we think that in an inflamed synovial hand joint an interaction takes place between synovium and subchondral bone, which could be influenced by blocking TNF."

The total synovitis score was similar at baseline and 1 year in both treatment groups. For bone marrow lesions, the total score was 5.4 (2-9) and 7.0 (0-9) in the placebo group versus 4.5 (3-9) and 3.7 (0-8) in the etanercept group. The presence of bone marrow lesions was associated with being in E-phase and R-phase. Synovitis was not associated with these phases.

The authors reported no relevant financial disclosures. Pfizer supplied the etanercept and a research grant.

DR. FÉLINE KROON

DR. RUTH WITTOEK



PROF. MARGREET KLOPPENBURG

Abstract Session
New Horizons in Osteoarthritis
Thursday 10:15 – 11:45
Capital Suite 14

Optimising methotrexate an economical choice in RA

A majority of patients who receive methotrexate monotherapy to begin treatment for rheumatoid arthritis in France appear to be receiving optimised therapy with a relatively low need for adding or switching to a biologic, based on preliminary results from the observational, multicentre cohort STRATEGE study.

On Thursday afternoon, first author Dr. René-Marc Flipo, who is Head of Rheumatology at Roger Salengro Hospital and Professor of Rheumatology at the University of Lille in France, will discuss the study, which comprises more than 800 patients from 176 rheumatology practise centers in France.

Although oral methotrexate monotherapy remains a mainstay in rheumatoid arthritis, instead of optimising methotrexate monotherapy by increasing the dose and/or switching to a parenteral form, it has been a concern that clinicians may be too quick to declare treatment failure and proceed to biologics or other drug combinations.

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"When patients are considered to have inadequate response to methotrexate monotherapy, this usually means that they have failed oral therapies at a dose below 15 mg," Dr. Flipo said in an interview. Currently, "we have very little scientific data to illustrate the efficacy of higher doses of up to 25 mg or of subcutaneous administration, which has greater bioavailability, and [which] clinicians are finding effective in current practise."

The aim of the STRATEGE study is to determine which therapeutic strategies are chosen for RA patients who have failed first-line methotrexate monotherapy and how they do after 6 months of treatment. So far, the study has shown that for more than 500 patients (over 60% of the cohort), methotrexate monotherapy has been optimised without switching to a biologic. Biologics have been used by more than 100 patients (about 14%) in the study, most of the time in association with methotrexate.

When 6-month follow-up is complete, "I suspect we will see that if rheumatologists use higher dosages [of methotrexate] and subcutaneous administration, you'll obtain low disease activity in about the same percentage of patients as those treated with methotrexate and a biologic agent," Dr. Flipo said.

"Though methotrexate is much cheaper than current biologic therapies, and rheumatologists are comfortable using it, that does not mean patients will or should prefer it," Dr. Flipo noted.

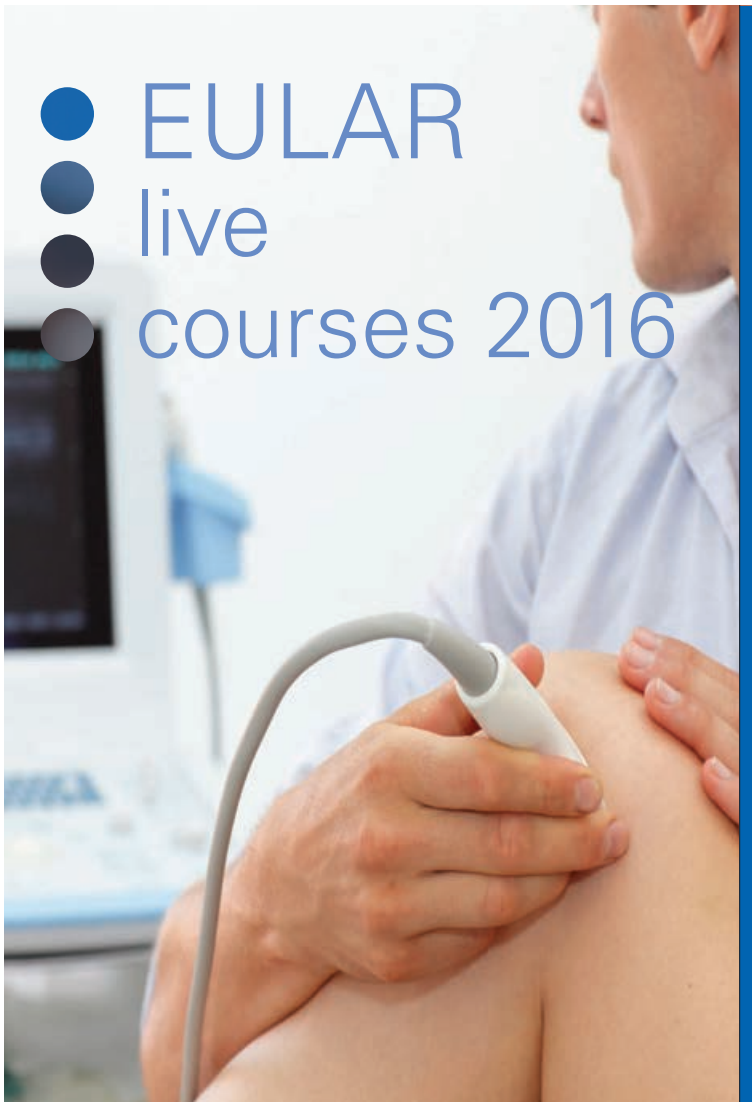
"If you have RA and you have the choice between weekly subcutaneous methotrexate with neutropenia, nausea, and loss of hair, or the possibility of one subcutaneous biologic treatment per month, I think most patients would prefer the monthly biologic. So the question is mainly of economics."

But it is still important to understand whether methotrexate can work if used more aggressively, particularly with subcutaneous administration, he said, adding that it has implications for resource-poor healthcare systems.

While the final results from STRATEGE are currently under analysis, Dr. Flipo will discuss the design of the study, the patients' baseline characteristics, and information gathered from participating rheumatologists on which strategies they choose in case of inadequate response to first-line methotrexate monotherapy.

The STRATEGE study is sponsored by Nordic Pharma.

Clinical Science Session
Optimisation of MTX in RA treatment
Thursday 15:30 – 17:00
Hall D



EULAR live courses 2016

· 23rd EULAR ultrasound course
Leeds, UK, 5 -7 June 2016
Madrid, Spain, 11-13 June 2017

· 5th EULAR course for ultrasound trainers in rheumatology
Leeds, UK, 4 - 5 June 2016
Madrid, Spain, 10-11 June 2017

· 7th EULAR capillaroscopy course
Genoa, Italy, 8-10 September 2016

· 17th EULAR postgraduate course
Prague, Czech Republic, 23-26 October 2016

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Dopamine may open new possibilities for bone repair in RA

Preliminary data from the first research study of the dopamine pathway in human bone tissue indicate that osteoblasts, the cells involved in bone formation, "express the key enzyme for dopamine production, [providing] the first proof of concept that not only the synovial tissue, but probably also the bone is able to produce neurotransmitters independent of the CNS," according to researcher Silvia Capellino, Ph.D.

This afternoon, Dr. Capellino of the Justus Liebig University Giessen (Germany) will present on the dopamine pathway and bone metabolism in rheumatoid arthritis (RA). This investigation stems from recent groundbreaking findings by Dr. Capellino and colleagues on the role of locally produced dopamine in RA, and their efforts to modulate it locally to reduce inflammation, without involving the CNS.

Clinical evidence supports the direct involvement of dopamine in arthritis. RA patients often develop restless leg syndrome, which involves the dopamine pathway, and schizophrenia patients who receive long-term treatment with dopamine-modulating drugs have lower incidence of RA. This makes the dopamine pathway a tempting target in treating RA.

However, any therapeutic benefits of modulating dopamine systemically are limited by the potential for unwanted effects on the CNS.

SILVIA CAPELLINO, PH.D.

Dr. Capellino and her colleagues began demonstrating several years ago that during RA, peripheral cells also produce dopamine and express dopamine receptors that affect autocrine/paracrine signaling, independent of the CNS, in inflamed synovial tissue. Synovial cells of people with RA produce dopamine and express high levels of dopamine receptors, the investigators found.

Moreover, this local sympathetic pathway can be modulated locally, too. "By injecting drugs used to control the release of sympathetic neurotransmitters just in the inflamed joints, we got a strong TNF [tumour necrosis factor] inhibition – about 60% reduction," Dr. Capellino said in an interview.

In addition to continuing the research in synovial cells, Dr. Capellino is working on uncovering the role of dopamine expression in bone cells and whether dopamine modulation might be used to promote bone repair in RA patients.

The proinflammatory cytokines produced during chronic inflammation in RA, such as interleukin-6 and TNF, induce an uncoupling of bone formation and resorption, resulting in bone loss. Understanding the role of neurotransmitters like dopamine in this process is important, Dr. Capellino said, because "so far there is no long-term therapy to preserve bone mass." While treatment with biologic agents and bisphosphonates can stem further loss, they cannot promote repair.

Now that Dr. Capellino and her colleagues have uncovered osteoblasts' expression of the key enzyme for dopamine production, "we need to find out how dopamine works on these cells, and how we can act on the local dopamine pathway to promote bone repair after the patient's already had bone loss."

This could mean either attempting to activate or inhibit dopamine, she said. "We do not yet know so far if dopamine plays the same pro- or anti-inflammatory role in the bone and in the synovial tissue. And there are different dopamine receptors that could activate completely different intracellular pathways. We have to first understand which receptor plays which role on which cell."

Dr. Capellino and colleagues have already learned that osteoblasts are able to uptake albumin. Therefore, treatment with albumin-coupled dopaminergic drugs would be one way of targeting affected tissues without flooding the central nervous system. Another option, she says, is to load dopamine or other dopaminergic drugs into "nanoparticles or other carriers that do not pass the blood-brain barrier."

Dr. Capellino's research is being conducted with funds from the European Commission, under a Marie Sklodowska-Curie Individual Fellowship, and the German Society for Rheumatology.

Basic and Translational Science Session
"Smoke a joint to protect the joint." Cannabidoids & neuropeptides in pain and inflammation
Thursday 15:30 – 17:00
Capital Suite 14

Glimpse of delaying or preventing RA seen in study

There may be a window during which the onset of rheumatoid arthritis can be delayed or even prevented in people at high risk of the disease, according to findings from a proof-of-principle study that will be presented this morning.

Lead investigator Dr. Daniëlle Gerlag and her associates conducted the randomised, double-blind, placebo-controlled PRAIRI study to determine if people who test positive for both anti-citrullinated protein antibodies (ACPA) and rheumatoid factor and have C-reactive protein levels of 3 mg/L or greater with or without subclinical synovitis on ultrasound or MRI of the hands go on to develop rheumatoid arthritis after receiving either a 1,000-mg single infusion of the anti-CD20 antibody rituximab or placebo.

DR. DANIËLLE GERLAG

They enrolled 81 people who each received 100 mg methylprednisolone prior to their randomised treatment and conducted follow-up over a median of 27 months. Over that period, 30 participants developed arthritis: 40% (16 of 40) in the placebo group after a median of 11.5 months, compared with 34% (14 of 41) in the rituximab group after a median of 16.5 months.

The point in time at which 25% of the patients in each group had developed arthritis was significantly in favor of individuals who had received rituximab (24 months), compared with placebo (12 months), according to a Cox proportional hazard analysis that took into account treatment effect over time.

According to Dr. Gerlag, who is head of the clinical unit at GlaxoSmithKline, the results are exciting because they represent first proof that an opportunity exists to delay and maybe even prevent arthritis in people at high risk of developing RA. "Primary prevention, defined as interventions targeted at preventing the development of RA-related systemic autoimmunity, is a growing and exciting area of research," she said in an interview.

Dr. Gerlag hopes that the research will eventually lead to a better understanding of how and if it is possible to influence the path of development of RA in the direction of cure. "We know already that smoking as well as obesity increases the chance of developing RA," she said. "Perhaps influencing these factors in people who carry a potential high risk might lead to preventing the development of autoantibodies" associated with RA.

High-risk patients such as those with family members with the disease often have autoantibodies that are present for many years before the development of symptoms of RA. These people could opt to have a blood test to detect the presence of these antibodies, she suggested.

Although the PRAIRI study was meant to prove the concept of using a single infusion of rituximab to delay the occurrence of arthritis, Dr. Gerlag believes prevention is a realistic goal in the future. The study results create "the possibility to prevent arthritis more permanently by, for instance, repeating this infusion on a yearly basis.

"Other agents and treatment regimes may also have a similar effect on delaying arthritis development," she added.

Dr. Gerlag and another coauthor disclosed that besides being employed by GlaxoSmithKline, they receive grant or research support from the Dutch Arthritis Foundation and the Netherlands Organisation for Health Research and Development.

Abstract Session
Prognosis and outcome in RA
Thursday 10:15 – 11:45
Hall B

Scenes from opening day in London

Photos by Gianluca Colla

Delegates arrive for the start of the 2016 Congress (top left and right). Presenters discuss the latest results from a variety of studies at a press conference (middle and bottom right). Prof. Anthony Redmond talks about important presentations to be given at Health Professionals sessions (bottom middle). President Gerd Burmester, President-Elect Hans Bijlsma, and past President Maurizio Cutolo attend the EULAR General Assembly (bottom left, left to right).

Final days to apply for the EULAR/ACR exchange programme

It's not too late to apply for the 2016 EULAR/ACR Exchange Programme, whose purpose is to promote the international exchange of clinical and research skills, expertise, and knowledge within rheumatology.

The program recognises outstanding rheumatology professional faculty in both laboratory and clinic-based research, and provides exposure to the exciting work being done by colleagues overseas. The exchange programme allows participants to share knowledge and experience, and creates opportunities for collaboration: It supports junior academic rheumatologists and rheumatology professionals' travel from Europe to the United States to experience the American College of Rheumatology Annual Meeting in Washington, D.C., 9-16 November, 2016; engage in a half-day exchange programme with American colleagues at the annual meeting; and participate in a subsequent site visit at a local institution.

We are inviting early-career investigators to apply for the programme. Successful candidates will receive a complimentary registration to the ACR Annual Meeting and a travel stipend of 2,000 EUR. The application period will close at noon on 15 June.

Applicants must fulfil the following requirements:

- Hold a nontenured faculty appointment or equivalent position (below the level of full professor) at an academic center in a EULAR member country.
- Have a doctoral degree (MD, PhD, DSc, or equivalent) in a field/area relevant to rheumatology.
- Demonstrate a firm commitment to academic medicine.
- Submit an abstract for presentation at the ACR Annual Meeting. Note that the abstract submission period for the ACR Annual Meeting ends at noon Eastern Time on 21 June.

To apply, complete the application form at www.eular.org/bursary_app_ACR.cfm. Each applicant will be asked to fill in / upload:

- A personal statement outlining how participation in the 2016 EULAR/ACR programme will benefit their research, career, and how they can contribute to the program (fill in directly).
- Current curriculum vitae (PDF format), which should include, if applicable: summary of teaching activities undertaken as a rheumatologist and mentoring/supervision activities (e.g., medical student projects, other PhD students, educational supervision (including date of activity).
- Letter of recommendation from a senior academician within rheumatology, as PDF.
- Letter of support from Chief of Rheumatology, as PDF.

For more information, please contact Gabriela Kluge (gabriela.kluge@eular.org) or during the congress visit her at the EULAR booth #910 in the EULAR Village in the Exhibition Hall.

Annual European Congress of Rheumatology EULAR 2017

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Modern imaging and psoriatic arthritis: a role for all stages

Psoriatic arthritis is a disease with a highly variable course that is difficult to predict.

Modern imaging methods – ultrasonography and MRI especially – hold promise for predicting both the severity of its course and patients' response to treatment or treatment cessation – but they're understudied and underused in psoriatic arthritis (PsA), according to Prof. Mikkel Østergaard of Copenhagen University Hospital at Rigshospitalet, in Denmark.

PROF. MIKKEL ØSTERGAARD

"There is a need in practise to predict or prognosticate what's going to happen with the disease, and the usual methods are not doing that job sufficiently well," said Prof. Østergaard, who will speak Thursday afternoon on his own and others' findings on how MRI and ultrasonography can be used predictively at various stages of PsA.

While MRI and ultrasonography are used more often with PsA in Europe than in other parts of the world, including the United States, "it's country dependent and still variable by area," Prof. Østergaard said in an interview. He noted that there are economic considerations in deciding on an imaging modality.

Still, he said, "either one can visualise changes with a much higher sensitivity than conventional x-rays. The important thing is that they are underused compared to what would be optimal."

In his presentation, Prof. Østergaard will describe current findings supporting the use of ultrasound and MRI to predict development of PsA in patients with psoriasis; to predict damage progression in PsA; to predict flare-ups for patients in remission; and to predict relapse in those being tapered off treatment with anti-rheumatic drugs.

Although current research supports a role for advanced imaging in each of these scenarios, Prof. Østergaard said, the evidence is currently strongest in two: predicting relapse and, particularly, identifying early disease.

One key group of concern comprises patients presenting with psoriasis who complain of some pain but have no obvious synovitis. Among these patients, "those that have findings of inflammation on imaging have a higher chance of actually getting clinical joint disease within a certain time frame," Prof. Østergaard said. "What we should do is follow those patients more closely and recognise that they are at increased risk instead of telling them not to worry about it, which is what often happens."

Complicating the picture is that the usual disease course has psoriasis preceding joint involvement. Generally, a dermatologist or general practitioner is the first physician consulted, and referral to rheumatology is often delayed.

"Psoriasis patients are not seen by rheumatologists unless they report joint symptoms, and even those that have them still may not be referred," Prof. Østergaard said.

Many psoriasis patients, of course, will never develop joint involvement. "At this stage, we cannot recommend that everyone with psoriasis should have ultrasound," he said. "That would be too big a step and an enormous amount of imaging."

But for the patient with psoriasis and any joint complaints, "it would be beneficial to do some imaging as well. Just screening those who report [joint] symptoms would be a major step forward compared to ... now."

Prof. Østergaard's research group aims to clarify whether there is a role for ultrasound imaging even earlier in the disease course, and whether there is benefit in treating people in whom subclinical disease is detected on imaging. The researchers also are trying to isolate specific predictors of therapeutic response or flare-up through imaging in people with established PsA.

Prof. Østergaard does not have any relevant disclosures.

Clinical Science Session
Advancements in the imaging of PsA
Thursday 13:30 – 15:00
Hall D

EULAR on-line courses 2016

- 11th EULAR on-line course on rheumatic diseases
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Continued from page 1

Abstract Session: New insights into imaging Room S20

How to Treat / Manage (HOT)
HOT Session 4 Hall E

PARE Session
Designing solutions to support young people to address the challenges of living with a rheumatic or musculoskeletal disease Room S19

11:45 – 13:30

Poster Tours
PARE - Poster Tour I
Axial SpA - Clinical aspects
Cartilage, Bone, Synovium
Clinical aspects of fibromyalgia
Comorbidities update 2016, part I
Crystal and metabolic bone diseases; bone diseases other than osteoporosis
How to treat osteoporosis in patients with elevated disease
Immunity in rheumatic diseases
Outcome measures of RMDs
Prognosis and outcome in RA
Psoriatic arthritis
RA treatments - non-biological, small molecules
SpA and PsA Basic and Translational research
Walk through new pathways, biomarkers and potential treatments in SLE and Sjögren's
PReS - Poster Tour: Arthritis in childhood

13:30 – 15:00

What is New (WIN)
WIN Session 3 ICC Auditorium

Challenges in Clinical Practice Session
Combined cases: Sjögren's and a pediatric case Hall B

Clinical Science Session
Advancements in the imaging of PsA Hall D
When and how to treat Raynaud's phenomenon and related complications Hall C

How to Treat / Manage (HOT)
HOT Session 5 Hall E

Outcome Science Session
Role of new imaging techniques as RMD outcomes Hall A

Joint Session HPR / PARE
"Fewer words - more action" - tailored care for men with rheumatic diseases? Capital Suite 07

Basic and Translational Science Session
Recent advances in our understanding of macrophage biology Capital Suite 11
Lubricants: potential as osteoarthritis treatment? Capital Suite 14

PReS Session
Extra-articular complications of JIA Capital Suite 02

The Young Rheumatologist
The elephant in the room: how to avoid biases in research? Capital Suite 01

Practical Skills Session
Crystals II Capital Suite 06
Laboratory I Capital Suite 13

PARE Session
Digital applications for the benefit of the patient Room S19

EULAR Projects in Clinical Affairs
EULAR Projects in Clinical Affairs Room S20

15:30 – 17:00

What is New (WIN)
WIN Session 4 ICC Auditorium

Challenges in Clinical Practice Session
Difficult vasculitis (pulmonary/renal & CNS) Hall B

Clinical Science Session
Optimisation of MTX in RA treatment Hall D
Joint replacement in OA: friend or foe? Hall C
EULAR - EMA Session Capital Suite 02

How to Treat / Manage (HOT)
HOT Session 6 Hall E

Outcome Science Session
How to identify and follow patients with inflammatory back pain? Hall A

Health Professionals Session
Physical activity assessment – what do we know, what do we do, how does it work? Capital Suite 07

Basic and Translational Science Session
How cell death shapes immunity and tolerance Capital Suite 11
"Smoke a joint to protect the joint." Cannabidoids & neuropeptides in pain and inflammation Capital Suite 14
The Young Rheumatologist - Teaching clinical skills Capital Suite 01

Practical Skills Session
Local procedures including aspirations, injections and biopsies I Capital Suite 06
MRI I Capital Suite 13

PARE Session
What is done for people with rare diseases? Can we do more? Room S19

EULAR Projects in Health Professionals
The Health Professionals' approach to pain management in inflammatory arthritis and osteoarthritis Room S20

EULAR offers bursaries for scientific training

Every spring and autumn, EULAR awards up to 10 training bursaries to applicants from European countries for clinical or laboratory work (3-6 months) in a clinical or research unit of another European country. The objective is to improve the standard of research and care and to foster collaboration across rheumatologic, clinical, and research centres in Europe.

The amount of the bursary depends on the length of stay and equals 1,000 euros for travel expenses plus 1,000 euros per month of stay (maximum of 7,000 euros).

The next application deadline is 30 September 2016.

Bursaries will not be made if the applicant is already abroad in training.

Only persons who work predominantly in the field of rheumatology are eligible for scientific training bursaries. The age of the candidate should not exceed 40 years.

Recipients are asked to submit both a midterm report as well as a final report to the EULAR Secretariat, focusing on the results they have achieved during their training. Based on their final report, participants may be given the chance to present their results in an abstract presentation at the next EULAR congress.

Applicants should submit an application together with the following documents:

- Curriculum vitae with date of birth and list of publications (if any).
- Outline of the clinical or laboratory project to be undertaken (maximum four pages including references).
- Written confirmation of acceptance from the host hospital or research institute (signed by the head of department), indicating the tentative time frame of the training period.

Application details are available at www.eular.org. Send your complete application in electronic form to the EULAR Secretariat at gabriela.kluge@eular.org.

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Satellite Symposia Programme Thursday, 9 June

List of Satellite Symposia as of 1 May 2016

08:15 – 09:45 **Hall B**

AbbVie

A vision for tomorrow – treating beyond the joints

The value of building enduring collaborations in rheumatology & ophthalmology

Chairperson(s): **Robert Landewé** (Netherlands)

08:15 Robert Landewé (Netherlands)

Welcome and introduction

08:30 Muhammad Haroon (Ireland)

Uveitis as an early feature of SpA

08:45 Athimalaipet Ramanan (United Kingdom)

Insights into the management of anterior uveitis associated with JIA

09:05 Antoine Brézin (France)

Current evidence for the therapeutic response in non-infectious uveitis

09:25 All

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

09:40 Robert Landewé (Netherlands)

Summary

08:15 – 09:45 **Hall E**

Hospira, a Pfizer company

Biosimilars in rheumatology: where, what, why, and how?

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

08:15 Josef S. Smolen (Austria)

Welcome and introduction

08:25 João Gonçalves (Portugal)

Where are we now?

08:50 Ulf Müller-Ladner (Germany)

What are we going to do and why?

09:15 Silvio Danese (Italy)

Ulf Müller-Ladner (Germany)

How are we going to get there?

09:40 Josef S. Smolen (Austria)

Audience Q&A and summary

09:45 Meeting close

08:15 – 09:45 **Hall C**

Bristol-Myers Squibb

Targeting unmet needs of autoantibody-driven inflammatory diseases: focus on seropositive rheumatoid arthritis

Chairperson(s): **Paul Emery** (United Kingdom)

08:15 Paul Emery (United Kingdom)

Welcome and introduction

08:17 Maurizio Cutolo (Italy)

A mechanistic approach to RA treatment: identifying appropriate cells and pathways of response

08:30 Tom Huizinga (Netherlands)

Can we identify a patient type? Exploring the evidence for predictive and prognostic role of autoantibodies

08:45 All

Questions and discussion of the first two presentations

08:55 Georg Schett (Germany)

Immune synapse and the adaptive immune response: systems that drive autoantibody formation

09:10 Rohit Aggarwal (United States)

What does the future hold? Exploring commonalities amongst autoantibody-driven inflammatory diseases

09:25 All

Questions and discussion of the last two presentations

09:35 All

Panel discussion, symposium summary and close

08:15 – 09:45 **Hall A**

Sanofi Genzyme Regeneron

IL-6 as a driver of joint destruction in rheumatoid arthritis: translating complex science into patient benefits

Chairperson(s): **Ernest Choy** (United Kingdom)

08:15 Ernest Choy (United Kingdom)

Welcome and introduction

08:20 Georg Schett (Germany)

The biology of IL-6 and its role in the pathogenesis of joint destruction

08:40 Désirée van der Heijde (Netherlands)

Imaging joint damage in RA: from clinical trials to clinical practice

09:00 Mark Genovese (United States)

Managing joint damage in RA: how successful are we?

09:20 All

Panel discussion/Q&A

08:15 – 09:45 **Capital Suite 07**

Medscape Education supported by an independent educational sponsorship from Eli Lilly

Evolution or revolution in RA clinical practice? Ask the experts

Chairperson(s): **Peter Taylor** (United Kingdom)

Bruno Fautrel (France)

Managing RA: current successes and failures

Ronald van Vollenhoven (Sweden)

Scientific advances in RA targets: what's new?

Maxime Dougados (France)

The future of managing RA: changing the paradigm in RA care

08:15 – 09:45 **Capital Suite 02**

Medac

"From gold to platinum standard: best practise and future perspectives of subcutaneous methotrexate"

Chairperson(s): **Stanley Cohen** (United States)

Stanley Cohen (United States)

Value of SC MTX in daily practice

Jürgen Braun (Germany)

MTX in the age of biosimilars and biologics

Eugeny Nasonov (Russia)

Cardiovascular effects of methotrexate in rheumatoid arthritis (RA): recent insights

J. M. W. Hazes (Netherlands)

Patient adherence to methotrexate in RA therapy – the crucial role of rheumatologists

08:15 – 09:45 **Capital Suite 09**

Biogen

Introducing new biosimilars into current treatment algorithms: interactive panel discussion

Chairperson(s): **John Isaacs** (United Kingdom)

08:15 John Isaacs (United Kingdom)

Opening and introduction

08:20 Interactive panel discussion

Moderated by **John Isaacs**

Faculty:

Arnold Vulto (Netherlands)

Thomas Dörner (Germany)

Tore Kvien (Norway)

Discussion topics:

Establishing comparability

Proving pharmacokinetic equivalence

Confirming similarity with reference product

Translating the totality of evidence into clinical practice

09:40 John Isaacs (United Kingdom)

Conclusions

17:30 – 19:00 **Hall B**

AbbVie

Unravelling the mystery between structure and sustained clinical outcomes

Chairperson(s): **Edward Keystone** (Canada)

17:30 Edward Keystone (Canada)

How biologics work: what we know and what we don't know

17:40 Leigh Revers (Canada)

Structural to function relationship of monoclonal antibody therapies

18:00 Edward Keystone (Canada)

What we know: evidence on long-term data and immunogenicity

18:20 Thomas Dörner (Germany)

What we don't know: Data generation needs to support switching of stable patients

18:45 All

Questions and answers

17:30 – 19:00 **Hall E**

MSD

"Persistence on therapy: a key factor in the successful management of rheumatic diseases"

17:30 Douglas Veale (Ireland)

Welcome and introductions

17:40 Dominique Baeten (Netherlands)

Persistence on therapy in rheumatology patients: a still unmet need

18:00 Douglas Veale (Ireland)

How are biologic therapies performing on persistence rates?

18:25 Xenofon Baraliakos (Germany)

What is the relevance of persistence on therapy in daily practice for physicians and patients?

18:40 All

Q&A

17:30 – 19:00 **Hall C**

Roche

Precision medicine: maximising treatment benefit for RA patients

Chairperson(s): **Ernest Choy** (United Kingdom)

17:30 Ernest Choy (United Kingdom)

Introduction

17:35 Eric Ruderman (United States)

Reviewing the role of glucocorticoids in RA management

17:53 Cem Gabay (Switzerland)

Monotherapy in the RA treatment landscape

18:11 Georg Schett (Germany)

Can biomarkers help guide biologic treatment approaches?

18:29 Ernest Choy (United Kingdom)

Innovating future treatment approaches in RA through previous clinical experiences

18:47 Ernest Choy (United Kingdom)

Summary

18:50 All

Panel Q&A

17:30 – 19:00 **Hall A**

Pfizer

Shaping the RA treatment paradigm: the evolution of biologic therapy

Chairperson(s): **Robert J. Moots** (United Kingdom)

17:30 Robert J. Moots (United Kingdom)

Welcome and introduction

17:35 Robert J. Moots (United Kingdom)

Biologics: an era of discovery

17:50 Juan Gómez-Reino (Spain)

Learning from the past: evidence and experience

18:15 Eduardo Mysler (Argentina)
Looking forward to the future: evolving our thinking
18:40 Robert J. Moots (United Kingdom)
Finding the right balance
19:00 Close

17:30 – 19:00 Capital Suite 07
Celgene

The challenge with PsA – It's complicated ...
Chairperson(s): **Helena Marzo-Ortega** (United Kingdom)
17:30 Helena Marzo-Ortega (United Kingdom)
Introduction
17:40 Georg Schett (Germany)
PsA immunopathology: decoding the complex interplay in PsA
17:55 Q&A
18:00 Frank Behrens (Germany)
PsA: managing a heterogeneous disease
18:15 Q&A
18:20 Alvin Wells (United States)
The PsA clinical challenge: treating its complexity with PDE4 inhibition
18:35 Q&A
18:40 All
Case study presentations and discussion
18:55 Helena Marzo-Ortega (United Kingdom)
Summary and close

17:30 – 19:00 Capital Suite 11
Sandoz

The evolving landscape of rheumatology: biosimilarity and extrapolation
Chairperson(s): **Peter Taylor** (United Kingdom)
17:30 Peter Taylor (United Kingdom)
Welcome and introduction
17:40 Emily Shacter (United States)
Laying the foundation: analytical and functional characterisation of protein products and the demonstration of molecular similarity
18:00 Craig Leonardi (United States)
Building the totality-of-the-evidence: confirming biosimilarity and supporting extrapolation
18:20 Peter Taylor (United Kingdom)
Impacting the clinical landscape: the role of biosimilar therapies in rheumatology
18:40 All
Panel discussion and summary
19:00 Close

17:30 – 19:00 Capital Suite 14
Amgen

Setting your sights on biosimilars: perspectives on antibodies in rheumatology
Chairperson(s): **Denis Choquette** (Canada)
17:30 Denis Choquette (Canada)
Opening remarks and objectives
17:35 Joel Kremer (United States)
Outlook on the biosimilar landscape in rheumatology and panel discussion
18:00 Leonard Calabrese (United States)
A critical look at biosimilar development and manufacturing
18:25 Denis Choquette (Canada)
Viewpoints and clinical considerations for biosimilars
18:50 All
Panel discussion and question-and-answer session

17:30 – 19:00 Capital Suite 02
Janssen

Think rheumatoid arthritis – causes, consequences and management
17:30 Josef S. Smolen (Austria)
Welcome and Introduction
17:35 Costantino Pitzalis (United Kingdom)
Pathophysiology of RA
17:50 Simon Jones (United Kingdom)
Comorbidities and adverse events associated with IL-6 intervention in rheumatic disease
18:05 Frank Mckenna (United Kingdom)
The psychological impact of rheumatic disease
18:20 Josef S. Smolen (Austria)
Upcoming therapeutic approaches in RA
18:45 Josef S. Smolen (Austria)
Q&A, conclusions, and closing remarks

17:30 – 19:00 Capital Suite 09
GSK

Optimising patient care in SLE: an interactive case-based workshop
Chairperson(s): **Andrea Doria** (Italy)
17:30 Andrea Doria (Italy)
Welcome and introduction
• Burden of disease and unmet needs in SLE management
• Treatment options in SLE and the role of biologics
• Continuing challenges: who to treat and when to treat
17:45 Greg Dennis (United States)
Optimising patient care in SLE: A state-of-the-art, interactive case study-based workshop
• Key considerations for diagnosis and initial choice of treatment
• Optimising standard of care
• Short- and long-term aims of treatment
• Measuring treatment success
• When to consider newer agents
18:50 Andrea Doria (Italy)
Summary of key learnings and concluding remarks

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, Neanderthals, 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.

ELENABURN/THINKSTOCK

The Natural History Museum is one of the United Kingdom's finest examples of Romanesque architecture and a work of art in itself.

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

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