Dear colleague,

We are happy to present the 17th issue of the EMEUNET-EULAR ‘Press Review’ Newsletter. In this issue you will find an overview of relevant articles published in top rheumatology journals and in major internal medicine journals. In this newsletter we once again included articles published electronically in the period between 1st of April 2022 to the 31st of July 2022 to bring you the latest updates in the field. The article selection includes translational and clinical research papers, sorted by the journals they were published in. In case you want to read the article in more detail, you can access it directly through a hyperlink.

We hope that you will enjoy reading this newsletter and look forward to meeting you soon at our Twitter JC meeting!

Giacomo Cafaro and Diego Benavent on behalf of the EMEUNET Newsletter Sub-Committee

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Van der Heijde et al (doi: 10.1136/annrheumdis-2022-222608) conducted a study to test the efficacy of Janus kinase inhibitors (JAKI) in 420 ankylosing spondylitis (AS) patients with an inadequate response to one or two biological disease-modifying antirheumatic drugs (bDMARDs) (tumour necrosis factor or interleukin-17 inhibitors). Significantly more patients achieved Assessment of SpondyloArthritis International Society 40 (ASAS40) response at week 14 with upadacitinib vs placebo (45% vs 18% p<0.0001), while 41% patients on upadacitinib vs 37% on placebo experienced side effects. Michielsens et al (doi: 10.1136/annrheumdis-2022-222260) conducted a monocentre, randomised controlled, non-inferiority (NI) trial, to compare the effect of a stepwise treat-to-target (T2T) tapering strategy (intervention) with a T2T strategy without tapering (control). A total of 122 patients with psoriatic arthritis (PsA) and axial spondyloarthritis (SpA) using tumour necrosis factor inhibitors (TNFi) with ≥6 months stable low disease activity (LDA) were randomised. At 12 months, they showed that, a T2T TNFi strategy with tapering attempt was non-inferior to a T2T strategy without tapering with regard to the proportion of patients still in LDA at 12 months, and resulted in a substantial reduction of TNFi use. Torgutalp et al (doi: 10.1136/annrheumdis-2022-222324) tested whether treatment with TNFi is associated with a time-shifted retardation of radiographic spinal progression in patients with axial SpA. A total of 243 patients from the German Spondyloarthritis Inception Cohort were included. They showed that TNFi treatment in the previous 2-year interval was significantly associated with reduction of modified Stoke Ankylosing Spondylitis Spine Score (mSASSS) progression, which was especially evident in patients who received TNFi both in the previous and in the current intervals: β=−0.58 (95% CI −1.02 to −0.13). Kerschbaumer et al (doi: 10.1136/annrheumdis-2021-221807) investigated the impact of pre-existing background therapy on placebo responses in randomised controlled clinical trials of rheumatoid arthritis (RA). They pooled placebo patients of the GO-AFTER and the SIRROUND-T trials, and assessed clinical responses between patients receiving placebo on top of continued methotrexate (MTX) and those receiving placebo without any background DMARDs. Patients with placebo + continued MTX had higher ACR20 and ACR50 response rates, and more patients in this group achieved Clinical Disease Activity Index (CDAI)-LDA at week 16 (25/285, 8.8%) compared to placebo only (2/113, 1.8%; p=0.013). Smele et al (doi: 10.1136/annrheumdis-2022-222679) looked into the pregnancy outcomes of Preconception Counseling in Active RA (PreCARA) study cohort. TNFi use during pregnancy was not associated with an increase of adverse pregnancy outcomes such as low birth weight, caesarean section, hypertensive disorders or congenital malformations, but was associated to increased birth weight of offspring of women with well-controlled RA (3.344 kg vs 3.171 kg, p=0.03).
Jourde-Chiche et al (doi: 10.1136/annrheumdis-2022-222435) investigated whether immunosuppressive therapy (IST) discontinuation after 2-3 years could be non-inferior to IST continuation for two or more years in proliferative lupus nephritis (LN) in 96 systemic lupus erythematosus (SLE) patients in the WIN-Lupus multicentre randomised controlled trial. Weaning maintenance IST (azathioprine or mycophenolate mofetil) was not non-inferior for relapse rate (LN occurred in 5/40 (12.5%) patients with IST continuation and in 12/44 (27.3%) patients with IST discontinuation (difference 14.8% (95% CI −1.9 to 31.5). Severe SLE flares (renal or extrarenal) were less frequent in patients with IST continuation (5/40 vs 14/44 patients; p=0.035).

McDermott et al (doi: 10.1136/annrheumdis-2022-222439) evaluated the effect of achieving a negative post-induction antineutrophil cytoplasmic antibody (ANCA) assay on the risk of relapse, end-stage renal disease (ESRD) and death in ANCA associated vasculitis (AAV) within five years. They used the Mass General Brigham (MGB) AAV cohort as the data source and compared the patients who achieved negative ANCA assay versus those who did not achieve it. Patients who had a serological remission had lower risk of relapse (HR 0.55, 95% CI 0.38 to 0.81), but this seronegativity was not associated with statistically significant reduction of the risk of ESRD or death within 5 years.

Plaçais et al (doi: 10.1136/annrheumdis-2022-222216) performed a multicentre prospective case-control study to quantify the risk of immune-related adverse events (irAEs) in patients with pre-existing autoimmune disease (pAID) treated with immune checkpoint inhibitors (ICIs) for melanoma. Over a median follow-up period of 7.2 months for cases and 6.9 months for controls, the Odds Ratio (OR) of developing all-grade irAEs among cases compared with controls were 1.91 (95% CI 1.56 to 2.27). Patients with pAID had an increased risk of multiple irAEs (OR 1.46, 95% CI 1.15 to 2.67), and a shorter time to irAE onset. Interestingly, baseline immunosuppression did not prevent irAE occurrence. Definitions of magnetic resonance imaging (MRI) lesions of the spine in patients with axial SpA have been recently updated and validated by Assessment of SpondyloArthritis international Society (ASAS) MRI working group by Baraliakos et al (doi: 10.1136/annrheumdis-2021-222081) and the domain and instrument selection for the core outcome set for axial SpA have been developed by Navarro-Compan et al (doi: 10.1136/annrheumdis-2022-222747). Most recent EULAR/PRES recommendations for vaccination of paediatric patients with autoimmune inflammatory rheumatic diseases were released by Jansen et al (doi: 10.1136/annrheumdis-2022-222574). Finally, Prof. Bijlsma (doi: 10.1136/annrheumdis-2022-222584) published an editorial including commentaries on ARD papers from 50 years ago, in which he emphasised how our specialty has moved forward and reminded us to credit our colleagues who worked in the past.
Monahan et al. (doi:10.1136/rmdopen-2021-002079) evaluated the presence of antibodies against post-translationally modified products in patients with neuropsychiatric systemic lupus erythematosus (NPSLE). Anti-malondialdehyde–acetaldehyde adducts (MAA), anti-advanced glycation end-products (AGE) and anti-carbamylated (CarP) antibodies were found to be statistically more frequent in SLE patients as compared with healthy controls (anti-MAA 29% vs 3%; anti-AGE: 18% vs 4%; anti-CarP: 14% vs 5%; , all p<0.0001). Anti-MAA and anti-CarP were more prevalent in patients with major NPSLE, emerging as a promising biomarker for NPSLE. Terier et al (doi:10.1136/rmdopen-2022-002275) calculated Subchondral Bone Attenuation Coefficient of the Sacroiliac margins (SBAC-SI) based on the sum of 24 identical circular regions of interest in CT scans of sacroiliac joint of the patients with ankylosing spondylitis (AS), diffuse idiopathic skeletal hyperostosis (DISH), osteitis condensans ili (OC) and relevant controls. SBAC-SI score was significantly higher in OC than in AS group (9727±2430 vs 3563±1860, p<0.001). van der Heijde et al (doi:10.1136/rmdopen-2022-002280) reported maintenance of improvement in signs and symptoms of ankylosing spondylitis at week 104 of upadacitinib treatment in the SELECT-AXIS 1 study and open-label extension. Among patients on continuous upadacitinib Assessment of SpondyloArthritis international Society 40 response (ASAS40) was achieved in 85.9% (as-observed) and 65.6% (non-responder imputation), and similar results were observed in patients who switched from placebo (88.7% and 63.8%, respectively). Up to 89.7% of patients had no radiographic progression. Rate of serious adverse events was 6.2/100 person-years. Ghang et al (doi: 10.1136/rmdopen-2021-001944) performed a post hoc analysis of the CARES trial and found that risk of major adverse cardiovascular events (MACE) was higher after discontinuation of xanthine oxidase inhibitors than during drug administration (HR 2.32; 95%CI 1.94 to 2.77; p<0.0001) with incidence rates per 100 person-years of 6.71 for the period after discontinuation and 3.11 while administration. Rebound hyperuricemia was significantly associated with higher MACE risk after drug discontinuation (HR 1.14; 95% CI 1.04 to 1.26). Morales-Ivorra et al (doi: 10.1136/rmdopen-2022-002458) proposed thermographic joint inflammation score (thermoJIS) as a promising tool to detect subclinical inflammation in rheumatoid arthritis (RA). ThermoJIS, obtained with the use of machine learning, correlated moderately with ultrasound scores (grey-scale synovial hypertrophy=0.49, p<0.001, power Doppler=0.51, p<0.001). In the retrospective cross-sectional study by Krekeler et al. (doi: 10.1136/rmdopen-2022-002383), chondrocalcinosis (CC) was found in 90.1% of patients with isolated crystal-induced calcium pyrophosphate deposition disease (CPPD). CC was noted in RA patients, showing more frequent prevalence in seronegative patients as compared to seropositive group (32.3% vs 16.6, p<0.001).
Margaret et al (doi:10.1002/art.42240) studied patient-specific joint flare patterns in 95 juvenile idiopathic arthritis patients, to distinguish local from systemic drivers of disease chronicity. During a mean follow-up of 12.5 years (IQ range 7.9-16.7 years), 95% of patients achieved inactive disease, in which which 81% (73 patients) flared at least once. Among 940 joints affected in 253 flares, 74% had been involved previously, but an extension of the disease to at least one new joint was described in 40% of flares, with a risk factor present even decades after onset and that was increased in flares that occurred off medications (54% vs. 36% on therapy, p=0.015). They concluded that flares preferentially affect previously inflamed joints but carry an ongoing risk of disease extension, confirming a joint-specific memory. Dietmar Krause et al (doi:10.1002/art.42245) compared the effect of three glucocorticoids bridging strategies (GBS) on radiographic and clinical outcomes in rheumatoid arthritis (RA), including high-dose and low-dose prednisolone. They analysed 395 randomized cases (n=132 High dose, n=131 Low-dose, n=132 placebo), where 375 (95%) remained in the modified intention-to-treat analysis. Mean changes (SD) in the modified Sharp/van der Heijde (mSvdH) radiographic scores of the 3 groups after one year were comparable: HDP 1.0 (2.0), LDP 1.1 (2.2), placebo 1.1 (1.5) units. They concluded that short-term GBS showed no benefits in their cohort with regards to progression of radiographic damage at one year. Working on Amyopathic dermatomyositis (ADM), Yan Ye et al (doi:10.1002/art.42264) described two possible distinct immune cell signatures that could predict the clinical outcomes in anti-MDA5 antibody-positive patients with interstitial lung disease (ILD). They measured by multi-colour flow cytometry 42 immune-cell phenotypes in the peripheral blood of 82 ADM-ILD patients and 82 age-sex-matched healthy donors. They identified a Cluster 1 enriched in the activated CD45RA+HLA-DR+CD8+T cells with decreased CD56dimNK proportions which showed a higher prevalence of rapidly progressive ILD and higher mortality; and a Cluster 2, characterised by non-activated-T cell-dominance, which showed better clinical outcomes with high survival. Baraliakos et al (doi: 10.1002/art.42282) reported the results of the 3-years phase 2b BE AGILE randomized controlled trial on the efficacy of bimekizumab in patients with active ankylosing spondylitis (AS). From weeks 0–156, 280/303 patients (exposure-adjusted incidence rate: 141.0/100 patient-years [PY]) had ≥1 treatment-emergent adverse event (nasopharyngitis and upper respiratory tract infection). 67/303 (9.8/100 PY) had moderate to mild and localize fungal infections. 10 patients (1.3/100 PY) had serious infections; no cases of active tuberculosis were reported. They concluded that bimekizumab safety profile was consistent with previous reports (with no new safety signals identified) and that efficacy in AS was sustained through the 3 years of treatment.
Shift et al (doi.org/keac335) described 2-year trajectories of disease activity in patients with juvenile idiopathic arthritis (JIA) in the Childhood Arthritis and Rheumatology Research Alliance Registry. Through the Juvenile Arthritis Disease Activity Score 10 joints (cJADAS10), they identified 5 trajectories in the 746 enrolled patients: High, Rapidly Decreasing (HRD) (n = 199, 26.7%); High, Slowly Decreasing (HSD) (n = 154, 20.6%); High, Increasing (HI) (n = 39, 5.2%); Moderate, Persistent (MP) (n = 218, 29.2%); and Moderate, Decreasing (MD) (n = 136, 18.2%). The majority of patients spent a significant portion of time at moderate to high disease activity levels. Janczi et al (doi.org/keac354) analysed pro-survival mechanism present in rheumatoid arthritis (RA) synovial fibroblasts (SFs) dependent on ADAM15 and Yes-Associated Protein kinase 1 (YAP1). They investigated by means of caspase 3 assays to determine detachment-induced apoptosis. They found that the silencing of ADAM15 or YAP1 in RASFs leads to significantly increased levels of detachment-induced caspase activity. On the other hand, non-silenced RASFs detachment caused simultaneous ADAM15-enhanced phosphorylation of YAP1 at S127, known for promoting its cytoplasmic localization. They concluded that this results can be potentially exploited for future therapeutic interventions. Working on systemic sclerosis (SSc)–associated myopathy Matas-García et al (doi.org/keac361) analysed the clinico-serological and histological phenotypes of 52 patients who underwent muscle biopsy for suspected myopathy. Of these, 14 biopsies were reported to have a fibrosing pattern, whereas 26 showed an inflammatory pattern that could be classified (according to the predominant pattern) into dermatomyositis (n = 7), necrotizing myopathy (n = 4) and non-specific myositis (n = 15). Also, patients with fibrosing pattern – compared to the inflammatory ones – reported a higher prevalence of cardiac comorbidities and abnormalities, with poor response to treatment and a higher mortality (42.9% vs 3.8%, P = 0.004) and lower cumulative survival (P = 0.035). They concluded that they identified two different phenotypes that must be taken into account to predict outcome. Luo et al (doi.org/keac218) investigated factors that could influence an important cause of death in systemic lupus erythematosus (SLE) - lupus nephritis (LN) – in a 496 SLE multi-ethnic cohort. Of these, 91 (18.3%) died, 165 (33.3%) developed LN and 33 (6.7%) developed end-stage renal failure. They reported no difference between men and women in either mortality or development of LN but also that Caucasian patients were significantly less likely to develop LN than other ethnic groups (P < 0.0001) but not less likely to die. Younger patients (diagnosed before the 28th year of age) were significantly more likely to develop LN (P < 0.0001) but significantly less likely to die (P = 0.0039). They concluded that, in their cohort, non-Caucasian ethnicity and younger age at diagnosis are associated with the risk of developing LN.
Shi et al (doi:10.1186/s13075-022-02811-z) assessed the levels and profiles of lymphocytes in patients with primary Sjogren’s syndrome (pSS), both with ILD (pSS-ILD) and without ILD (pSS-non-ILD). Comparing to healthy controls, pSS patients had significantly lower absolute counts of NK, Th2 cells (pSS-ILD group), higher proportion and absolute number of B cells (pSS-non-ILD group). Besides lower Th2 count (OR=0.947) and higher Th1/Th2 ratio (OR=1.021), older age and positivity for anti-La or anti-Ro52 were associated with ILD. In the nationwide cohort study Jeong et al. (doi:10.1186/s13075-022-02871-1) analysed the risk of herpes zoster infection (HZ) in patients with seropositive rheumatoid arthritis (RA) treated with bDMARDs or tsDMARD. Overall, 14.4% had HZ during first-line bDMARD/tsDMARD. Tofacitinib (aHR, 2.46; 95% CI, 1.61-3.76; P<0.001), infliximab (aHR, 1.36; 95% CI, 1.06–1.74; P=0.017) and adalimumab (aHR, 1.29; 95% CI, 1.02–1.64; P=0.032) were associated with increased HZ risk compared to abatacept. Michailidou et al. (doi:10.1186/s13075-022-02849-z) found that levels of calprotectin and N-formyl Methionine (fMET) are elevated in patients with antineutrophil cytoplasmic autoantibody-associated vasculitis (AAV) and large-vessel vasculitis (LVV). Levels of fMET were associated with disease activity only in granulomatosis with polyangiitis (p=0.02). Levels of calprotectin showed a positive correlation with creatinine in AAV (p=0.01), but not in LVV. Circulating fMET were found able to induce de novo neutrophil activation. Xanthouli et al. (doi:10.1186/s13075-022-02863-1) analyzed the results of echocardiography and right heart catheterization in 225 patients with systemic sclerosis (SSc) at baseline and after a follow-up of 3.2±2.7 years. Factors significantly associated with worse survival were: TAPSE at rest <18 mm, increase of cardiac index (CI) during exercise <2 l/min, RV pulmonary vascular reserve ≥3 mmHg/l/min, peak CI <5.5 l/min/m², pulmonary arterial compliance <2 ml/mmHg, TAPSE/systolic pulmonary arterial pressure (sPAP) ratio ≤0.6 ml/mmHg and echocardiographic qualitative RV function at rest (all p<0.01). Rincón-Arévalo et al. (doi:10.1186/s13075-022-02837-3) studied in vitro the effects of circulating medium/large size extracellular vesicles (m/IEVs) on B cells responses in rheumatoid arthritis. Decreased proportion of CD69+ and CD86+ was observed if B cells were activated by agonist of the antigen receptor in the presence of m/IEVs. When monocyte-derived macrophages, previously exposed to m/IEVs, were cocultured with autologous B cells, higher frequency of CD69+ cells was observed in RA patients, but not healthy donors. In the RNA-seq analysis on samples collected from placentas from mothers with systemic lupus erythematosus (SLE) and normal full-term pregnancies (NT) Li et al (doi:10.1186/s13075-022-02825-7) found 52 dysregulated long noncoding RNAs and 130 dysregulated mRNA in SLE placentas, many of which were involved in signaling pathways, cell differentiation, intracellular processes and DNA repair.
Soulby et al (doi:10.1002/acr.24991) investigated cumulative social disadvantage and its association with arthritis in children. A cross-sectional analysis of the National Survey of Children’s Health (2016-2019) was performed. A cumulative social disadvantage score was generated including as variables low guardian education, low household income level, underinsured status, and high adverse childhood experience score. Cumulative social disadvantage was associated with an arthritis diagnosis, with the highest odds among those with a score of 4 (aOR 12.4, 95% CI: 2.9-53.3). Cumulative social disadvantage was also associated with increased odds of moderate-to-severe arthritis activity (aOR 12.4, 95% CI: 1.8-82.6), suggesting a cumulative association between social disadvantage and arthritis diagnosis and outcomes. Barhaiya et al (doi: 10.1002/acr.24974) examined Ultraviolet radiation (UV) exposure and systemic lupus erythematosus (SLE) risk in The Nurses’ Health Study. Environmental UV exposure was estimated by linking geocoded residential addresses to a spatiotemporal UV exposure model. With 6,054,665 person-years of exposure, they identified 297 incident SLE cases. Compared to the lowest UV exposure tertile, risk of overall SLE did not show significant results (HR 1.28 [95%CI 0.96-1.70]), although women in the highest tertile had increased risk of malar rash (HR 1.62 [95% CI 1.04-2.52]). Therefore, the authors concluded that UV exposure may trigger SLE onset with malar rash among susceptible women. Delving et al (doi: 10.1002/acr.24958) evaluated the prevalence and impact on damage accumulation of different levels of disease activity in patients with granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA). Three levels of remission were defined: complete remission (CR), clinical remission off therapy (CROffT) and clinical remission on therapy (CROnT). During the 5-year follow-up, 10 (6.0%) patients achieved prolonged CR, 6 (3.6%) prolonged CROffT, and 89 (53.3%) prolonged CROnT. This study highlights the need for different disease activity levels to be tested in large cohorts in order to validate a treat-to-target approach in ANCA-associated vasculitides. Zanetti A et al (doi: 10.1002/acr.24897) compared the efficacy and costs of an Early Arthritis Clinic (EAC) compared with patients followed according to standard of care. A retrospective study on administrative health databases of patients with a new diagnosis of rheumatoid arthritis (RA) was conducted. Mean pharmaceutical (2602 versus 1945 €) and outpatient (2447 versus 1778€) costs were higher in the EAC cohort. A higher rate of non-EAC patients had a low adherence to quality-of-care indicators. The expected number of hospitalizations and the length of stay were statistically lower in EAC vs non-EAC (1.51 [95% CI 1.24-1.85] and 2.29 [95% CI 1.64-3.20], respectively. The use of an early identification and referral model for RA may generate cost savings. An EAC service for diagnosing RA patients can reduce number and length of hospitalization.
Negrón et al (doi:10.1016/j.semarthrit.2022.152028) aimed to identify patient-centered domains with long-term relevance for rheumatoid arthritis (RA) patients. For this, they conducted semi-structured individual cognitive interviews with RA patients with at least five years of disease duration, sampled from five different countries. Six main themes, representing important aspects of the daily life with RA were generated: (i) Living with symptoms and functional limitations, (ii) Lack of participation, (iii) Partner and family issues, (iv) Risk of damage to vital organs, (v) Coping strategies, and (vi) Healthcare concerns. These domains may be considered in patient-centered longitudinal studies. Lyu et al (doi:10.1016/j.semarthrit.2022.152022) aimed to identify specific biomarkers to reflect the progression of gouty arthritis (GA) with a metabolomic approach. A total of 547 sequentially phased GA patients and healthy volunteers were recruited. The quantitative results showed the serum concentration of kynurenic acid (Kyna), N1-Methyl-2-pyridone-5-carboxamide (2Py), DL-2- Aminoadipic acid (2AMIA) and 5-hydroxyindole acetic acid (5-HIAA) of patients with sequential stages showed a strictly monotonic trend, and area under the curve (AUC) was 0.97, 0.97, 0.96 and 0.95, respectively. Given these results, it may be inappropriate to use a single biomarker to define the GA phase. The four biomarkers obtained in this study could be adopted in an integrated manner to assess the progression of GA with sequential phases. Ni et al (doi:10.1016/j.semarthrit.2022.152013) aimed to decipher the causal effect of smoking on the risk of osteoarthritis (OA) from a genetically informed perspective. Genetically liability for smoking initiation had an effect estimate consistent with increased risk for overall OA (OR:1.61, 95% CI 1.43–1.81). Additionally, multivariate analysis revealed a strong evidence for an effect of smoking initiation on the risk of overall OA (OR:1.45, 95%CI 1.31–1.619) and its subtypes after controlling for BMI. These findings support an independent deleterious causal effect of smoking on OA risk, further reinforcing the importance of smoking cessation interventions and obesity control in the general population. Abe et al (doi:10.1016/j.semarthrit.2022.151994) conducted a study in which resting-state structural and functional MRI data were acquired from patients with inflammatory arthritis (IA), patients with OA and healthy controls. The value of brain functional connectivity (FC) between left insular cortex (IC) and anterior cingulate cortex (ACC) was significantly low in IA patients compared with OA patients and HCs. They demonstrated that the FC between left anterior long insular gyrus as a subdivision of IC and ACC was significantly associated with therapeutic response to biologics regarding the improvement of patients’ global assessment (PGA). The authors concluded that disease-specific resting-state FC would be a clinical decision-making tool with predictability for treatment response in both RA and SpA.
Meryl et al (DOI: 10.1056/NEJMoai2202106) investigated whether supplemental vitamin D3 (2000 IU per day) would result in a lower risk of fractures than placebo in an ancillary study of the Vitamin D and Omega-3 Trial (VITAL). Incident fractures were reported by participants on annual questionnaires and adjudicated by centralized medical-record review. Participants were not recruited on the basis of vitamin D deficiency, low bone mass, or osteoporosis. The primary endpoints were incident total, non-vertebral, and hip fractures. Among 25,871 participants (50.6% women), 1991 incident fractures in 1551 participants were confirmed over a median follow-up of 5.3 years. Supplemental vitamin D3, as compared with placebo, did not have a significant effect on total fractures (which occurred in 769 of 12,927 participants in the vitamin D group and in 782 of 12,944 participants in the placebo group; HR, 0.98; 95% confidence interval [CI], 0.89 to 1.08; p=0.70), non-vertebral fractures (HR, 0.97; 95% CI, 0.87 to 1.07; p=0.50), or hip fractures (HR, 1.01; 95% CI, 0.70 to 1.47; p=0.96). There was no modification of the treatment effect according to baseline characteristics, including age, sex, race or ethnic group, body-mass index, or serum 25-hydroxyvitamin D levels. Deodhar et al (DOI: 10.1016/S0140-6736(22)01212-0) reported the results of upadacitinib in active non-radiographic axial spondyloarthritis, with objective signs of inflammation based on MRI or elevated C-reactive protein and an inadequate response to non-steroidal anti-inflammatory drugs, in a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial (SELECT-AXIS 2). 314 patients were enrolled into the study, and 313 received study drug (156 in the upadacitinib group and 157 in the placebo group). A significantly higher ASAS40 response rate was achieved in patients with upadacitinib compared with placebo at week 14 (70 [45%] of 156 patients vs 35 [23%] of 157 patients; p<0.0001; treatment difference 22%, 95% CI 12–32). The rate of adverse events up to week 14 was similar in the upadacitinib group (75 [48%] of 156 patients) and placebo group (72 [46%] of 157 patients). Krijbolder et al (DOI: 10.1016/S0140-6736(22)01193-X) investigated whether earlier intervention (methotrexate [MTX]) in rheumatoid arthritis (RA), in the preceding phase of arthralgia and subclinical joint inflammation, could prevent the development of clinical arthritis or reduce the disease burden, in a randomised, double-blind, placebo-controlled, proof-of-concept-trial. Adults aged 18 years or older with arthralgia clinically suspected of progressing to RA and MRI-detected subclinical joint inflammation were randomly assigned (1:1) to a single intramuscular glucocorticoid injection (120 mg) and a 1-year course of oral MTX (up to 25 mg/week), or placebo (single injection and tablets for 1 year). 236 were enrolled and randomly assigned to active treatment (n=119) or placebo (n=117). At 2 years, the frequency of the primary endpoint (development of clinical arthritis (fulfilling the 2010 RA classification criteria or involving two or more joints) that persisted for at least 2 weeks) was similar between the groups (23 [19%] of 119 participants in the MTX group vs 21 [18%] of 117 in the placebo group; HR 0.81, 95% CI 0.45 to 1.48). Nevertheless, MTX modified the disease course as shown by sustained improvement in MRI-detected inflammation, related symptoms, and impairments compared with placebo.
17th Mediterranean Rheumatology Symposium & Basic Ultrasound Course
• When and Where: 02-04 Oct 2022, Antalya, Turkey
• Website: https://antalyaultrasound.com/registration-accommodation/

European Lupus Meeting
• When and Where: 5-8 Oct 2022, Stockholm, Sweden
• Website: https://sleuromeeting.com/

20th Biennial Meeting of the European Society of Immunodeficiencies
• When and Where: 12-15 Oct 2022, Gothenburg, Sweden
• Website: https://esidmeeting.org/

4th EUVAS Vasculitis Course
• When and Where: 13-15 Oct 2022, Florence, Italy
• Website: https://events.lenagroup.eu/eve-lab/2022/euvas/

Musculoskeletal Ultrasound in Rheumatology - Basic course
• When and Where: 20-22 Oct 2022, Rome, Italy
• Website: https://web.aimgroupinternational.com/2022/mskrome/

ACR Convergence 2021
• When and Where: 10–14 Nov 2022, Pennsylvania, USA
• Website: https://www.rheumatology.org/Annual-Meeting

BSR Core skills in rheumatology
• When and Where: 24-25 Nov 2022, Online
• Website: https://www.rheumatology.org.uk/events-learning/courses/core-skills-rheumatology
EULAR ONLINE COURSES AND MODULES

Compilation of EULAR Online Modules
EULAR has developed e-learning opportunities with the newest updates in the field of rheumatology. 99 modules are available, covering different areas of rheumatology.

- **Fee**: 25 EUR for each module
- **Start**: no deadline / any time
- **Available for**: 1 year after booking

11th EULAR Online Introductory Ultrasound Course
The course, covering 7 modules, is designed for approx. 7 months of training. The expected learning time per week is around 2 1/2 hours. Upon passing the examination, a EULAR certificate will be issued.

- **Fee**: 150 EUR
- **Start**: 17.10.2022
- **Available for**: 1 year + 1 year extension

12th EULAR Online Course on Systemic Sclerosis
The course consists of 10 modules dealing with physiopathology, clinical aspects and management of SS. All modules are developed by EUSTAR.

- **Fee**: 150 EUR
- **Start**: 17.10.2022
- **Available for**: 1 year + 1 year extension

17th EULAR Online Course on Rheumatic Diseases
The course is managed by a scientific course committee controlling the structure and content of the course and performing regular quality control and advancement. The full version covers the entire field of rheumatology and consists of 55 illustrated modules (of which some are optional), each one covering a specific topic. The expected learning time per week is calculated around 2 1/2 hours but very flexible for the learners who can enter the learning system at any time and have available free of charge an extra year if needed.

Knowledge and skills are targeted to suit a level of knowledge appropriate for the final years of training as a rheumatologist.

- **Fee**: 150 EUR
- **Start**: 17.10.2022
- **Available for**: 2 years + 1 year extension
**EULAR ONLINE COURSES AND MODULES**

**14th EULAR Online Course on Connective Tissue Diseases**
The Course consists of 16 modules which deal with immunology and systemic auto-immune diseases, such as SLE, scleroderma, and vasculitis.
- **Fee:** 150 EUR
- **Start:** 17.10.2022
- **Available for:** 1 year + 1 year extension

**2nd EULAR Online Course on Patient Education for Physicians and Health Professionals**
The Course consists of 4 modules (approx. 6 hours each). The learning objectives are: understand the problematics of chronic rheumatic diseases, understand issues of patient education, develop attitudes in the relationship with the patient, elaborate a program of patient education, perform an educational diagnosis, design and animate educational workshops evaluate a program and among different learning objectives. Upon passing the examination a EULAR certificate will be issued.
- **Fee:** 150 EUR
- **Start:** 17.10.2022
- **Available for:** 1 year + 1 year extension

**4th EULAR Online Course for Systemic Lupus Erythematosus**
The Course consists of 12 modules covering the recent updates in diagnosing and managing SLE, as well as the recent updates to management guidelines.
- **Fee:** 150 EUR
- **Start:** 17.10.2022
- **Available for:** 1 year + 1 year extension

**5th EULAR Online Course on Imaging in RMDs**
The Course covers 3 modules. The learner level is aimed primarily at Section Residents and Fellows in Training as well as Rheumatologists. It aims to educate rheumatologists and future rheumatologists on how to interpret imaging examinations in chronic inflammatory RMDs and to use the imaging results to guide their daily treatment.
- **Fee:** 150 EUR
- **Start:** 17.10.2022
- **Available for:** 1 year + 1 year extension
EULAR ONLINE COURSES AND MODULES

8th EULAR Online Course for Health Professionals in Rheumatology
The course consists of a total of 8 modules. Care is given to integrate the multidisciplinary perspective of the treatment of rheumatic diseases.
➢ Fee: 150 EUR
➢ Start: 17.10.2022
➢ Available for: 1 year + 1 year extension

9th EULAR/PRES Online Course in Paediatric Rheumatology
The 11-module course represents a joint effort of EULAR and the Paediatric Rheumatology European Society (PRES), offering a deep insight of all the aspects related to rheumatic diseases in children and adolescents including their impact on the growing body and the differential diagnosis with other paediatric disorders.
➢ Fee: 150 EUR
➢ Start: 17.10.2022
➢ Available for: 1 year + 1 year extension

EULAR Learning Material for RA
This collection of educational slide decks has been developed and put together by an initiative to highlight the importance of early detection and treatment of Rheumatoid Arthritis. It also looks at the various tools available to practitioners as well as best practices.
The following modules can be accessed through the EULAR School of Rheumatology:
➢ Non-pharmacological patient management in RA
➢ Patient-reported outcomes (PROs)
➢ Rheumatoid arthritis and comorbidity
➢ Importance of shared decision-making to treatment outcomes
➢ Importance of early recognition and treatment of RA
➢ Treating patients to target
By 2023, EULAR will be the leading provider of education in rheumatic and musculoskeletal diseases (RMDs).

**EULAR School of Rheumatology**

**EULAR Online courses:**
- RMD: EULAR Course on Rheumatic Diseases
- US: EULAR Online Introductory Ultrasound Course
- IMG: EULAR Online Course on Imaging in RMDs
- PAED: EULAR / PRES Online Course in Paediatric Rheumatology
- HPR: EULAR Online Course for Health Professionals in Rheumatology
- SSc: EULAR Online Course on Systemic Sclerosis

**The EULAR Educational Cooperation with National Societies (EULAR ECONS)**
The EULAR Research Center

How does it work?

1. Select your support area and describe your needs in a short online form
2. Get matched with an experienced scientist
3. Obtain up to 10 hours of free consultation
4. Share your feedback upon service completion

Support Areas

- Basic/Translational Research (using patient/human materials, e.g. cells, serum...or Dedicated animal models of RMDs to address bedside-to-bench research questions)
- Clinical Research
- Epidemiology and Public Health
- Health Services Research
- Implementation Science

✔ Study design
✔ Statistical methods
✔ Sampling strategy
✔ Data collection and analysis
✔ Patient involvement
✔ Participant recruitment strategy
✔ Access to patient and human materials
✔ Access to equipment and technologies
✔ Research reporting
✔ EU grant writing support

The EULAR Research Consultation Service is offered through the EULAR Research Centre. The service is available for researchers based in EULAR-affiliated countries.
The EULAR Outcome Measures Library (OML) aims to be a comprehensive database of validated instruments (indices, questionnaires, scales, or others), with an emphasis on patient-reported outcomes (PRO) used in rheumatology. The EULAR OML was created by rheumatologists, health professionals, students and patients, all of whom are engaged in the field of rheumatology.

The database includes a detailed description of each instrument, including the instrument itself (and validated language versions, if available), useful references, a description of the population(s)/setting(s) where it has been validated, recommendations and rules for use, guideline for interpretation of the results in clinical practice or in research, information on the most relevant psychometric properties of each instrument. Instruments are categorized by disease or by topic. Also, guidelines for interpretation of results in both practice and research settings are provided. The OML is an ongoing project and is frequently updated with the most recent information on PROs in rheumatology.

For more information visit:

http://oml.eular.org/
The European Alliance of Associations for Rheumatology (EULAR) is very concerned about the situation in Ukraine, and it condemns Russia's unacceptable act of aggression towards the country. As hospitals are being attacked and access to medical aid is interrupted, EULAR wants to respond to this humanitarian crisis and particularly support the Ukrainian people with rheumatic and musculoskeletal diseases (RMDs), who need urgent treatment and assistance.

Together with EMEUNET, EULAR has developed a support programme for young Ukrainian rheumatologists, enabling them to take up their profession, maintain and further develop their skills, and provide care to a range of patients, including particularly displaced Ukrainian RMD patients. Across Europe, Ukrainian rheumatologists or rheumatologists in training can apply for this programme, sponsoring their employment in one of EULAR’s various partner hospitals or institutes. EULAR will fund up to 20 such positions, allowing for a stable income for a Ukrainian physician who had to flee their country, and securing medical treatment for Ukrainian refugees with RMDs. EULAR will provide €500,000 for this purpose.

What: Funding programme for displaced Ukrainian physicians
Who can apply: Hospitals or medical institutions (employers) in countries with many displaced Ukrainian refugees
Target group: Ukrainian rheumatologists, focus on rheumatologists in training
How much: 20,000 – 30,000 EUR/year

Please send your application to eular@eular.org.
EMEUNET PODCASTS!

Are you too busy to read the whole Newsletter? Do you want to keep updated about the main EMEUNET activities and save time?

With our Podcasts, you can get updated while on the go, with extracts of the recent newsletters, highlights of the most recent publications in the field of Rheumatology, selected for you by EMEUNET members (What Is New), interviews and review of other EMEUNET activities.

Where to listen:

- Anchor
- Apple Podcasts
- Breaker
- Google Podcasts
- Overcast
- Pocket Casts
- Radio Public
- Spotify

SHARE YOUR IDEAS!

Over the years EMEUNET has developed several projects covering different topics and areas of interest. However, we always appreciate any suggestions and welcome new ideas to expand on what we currently offer to EMEUNET members. Make your voice heard and share your ideas with us!

For additional suggestions and ideas, just write down some lines to summarize your proposal and send it either via email at emeunet@eular.ch or through our website (http://emeunet.eular.org/contact_us.cfm). Don’t forget to provide your contacts so we can come back to you for additional details!

More information about EMEUNET can be found at http://emeunet.eular.org

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