EDITORIAL

Dear young rheumatologists and researchers in rheumatology,

It is a real pleasure to be sharing with you the “best of” the last ACR congress, prepared by EMEUNET members.

EMEUNET continues to grow as a group of young European rheumatologists and researchers, aimed at promoting education and research, widening collaborations and integrating with EULAR activities. There are currently 443 members in the EMEUNET Member Database.

After a very successful endeavor in 2012, this year EMEUNET will again organise an EULAR-endorsed epidemiology course (please see below).

We hope EMEUNET keeps being embraced by the young Rheumatology community and more of you become involved in rheumatology education, research and EULAR.

Do not hesitate to sign up!

Best wishes, and a happy new year!

Cécile Gaupux-Viala, Xenofon Baraliakos & Pedro Machado,

on behalf of the Newsletter Subgroup

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Newsletter Topic: ACR 2012 Highlights!

In this edition of EMEUNews, we would like to draw your attention to what we believe have been the most interesting presentations at the ACR Meeting 2012

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BASIC RESEARCH

Anna Engler, MSc, in Molecular Biomedicine, is a PhD student at the Center of Experimental Rheumatology, University Hospital Zurich, Switzerland. Her research focuses on epigenetic changes and regulation of miRNA biogenesis in rheumatoid arthritis.

The first 3-staged genome-wide association study on the progression of joint damage in anti-citrullinated peptide antibody (ACPA)-positive rheumatoid arthritis (RA) was presented by Knevél et al. (AB 2670) from the Leiden University Medical Center, Leiden, Netherlands. The study encompassed the findings of high-quality radiological data with in vitro and ex vivo studies and has shown that a genetic variant in “Sperm associated AntiGen16” (SPAG16) is associated with less progression of joint damage. Decreased production of the matrix metalloproteinase MMP3 by fibroblast-like synoviocytes (FLS), resulting in decreased matrix destructive potential of FLS, has been identified as a molecular mechanism of reduced joint damage in patients with the minor allele of SPAG16.

Sherlock et al. (AB 725) from Merck Research Laboratories, Palo Alto, USA have presented an interesting study on the characterization of cells expressing interleukin-23 (IL-23) receptor in the GFP reporter mice. Serum concentrations of IL-23 are elevated and polymorphisms in the IL-23 receptor are associated with ankylosing spondylitis. However, the correlation between primarily affected sites of inflammation and dysregulation in IL-23 is not understood. In this study the novel tissue resident IL-23 receptor positive (IL-23R+) T lymphocytes were precisely localized and characterized in entheses, the aortic root and the uvea. The highly restricted anatomical distribution of IL-23R+ cells could explain the specificity of localization of inflammation sites and the known genetic associations with IL-23.

Fascinating insights in the distinct roles of environmental and genetic factors in developing ACPA and ACPA-positive RA were shown in a study of Haj Hensvold et al. (AB 1615) from Karolinska Institute, Stockholm, Sweden. Investigation of a large population-based cohort of middle-aged twins revealed that environment, life style and stochastic factors (such as smoking) may be more important than genetics in determining which individuals develop ACPA. The genetic factors, however, seem to be more important in determining which persisting ACPA-positive individuals will ultimately develop arthritis.

With the first report on a functional role of long noncoding RNAs (lncRNAs) in RA, Trenkmann et al. (AB 892) from the Center of Experimental Rheumatology, Zurich, Switzerland opened a new chapter in the book of epigenetics in RA. LncRNAs can interact with the epigenetic machinery of cells thus affecting gene expression. The IncRNA HOTAIR showed strong epigenetic repression in RA synovial fibroblasts and its expression was further reduced by inflammatory mediators. This decrease in HOTAIR levels was associated with increased matrix destructive properties of RA synovial fibroblasts.
The majority of studies in the RA I category addressed at least one of the following ultimate goals: improving disease outcomes, optimizing treatment approaches and/or decreasing the risk of comorbidities.

Combe et al (AB 830) based on the longitudinal observations from the ESPoir cohort reported 5-year favorable outcome (i.e. low disease activity scores, low rate of radiographic progression, limited need for joint surgeries and no increase in comorbidity risk) in patients with very early/evolving RA. During the 5-year follow-up patients were closely monitored; 82.7% of patients received conventional DMARDs, 60% used corticosteroids; 18.3% received biologics. These findings reinforce the need for early referral to a rheumatologist and early effective treatment in patients with RA.

Implementation of treat-to-target strategies and introduction of biologics have substantially affected the management of RA in recent years. Considering wider use of these steroid-sparing agents Makol et al (AB 2481) aimed to compare whether there was a change in corticosteroid use in RA in the recent years. Using the data on corticosteroid use over time from a large population-based inception RA cohort the authors found that, unlike expected, the proportion of patients on corticosteroids at any given time of disease was higher in more recent years (1995-2007) than in 1980-1994.

Addressing the association of RA inflammatory activity and cardiovascular comorbidity in RA, Arts et al (AB 1682) assessed the impact of clinical remission (DAS28<2.6) on cardiovascular risk in RA. In a large cohort of RA patients, sustained remission was significantly associated with a lower risk of cardiovascular events. The authors suggested that tight control of disease activity may be beneficial for cardiovascular risk reduction in RA.

The prevalence and predictive factors of sustained remission in early RA were examined by Xiong et al (AB 2610). The authors reported that about 40% of patients achieved remission by ACR/EULAR or SDAI criteria within 2 years. Only a minority (2%) of patients received biologics during the first 3 months of treatment, while methotrexate alone or in combination with other conventional DMARDs was used in >30% of patients. Sustained remission was eventually achieved in >55% of patients. Younger age, lower pain scores and earlier time-to-first remission, but not other RA characteristics and treatments, were predictive of sustained remission in RA. These findings suggest that sustained remission is possible in patients with early RA initially treated with conventional DMARDs. However, the optimal treatment approach for sustained remission remains to be determined.

Discontinuing anti-TNF therapy? That is the question! Discontinuing anti-TNF therapy after achieving a stable low disease activity or remission (REM) state in rheumatoid arthritis (RA) has become an important area of investigation in current rheumatology from the risk-benefit point of view including health-economic considerations. Although the sample size is limited, the results of the HONOR study indicated that after reaching REM (DAS28-ESR<2.6 achieved for at least 6 months) with adalimumab (ADA) + MTX 36% patients with long-standing RA could discontinue ADA for ≥12 months without functional impairment and radiographic damage progression (Tanaka Y. et al., abstract 771). In the ADMIRE trial, remission was rarely maintained in patients with long standing RA in stable remission (DAS 28<2.6 for ≥3 months) on combination therapy with ADA+MTX who discontinued ADA: at 28 weeks, 15/16 patients (94%) and 5/15 patients (33%) in arms ADA+MTX and MTX, respectively, were in remission (P<0.001) (Chatzidionysiou K. et al., abstract 776). The STRASS trial compared 2 therapeutic strategies for the management of remission in established RA patients: DAS28-driven step-down strategy with progressive spacing of TNF-blocker injections and strategy maintaining the therapy. Spacing of TNF-blockers was feasible in 82% of patients. Although Fautrel et al failed to demonstrate the equivalence between the 2 strategies (trial underpowered), the spacing strategy did not result in a significant increase in disease activity or functional impairment. The impact of the spacing strategy on X-ray structural damage is currently being analyzed (Fautrel B. et al., LB7).

The AMPLE study, ABATAccept versus ADALIMUMAB: draw! (Weinblatt M. et al., abstract 2449) In the AMPLE study, biologic-naïve RA patients with an inadequate response to MTX were randomized to 125 mg ABA weekly or 40 mg ADA bi-weekly, in combination with MTX. A total of 646 patients were randomized and treated; 86.2% of ABA patients and 82.0% of ADA patients completed 12 months. This first head-to-head study in RA patients comparing biologic agents on background MTX demonstrated that subcutaneous ABA is comparable to ADA by most efficacy measures, including radiographic progression. Safety was generally similar with fewer discontinuations and injection site reactions observed with ABA.

Nanobodies... but macroimportant! (Van Roy M. et al., abstract 336; De Bruyn S. et al., abstract 1307; Fleischmann R.M. et al., abstract 1311; Zhang X. et al., abstract 1634) Nanobodies are therapeutic proteins based on the smallest functional fragments of heavy chain-only antibodies, naturally occurring in the Camelidae family. Nanobodies have specific molecular features of interest (small size, low immunogenicity potential, manufacturability). There are already nanobodies anti IL-6 receptor and anti-TNF in progress in RA... a promising way!
Kavanaugh et al (AB772) presented the results of a phase-4 randomized, double-blind, 24-week study with the aim to directly compare the efficacy of adalimumab as monotherapy and tocilizumab (8mg/kg) as monotherapy. At week 24 the mean change from baseline in DAS28 was significantly greater for the IL6 receptor inhibitor than for adalimumab (-3.3 vs. -1.8, respectively, p<0.0001), which was the primary endpoint. Several other efficacy measures differed significantly between the groups, in favor of tocilizumab, such as remission rate, ACR responses, and other. The results suggest that tocilizumab is superior to adalimumab as monotherapy.

Results of a post-hoc analysis of another comparative trial, the ORAL standard study, was presented by van Vollenhoven et al (AB1297), where low disease activity rates (DAS28<3.2) were similar between tofacitinib and adalimumab, for patients on stable methotrexate dose. Failure to achieve ≥0.6 improvement in DAS28 from baseline within the first 3 months of tofacitinib treatment was predictive of a low probability of achieving low disease activity at 1 year.

Cohen et al (AB2485) presented results on efficacy and safety of 5 versus 10mg tofacitinib twice daily in a pooled phase 3 and long-term extension RA population. Approximately 1100 patients were included in each group. Both doses were effective, but the likelihood of achieving the more stringent outcomes (ACR70, DAS28<3.2 and ≥2.6) was greater with the 10mg. Differences were noted in serious infection events rates in favor of 5mg, but apart from that event rates for safety were generally similar between the two doses and within the ranges observed with the approved biologic therapies.

The efficacy of an oral inhibitor of JAK1 and JAK2, baricitinib, was evaluated in a blinded study in patients with active RA and inadequate response to methotrexate (Genovese et al, AB2487). All doses of baricitinib were associated with significantly better efficacy than placebo (ACR70, DAS28<3.2 and ≥2.6) was greater with the 10mg. Differences were noted in serious infection events rates in favor of 5mg, but apart from that event rates for safety were generally similar between the two doses and within the ranges observed with the approved biologic therapies.

Burmester et al (AB2545) presented a randomized, controlled, parallel group phase 3 trial with the objective to compare the efficacy and safety of tocilizumab subcutaneous and intravenous regimen in RA patients with an inadequate response to DMARDs. The results indicate similar efficacy and safety between the two groups.

Chiu et al (AB 2616): The objective of the study was to identify Ps patients at risk for developing arthritis and identify markers of arthritis susceptibility that are valid, reliable and feasible. Due to previous studies the authors hypothesized that Ps patients who have higher frequency of DC-STAMP+CD14+ cells are more likely to develop arthritis and that OCP frequency and DC-STAMP+CD14+ expression increases during transition from PS to PsA. In 6/6 patients developing PsA as monotherapy the authors found an increase of OCP frequency and DC-STAMP+CD14+ expression when developing PsA. The authors also concluded that OCP and DC-STAMP+ could also serve as a treatment response marker as they found a decline of OCP frequency and DC-STAMP+CD14+ in responders to treatment. Given these findings, the authors recommend further studies to investigate the potential of these markers as predictors of arthritis susceptibility in PsA patients.

Ritchlin et al (AB 2557): In this phase 3 study, the effect of Ustekinumab was studied in 312 patients with active Psoriatic Arthritis (PsA; SJC and TJC ≥5) and were especially interested whether there are differences in response (primary endpoint ACR 20 at week 24; secondary endpoints ACR50, ACR70, HAQ and PASI75 at week 24) of patients prior exposed to TNFi (n=180) compared to those without. The authors could demonstrate efficacy of Ustekinumab in TNF naïve patients as well as experienced subjects, though response rates were lower in those with prior use of TNFi. Furthermore efficacy was demonstrated with and without MTX.

Fagerli et al (AB 2560): As it is known that in RA concomitant MTX improves efficacy of TNFi whereas in AS concomitant DMARD do not improve efficacy of TNFi, Fagerli et al studied whether patients with PsA receiving concomitant MTX with their first TNFi had better response and drug survival than patients receiving TNFi monotherapy. To answer this question patients with PsA of the NOR-DMARD registry receiving their first TNFi (n=440) either with (n=270) or without (n=170) concomitant MTX were included in this study and baseline characteristics as well as response rates and drug survival rates were compared between those two groups. The authors found similar response to first TNFi in PsA patients with or without concomitant MTX with a trend towards improved 3 year drug survival in patients with concomitant MTX – these results were most prominent in patients receiving infliximab as TNFi. Limitations to consider: confounding by indication (patients with concomitant MTX had higher swollen joint count at baseline); lack of information about axial disease; dactylitis.

Psoriatic arthritis

Helga Radner currently works as rheumatology fellow at the Medical University Vienna. Her special research focus is on outcomes in chronic inflammatory rheumatic diseases, mainly rheumatoid arthritis, and on comorbidities and their influence on important outcomes. Currently she is the EMEUNET Website Subgroup leader.

Psoriatic arthritis

Katerina Chatzidionysiou, MD, is a clinical fellow at Karolinska University Hospital (Stockholm) and currently a PhD candidate at Karolinska Institute. Her research focus is on biologic treatment of rheumatoid arthritis.
Haroon N et al (AB 782) showed in their work that anti-TNF drugs do slow radiographic progression in ankylosing spondylitis. The authors performed analysis of data from 376 patients with ankylosing spondylitis from a multicenter longitudinal cohort. All patients had least 2 sets of radiographs at least 1.5 years apart (range 1.5 to 9 years) and different duration of anti-TNFs exposure. After adjustment for gender, disease duration, level of acute phase reactants, and structural damage extent at baseline, anti-TNF use was significantly associated with decrease in radiographic spinal progression: odds ratio for radiographic spinal progression (worsening of the modified Stoke Ankylosing Spondylitis Spine Score (mSASSS) by ≥1 unit per year) in anti-TNF users was 0.44 (95% confidence interval 0.24-0.79), p=0.006.

Ramiro S et al (AB 572) presented important data on the long-term natural course of radiographic spinal progression in AS. Spinal radiographs of 186 patients with ankylosing spondylitis from the Outcome in AS International Study (OASIS) were analysed. At the group level, a linear progression of the mSASSS was observed with a mean increase of about 1 mSASSS unit per year (about 2 mSASSS units/year). About 30% of all patients developed at least one new syndesmophyte over the period of observation. Radiographic progression occurred significantly faster in males (vs females) and in HLA-B27 positive patients (vs HLA-B27 negative). HLA-B27 positive male (but not female) patients had a significantly higher progression than HLA-B27 negative males.

Results from the INFliximab as First line therapy in patients with early, Active Spondyloarthritis Trial (INFAST) Part I and Part II were presented by Sieper J at al (AB 549, 779, 1365). In the first part of the trial infliximab plus naproxen was compared to naproxen alone in patients with early axial spondyloarthritis (symptom duration <3 years). ASAS partial remission at week 28, the primary outcome, was achieved by more patients treated with infliximab + naproxen (61.9%) than with naproxen alone (35.3%), p=0.002. Interestingly, 15.7% of the patients under naproxen vs. 29.5% under infliximab+naproxen achieved complete resolution of inflammation in the spine (p=0.08), indicating that non-steroidal anti-inflammatory drugs (NSAIDs) might have an impact on active inflammation in the spine in axial spondyloarthritis. At week 28 patients who achieved remission were re-randomised to either naproxen or no therapy for further 24 weeks. At week 52, similar percentages of patients in the naproxen and no-treatment groups maintained partial remission (47.5 vs 40%) indicating that continuous treatment with NSAIDs is rather unable to prevent a disease flare after discontinuation of anti-TNF therapy in patients with axial SpA.
Systemic sclerosis (SSc)
Important advances in the approach of the SSc patients were introduced. Preliminary joint EULAR and ACR classification criteria for SSc were presented by Pope et al (AB L3) to aid the diagnosis of early and limited cutaneous SSc. For the management of PAH, experts introduced the EPOSS guidelines for performing RHC in the suspicion of PAH (AB 1462) and the DETECT algorithm: a non-invasive screening tool (AB 851). Cautious use of ACE inhibitors in patients with early SSc was suggested by Hudson et al (AB 728), by showing that exposure to an ACE inhibitor prior to the onset of scleroderma renal crisis is associated with an increased risk of death during the first year of follow-up. Tyndall et al (AB L2) reported the final results of the ASTIS trial, indicating the superiority of HSCT over pulse cyclophosphamide in patients with early dcSSc: HSCT prolonged event-free and overall survival with HSCT, despite 10% treatment-related mortality and greater deterioration in renal function.

Myositis
Allenbach et al (AB 220) reported the results of a phase II trial on patients with anti-Jo1 positive myositis refractory to conventional treatments: rituximab was effective in 50% of the cases, permitting a reduction of immunosuppressants.

Sjogren’s syndrome (pSS)
Several studies investigated key agents in the treatment of pSS. Rituximab failed to show efficacy in active recent and/or systemic pSS when evaluated in a 24 week placebo-controlled trial (AB 2554). Interestingly, Gottenberg et al (AB L9) found no evidence of short term efficacy of hydroxychloroquine in pSS; a favorable response was seen in 19.2% of patients receiving placebo and 19.6% receiving hydroxychloroquine. However, preliminary studies by Adler and co-workers showed that abatacept bears the potential of a disease-modifying biologic agent in pSS, by reducing inflammation in glandular tissue (AB 2553). An open label phase II trial on belimumab reached its primary end-point in 63% (19/30) of patients, warranting future trials (AB 2555).

Vasculitis
Two important studies on outcomes of maintenance therapies in vasculitides were presented. In ANCA-associated vasculitis, rituximab every 6 months was superior to azathioprine in maintaining remission (3.6% vs. 27.1% relapses in the RTX vs. AZA arm) (AB 1652). For patients with granulomatosis with polyangiitis long-term maintenance therapy (>18 months) was associated with fewer relapses; conversely, discontinuation and low doses of maintenance therapy were associated with a high relapse rate (AB 1653).

Weber U et al (abstract 778) assessed the incremental diagnostic value of spinal MRI both separately from and combined with SJJ MRI in early SpA compared to SJJ MRI alone. The study was based on independent cohorts of consecutive patients with back pain and 20 healthy controls. There were up to 16% of nr-axSpA patients who showed spinal lesions in the absence of SJJ lesions, while up to 19% of nr-axSpA patients considered having a negative SJJ MRI showed a positive spinal MRI according to global assessment. Overall, Spinal MRI added little incremental value compared to SJJ MRI alone in terms of lesion detection and classification of early SpA patients.

Luz R et al (abstract 808) evaluated the findings of a new ultrasound score (US10) of the hand and wrist joints to predict treatment failure in early RA patients (<1 year symptom with no previous DMARDs). The US10 included the following joints: wrist, second and third metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints. Using a follow-up of 12 months of treatment, the US10, was found to be useful to predict the first and second DMARD failure in early RA patients.

Agarwal V et al (abstract 1017) examined patients with chronic knee arthritis and compared conventional, diffusion tensor imaging (DTI) and dynamic contrast enhanced (DCE) MRI (3T) followed by arthroscopic synovial biopsy. Overall, 65 patients (45 male) were examined. DTI and DCE metrics captured cellular and molecular events and correlated with the degree of synovial inflammation. The authors conclude that these imaging systems may replace synovial histology in future.

Finally, Gärtner et al aimed to evaluate the differences of clinically and sonographically active joints in RA. Sonographic imaging of 22 joints of the hands of RA patients in clinical remission were investigated by grey scale synovial hypervascularity (GSSH) and power Doppler (PD) signal. Among the 1320 joints of patients in remission 67.2% were GSSH positive and 20.4% were PD positive. Clinical joint swelling was 100% specific for sonographic activity. Overall, sonography revealed residual signals of joint activity in patients in CDAI remission.
The investigational agent odanacatib (50mg/week) was investigated in a 24-month RCT (Chapurlat et al, AB727). The study included 243 postmenopausal women ≥60 years of age with low BMD T-score (≤ -2.5 but > -3.5) at the total hip, femoral neck or trochanter but no history of hip fracture and who had been treated with alendronate for ≥3 years. The study was not designed or powered to evaluate the effect on fractures. The overall safety profile appeared similar between odanacatib and placebo, and the treatment group showed incremental gains in BMD at all three hip sites and lumbar spine. Biomarker results suggested that odanacatib decreases bone resorption while preserving bone formation.

Mhuircheartaigh et al (AB820) investigated whether an incident fracture following rheumatoid arthritis (RA) diagnosis increases the risk for subsequent cardiovascular disease (CVD). The authors studied a population-based inception cohort who fulfilled 1987 ACR criteria for RA and an equal number of age- and sex-matched controls. In women and men with RA, an incident fracture was associated with an increased risk of subsequent CVD. Although the mechanism underlying this association remains to be clarified, the authors suggest that a new fracture in a RA patient should be considered a sentinel event that prompts further evaluation of their cardiovascular risk.

Runhaar et al (AB2471) presented a RCT of oral glucosamine (1500 mg/day) and a tailor made diet and exercise program (2x2 factorial design) for the prevention of knee osteoarthritis (KOA) in overweight (BMI≥27) females. In total, 407 women (50-60 years) with no clinical or radiographic KOA met all inclusion criteria. The primary outcome was incidence of KOA, defined by a Kellgren and Lawrence score≥2, joint space narrowing of ≥1.0mm or incident clinical KOA (ACR criteria). Although safe compared to placebo, crystalline glucosamine sulphate was ineffective for the prevention of KOA in overweight females over 2.5 years of follow-up.

Results of the SEKOIA trial were presented by Reginster et al (AB254, 255, 256 and 1596). SEKOIA was a 3-year RCT conducted at 95 centers in 16 countries. A total of 1683 patients with mild to moderate primary KOA (ACR criteria) were randomly assigned to strontium ranelate at 1 g/day or 2 g/day or to placebo. Three years of treatment with strontium ranelate prevented structural damage in patients with knee OA. Beneficial effects on structure were observed with both the 1g and 2g doses. The effects on structure also translated into less progression of KOA to thresholds that lead to knee surgery, and doses of 2 g/day significantly improved symptoms and pain.

In the last ACR, Daria et al (AB 165), in a retrospective cohort study evaluated the relationship between colchicine and cardiovascular outcomes. They identified all active patients with an assigned ICD-9 code for gout or hyperuricemia between 2000-09 and confirmed gout using ACR criteria. Pharmacy records were used to identify subjects on daily colchicine for 30 days (colchicine group). Subjects receiving no colchicine prescriptions formed the control group. A total of 183 patients were enrolled. Colchicine and control groups had similar rates of cardiovascular risk factors. Colchicine users experienced no myocardial infarction (MI) while on their medication. Control patients had 4 MIs, and 3 MIs occurred during colchicine lapses (mean time from last colchicines use to MI 5.9 months). These data suggest that colchicine is protective against MI, though probably only during active use.

Following, Terkeltaub et al (AB 813) analyzed efficacy and safety data from three 16-week placebo control clinical trials of 80 or 160 mg/week rilonacept for gout flare prophylaxis in patients with chronic kidney disease (CKD, estimated glomerular filtration rate of ≤ 60 ml/min/1.73 m²). Patients with initial serum urate ≥7.5 mg/dL, 2 gout flares in the prior year, and initiating ULT were included. Pooled data from the 3 studies showed a consistent effect of rilonacept to prevent gout flares in patients with CKD, 27% vs 55% in the placebo group. The incidence of treatment-emergent adverse events (AEs) and serious AEs, respectively, were similar between treatment groups.

Changes in gout patients clinical profile in the last two decades were shown in a work of Perez-Ruiz et al (AB 1906). A prospective cohort of 904 gout patients was analyzed. Patients were stratified in two decades, from 1992-2002 and from 2002-2012. In the second decade, a statistically significant increase in age, number of flares, and body mass index were observed. Baseline serum urate and time from onset of gout to referral were not statistically different. Polycarticular involvement and tophi were significantly more frequent in the second decade, although the percentage of patients naïve to ULT (63.8 vs. 59.3%) or allergic to allopurinol (4.9 vs. 5.7%) were similar. Comorbidities were more common in the second decade. Interestingly, the mean serum urate reduction and percentage reduction from baseline were greater in the second decade (3.4 vs. 3.7 mg/dL and 38 vs. 45%), so that the percentage of patients averaging serum urate 6 mg/dL while on follow-up remained pretty good (87 and 89%).
EMEUNET website and registration

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

Sign in for EMEUNET! You can easily register online and get in contact with other young rheumatologists and researchers in rheumatology.

You can also reach us through the following email: emeunet@eular.ch.

Events: January - May 2013

2nd Musculoskeletal Sonography Course for Rheumatologists (basic)
Zagreb, Croatia, 31.01.13–02.02.13

Frontiers in Rheumatology 2013
London, UK, 14.02.13–15.02.13
http://www.regonline.co.uk/builder/site/Default.aspx?EventID=1158347

Paris International Shoulder Course
Paris, France, 14.02.13–16.02.13

Sonoanatomy Course V
Barcelona, Spain, 21.02.13–22.02.13

33rd European Rheumatology Research Workshop (EWRR)
Prague, Czech Republic, 28.02.13–03.03.13
http://www.ewrr.org/index.html

1st International Workshop on Ultrasound in Large Vessel Vasculitis and Polymyalgia Rheumatica
Kristiansand, Norway, 15.03.13–17.03.13

7th Congress of the African League of Associations for Rheumatology and 23rd Congress of the South African Rheumatism and Arthritis Association
Durban, South Africa, 03.04.13–06.04.13
http://www.aflar.net/index.php

Controversies in Rheumatology and Autoimmunity (CORA)
Budapest, Hungary, 04.04.13–06.04.13
http://www2.kenes.com/cora/Pages/Home.aspx

European Society for Clinical Investigation Annual Scientific Meeting
Albufeira, Portugal, 17.04.13–20.04.13
http://www.esci.eu.com/meetings/

European Congress on Osteoporosis and Osteoarthritis
Rome, Italy, 17.04.13–20.04.13
http://www.ecceo13-ifo.org/

2013 Osteoarthritis Research Society International (OARSI) World Congress
Philadelphia, USA, 18.04.13–21.04.13
http://2013.oarsi.org/welcome-0

European Calcified Tissue Society Congress (ECTS 2013)
Lisbon, Portugal, 18.05.13–21.05.13
http://www.ectscongress.org/2013/
EULAR EPIDEMIOLOGY COURSE 2013

After a very successful endeavor in 2012, for the second time, EMEUNET is co-organizing an EULAR-endorsed Epidemiology course.

When: 5-6 July 2013 (1.5 days)

Where: Berlin, Germany (German Rheumatism Research Center)

Registration deadline: 31 April 2013. There will be 10 EULAR bursaries available.

Details: course targeting young researchers with an interest in epidemiology. The course will focus on the design, analysis and interpretation of observational studies.

Faculty: Daniel Aletaha, Loreto Carmona, William Dixon, Robert Landewé, Désirée van der Heijde, Angela Zink

Course organizers: Loreto Carmona, Laure Gossec, Pedro Machado, Angela Zink

ACR 2012 - EMEUNET group photo
The selection of presentations for this newsletter is totally personal, limited and consecutively very incomplete.

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