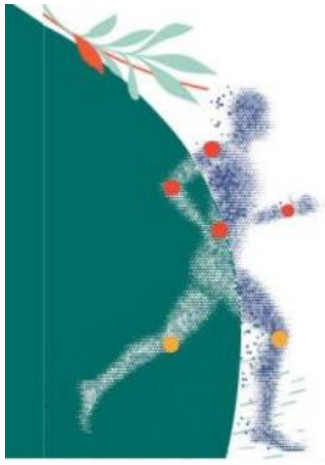

Εαρινές ημέρες Ρευματολογίας

13-15 Μαΐου 2022

Xenia Poros Image Hotel

ΠΟΡΟΣ

ΕΛΛΗΝΙΚΗ ΡΕΥΜΑΤΟΛΟΓΙΚΗ ΕΤΑΙΡΕΙΑ • ΑΘΗΝΑΙ •

Σύγχρονος θεραπευτικός αλγόριθμος στην αγκυλοποιητική σπονδυλίτιδα: τι αλλάζει

ΙΠΠΟΚΡΑΤΕΙΟ
ΓΕΝΙΚΟ ΝΟΣΟΚΟΜΕΙΟ
ΘΕΣΣΑΛΟΝΙΚΗΣ

Νικόλαος Κούγκας
Ρευματολόγος
Δ΄Παθολογική Κλινική ΑΠΘ

Σύγκρουση συμφερόντων

- Καμία για τη συγκεκριμένη παρουσίαση

Περιστατικό 1

- Άνδρας 27 ετών
- Διάγνωση ΑΣ από 3 ετίας
- Χωρίς εξωαρθρικές εκδηλώσεις
- Αστοχία σε 2 ΜΣΑΦ
- ASDAS 4,04

Περιστατικό 2

- Γυναίκα 37 ετών
- ΑΣ από 7 ετίας υπό αγωγή με Anti-TNFa
- Καλή ανταπόκριση από τον αξονικό σκελετό
- Υποτροπιάζοντα επεισόδια ολιγοαρθρίτιδας κάτω άκρων

Περιστατικό 3

- Άνδρας 58 ετών, καπνιστής 40 p/y
- ΑΣ από 23 ετών
- Υπό βιολογικό παράγοντα από 20 ετίας
  - BASDAI 0,6
  - BASFI 5,8
- Πρόσφατό ΟΕΜ, επιθυμία διακοπής θεραπείας

Recommendation

2016 update of the ASAS-EULAR management recommendations for axial spondyloarthritis

Désirée van der Heijde,[1] Sofia Ramiro,[1] Robert Landewé,[2,3] Xenofon Baraliakos,[4] Filip Van den Bosch,[5] Alexandre Sepriano,[1,6] Andrea Regel,[4] Adrian Ciurea,[7] Hanne Dagfinrud,[8] Maxime Dougados,[9,10] Floris van Gaalen,[1] Pál Géher,[11] Irene van der Horst-Bruinsma,[12] Robert D Inman,[13] Merryn Jongkees,[14] Uta Kiltz,[4] Tore K Kvien,[15] Pedro M Machado,[16] Helena Marzo-Ortega,[17,18] Anna Molto,[9,10] Victoria Navarro-Compàn,[19] Salih Ozgocmen,[20] Fernando M Pimentel-Santos,[21] John Reveille,[22] Martin Rudwaleit,[23,24,25] Jochen Sieper,[26] Percival Sampaio-Barros,[27] Dieter Wiek,[28] Jürgen Braun[4]

Update ASAS-EULAR management recommendations 2016

EULAR-ASAS recommendations

8	Patients with purely axial disease should normally not be treated with csDMARDs§; sulfasalazine† may be considered in patients with peripheral arthritis	1a†	A	9.2 (0.78) 100% ≥8
9	bDMARDs should be considered in patients with persistently high disease activity despite conventional treatments (figure 1); current practice is to start with TNFi therapy	1a (TNFi); 1b (IL-17i)	A	9.6 (1.09) 93% ≥8
10	If TNFi therapy fails, switching to another TNFi* or IL-17i** therapy should be considered	2* 1b**	B* A**	9.6 (0.95) 97% ≥8
11	If a patient is in sustained remission, tapering of a bDMARD can be considered	2	B	9.1 (1.57) 97% ≥8
12	Total hip arthroplasty should be considered in patients with refractory pain or disability and radiographic evidence of structural damage, independent of age; spinal corrective osteotomy in specialised centres may be considered in patients with severe disabling deformity	4	C	9.4 (0.82) 100% ≥8

Arthritis & Rheumatology
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American College of Rheumatology
Empowering Rheumatology Professionals

SPECIAL ARTICLE

2019 Update of the American College of Rheumatology/ Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis

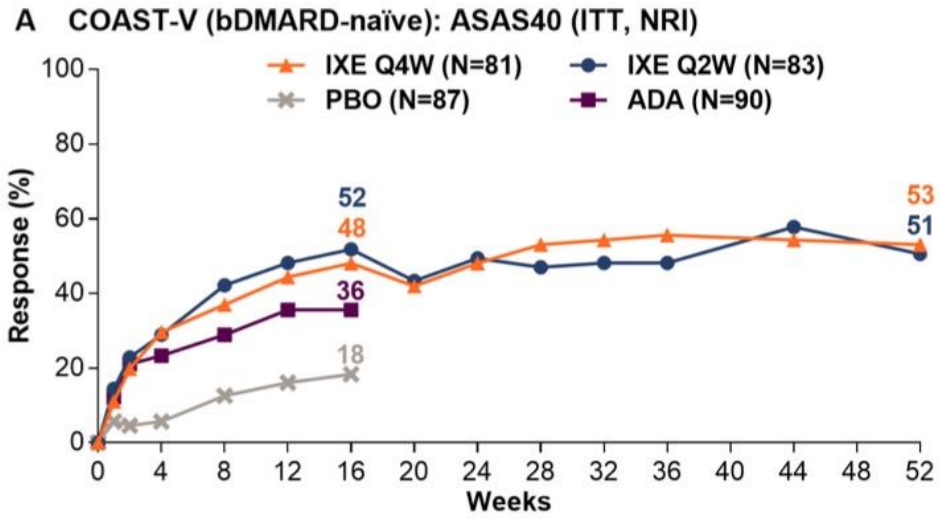
Michael M. Ward,[1] Atul Deodhar,[2] Lianne S. Gensler,[3] Maureen Dubreuil,[4] David Yu,[5] Muhammad Asim Khan,[6] Nigil Haroon,[7] David Borenstein,[8] Runsheng Wang,[9] Ann Biehl,[1] Meika A. Fang,[10] Grant Louie,[11] Vikas Majithia,[12] Bernard Ng,[13] Rosemary Bigham,[14] Michael Pianin,[15] Amit Aakash Shah,[16] Nancy Sullivan,[17] Marat Turgunbaev,[16] Jeff Oristaglio,[17] Amy Turner,[16] Walter P. Maksymowych,[18] and Liron Caplan[19]

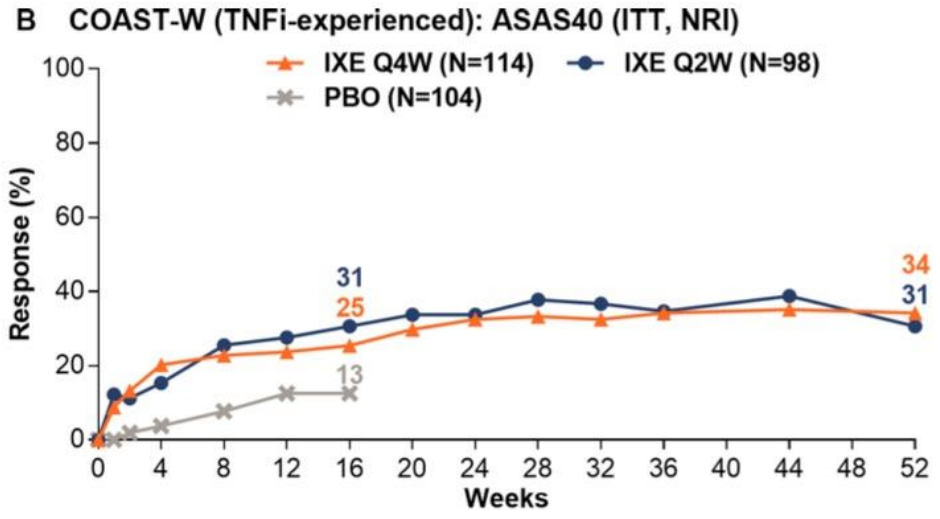
ACR 2019 recommendations

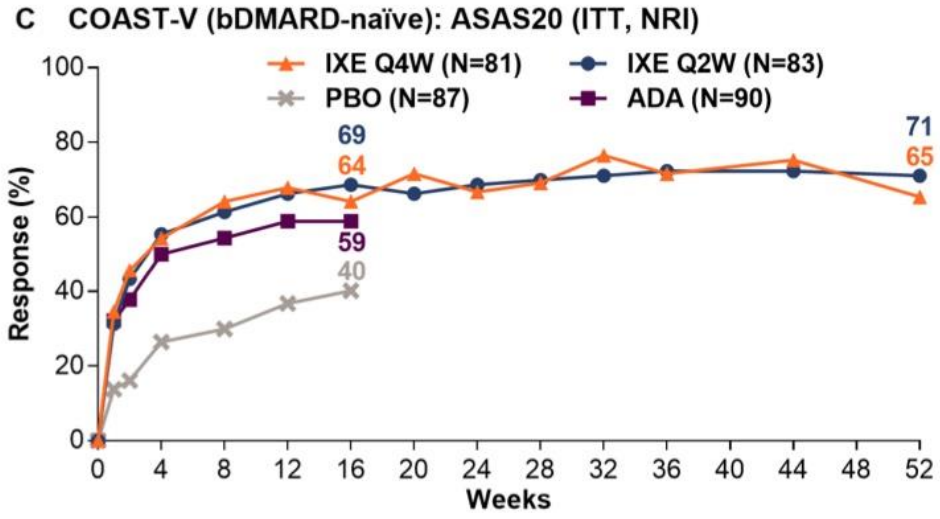
4.	In adults with active AS despite treatment with NSAIDs, we conditionally recommend treatment with sulfasalazine, methotrexate, or tofacitinib over no treatment with these medications. Sulfasalazine or methotrexate should be considered only in patients with prominent peripheral arthritis or when TNFi are not available.	Very low to moderate	7
5.	In adults with active AS despite treatment with NSAIDs, we conditionally recommend treatment with TNFi over treatment with tofacitinib.	Very low	60
6.	In adults with active AS despite treatment with NSAIDs, we strongly recommend treatment with TNFi over no treatment with TNFi.	High	6
7.	We do not recommend any particular TNFi as the preferred choice.	Moderate	5
8.	In adults with active AS despite treatment with NSAIDs, we strongly recommend treatment with secukinumab or ixekizumab over no treatment with secukinumab or ixekizumab.	High	58
9.	In adults with active AS despite treatment with NSAIDs, we conditionally recommend treatment with TNFi over treatment with secukinumab or ixekizumab.	Very low	59
10.	In adults with active AS despite treatment with NSAIDs, we conditionally recommend treatment with secukinumab or ixekizumab over treatment with tofacitinib.	Very low	61

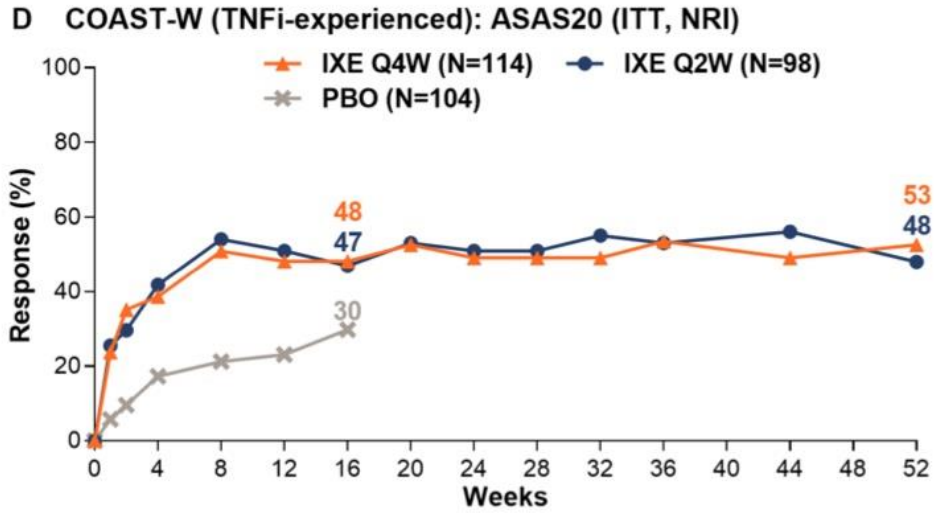

OLD BUSINESS
WAY
NEW BUSINESS
WAY

Ixekizumab

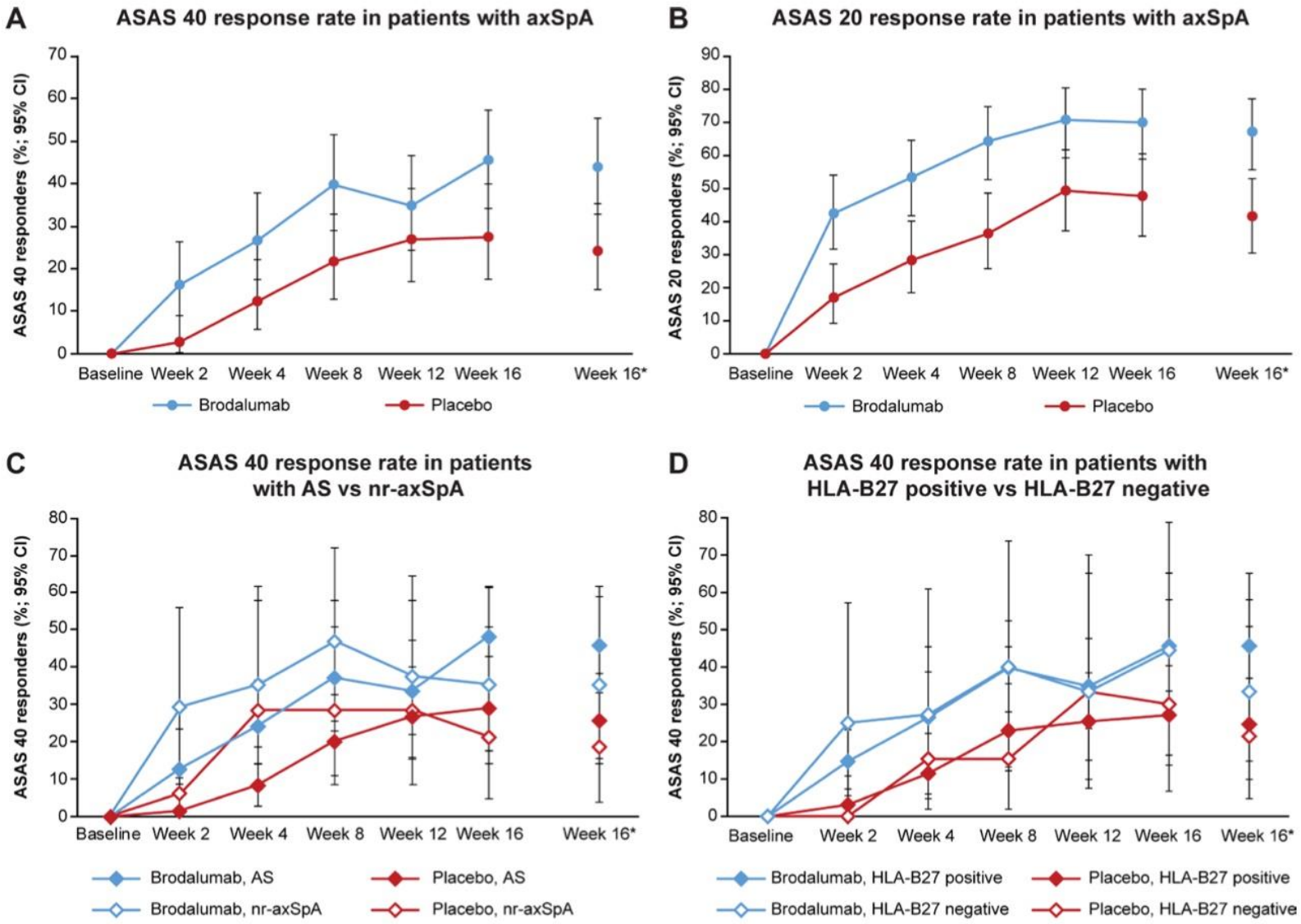

A COAST-V (bDMARD-naïve): ASAS40 (ITT, NRI)
IXE Q4W (N=81)
IXE Q2W (N=83)
PBO (N=87)
ADA (N=90)
Response (%)
Weeks
52
48
36
18
53
51


B COAST-W (TNFi-experienced): ASAS40 (ITT, NRI)
IXE Q4W (N=114)
IXE Q2W (N=98)
PBO (N=104)
Response (%)
Weeks
31
25
13
34
31

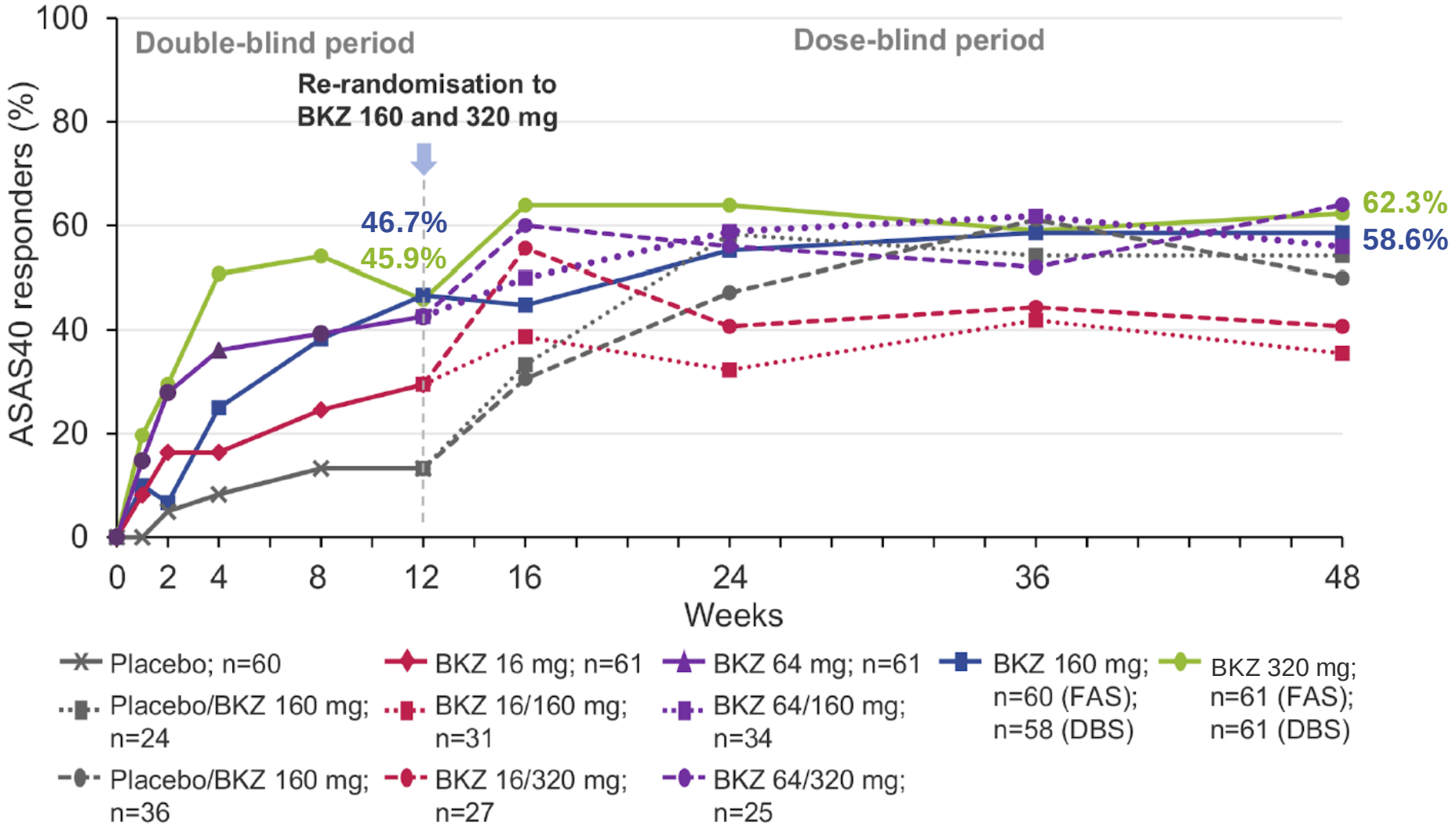

C COAST-V (bDMARD-naïve): ASAS20 (ITT, NRI)
IXE Q4W (N=81)
IXE Q2W (N=83)
PBO (N=87)
ADA (N=90)
Response (%)
Weeks
69
64
59
40
71
65


D COAST-W (TNFi-experienced): ASAS20 (ITT, NRI)
IXE Q4W (N=114)
IXE Q2W (N=98)
PBO (N=104)
Response (%)
Weeks
48
47
30
53
48

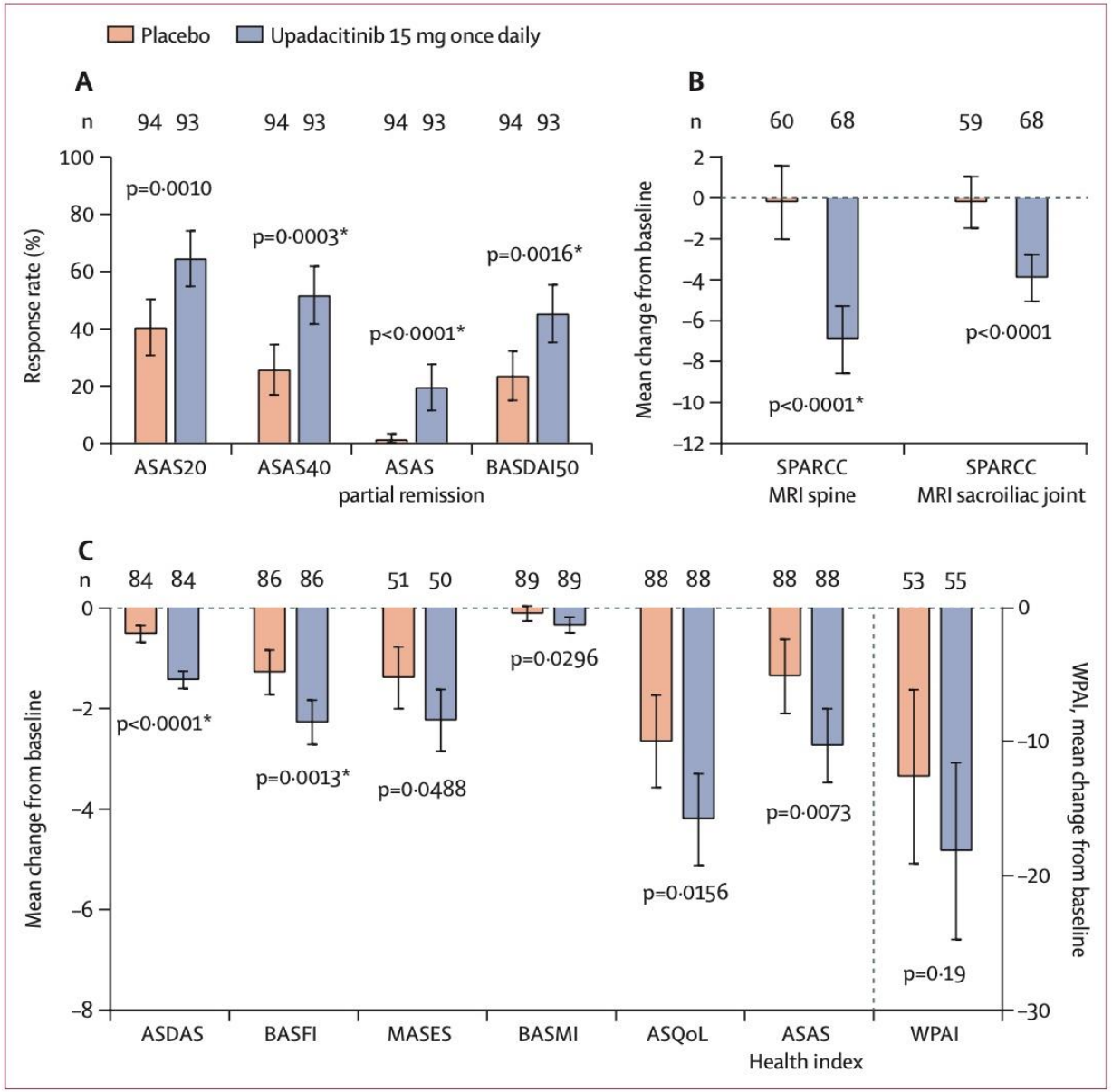
Brodalumab


A
ASAS 40 response rate in patients with axSpA
ASAS 40 responders (%; 95% CI)
Baseline Week 2 Week 4 Week 8 Week 12 Week 16 Week 16*
Brodalumab
Placebo
B
ASAS 20 response rate in patients with axSpA
ASAS 20 responders (%; 95% CI)
Baseline Week 2 Week 4 Week 8 Week 12 Week 16 Week 16*
Brodalumab
Placebo
C
ASAS 40 response rate in patients with AS vs nr-axSpA
ASAS 40 responders (%; 95% CI)
Baseline Week 2 Week 4 Week 8 Week 12 Week 16 Week 16*
Brodalumab, AS
Brodalumab, nr-axSpA
Placebo, AS
Placebo, nr-axSpA
D
ASAS 40 response rate in patients with HLA-B27 positive vs HLA-B27 negative
ASAS 40 responders (%; 95% CI)
Baseline Week 2 Week 4 Week 8 Week 12 Week 16 Week 16*
Brodalumab, HLA-B27 positive
Brodalumab, HLA-B27 negative
Placebo, HLA-B27 positive
Placebo, HLA-B27 negative

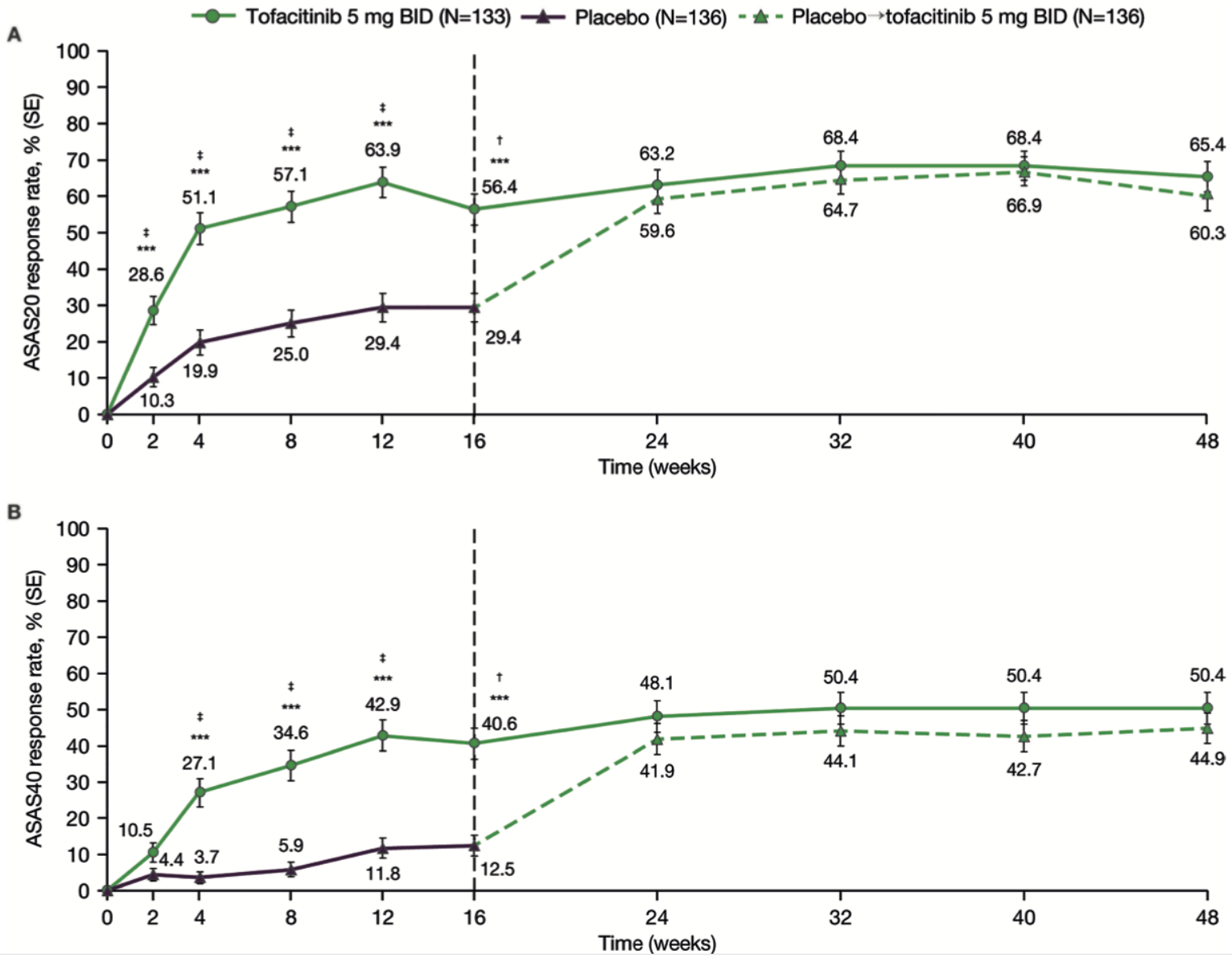
Bimekizumab



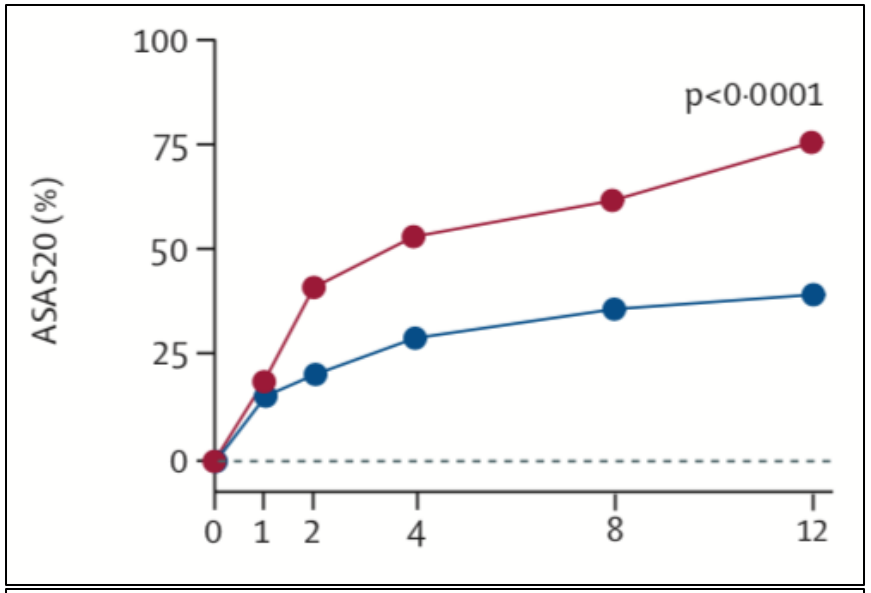
Upadacitinib

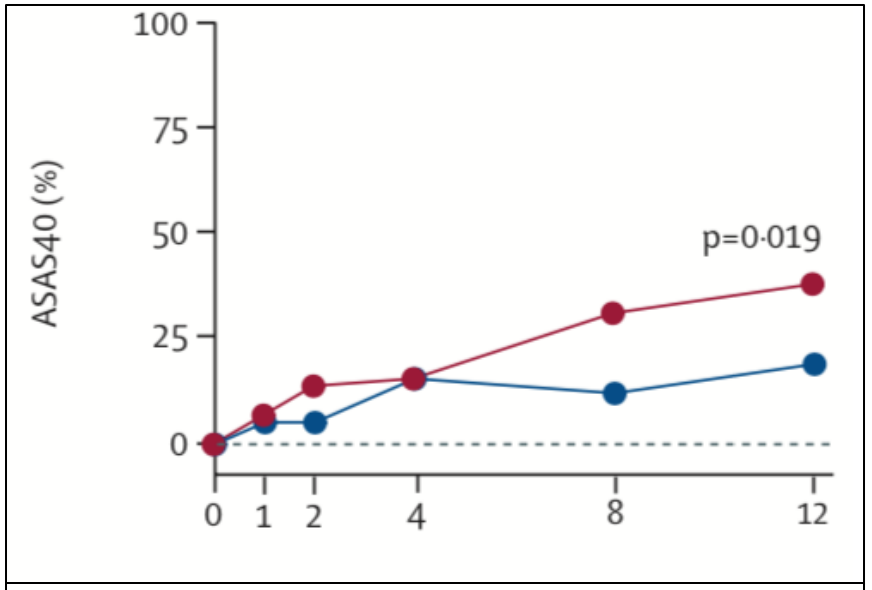


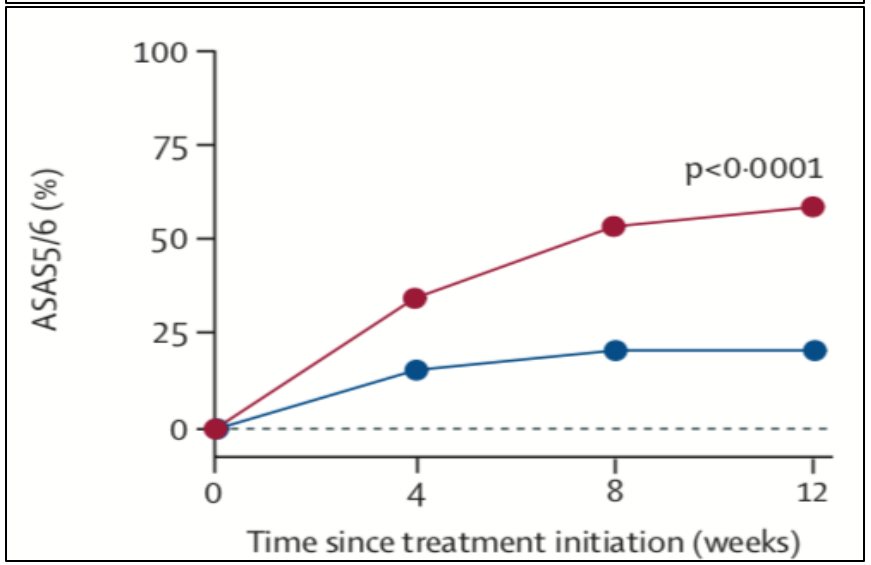
Tofacitinib

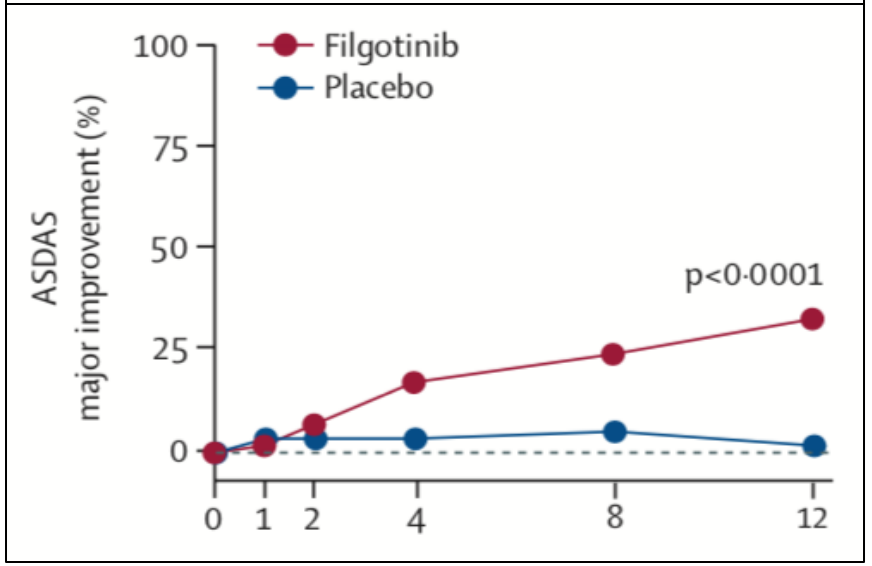


Filgotinib


ASAS20 (%)
100
75
50
25
0
p<0·0001
0 1 2 4 8 12


ASAS40 (%)
100
75
50
25
0
p=0·019
0 1 2 4 8 12


ASAS5/6 (%)
100
75
50
25
0
p<0·0001
0 4 8 12
Time since treatment initiation (weeks)


Filgotinib
Placebo
ASDAS
major improvement (%)
100
75
50
25
0
p<0·0001
0 1 2 4 8 12

EULAR-ASAS recommendations

6	Analgesics, such as paracetamol and opioid-(like) drugs, might be considered for residual pain after previously recommended treatments have failed, are contraindicated, and/or poorly tolerated	5	D	8.8 (0.94) 100% ≥8
7	Glucocorticoid injections* directed to the local site of musculoskeletal inflammation may be considered. Patients with axial disease should not receive long-term treatment with systemic glucocorticoids‡	2* 5‡	B* D‡	9.4 (0.78) 100% ≥8
8	Patients with purely axial disease should normally not be treated with csDMARDs§; sulfasalazine† may be considered in patients with peripheral arthritis	1a†	A	9.2 (0.78) 100% ≥8
9	bDMARDs should be considered in patients with persistently high disease activity despite conventional treatments (figure 1); current practice is to start with TNFi therapy	1a (TNFi); 1b (IL-17i)	A	9.6 (1.09) 93% ≥8

ACR 2019 recommendations

13. In adults with active AS despite treatment with the first TNFi used, we conditionally recommend treatment with a different TNFi over treatment with a non-TNFi biologic in patients with secondary nonresponse to TNFi.	Very low	10
14. In adults with active AS despite treatment with the first TNFi used, we strongly recommend against switching to treatment with a biosimilar of the first TNFi.	Very low	62
15. In adults with active AS despite treatment with the first TNFi used, we conditionally recommend against the addition of sulfasalazine or methotrexate in favor of treatment with a new biologic.	Very low	9
16. We strongly recommend against treatment with systemic glucocorticoids.†	Very low	4

CORRECTED PROOF

The impact of a csDMARD in combination with a TNF inhibitor on drug retention and clinical remission in axial spondylarthritis

Michael Nissen ✉, Bénédicte Delcoigne, Daniela Di Giuseppe, Lennart Jacobsson, Merete Lund Hetland, Adrian Ciurea, Lucie Nekvindova, Florenzo Iannone, Nurullah Akkoc, Tuulikki Sokka-Isler ... Show more

Rheumatology, keac174, https://doi.org/10.1093/rheumatology/keac174

Results

Amongst 24 171 axSpA patients, 32% received csDMARD co-therapy (range across countries: 13.5% to 71.2%). The co-therapy group had more baseline peripheral arthritis and higher CRP than the monotherapy group. One-year TNFi-retention rates (95% CI): 79% (78, 79%) for TNFi monotherapy *vs* 82% (81, 83%) with co-therapy ($P < 0.001$). Remission was obtained in 20% on monotherapy and 22% on co-therapy ($P < 0.001$); adjusted OR of 1.16 (1.07, 1.25). Remission rates at 12 months were similar in patients with/without peripheral arthritis.

Conclusion

This large European study of axial SpA patients showed similar one-year treatment outcomes for TNFi monotherapy and csDMARD co-therapy, although considerable heterogeneity across countries limited the identification of certain subgroups (e.g. peripheral arthritis) that may benefit from co-therapy.

CLINICAL SCIENCE

Effectiveness of secukinumab versus an alternative TNF inhibitor in patients with axial spondyloarthritis previously exposed to TNF inhibitors in the Swiss Clinical Quality Management cohort

Raphael Micheroli,[1] Christoph Tellenbach ,[1,2] Almut Scherer,[2] Kristina Bürki,[1] Karin Niederman,[3] Michael J Nissen,[4] Pascal Zufferey,[5] Pascale Exer,[6] Burkhard Möller ,[7] Diego Kyburz,[8] Adrian Ciurea [1]

Results SEC was more often used as third-line or later-line biological drug (76% vs 40% for TNFi). Patients starting SEC had higher BASDAI, Bath Ankylosing Spondylitis Functional Index, Bath Ankylosing Spondylitis Metrology Index and C reactive protein levels. A comparable risk of drug discontinuation was found for SEC versus TNFi (HR 1.14, 95% CI 0.78 to 1.68 in the PS-based analysis and HR 1.16, 95% CI 0.79 to 1.71 in the multiple-adjusted analysis). No significant difference in BASDAI50 responses at 1 year was demonstrated between the two modes of biological drug action, with CI of estimates being, however, wide (OR for SEC vs TNFi 0.76, 95% CI 0.26 to 2.18 and 0.78, 95% CI 0.24 to 2.48 in the PS-based and the covariate-adjusted model, respectively).

Conclusion Our data suggest a comparable effectiveness of SEC versus an alternative TNFi after prior TNFi exposure.

EULAR-ASAS recommendations

10	If TNFi therapy fails, switching to another TNFi* or IL-17i** therapy should be considered	2* 1b**	B* A**	9.6 (0.95) 97% ≥8
11	If a patient is in sustained remission, tapering of a bDMARD can be considered	2	B	9.1 (1.57) 97% ≥8
12	Total hip arthroplasty should be considered in patients with refractory pain or disability and radiographic evidence of structural damage, independent of age; spinal corrective osteotomy in specialised centres may be considered in patients with severe disabling deformity	4	C	9.4 (0.82) 100% ≥8
13	If a significant change in the course of the disease occurs, causes other than inflammation, such as a spinal fracture, should be considered and appropriate evaluation, including imaging, should be performed	5	D	9.9 (0.31) 97% ≥8

ACR 2019 recommendations

Table 2. (*Cont'd*)

Recommendation	Level of evidence	PICO
27. In adults receiving treatment with a biologic, we conditionally recommend against tapering of the biologic dose as a standard approach.	Very low to low	65
28. In adults receiving treatment with an originator TNFi, we strongly recommend continuing treatment with the originator TNFi over mandated switching to its biosimilar.	Very low	63
29. We strongly recommend treatment with physical therapy over no treatment with physical therapy.†	Low	19

CLINICAL SCIENCE

Maintenance of clinical remission in early axial spondyloarthritis following certolizumab pegol dose reduction

Robert BM Landewé,[1,2] Désirée van der Heijde ,[3] Maxime Dougados,[4] Xenofon Baraliakos,[5] Filip E Van den Bosch,[6] Karl Gaffney,[7] Lars Bauer,[8] Bengt Hoepken,[8] Owen R Davies,[9] Natasha de Peyrecave,[10] Karen Thomas,[8] Lianne Gensler[11]

Results At Week 48, 43.9% (323/736) patients achieved sustained remission, of whom 313 were randomised to CZP full maintenance dose, CZP reduced maintenance dose or placebo. During Weeks 48 to 96, 83.7% (87/104), 79.0% (83/105) and 20.2% (21/104) of patients receiving the full maintenance dose, reduced maintenance dose or placebo, respectively, were flare-free ($p<0.001$ vs placebo in both CZP groups). Responses in radiographic and non-radiographic axSpA patients were comparable.

Conclusions Patients with early axSpA who achieve sustained remission at 48 weeks can reduce their CZP maintenance dose; however, treatment should not be completely discontinued due to the high risk of flare following CZP withdrawal.

CLINICAL SCIENCE

Continuing versus withdrawing ixekizumab treatment in patients with axial spondyloarthritis who achieved remission: efficacy and safety results from a placebo-controlled, randomised withdrawal study (COAST-Y)

Robert BM Landewé ,[1] Lianne S Gensler,[2] Denis Poddubnyy ,[3] Proton Rahman,[4] Maja Hojnik,[5] Xiaoqi Li,[5] Soyi Liu Leage,[5] David Adams,[5] Hilde Carlier,[5] Filip Van den Bosch ,[6,7] on behalf of the COAST-Y study group

Results Of 773 enrolled patients, 741 completed the 24-week lead-in period and 155 entered the RWRP. Forty weeks after randomised withdrawal, 83.3% of patients in the combined IXE (85/102, p<0.001), IXE Q4W (40/48, p=0.003) and IXE Q2W (45/54, p=0.001) groups remained flare-free versus 54.7% in the PBO group (29/53). Continuing IXE significantly delayed time-to-flare versus PBO, with most patients remaining flare-free for up to 20 weeks after IXE withdrawal.

Conclusions Patients with axSpA who continued treatment with IXE were significantly less likely to flare and had significantly delayed time-to-flare compared with patients who withdrew to PBO.

Περιστατικό 1

- Άνδρας 27 ετών
- Διάγνωση ΑΣ από 3 ετίας
- Χωρίς εξωαρθρικές εκδηλώσεις
- Αστοχία σε 2 ΜΣΑΦ
- ASDAS 4,04

Περιστατικό 1

- Anti-TNFa (EULAR-ACR recommendations)
- IL 17 inhibitors
- JAK inhibitors

Περιστατικό 2

- Γυναίκα 37 ετών
- ΑΣ από 7 ετίας υπό αγωγή με Anti-TNFa
- Καλή ανταπόκριση από τον αξονικό σκελετό
- Υποτροπιάζοντα επεισόδια ολιγοαρθρίτιδας κάτω άκρων

Περιστατικό 2

- Προσθήκη DMARD (EULAR recommendation)
- Anti-TNFa (ACR recommendation)
- IL 17 inhibitors
- JAK inhibitors

Περιστατικό 3

- Άνδρας 58 ετών, καπνιστής 40 p/y
- ΑΣ από 20 ετών
- Υπό βιολογικό παράγοντα
  - BASDAI 0,6
  - BASFI 5,8
- Πρόσφατό ΟΕΜ, επιθυμία διακοπής θεραπείας

Περιστατικό 3

- Σταδιακή μείωση του βιολογικού παράγοντα αλλά όχι διακοπή