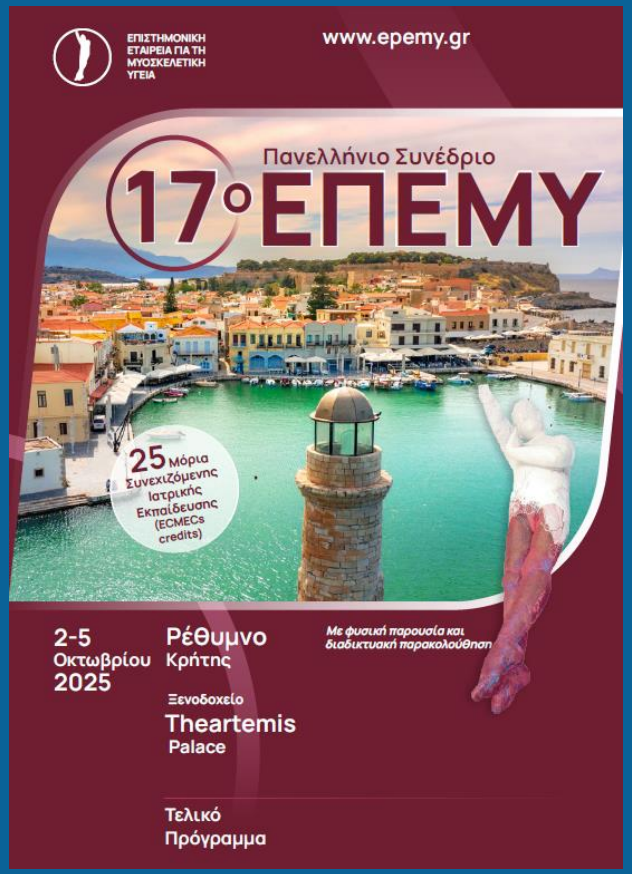


Θεραπεύοντας τη φλεγμονή:

πώς η εκλεκτική αναστολή του JAK-STAT γεφυρώνει την απόσταση μεταξύ ειδικοτήτων

Προεδρείο:

Θεόδωρος Δημητρούλας, Ρευματολόγος, Καθηγητής Ρευματολογίας ΑΠΘ, Δ΄ Πανεπιστημιακή Παθολογική Κλινική, ΓΝ Ιπποκράτειο, Θεσσαλονίκη

Ομιλητές:

Αργυρώ Βενετσάνη, Ρευματολόγος, Ηράκλειο Κρήτης

Κωνσταντίνος Καρμίρης, Αναπληρωτής Καθηγητής, Γαστρεντερολογίας, Τμήμα Ιατρικής, Πανεπιστήμιο Κρήτης, Γαστρεντερολογική Κλινική ΠΑΓΝΗ, Ηράκλειο

Δήλωση Συμφερόντων

Δημητρούλας Θεόδωρος
Τιμητική αμοιβή από την Abbvie για την συγκεκριμένη παρουσίαση

Βενετσάνη Αργυρώ
Τιμητική αμοιβή από την Abbvie για την συγκεκριμένη παρουσίαση

Καρμίρης Κωνσταντίνος
Τιμητική αμοιβή από τις Abbvie, BMS, Genesis, Innovis, Johnson & Johnson, Pfizer για διαλέξεις σε Δορυφορικά Συμπόσια - Ημερίδες & από τις Abbvie, Amgen, BMS, Faran, Ferring, Galenica, Genesis, Johnson & Johnson, Pfizer, Takeda για συμμετοχή σε εκπαιδευτικά προγράμματα και Συμβουλευτικές Επιτροπές

Several drug option in treating inflammatory arthropathies

TNF inhibitor

Adalimumab
Certolizumab
Etanercept
Infliximab
Golimumab

IL17 inhibitor

Ixekixumab
Secukinumab
Bimekizumab

IL12/23 inhibitor

Ustekinumab

IL23 inhibitor

Risankizumab
Guselkumab

CTA4-Ig

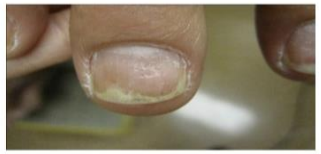
Abatacept

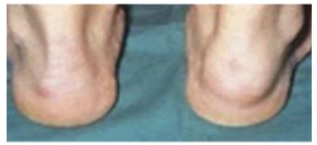
JAK inhibitor

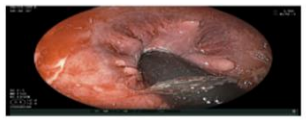
Tofacitinib
Baricitinib
Upadacitinib

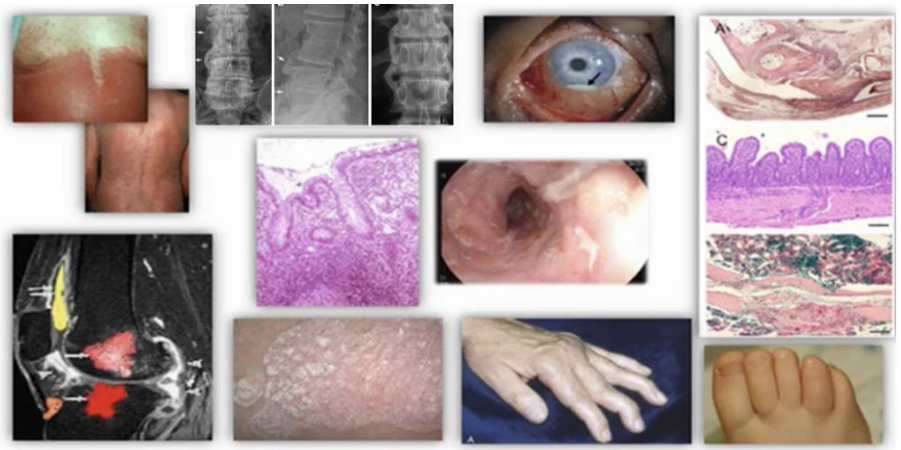
PDE4i

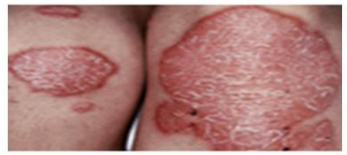
Apremilast

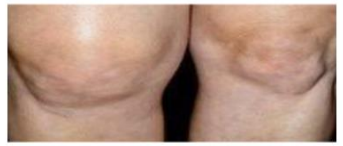












Speaker's opinion

Approvals shown here based on EMA.. https://ec.europa.eu/health/documents/community-register/html/

THE LANCET
FULL-TEXT ARTICLE

Rheumatoid arthritis: strategy more important than agent

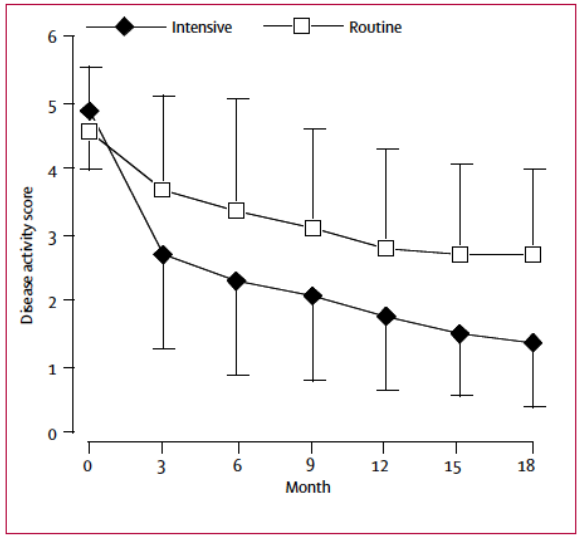
"… the most important information to be gathered from clinical trials in RA is not necessarily comparison of agents, but rather **the strategy of tight control**, aiming for remission."

1/ treatment target definition
2/ disease activity evaluation
3/ modification of therapeutic strategy

- Sokka 2009 Aug 8;374(9688):430-2.

T2T studies in Rheumatology

TICORA



Grigor C, et al. Lancet 2004; 364: 263–69

✓

TICOPA

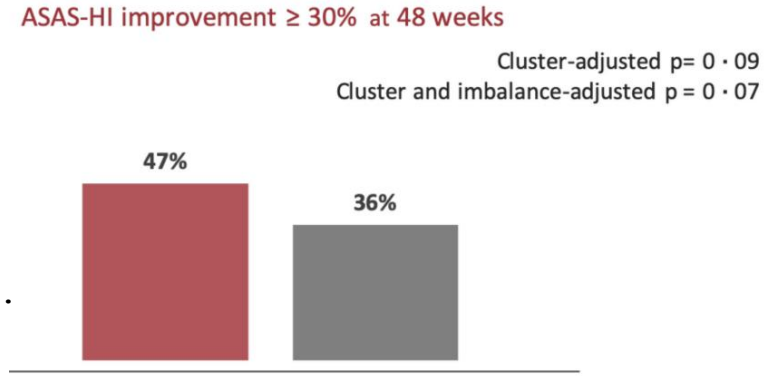
ACR20 at 48 weeks

Parameter	OR & 95% CI	p-value
Treatment arm: Tight control vs Standard care	1·91 (1·03, 3·55)	0·0392

Coates LC, et al. Lancet 2015 19;386:2489-98.

✓

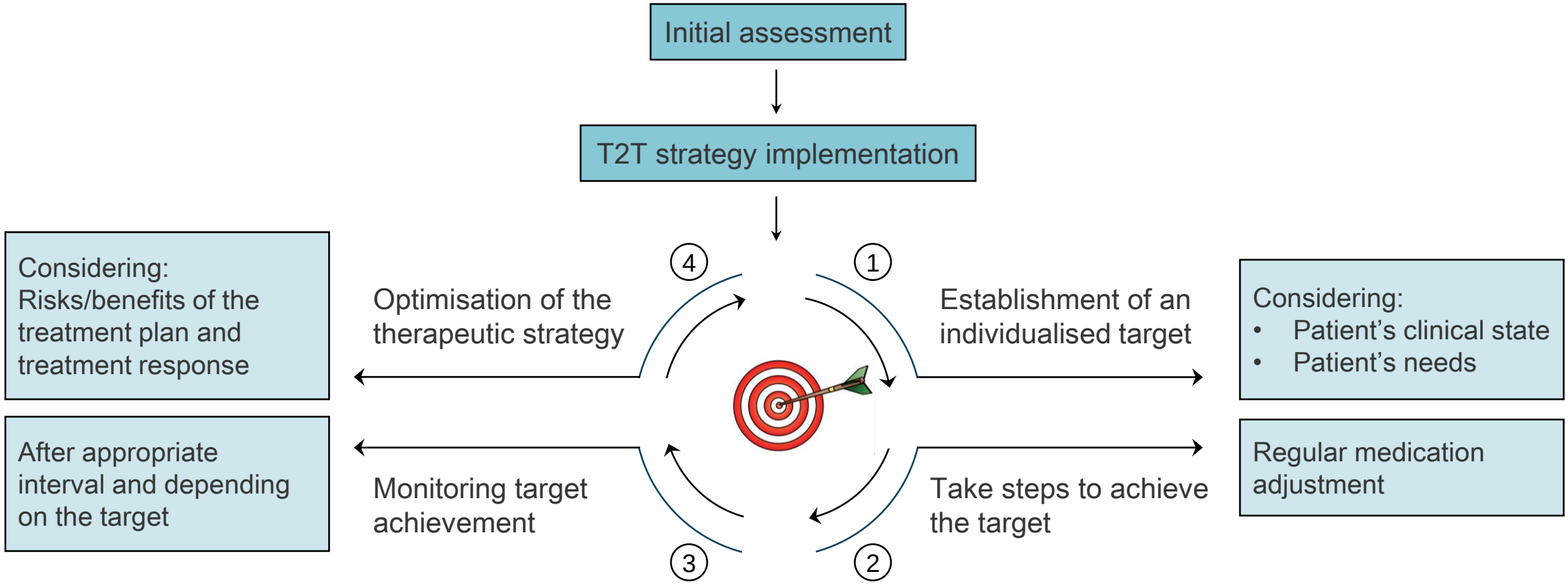
TICOSPA



Molto A, et al. Ann Rheum Dis 2021;80:1436–14

✗

Βασικές αρχές της στρατηγικής T2T



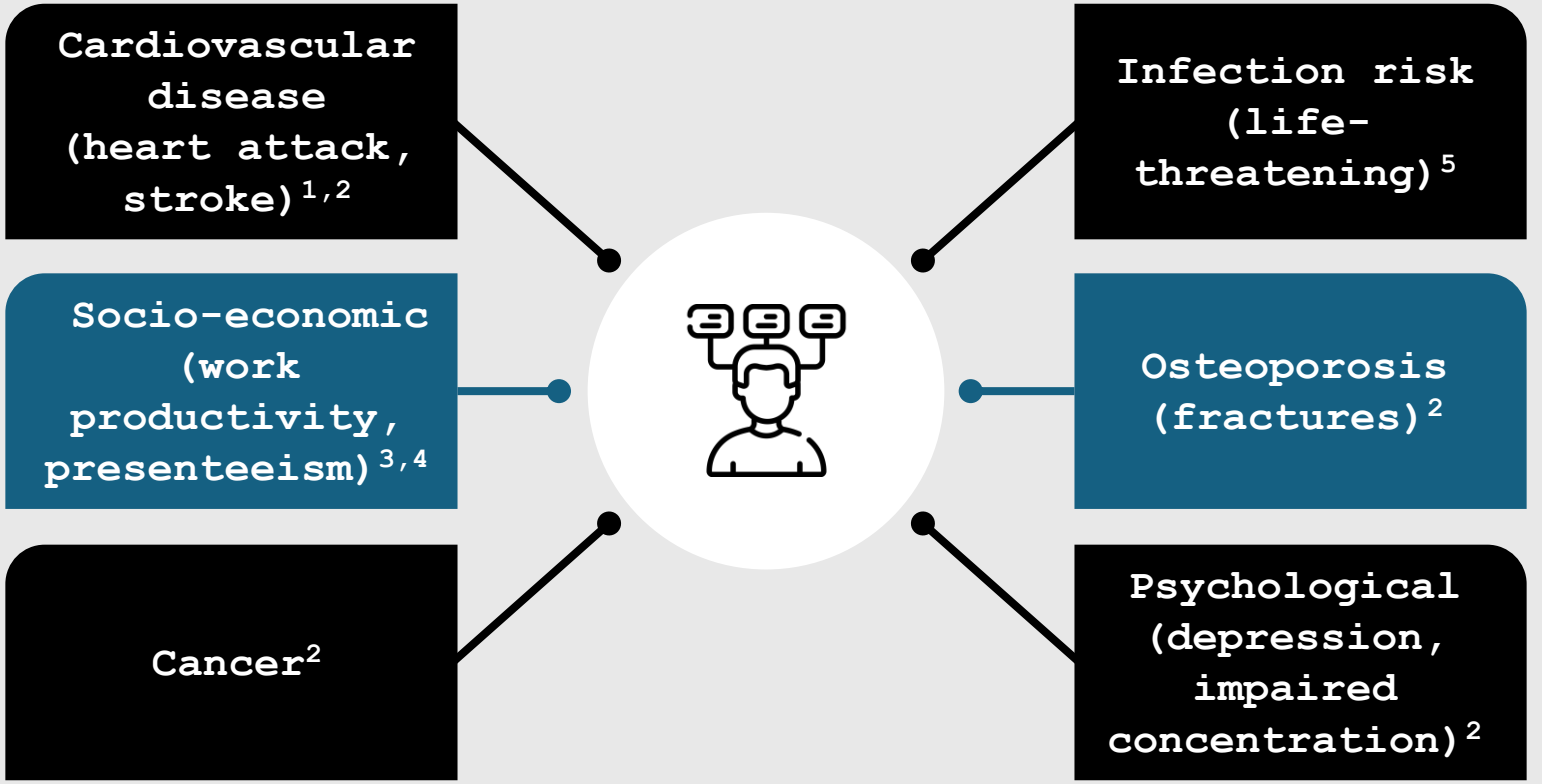
- T2T = treat-to-target.

Sánchez ARP, et al Nat Rev Rheumatol 2022;18

Τα οφέλη της ύφεσης

Remission can reduce CV risk[6]

Remission is associated with reduced absenteeism and less activity impairment[4] along with near normal QoL values[7]
Increased disease activity increases the risk of lymphoma[8]



Infection rates increase significantly in absence of sustained remission[11]

Increasing DAS28 category is associated with a higher incidence of major orthopedic surgery[10]

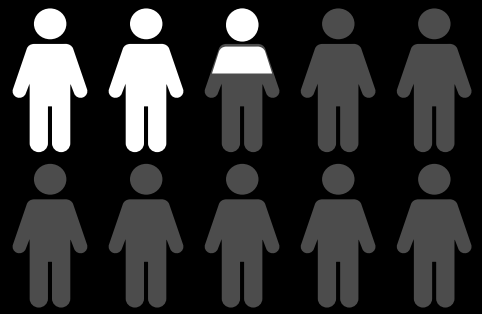
Remission is associated with reduced anxiety and depression[9]

CV, cardiovascular; DAS28, 28-joint Disease Activity Score; QoL, quality of life; RA, rheumatoid arthritis.

Adapted from: 1. McInnes IB. Ann Rheum Dis. 2015;74(4):694-702; 2. McInnes IB, et al. N Engl J Med. 2011;365(23):2205-19; 3. Sokka T, et al. Arthritis Res Ther. 2010;12(2):R42; 4. Kim D, et al. J Rheum. 2017;44(8):1112-7; 5. Listing J, et al. Rheumatology (Oxford). 2013;52(1):53-61; 6. Solomon DH, et al. Arthritis Rheum. 2015;67(6):1449-55; 7. Linde L, et al. J Rheumatol. 2010;37(2):285-90; 8. Baecklund E, et al. Arthritis Rheum. 2006;54(3):692-701; 9. Kekow J, et al. Rheumatology (Oxford). 2011;50(2):401-9; 10. Nikiphorou E, et al. Ann Rheum Dis. 2016;75(12):2080-6; 11. Accortt NA, et al. Arthritis Care Res (Hoboken). 2018;70(5):679-84.

Πόσοι ασθενείς επιτυγχάνουν ύφεση νόσου;

RA Patients



24%

of patients with RA achieve **remission (DAS28 <2.6)** after 24 months[4,#]

PsA Patients

22.9%

of PsA patients fulfill **MDA** in daily clinical practice[2,†]

30%

of PsA patients achieve **sustained remission** (DAPSA score ≤4)[3,‡]

axSpA Patients

10-15%

of patients with axSpA receiving TNFi ± csDMARD had **inactive disease (ASDAS ID)** after 12 months[1,*]

[#]Systematic review and meta-analysis of real-world studies: 31 studies, 82,450 patients with RA.

[†]Cross-sectional study of 141 PsA patients.

[‡]Longitudinal cohort of PsA patients receiving csDMARDs (n=22) or biologic DMARDs (n=58) in clinical practice. Sustained remission was defined when patients achieved a DAPSA score ≤4 for at least 12 months.

[*]Prospective cohort of patients with axSpA starting treatment with a TNFi (N=1,914) (Swiss Clinical Quality Management).

ASDAS, Ankylosing Spondylitis Disease Activity Score; axSpA, axial spondyloarthritis; cs, conventional synthetic; DAPSA, Disease Activity in Psoriatic Arthritis; DMARD, disease-modifying anti-rheumatic drug; ID, inactive disease; MDA, minimal disease activity; PsA, psoriatic arthritis; RA, rheumatoid arthritis; SpA, spondyloarthritis; TNFi, tumour necrosis factor inhibitor.

Adapted from: 1. Nissen MJ, et al. Arthritis Rheumatol. 2016;68(9):2141-50; 2. Michelsen B, et al. J Rheumatol. 2017;44(4):431-6; 3. Lubrano E, et al. Rheumatol Ther. 2019;6(4):521-8. 4. Yu C, et al. Clin Rheumatol. 2019;38(3):727-38.

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MEDITERRANEAN JOURNAL OF RHEUMATOLOGY
SPECIAL ISSUE ON AXIAL SPONDYLOARTHRITIS

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March 2022 | Volume 33 | Issue 1
SUPPLEMENT

Treat-to-Target in Axial Spondyloarthritis: Are we there yet?

Krystel Aouad[1], Bassel El-Zorkany[2]

[1]Sorbonne University, INSERM, Institut Pierre Louis d'Épidémiologie et de Santé Publique, Paris, France, [2]Rheumatology Department, Cairo University, Cairo, Egypt

THE OPTIMAL TREATMENT TARGETS

Treat-to-target strategy relies primarily on defining the specific target. Identifying the ideal treatment target in axSpA is a crucial step that may be challenging because of disease heterogeneity that includes axial and peripheral symptoms as well as extra-musculoskeletal manifestations (EMM). The target in chronic inflammatory diseases, particularly in axSpA and PsA, is to achieve remission/inactive disease.[6] Clinical remission is defined as the absence of clinical and laboratory evidence of significant disease activity: of both musculoskeletal involvement (arthritis, dactylitis, enthesitis, axial disease) and EMM.[6] Once remission is achieved, this state should be sustained over time. It is usually recommended to monitor disease activity at least 6 monthly[9] or even closer (e.g., every 1-3 months) in patients with high disease activity.[6]

CHALLENGES OF T2T STRATEGY

Although the T2T concept seems very promising in axSpA, many challenges remain and are open to debate. First, concerning disease activity scores, the use of ASDAS alone to define remission is not universally accepted in such a heterogeneous disease. The ideal target for disease activity would be a composite index that includes the different clinical manifestations, objective measures of systemic inflammation, PROs for quality of life and physical function as well as structural progression scores.[25] Yet, there is no composite score today that incorporates all these domains. In clinical practice, rheumatologists take into account other aspects of the disease to define a patient in remission.[26,27] Both NSAIDs use and EMM (eg., inflammatory bowel disease (IBD), psoriasis and uveitis) not included in ASDAS, ASAS-PR and BASDAI, are important elements

Aouad K, El-Zorkany B. Treat-to-Target in Axial Spondyloarthritis: Are we there yet? Mediterr J Rheumatol 2022;33(Suppl 1):137-41

Difficult-to-Manage Axial Spondyloarthritis

Evgenia Emmanouilidou[1], Irini D. Flouri[1], Antonios Bertsias[1], Eleni Kalogiannaki[1], George Bertsias[1,2], Prodromos Sidiropoulos[1,2]

[1]Rheumatology and Clinical Immunology, University Hospital of Heraklion and University of Crete Medical School, Heraklion, Greece, [2]Institute of Molecular Biology and Biotechnology, Foundation for Research and Technology, Heraklion, Greece

Mediterr J Rheumatol 2024 Dec 31;35(Suppl3):542-548.

Table 1. Characteristics of relevant studies found.

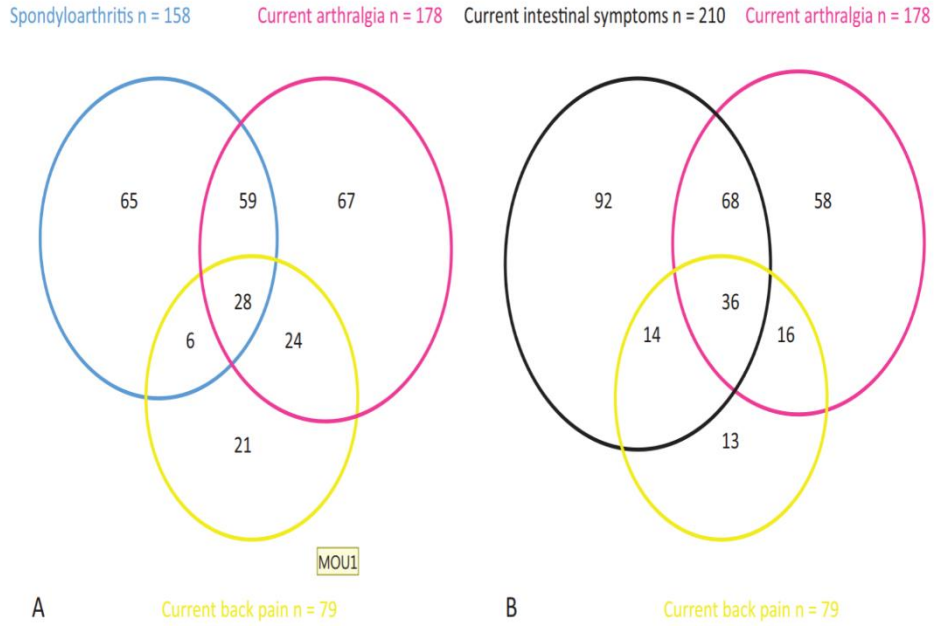
Author (year)	Study design	Definition of D2T/M SpA	Population	Prevalence of D2T/M SpA	Characteristics of D2T/M SpA group
Di Giuseppe D, et al. (2022)[14]	Multicentric cohort study (5 Scandinavian registries)	Treatment with ≥ 3, ≥ 4, ≥ 5 b/tsDMARDs within 3 years' follow up	6056 axSpA patients starting 1st b/tsDMARD	Treatment with ≥ 3, ≥ 4, and ≥ 5 b/tsDMARDs was 8%, 3% and 1%, respectively	• Female gender • Short disease duration • High patient global score • Comorbidities (unspecified) • Psoriasis • No uveitis
Dua D, et al. (2022)[21]	Retrospective cohort study	Failure of ≥ 3 b/tsDMARDs and/or ≥2 b/tsDMARDs with different MOA	166 axSpA patients under b/tsDMARD treatment	27% D2T axSpA	• HLA-B27 positivity • Early usage of b/tsDMARD • High BASDAI • Concomitant chronic widespread pain
Philippoteaux C, et al. (2023)[12]	Multicentric cohort study (3 French centres)	**D2T axSpA:** Failure of ≥ 2 b/tsDMARDs with different MOA **Very D2T axSpA:** Failure of ≥ 2 b/tsDMARDs in less than 2 years of follow-up	311 axSpA patients under b/tsDMARD treatment	28.3% D2T axSpA 3.8% very D2T axSpA	**D2T axSpA group** • Peripheral involvement • High BASDAI at baseline • Uveitis at baseline • Fibromyalgia **Very D2T axSpA group** • High CRP level at baseline • IBD and uveitis at baseline • No fibromyalgia
Fakih O, et al. (2023)[11]	Nationwide (France) cohort study	Failure of ≥3 b/tsDMARDs and/or ≥2 b/tsDMARDs with MOA	10798 axSpA patients under bDMARD treatment None received tsDMARD	19.59% D2T axSpA	• Female gender • Peripheral involvement • Psoriasis • Hypertension • Depression • Severe smoking • Severe obesity
Saygın Oğüt T, et al. (2024)[13]	Cross-sectional study	Failure of ≥3 b/tsDMARDs and/or ≥2 b/tsDMARDs with MOA	166 axSpA patients under b/tsDMARD treatment	22.9% D2T axSpA	• Fibromyalgia • High activity indices • High acute phase response indicators • Worse quality of life
Vassilakis KD, et al. (2024)[15]	Nationwide (Greek) cohort study	At least 6 months' disease duration and failure of ≥1 cDMARD and ≥2 b/tsDMARDs with different MOA and either at least MODA defined as DAPSA >14 and/or not at MDA	467 PsA patients	16.5% D2T PsA	• Extensive psoriasis • High BMI • Female gender • Axial disease • History of IBD

The Impact of Spondyloarthritis and Joint Symptoms on Health-Related Quality of Life and Fatigue in IBD Patients. Results From a Population-Based Inception Cohort (20-Year Follow-up in the Ibsen Study)

Alvilde Maria Ossum, MD,[,†,●] Øyvind Palm, MD, PhD,[‡] Milada Cvancarova, PhD,[§] Tomm Bernklev, PhD,[†,¶] Jørgen Jahnsen, MD, PhD,[†,‖] Bjørn Moum, MD, PhD,[*,†], and Marte Lie Høivik, MD, PhD[*]; for the IBSEN Study Group*

TABLE 3. The Variables Spondyloarthritis, Current Arthralgia, Current Back Pain, and Current Intestinal Symptoms in the Multiple Linear Regression Models for the 8 Domains of the SF-36, the N-IBDQ Total Score, and the FQ Total Score

	Spondyloartritis	Current Arthralgia	Current Back Pain	Current Intestinal Symptoms
Physical Function		–4.1 (–7.4 to –0.9)[c]	**–14.2 (–18.3 to –10.1)[a]**	**–4.5 (–7.6 to –1.3)[b]**
Role Physical		**–15.0 (–22.0 to –8.1)[a]**	**–18.7 (–27.3 to –10.0)[a]**	**–14.1 (–20.8 to –7.4)[a]**
Bodily Pain	–5.0 (–9.0 to –1.0)[c]	**–16.0 (–20.1 to –11.9)[a]**	**–20.2 (–25.3 to –15.1)[a]**	**–11.8 (–15.7 to –7.9)[a]**
General Health		**–11.3 (–15.7 to –6.9)[a]**	–5.7 (–11.1 to –0.2)[c]	**–7.1 (–11.3 to –2.8)[b]**
Vitality		**–9.3 (–13.4 to –5.3)[a]**	**–7.9 (–13.0 to –2.8)[b]**	**–9.4 (–13.3 to –5.4)[a]**
Social Functioning		**–9.1 (–13.7 to –4.4)[a]**	**–8.2 (–14.1 to –2.4)[b]**	**–8.1 (–12.6 to –3.6)[a]**
Role Emotional		**–11.9 (–18.9 to –4.9)[b]**	–9.6 (–18.4 to –0.8)[c]	
Mental Health		–3.5 (–6.8 to –0.2)[c]	–4.5 (–8.6 to –0.3)[c]	
N-IBDQ total score		**–7.1 (–11.8 to –2.5)[b]**	**–9.3 (–15.0 to –3.5)[b]**	**–21.0 (–25.6 to –16.5)[a]**
Fatigue Questionnaire total score		**2.7 (1.7 to 3.7)[a]**	**1.9 (0.7 to 3.2)[b]**	**1.8 (0.8 to 2.7)[a]**



Ossum et al, Inflamm Bowel Dis. 2020 Jan 1;26(1):114-124

Complex management requires close collaboration of rheumatologists and gastroenterologists

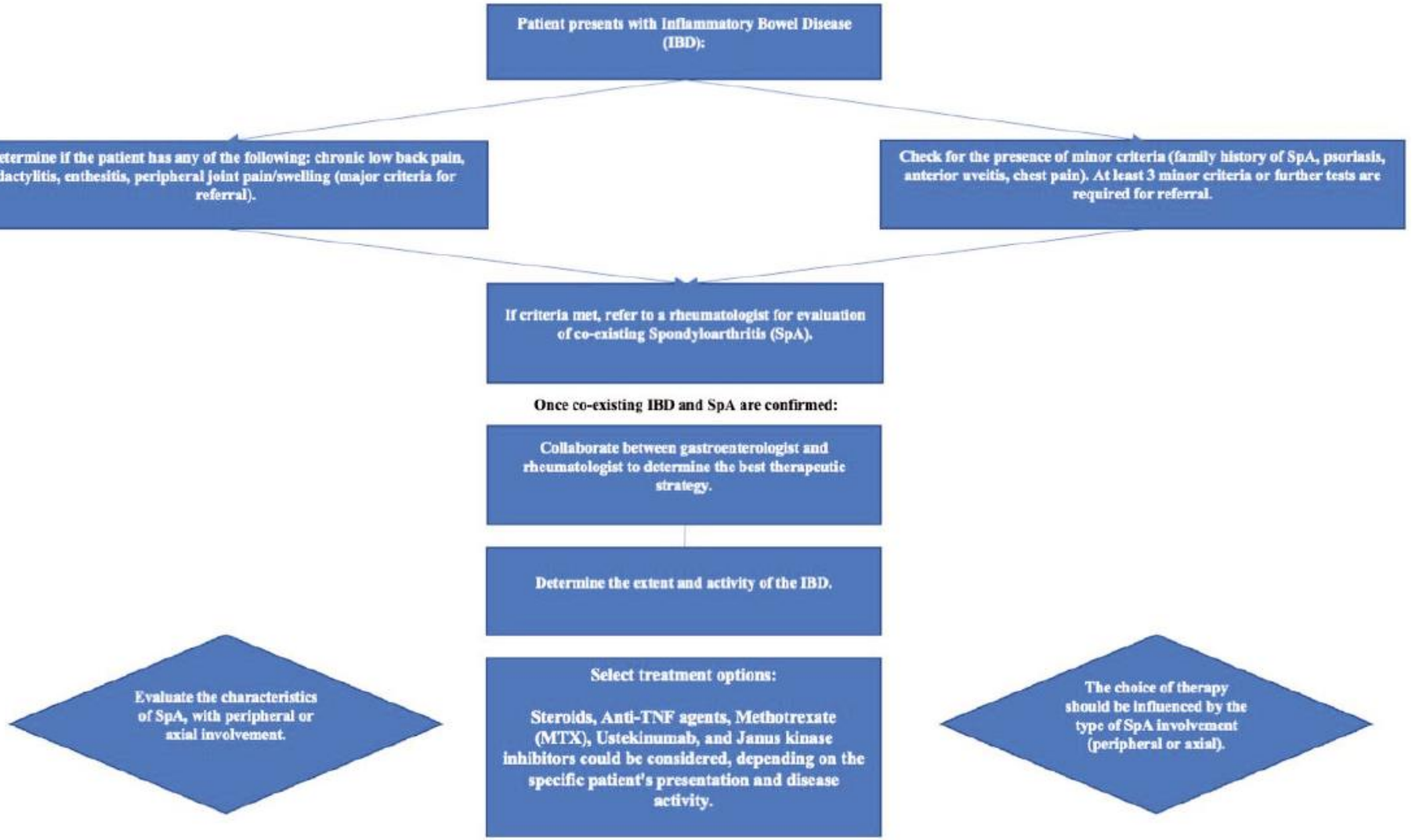


Figure 3. Flowchart referral to rheumatologists.

The holistic management of peripheral spondyloarthritis: focus on articular involvement in patients with inflammatory bowel disease. (2024). *Reumatismo*, *77*(1). https://doi.org/10.4081/reumatismo.2024.1688

Several drug option in treating inflammatory arthropathies

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Etanercept
Infliximab
Golimumab

IL17 inhibitor

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Bimekizumab

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JAK inhibitor

Tofacitinib
Baricitinib
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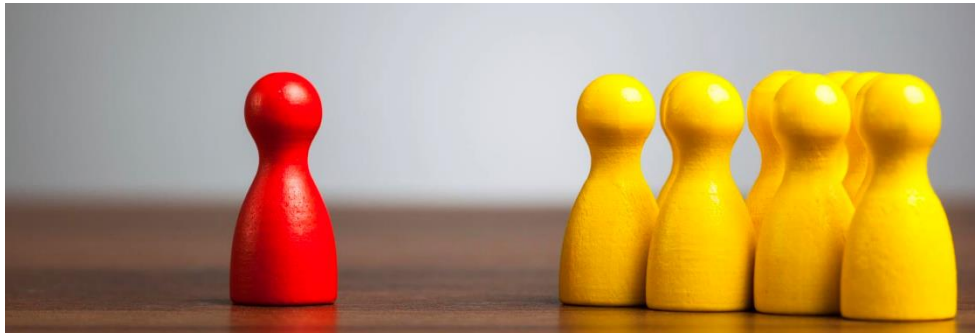
PDE4i

Apremilast

?



?

Speaker's opinion

Approvals shown here based on EMA.. https://ec.europa.eu/health/documents/community-register/html/

Πως διαχειρίζομαι έναν ασθενή με ρευματοειδή αρθρίτιδα σήμερα;

Στόχος της θεραπείας η ύφεση/ΧΕΝ σε όλους τους ασθενείς[1]

Η ύφεση είναι ένας επιτεύξιμος στόχος στην ΡΑ[1,4]

Βελτιώσεις στον πόνο και την κόπωση[2,3]

Θεραπείες που να ικανοποιούν τις προτιμήσεις και τις ανάγκες των ασθενών[5]

Θεραπείες που να είναι καλά ανεκτές[5]

ΧΕΝ: χαμηλή ενεργότητα νόσου, ΡΑ:ρευματοειδής αρθρίτιδα

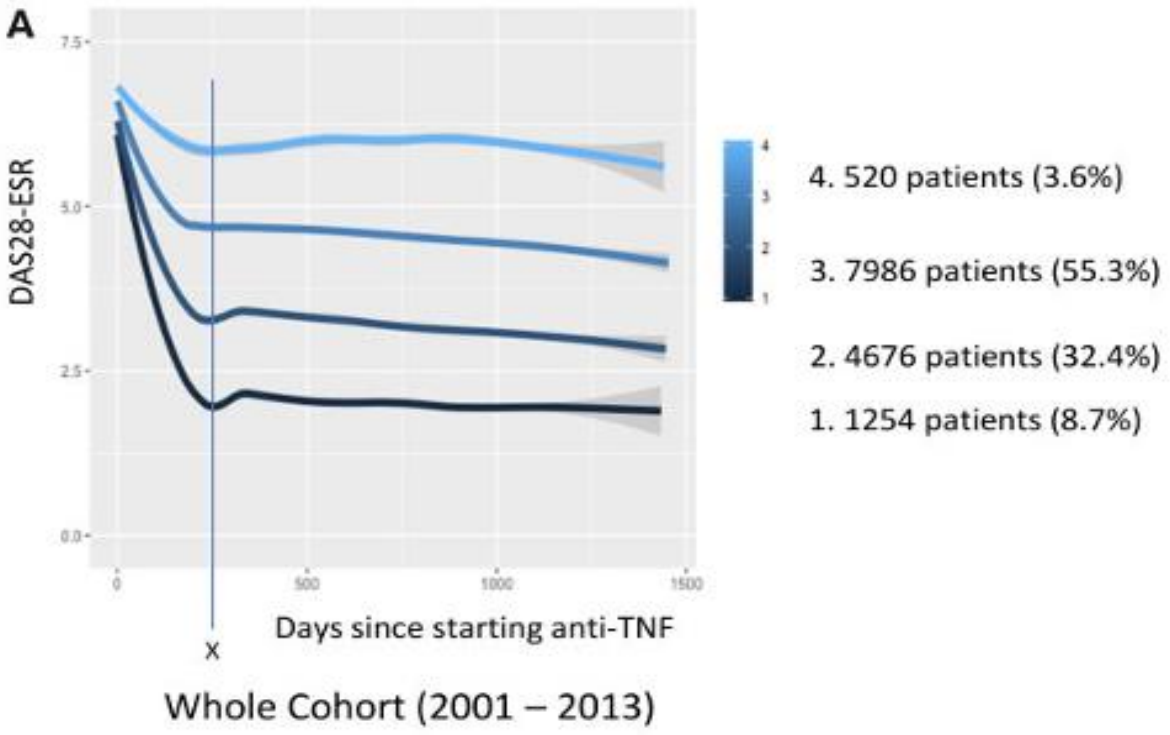
1. Smolen JS et al. Ann Rheum Dis 2020;79:685–699; 2. Druce KL et al. Rheumatology 2019;58:v29–v34; 3. Olofsson T et al. Arthritis Care Res 2018;70:1712–1716; 4. Silvagni E et al. BMJ Open 2018;8(9):e021447; 5. Meier FMP and McInnes I. Best Pract Res Clin Rheumatol 2014;28:605e624.

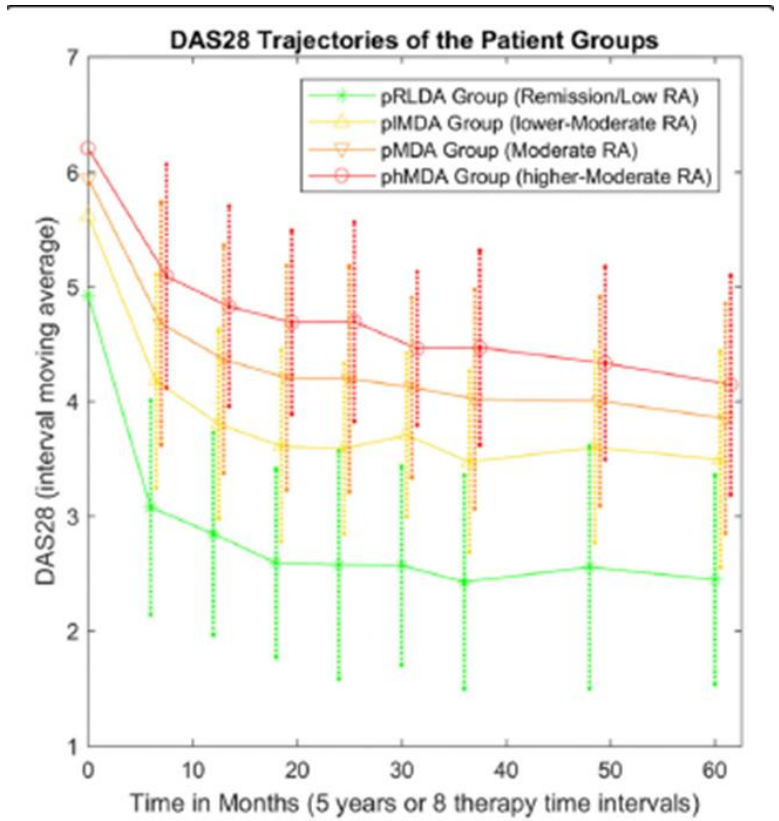
ΠΑΙΖΕΙ ΡΟΛΟ Ο ΧΡΟΝΟΣ?

Speaker’s opinion

British Society for Rheumatology
Rheumatoid Arthritis Register

Η έγκαιρη και με κατάλληλη θεραπευτική παρέμβαση με στόχο, φαίνεται να σχετίζεται με καλύτερα μακροχρόνια αποτελέσματα





Different trajectories of response identified at **6 months** are indicative of future outcomes, with maximal therapeutic benefit identified 250 days after starting anti-TNF

DAS: Disease activity score ESR: Erythrocyte Sedimentation Rate pRLDA, patients with persistent remission or low disease activity; pMDA, patients with persistent moderate disease activity; plMDA, patients with persistent lower-moderate disease activity; phMDA, patients with persistent higher-moderate disease activity, RA: rheumatoid arthritis

Hamman et al Rheumatology (Oxford). 2020 Jul 1;59(7):1709-1714
Genitsaridi et al. Arthritis Research & Therapy (2020) 22:226

ΟΣΟ ΠΙΟ ΓΡΗΓΟΡΑ ΦΤΑΣΩ ΣΤΗΝ ΥΦΕΣΗ ΤΟΣΟ ΤΟ ΚΑΛΥΤΕΡΟ!!!

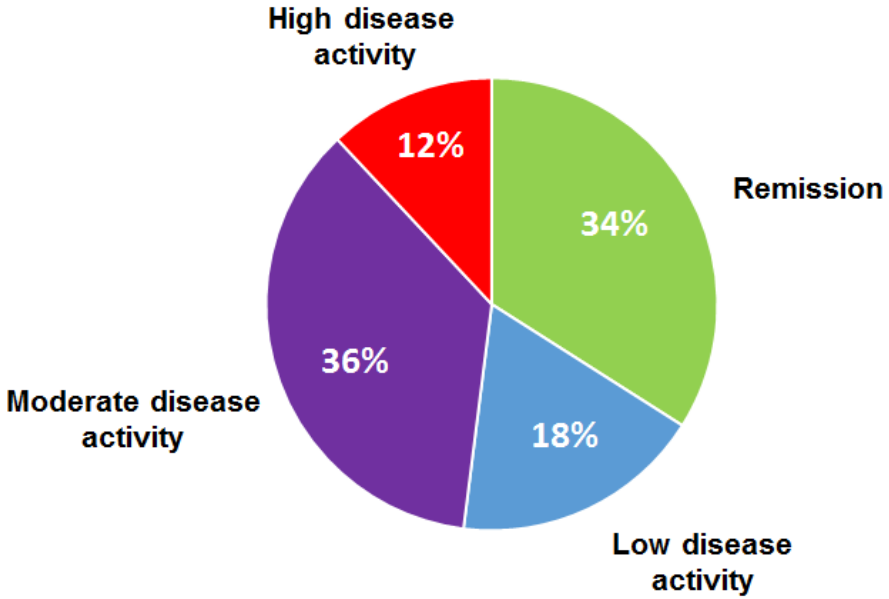
- Η έγκαιρη και συστηματική παρέμβαση θα καθορίσει/ προβλέψει την πορεία του ασθενή μας

ΤΩΡΑ, ΑΛΛΑ ΚΑΙ ΣΤΟ ΜΕΛΛΟΝ

Speaker's opinion

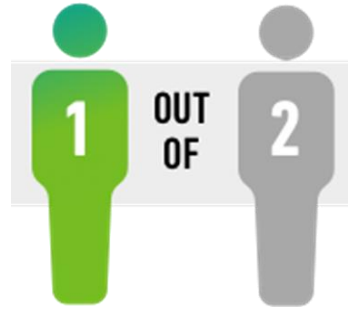
Ποιο ποσοστό των ασθενών μας πετυχαίνει τελικά ΥΦΕΣΗ?

Disease activity at the First evaluation of the whole RA cohort



ΜΟΝΟ 1 ΣΤΟΥΣ 3 ΗΤΑΝ ΣΕ ΥΦΕΣΗ!!! 34%

Rheums are planning to switch to a different therapy only in



SENSE

uncontrolled RA patients

Patients with sub optimally controlled RA in Greece have low treatment satisfaction and poor self-reported outcomes, albeit high self-reported treatment adherence. Similarly to the global SENSE study results, the need for patient-centric treatment approaches in order to improve disease outcomes is emphasized.

Thomas et al.,Ther Adv Musculoskel Dis 2020, Vol. 12: 1–12
Thomas K., et al. Mediterr J Rheumatol 2018; 29(1): 27-37

Mediterr J Rheumatol 2022;33(1):14-34 https://doi.org/10.31138/mjr.33.1.14

ΕΙΜΑΣΤΕ ΕΥΧΑΡΙΣΤΗΜΕΝΟΙ ???

Speaker’s opinion

ΤΕΛΙΚΑ ΣΤΟΧΕΥΟΥΜΕ ΤΗΝ ΥΦΕΣΗ?

Speaker’s opinion

ΜΗΠΩΣ "ΧΑΝΟΥΜΕ" ΑΥΤΟΥΣ ΠΟΥ ΕΧΟΥΝ ΜΕΤΡΙΑ ΕΝΕΡΓΟΤΗΤΑ???

Speaker’s opinion

Γιατί τους χάνουμε άραγε??

- Υπάρχει τρόπος να το αποφύγουμε?
- Μετράμε DAS28??
- Συχνή επαφή με τον ασθενή? Οικονομική εξάρτηση επηρεάζει τη δουλειά μας?
- Εγρήγορση δική μας
- Εκπαίδευση του ασθενή

Image-Courtesy of Dr. Venetsani

DAS: Disease activity score

Speaker's opinion

PA 2024 ♀

ΚΑΤΕΡΙΝΑ

47 ετών

Καπνίστρια

DAS-28 5,13

ΚΑΘΙΣΤΙΚΗ ΖΩΗ

Height	162 cm	Λογίστρια
Weight	78 Kg	Μητέρα 2 τέκνων (2 και 5 ετών)
Δεν Γυμνάζεται		Μητέρα και Γιαγιά με PA

Ιστορικό ασθενούς

- Αρθρίτιδα άκρων χεριών άμφω με προσβολή καρπών άμφω, ΜΚΦ και ΦΦ άμφω, γονάτων άμφω, και άκρων ποδιών άμφω
- Κόπωση, πρωινή δυσκαμψία 1 ώρα
- Κακή ψυχολογία
- Θα ήθελε να αισθάνεται όσο το δυνατόν ελεύθερη από την θεραπεία
- Δεν λαμβάνει Φάρμακα

Κλινικά Χαρακτηριστικά

CRP (mg/dL)	5 (<5)
Anti-CCP	ΑΡΝΗΤΙΚΟ
ΤΚΕ	45 mmHg
RF	ΘΕΤΙΚΟ

Speaker’s opinion

PA 2024 ♀

ΚΑΤΕΡΙΝΑ

47 ετών

Καπνίστρια

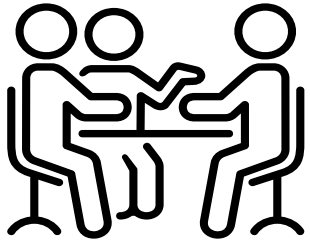
ΚΟΠΩΣΗ, ΑΔΥΝΑΜΙΑ, ΚΑΚΗ ΨΥΧΟΛΟΓΙΑ!!

ΘΕΛΕΙ ΝΑ ΕΠΙΣΤΡΕΨΕΙ …ΓΡΗΓΟΡΑ..ΣΤΗ ΖΩΗ ΤΗΣ!

ΘΕΡΑΠΕΥΤΙΚΗ ΑΓΩΓΗ

- Σύσταση για διακοπή καπνίσματος
- Διατροφή
- Γυμναστική
- Φαρμακευτική Αγωγή
- Συζήτηση για πιθανή επαφή με ψυχολόγο!

Speaker’s opinion



ΣΥΝΤΑΓΟΓΡΑΦΟΥΜΕ ΓΥΜΝΑΣΤΙΚΗ?

Speaker’s opinion

Πορεία νόσου

Διάγνωση Ρευματοειδούς αρθρίτιδας

Έναρξη MTX

1 μήνα

Γυμναστική

2 μήνες

Κλινική βελτίωση

3 μήνες

Με τι προχωράω ;

<u>Έναρξη θεραπείας</u>
Πρεδνιζολόνη 10mg
Φυλλικό οξύ 5mg
Per os MTX 15mg

<u>Τροποποίηση θεραπείας</u>
Πρεδνιζολόνη 5mg
Φυλλικό οξύ 5mg
MTX 20mg
Pilates 2/week
Τηλεφωνική επικοινωνία

Τ**ΡΙΧΟΠΤΩΣΗ**

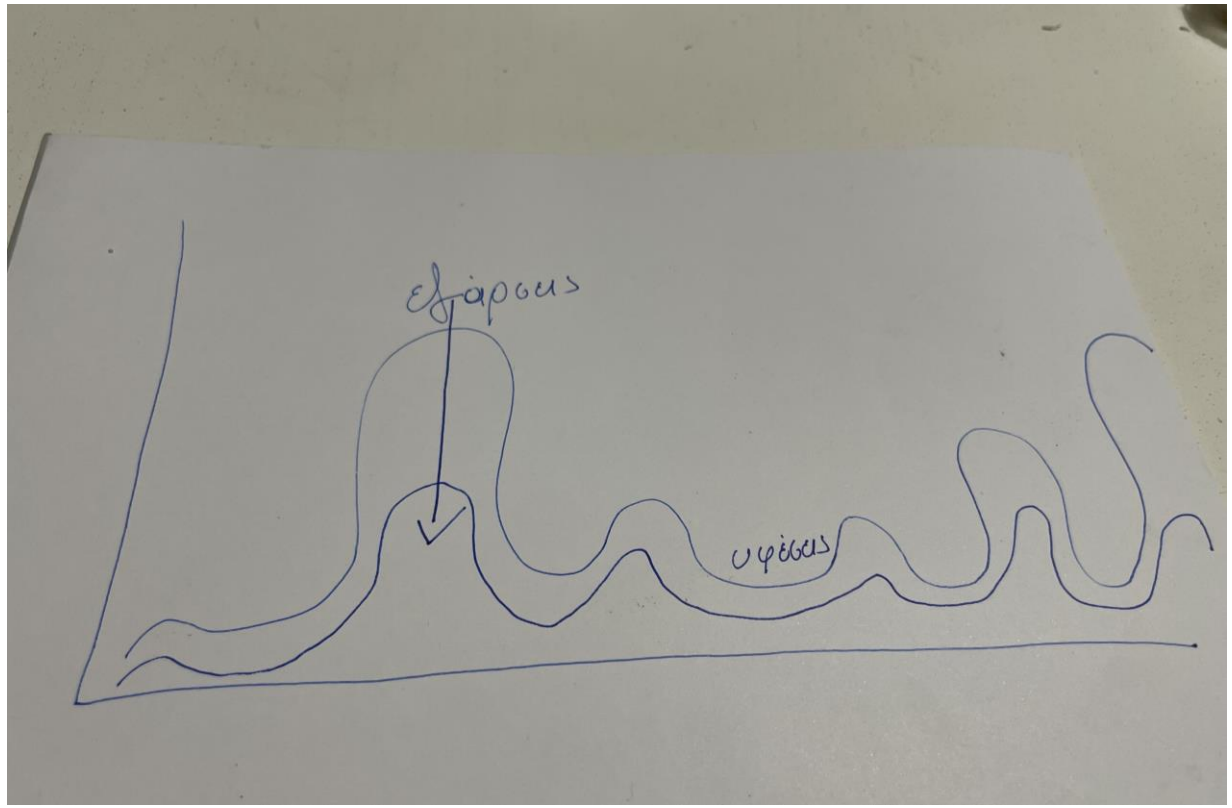
ΓΕΣ Διαταραχές

ΔΙΑΚΟΠΗ ΚΑΠΝΙΣΜΑΤΟΣ

Speaker’s opinion

Πορεία νόσου

Είμαστε ευχαριστημένοι?



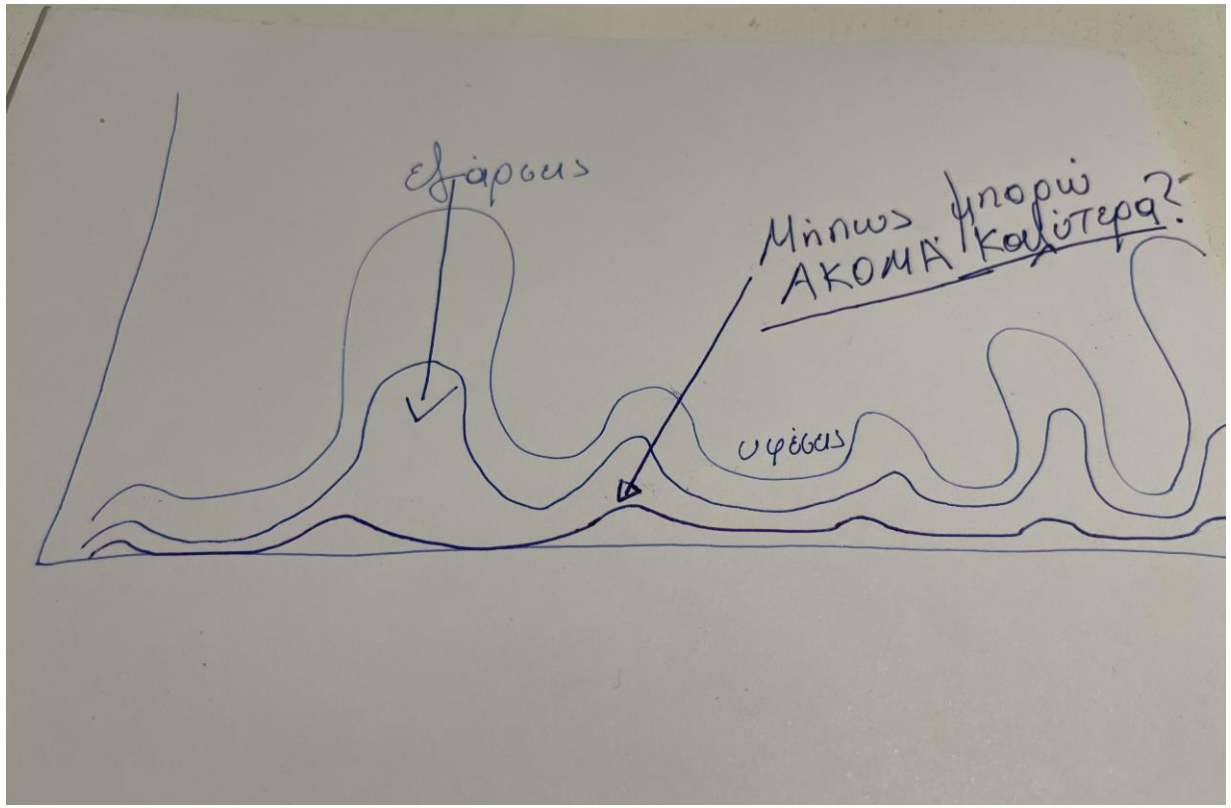
ΚΛΙΝΙΚΗ ΒΕΛΤΙΩΣΗ ΜΕ ΤΗΝ ΜΕΘΟΤΡΕΞΑΤΗ ΣΤΟΥΣ 3 ΜΗΝΕΣ

Speaker's opinion

Πορεία ασθενούς

Μήπως μπορώ και ακόμα καλύτερα ;

Τριχόπτωση και ΓΕΣ διαταραχές



Γενικά η ασθενής όμως είναι ευχαριστημένη σε σχέση με το πως ήταν

Speaker's opinion

Achieving clinical remission improves outcomes and reduces patient burden beyond symptoms and signs of the disease

Remission can reduce cardiovascular risk[5]

Cardiovascular disease[1,2]

Gastrointestinal conditions[1,2]

Increased disease activity increases the risk of lymphoma[6]

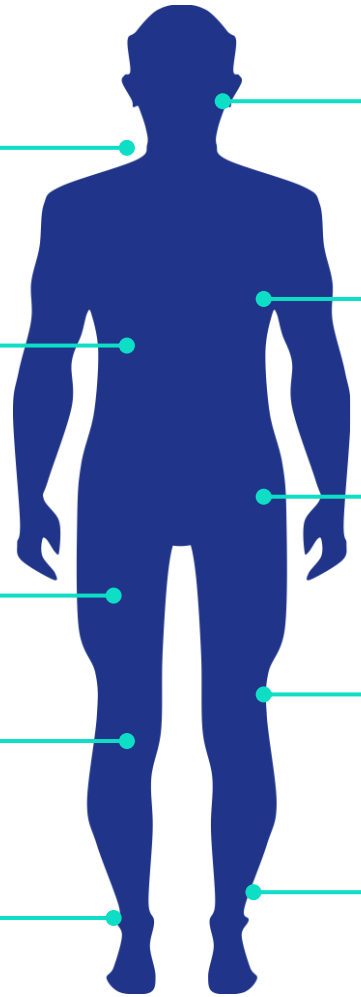
Malignancy[1,2]

Infection rates increase significantly in absence of sustained remission[7]

Infections[1,2]

Increasing DAS28 associated with a higher incidence of major orthopedic surgery[8]

Osteoporosis[1,2]



Depression[1,2]

Reduced anxiety & depression[9]

Respiratory disease[1,2]

Hepatic/renal disease[1,2]

Fibromyalgia and other musculoskeletal disease[1,2]

Socio-economic (work productivity presenteeism)[3,4]

Reduced absenteeism & less activity impairment[4] along with near normal QoL values[10]

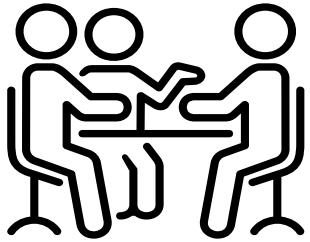
DAS28, Disease Activity Score based on 28 joints; QoL, quality of life.

Adapted from:
1. McInnes IB, et al. Ann Rheum Dis. 2015;74:694-702; 2. McInnes IB, et al. N Engl J Med. 2011;365:2205-19; 3. Sokka T, et al. Arthritis Res Ther. 2010;12:R42; 4. Kim D, et al. J Rheum. 2017;44:1112-7; 5. Solomon DH, et al. Arthritis Rheum. 2015;67:1449-55; 6. Baecklund, E, et al. Arthritis Rheum. 2006;54:692-701; 7. Accortt NA, et al. Arthritis Care Res. 2018;70:679-84; 8. Nikiphorou E, et al. Ann Rheum Dis. 2016;75:2080-6; 9. Kekow J, et al. Rheumatology (Oxford) 2011;50:401-9; 10. Linde L, et al. J Rheum. 2010;37:285-90.

“Treat the patient, not the disease”

Many comorbidities are overlooked in treatment choice.

Speaker’s opinion



ΜΗΠΩΣ ΕΜΕΙΣ ΠΡΕΠΕΙ ΝΑ ΑΝΕΒΑΣΟΥΜΕ ΤΟΝ ΠΗΧΗ ΤΩΝ ΠΡΟΣΔΟΚΙΩΝ?

Speaker’s opinion

ΕΠΟΜΕΝΟ ΒΗΜΑ ΤΟ 2025?

ΕΣΕΙΣ ΤΙ ΘΑ ΚΑΝΑΤΕ ?

- 1. Δεν αλλάζω τίποτα !
- 2. Μειώνω την Μεθοτρεξάτη και περιμένω?
- 3. Προσθέτω σε μικρότερη δόση MTX, βιολογικό παράγοντα ή κάποια στοχευμένη θεραπεία?
- 4 . Αλλαγή σε άλλο cDMARD π.χ Λεφλουνομίδη?
- 5 . Προσθήκη Υδροξυχλορωκίνης σε MTX?

Speaker’s opinion

Πορεία νόσου

Διάγνωση Ρευματοειδούς αρθρίτιδας

Έναρξη MTX

1 μήνα

Γυμναστική

2 μήνες

Κλινική βελτίωση

3 μήνες

Με τι προχωράω ;

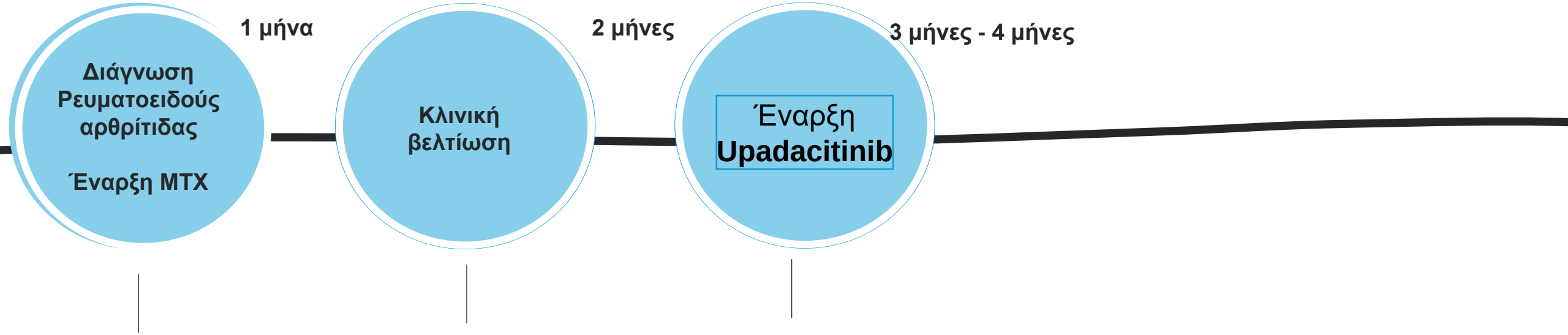
Έναρξη θεραπείας
Πρεδνιζολόνη 10mg
Φυλλικό οξύ 5mg
Per os MTX 15m

Τροποποίηση θεραπείας
Πρεδνιζολόνη 5mg
Φυλλικό οξύ 5mg
MTX 20mg
Pilates 2/week
Τηλεφωνική επικοινωνία

Τ**ΡΙΧΟΠΤΩΣΗ**
ΓΕΣ Διαταραχές
ΔΙΑΚΟΠΗ ΚΑΠΝΙΣΜΑΤΟΣ
Αναγκαστική μείωση δόσης
MTX 15 mg

Speaker's opinion

Πορεία ασθενούς



<u>Έναρξη θεραπείας</u>
Πρεδνιζολόνη 10mg
Φυλλικό οξύ 5mg
Per os MTX 15mg

<u>Τροποποίηση θεραπείας</u>
Πρεδνιζολόνη 5mg
Φυλλικό οξύ 5mg
MTX 20mg

<u>Έναρξη στοχευμένης θεραπείας</u>
Upadacitinib 15mg
Φυλλικό οξύ 5mg
MTX 15mg p.os

Speaker's opinion

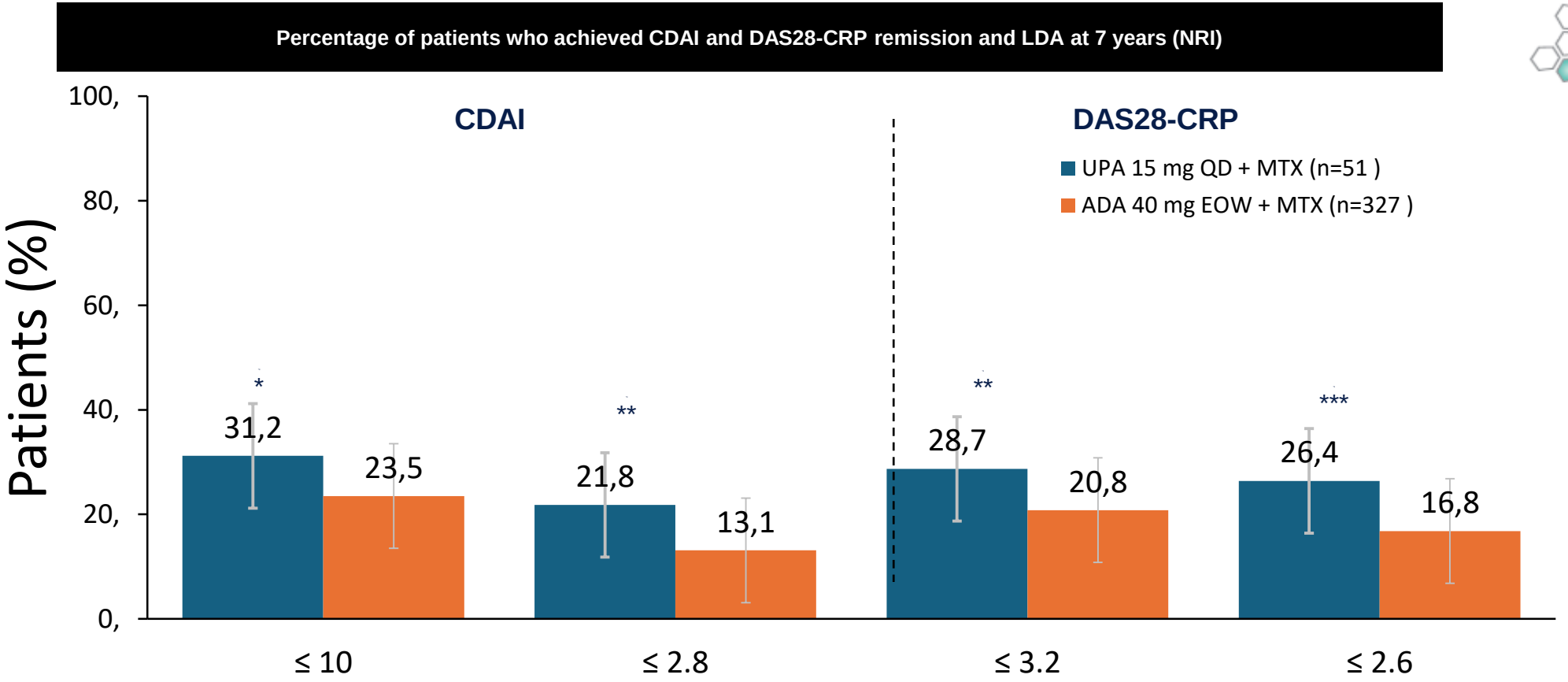
Τι σκεφτόμαστε όταν επιλέγουμε έναν βιολογικό παράγοντα - tsDMARDs;

- Αποτελεσματικότητα
  - **ΕΠΙΤΕΥΞΗ ΥΦΕΣΗΣ !**
- Ασφάλεια
- Παραμονή στη θεραπεία/Επιβίωση του φαρμάκου
- Αναστολή της εξέλιξης της νόσου

tsDMARDs: targeted synthetic disease-modifying antirheumatic drugs

Josef S Smolen et al. Ann Rheum Dis 2020;79:685-699

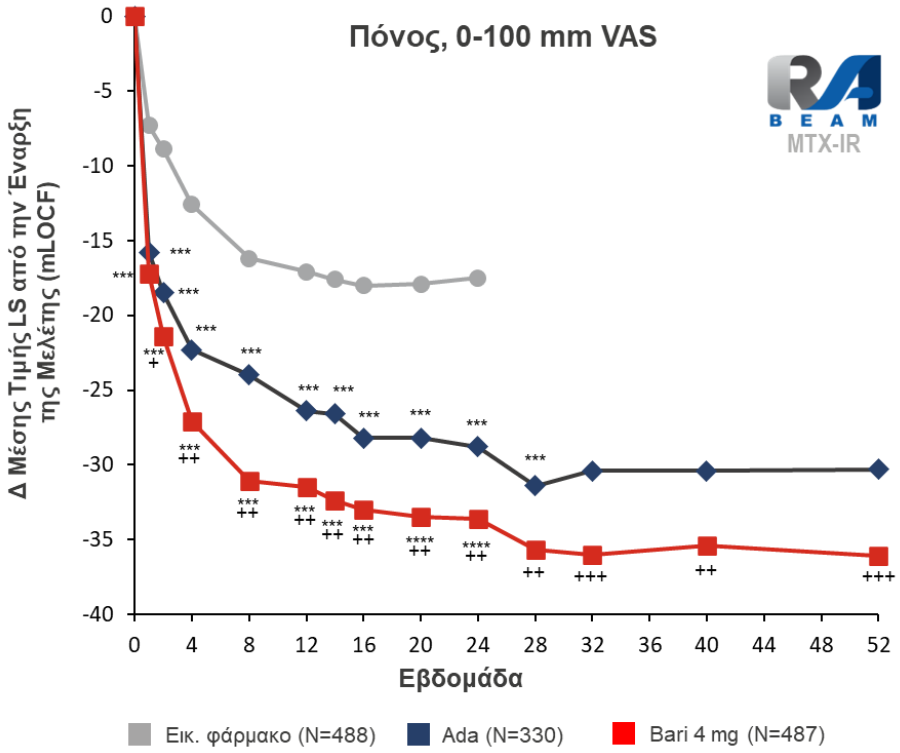
Μακροχρόνια Διατήρησης Ύφεσης στα 7 έτη (NRI)

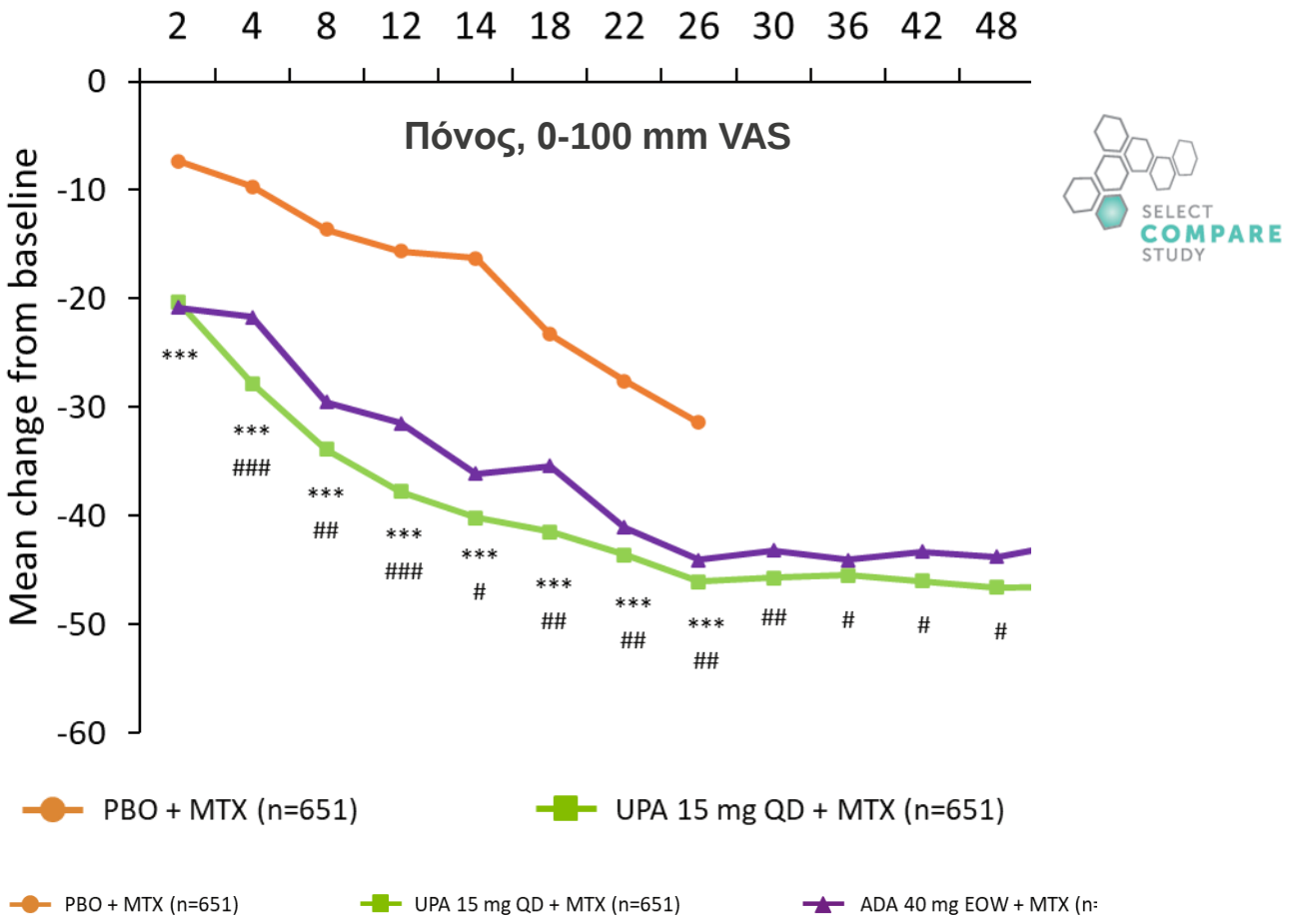


SELECT COMPARE STUDY

- Treatment groups are by initial randomization. *P < .05, **P < .01, ***P < .001 for UPA + MTX versus ADA + MTX. All P values are nominal. NRI was used for patients who were rescued or prematurely discontinued study drug, as well as for missing data. [a]252 patients were rescued to ADA and were considered nonresponders for this analysis. [b]159 patients were rescued to UPA and were considered nonresponders for this analysis. ; DAS28-CRP=28-joint Disease Activity Score based on C-reactive protein; CDAI, Clinical Disease Activity Index; EOW=every other week; IR=inadequate response; MTX=methotrexate; NRI=nonresponder imputation; QD=once daily; UPA=upadacitinib.
- **1.** Fleischmann R et al. EULAR 2025. POS0540.

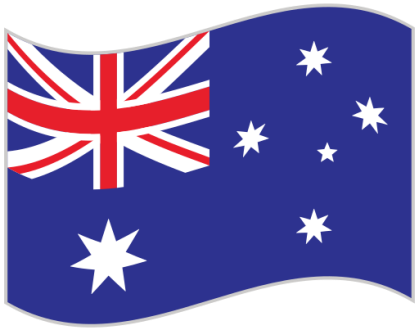
JAK inhibition has better outcomes in speed of action and pain control compared to adalimumab





Taylor PC, et al. N Engl J Med 2017;376(7):652-662.
Fleischmann R, et al. Arthritis Rheum 2019;71:1788–800

AUSTRALIAN REAL-WORLD STUDY
Treatment patterns, persistence and effectiveness of UPA in RA



OPAL network:[1,2]

>100 Rheumatologists, practicing in
>40 predominantly private clinics

All patients n=7089

▪ **UPA**	2624
▪ **Other JAKi**	925
▪ **TNFi**	3540

STUDY OBJECTIVES[1]

In real-world Australian patients with rheumatoid arthritis (RA) from the OPAL dataset:

Assess treatment patterns, persistence, and effectiveness of UPA:

- Overall
- By line of advanced therapy (first, second or ≥ third line)
- As monotherapy or in combination with csDMARDs in a propensity score-matched cohort

Descriptively compare UPA to other JAKis* and TNFis‡ in propensity score-matched cohorts to evaluate:

- Persistence
- Effectiveness

Assess treatment persistence and effectiveness in patients switching from:

- 1st line TNFi ‡ to 2nd line TNFi ‡
- 1st line TNFi ‡ to 2nd line UPA
- 1st line other JAKi * to 2nd line UPA

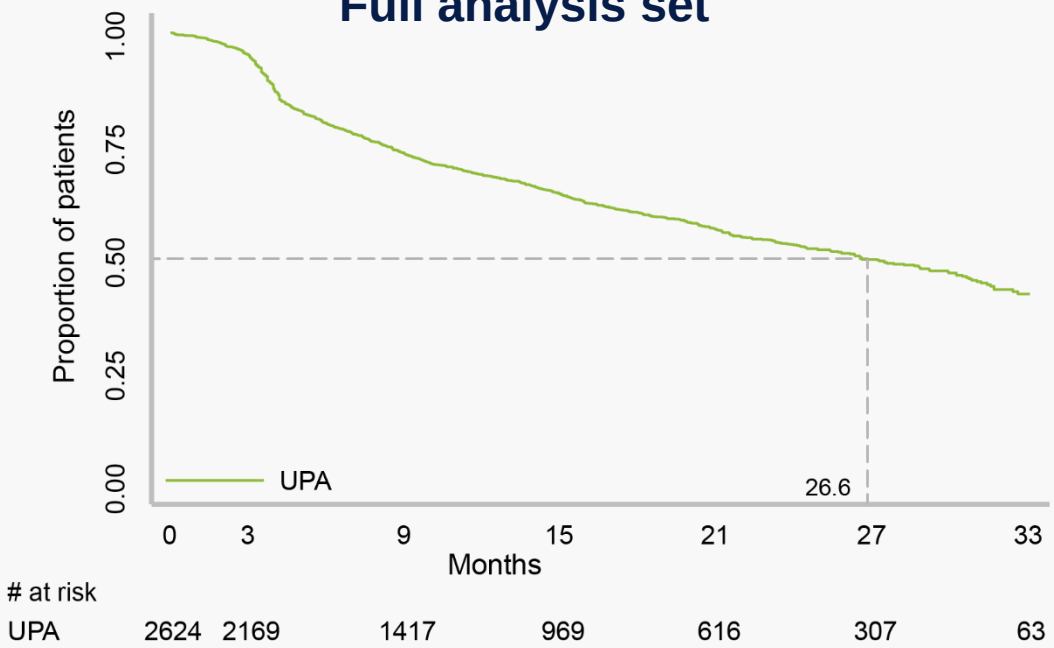
*Baricitinib and tofacitinib; ‡adalimumab, certolizumab , etanercept, golimumab, infliximab.
csDMARD, conventional synthetic disease-modifying anti-rheumatic drug; **JAKi**, Janus kinase inhibitor; **RA**, rheumatoid arthritis; **TNFi**, tumour necrosis factor inhibitor; **UPA**, upadacitinib.

1. Youssef P *et al. Rheumatol Ther.* 2025 Feb;12(1):173-202. doi: 10.1007/s40744-024-00736-4. Epub 2025 Jan 6.

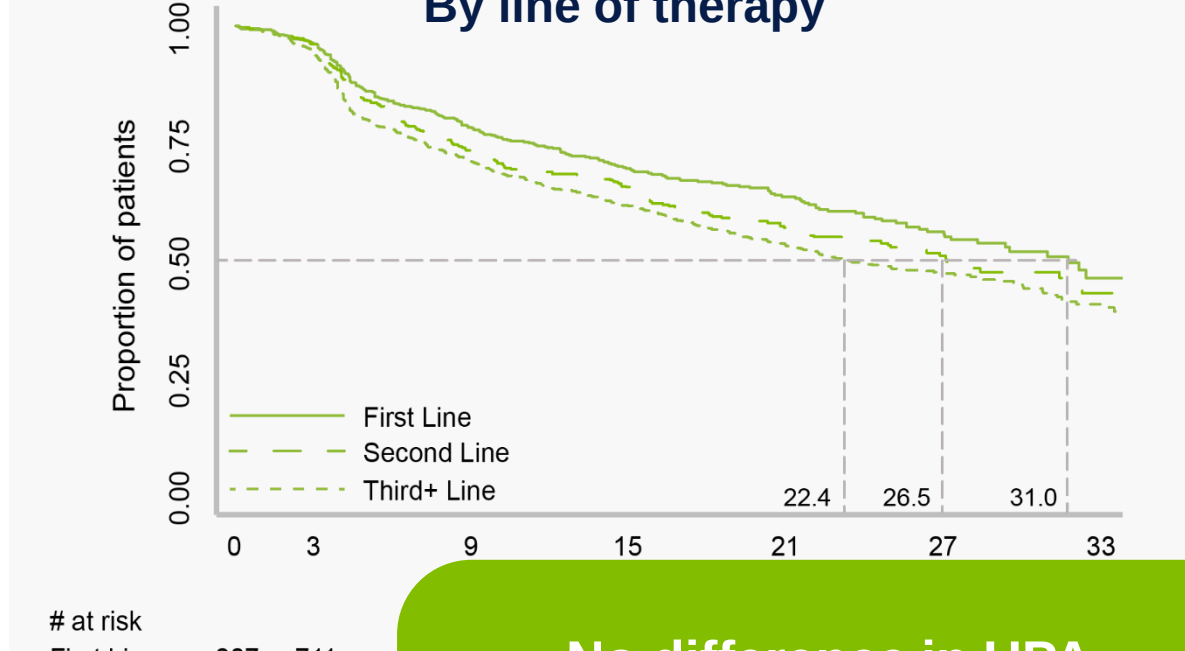
Treatment persistence for RA patients prescribed UPA

Kaplan-Meier estimates of treatment persistence

Full analysis set



By line of therapy



No difference in UPA persistence by line of therapy

Kaplan-Meier analysis estimating treatment persistence through 33 months is presented for all patients prescribed UPA in the (a) full analysis set and (
patients at risk is the total number of patients included at each timepoint.

Persistence does not necessarily infer clinical efficacy or safety, nor persistence data comparisons infer clinical superiority.

For patients prescribed UPA at index, 27% were reported to have discontinued treatment due to lack of efficacy and 17.6% due to adverse reaction.

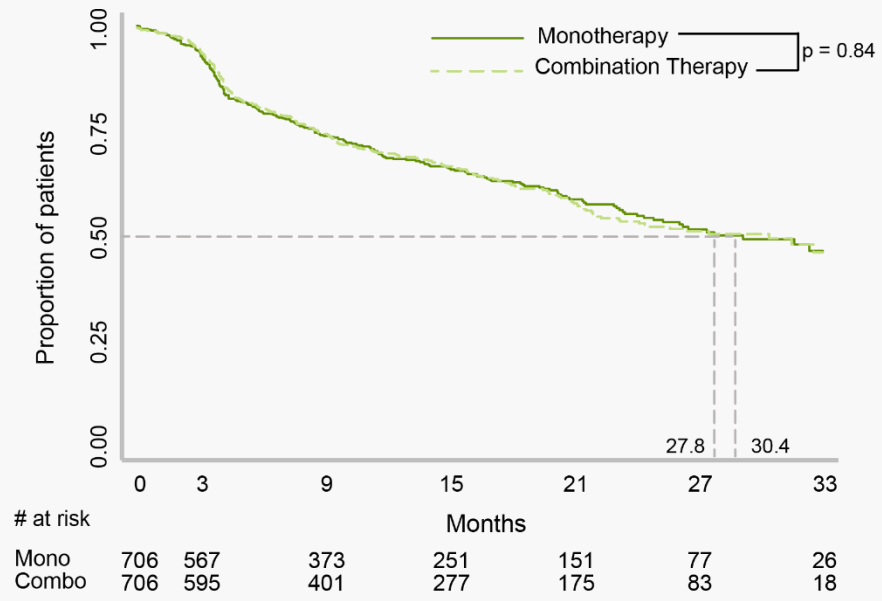
RA, rheumatoid arthritis; **UPA**, upadacitinib.

1. Youssef P *et al. Rheumatol Ther.* 2025 Feb;12(1):173-202. doi: 10.1007/s40744-024-00736-4. Epub 2025 Jan 6.

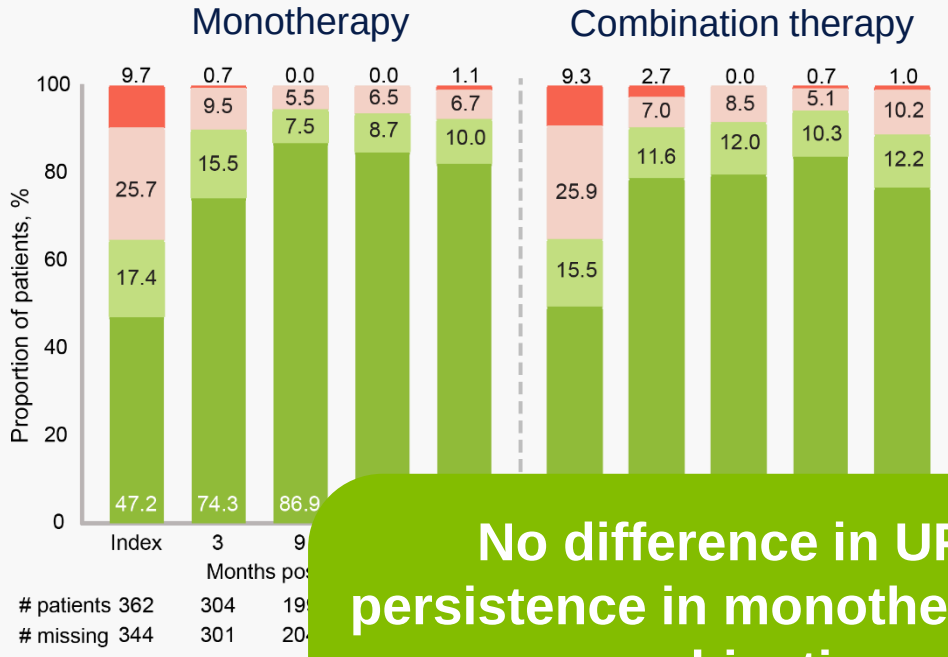
Treatment persistence and effectiveness in RA patients prescribed UPA as monotherapy or in combination with csDMARDs at index[1]

PROPENSITY SCORE-MATCHED COHORT (AO)

Kaplan-Meier estimate of treatment persistence



Proportion of patients in DAS28CRP(3) categories



No difference in UPA persistence in monotherapy or combination

All data are reported as observed (AO). For the Kaplan-Meier curves, the number of patients at risk is the total number of patients included at each tim
treatment groups. For DAS28CRP(3) categories, the number of patients with data available for calculation of a DAS28CRP(3) score and the number of patients with a missing score are reported below the graphs.
Differences in the proportion of patients in each category at each timepoint for the 2 treatment groups were determined by ANOVA.
Persistence does not necessarily infer clinical efficacy or safety, nor persistence data comparisons infer clinical superiority.

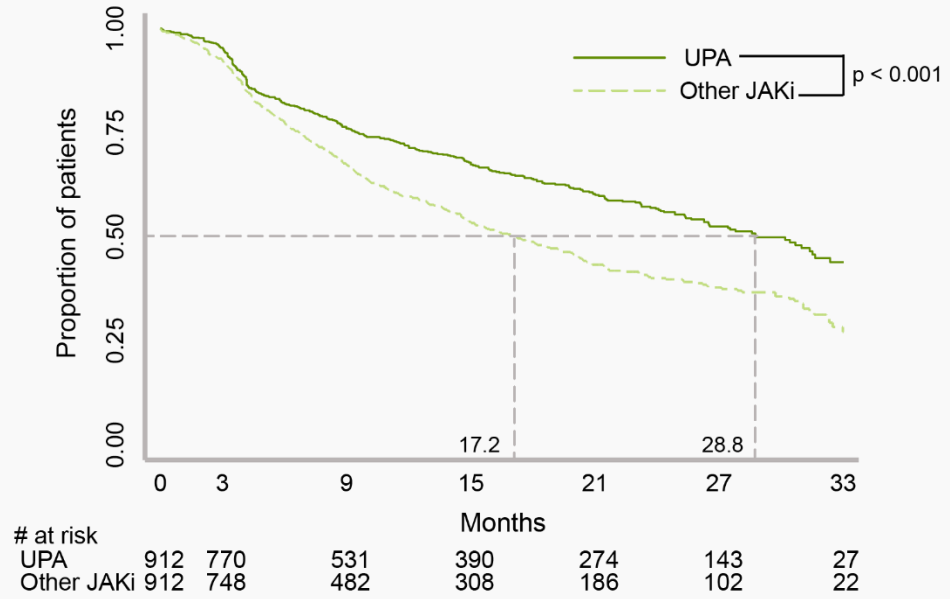
AO, as observed; **ANOVA**, analysis of variance; **csDMARDs**, conventional synthetic antirheumatic disease-modifying drugs; **DAS28CRP(3)**, 28-joint disease activity score base on C-reactive protein (3 variables); **RA**, rheumatoid arthritis; **UPA**, upadacitinib.

1. Youssef P *et al. Rheumatol Ther.* 2025 Feb;12(1):173-202. doi: 10.1007/s40744-024-00736-4. Epub 2025 Jan 6.

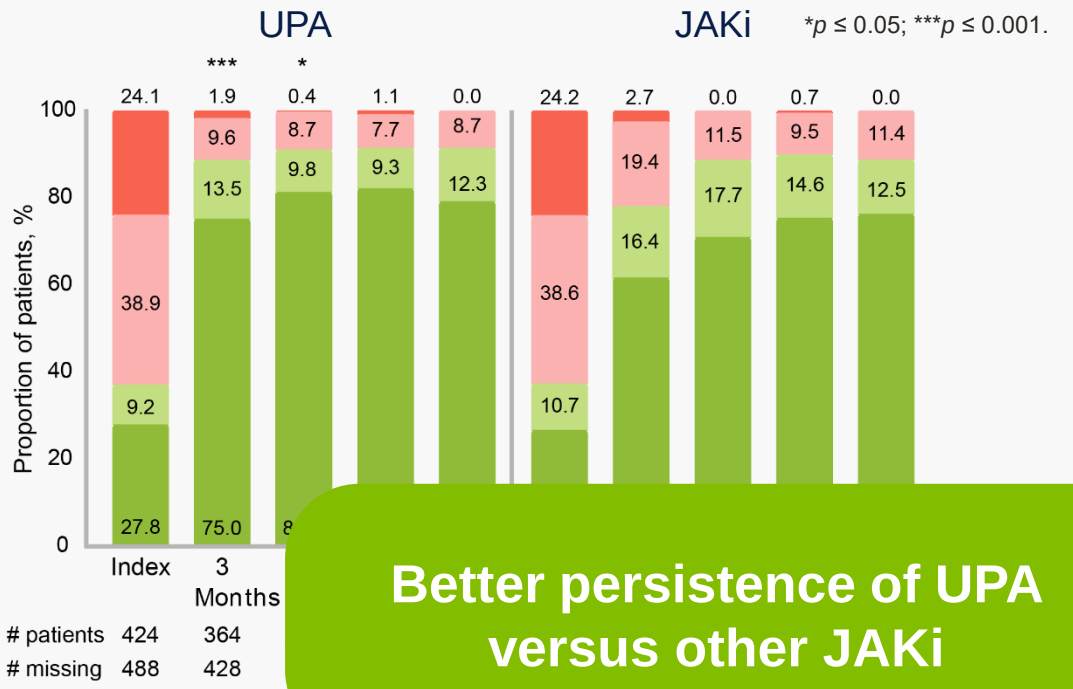
Treatment persistence and effectiveness in RA patients prescribed UPA and other JAKis

PROPENSITY SCORE-MATCHED COHORT (AO)

Kaplan-Meier estimate of treatment persistence



Proportion of patients in DAS28CRP(3) categories



Better persistence of UPA versus other JAKi

For the Kaplan-Meier curves, the number of patients at risk is the total number of patients included at each timepoint. Nominal *P* values were calculated
groups. For DAS28CRP(3) categories, the number of patients with data available for calculation of a DAS28CRP(3) score and the number of patients with a missing score are reported below the graphs. Differences in the proportion of patients in each in each disease activity category at each timepoint for the 2 treatment groups were determined by ANOVA, nominal P values reported.
Persistence does not necessarily infer clinical efficacy or safety, nor persistence data comparisons infer clinical superiority.

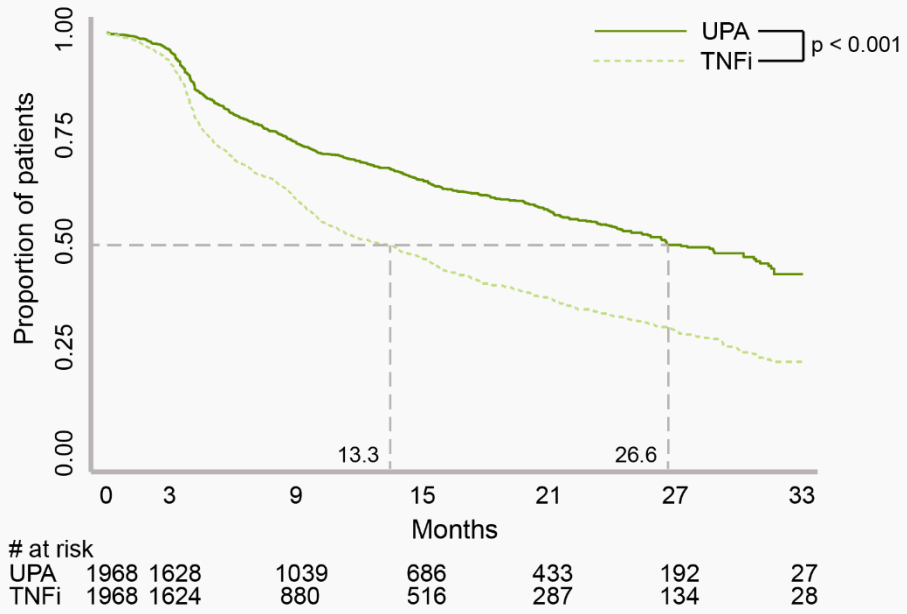
AO, as observed; **ANOVA**, analysis of variance; **csDMARDs**, conventional synthetic antirheumatic disease-modifying drugs; **DAS28CRP(3)**, 28-joint disease activity score base on C-reactive protein (3 variables); **JAKi,** Janus kinase inhibitor; **RA**, rheumatoid arthritis; **UPA**, upadacitinib.

1. Youssef P *et al. Rheumatol Ther.* 2025 Feb;12(1):173-202. doi: 10.1007/s40744-024-00736-4. Epub 2025 Jan 6.

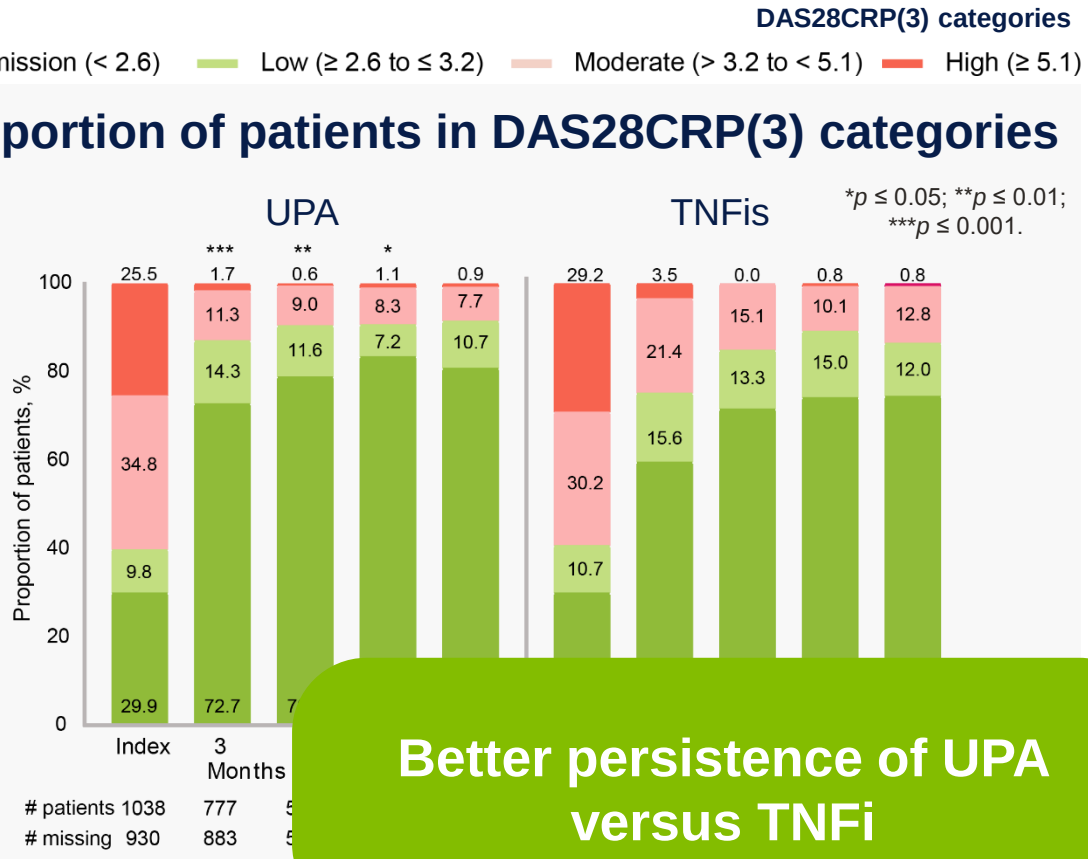
Treatment persistence and effectiveness in RA patients prescribed UPA and TNFis

PROPENSITY SCORE-MATCHED COHORT (AO)

Kaplan-Meier estimate of treatment persistence



Proportion of patients in DAS28CRP(3) categories



Better persistence of UPA versus TNFi

For the Kaplan-Meier curves, the number of patients at risk is the total number of patients included at each timepoint. Nominal *P* values were calculate
DAS28CRP(3) categories, the number of patients with data available for calculation of a DAS28CRP(3) score and the number of patients with a missing score are reported below the graphs. Differences in the proportion of patients in each in each disease activity category at each timepoint for the 2 treatment groups were determined by ANOVA, nominal P values reported.
Persistence does not necessarily infer clinical efficacy or safety, nor persistence data comparisons infer clinical superiority.

AO, as observed; **ANOVA**, analysis of variance; **csDMARDs**, conventional synthetic antirheumatic disease-modifying drugs; **DAS28CRP(3)**, 28-joint disease activity score base on C-reactive protein (3 variables); **RA**, rheumatoid arthritis; **TNFi**, tumour necrosis factor inhibitor; **UPA**, upadacitinib.

1. Youssef P *et al. Rheumatol Ther.* 2025 Feb;12(1):173-202. doi: 10.1007/s40744-024-00736-4. Epub 2025 Jan 6.

Υψηλό προφίλ ασφάλειας του UPA από τις μελέτες στις Ρευματολογικές ενδείξεις του φαρμάκου: 8,5 έτη δεδομένα ασφάλειας

ΑΠΟΤΕΛΟΥΝΤΑΝ ΑΠΟ

16

κλινικές μελέτες σε όλες τις ενδείξεις

ΜΕ

8.632

ασθενείς που λάμβαναν upadacitinib **15 mg ή 30 mg**

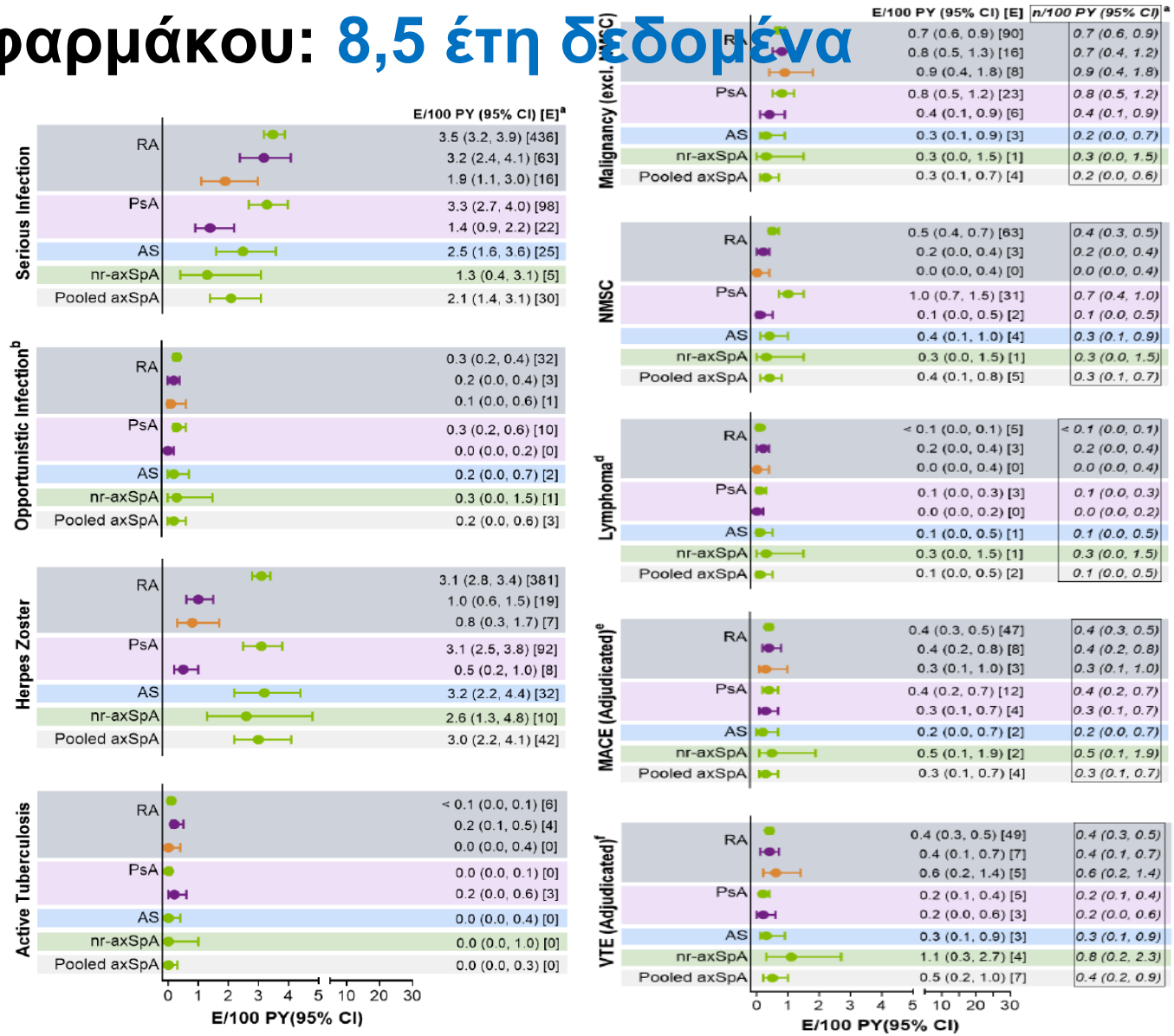
ΜΕ ΠΕΡΙΣΣΟΤΕΡΑ ΑΠΟ

24.000

ανθρωποέτη έκθεσης σε upadacitinib **15 mg & 30 mg**

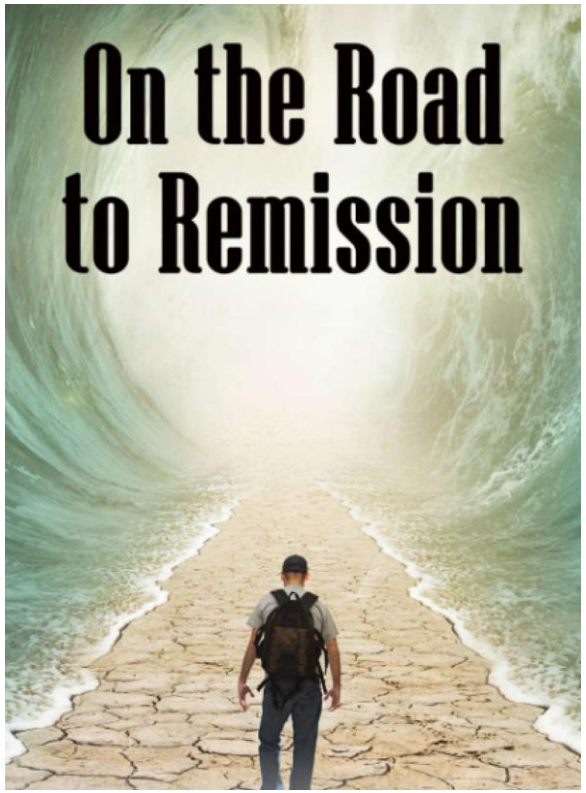
8.5

Έτη στην PA



RA: UPA 15 mg QD (N = 3209), ADA 40 mg EOW (N = 579), MTX (N = 314); PsA: UPA 15 mg QD (N = 907), ADA 40 mg EOW (N = 429); AS: UPA 15 mg QD (N = 182); AD: UPA 15 mg QD (N = 1340), UPA 30 mg QD (N = 1353). PA: Ρευματοειδής Αρθρίτιδα, ΨΑ: Ψωριασική αρθρίτιδα, ΑΣ: Αξονική Σπονδυλοαρθρίτιδα, ΑΔ¨Ατοπική Δερματίτιδα AD, atopic dermatitis; ADA, adalimumab; AS, ankylosing spondylitis; CPK, creatine phosphokinase; E, event; EOW, every other week; GI, gastrointestinal; MACE, major adverse cardiovascular events; PsA, psoriatic arthritis; PY, patient years; QD, once daily; RA, rheumatoid arthritis; , TBTEAE, treatment-emergent adverse event; UPA, upadacitinib; Burmester GR et al. RMD Open 2023; 9:e002735. doi: 10.1136/rmdopen-2022-002735, Charles-Schoeman et al. Rheumatol Ther (2024) 11:157–175. Burmester G et al. EULAR 2025. POS1097

“On the road to remission, JAK inhibition”

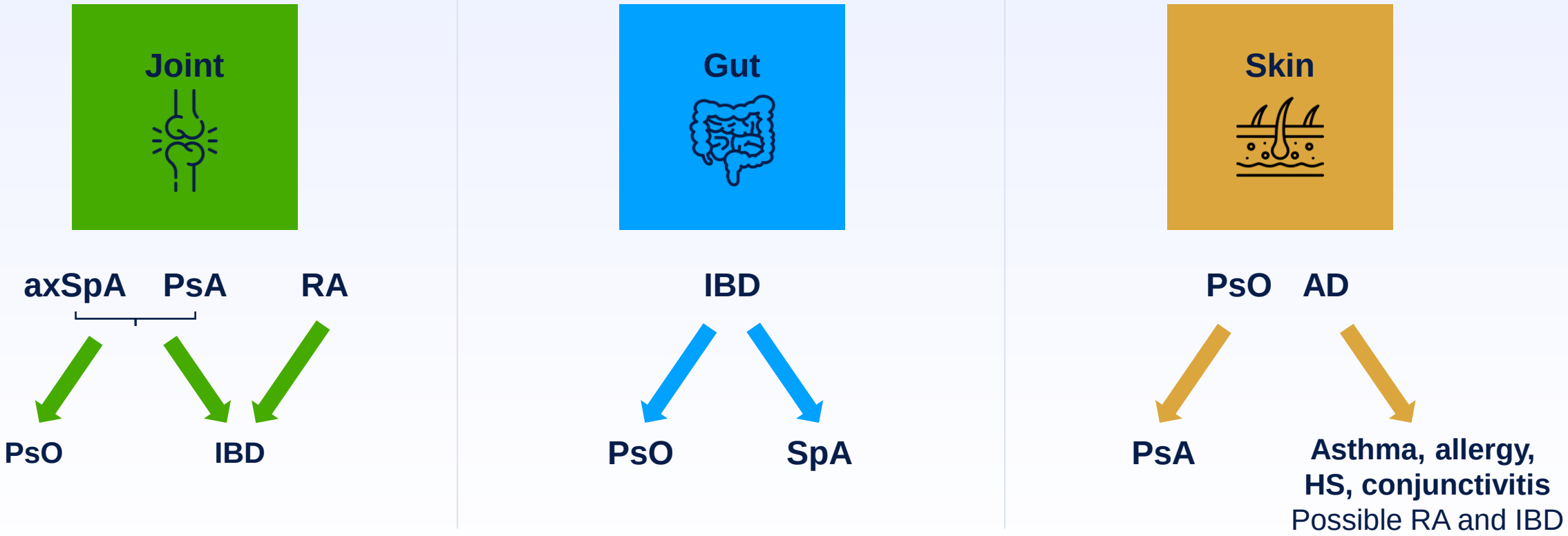


Upadacitinib may offer

- **Higher efficacy** (RCTs) and **effectiveness** (RWE) compared to other bDMARDs and perhaps other JAKis
- Improved and quick **disease control**
- **Monotherapy**
- **No differences in second line** therapy

Speaker’s opinion

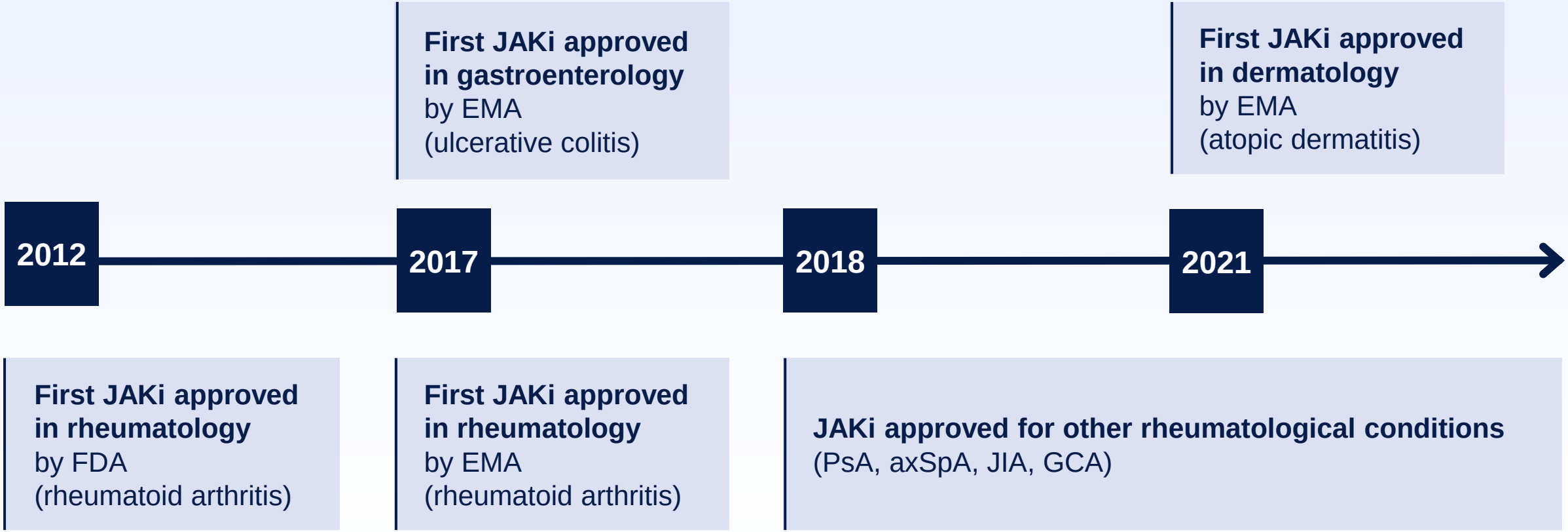
Όλο και περισσότερα στοιχεία υποδηλώνουν μια ισχυρή σύνδεση μεταξύ πολλών ανοσοδιαμεσολαβούμενων φλεγμονωδών νοσημάτων (IMIDs)



AD, atopic dermatitis; axSpA, axial spondylarthritis; HS, hidradenitis supperativa; IBD, inflammatory bowel disease; PsA, psoriatic arthritis; PsO, psoriasis; RA, rheumatoid arthritis.

1. Chia AYT, et al. Front Med (Lausanne). 2021;16:737256; 2. Oliveira M de F, et al. An Bras Dermatol. 2015;90(1):9–20; 3. Alizadeh M, et al. Dig Dis Sci. 2024; doi: 10.1007/s10620-024-08478-7; 4. Vashist S, et al. Indian Dermatol Online J. 2020; 11(5):753–9; 5. Attalla MG, et al. Cureus. 2019;11(9):e5695; 6. Schmitt J, et al. J Allergy Clin Immunol. 2016 Jan;137(1):130-136; 7. Chiesa Fuxench ZC, et al. JAMA Dermatol. 2023 Oct 1;159(10):1085-1092; 8. Sherman S, et al. J Am Acad Dermatol. 2021;85(6):1473–9; 9. Kolb L, et al. Atopc Dermatitis. StatPearls. https://www.ncbi.nlm.nih.gov/sites/books/NBK448071/ Accessed May 2025.

Η χρήση των JAKi έχει εξελιχθεί από την πρώτη τους εμφάνιση το 2012 και έχει αποδειχθεί ότι αντιμετωπίζει πολλαπλά IMID



Approvals shown here based on EMA. JAKi first approved for RA in 2012 in the US.
axSpA, axial spondyloarthritis; EMA, European Medicines Agency; EME, Efficacy and Mechanism Evaluation; GCA, giant cell arteritis; iMIDs, immune-mediated inflammatory diseases; JIA, juvenile idiopathic arthritis; JAKi, Janus kinase inhibitor; PsA, psoriatic arthritis; RA, rheumatoid arthritis.

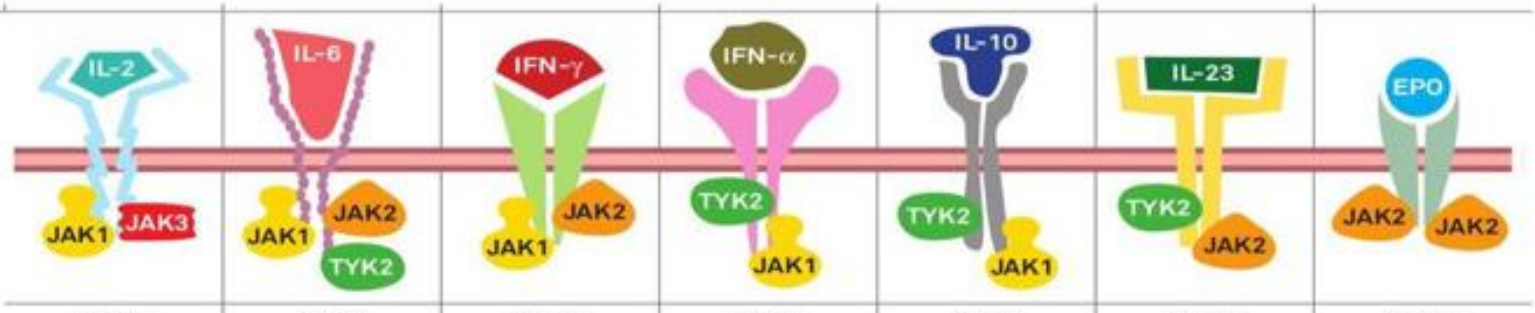
Adapted from: https://ec.europa.eu/health/documents/community-register/html/
Baricitinib (Olumiant) Summary of Product Characteristics Updated Jan 16, 2025; Filgotinib (Jyseleca) Summary of Product Characteristics Updated Oct 10, 2024; Tofacitinib (Xeljanz) Summary of Product Characteristics Updated March 24, 2025; Upadactinib (Rinvoq) Summary of Product Characteristics. Updated April 14, 2025; Abrocitinib (Cibinqo) Summary of Product Characterstics Updated Feb 2, 2025; Ritlecitinib (Litfulo) Summary of Product Characteristics Updated Feb 27, 2025.

JAKis: 1st and 2nd Generation

‘Pan-JAKis

2nd Generation

JAKis Selective



		STAT 1, 3, 5, 6	STAT 1, 3, 5	STAT 1, 3, 5	STAT 1, 2, 3	STAT 1, 3, 5	STAT 3, 4	STAT 5
Drug	**Selectivity***							
Baricitinib	JAK1, 2	+	+	+	+	+	+	+
Filgotinib	JAK1	+	+	+	+	+	-	-
Peficitinib	JAK1, 2, 3	+	+	+	+	+	+	+
Tofacitinib	JAK1, 2, 3	+	+	+	+	+	+	+
Upada-citinib	JAK1, (2)	+	+	+	+	+	+	+

* also taking the clinical perspective into account

JAK, Janus kinase; JAKis, Janus kinase inhibitors

Οι JAKis διαφέρουν ανάλογα με τις εγκεκριμένες τους ενδείξεις

Indication	Baricitinib	Filgotinib	Tofacitinib	Upadacitinib	Abrocitinib	Ritlecitinib
Rheumatologic diseases						
Rheumatoid arthritis	✓	✓	✓	✓		
Psoriatic arthritis			✓	✓		
Radiographic axSpA			✓	✓		
Nonradiographic axSpA				✓		
Giant cell arteritis*				✓		
Juvenile idiopathic arthritis	✓		✓	✓		
Dermatologic diseases						
Atopic dermatitis	✓			✓	✓	
Alopecia areata	✓					✓
Inflammatory bowel diseases						
Crohn's disease				✓		
Ulcerative colitis		✓	✓	✓		

Approvals shown here based on EMA. *La indicación de arteritis de células gigantes se encuentra pendiente de decisión de su inclusión en la prestación del SNS en España.
axSpA, axial spondyloarthritis; EMA, European Medicines Agency; IMID, immune-mediated inflammatory diseases; JAK, Janus kinase; TEC, tyrosine kinase expressed in hepatocellular carcinoma.

Approvals shown here based on EMA.. https://ec.europa.eu/health/documents/community-register/html/
IMID, immune-mediated inflammatory diseases; JAK, Janus kinase; TEC, tyrosine kinase expressed in hepatocellular carcinoma.
Adapted from: Baricitinib (Olumiant) Summary of Product Characteristics Updated Jan 16, 2025; Filgotinib (Jyseleca) Summary of Product Characteristics Updated Oct 10, 2024; Tofacitinib (Xeljanz) Summary of Product Characteristics Updated March 24, 2025; Upadactinib (Rinvoq) Summary of Product Characteristics. Updated April 14, 2025; Abrocitinib (Cibinqo) Summary of Product Characterstics Updated Feb 2, 2025; Ritlecitinib (Litfulo) Summary of Product Characteristics Updated Feb 27, 2025.

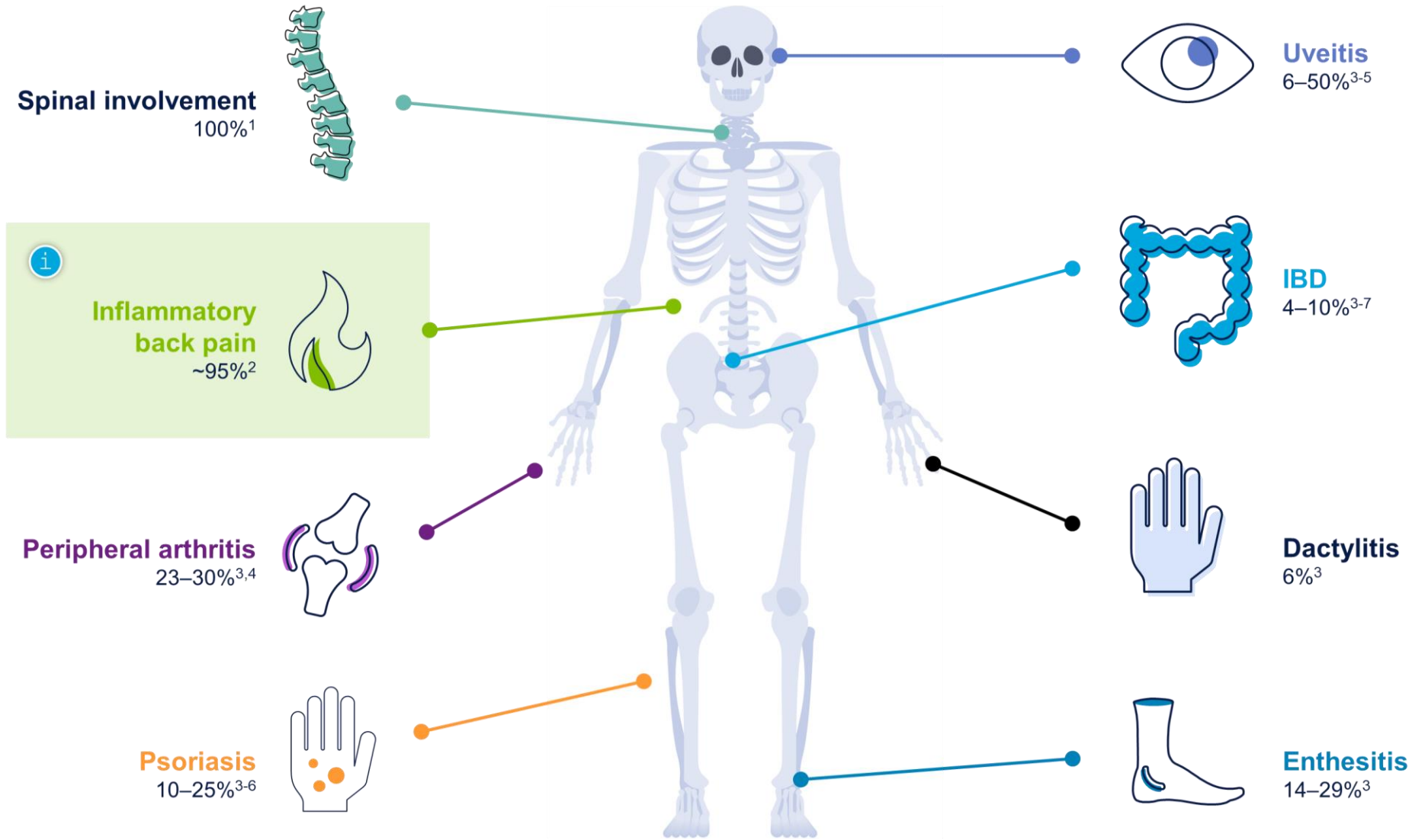
Η εφαρμογή του **Treat To Target** λειτουργεί διαφορετικά στην **AxSpA** ?

Speaker’s opinion

	RA	AxSpA
Στόχος της θεραπείας	Πρόληψη της **δομικής καταστροφής** των περιφερικων αρθρώσεων (διαβρώσεις)	Ελεγχος των συμπτωματων (πόνος δυσκαμψία) και βελτίωση της λειτουργικότητας
Αντικειμενικοί δείκτες	Πιο εύκολα μετρήσιμοι δεικτες Αριθμός επωδυνων / πρησμένων αρθρώσεων , εργαστηριακες εξετάσεις crp, ΤΚΕ	**Πιο Υποκειμενικοι δείκτες** 1.Δυσκολία αντικειμενικης αξιολόγησης , βασίζονται σε ερωτηματολογία ασθενούς BASDAI, ASDAS 2. Η φλεγμονή στον αξονικό σκελετό είναι δύσκολα μετρήσιμη
Πρόκληση	Η ανταπόκριση στη θεραπεία είναι άμεσα ορατή στους αντικειμενικούς δείκτες	Η εξέλιξη της νόσου (αγκύλωση) είναι αργή και τα ακτινολογικά ευρήματα καθυστερούν

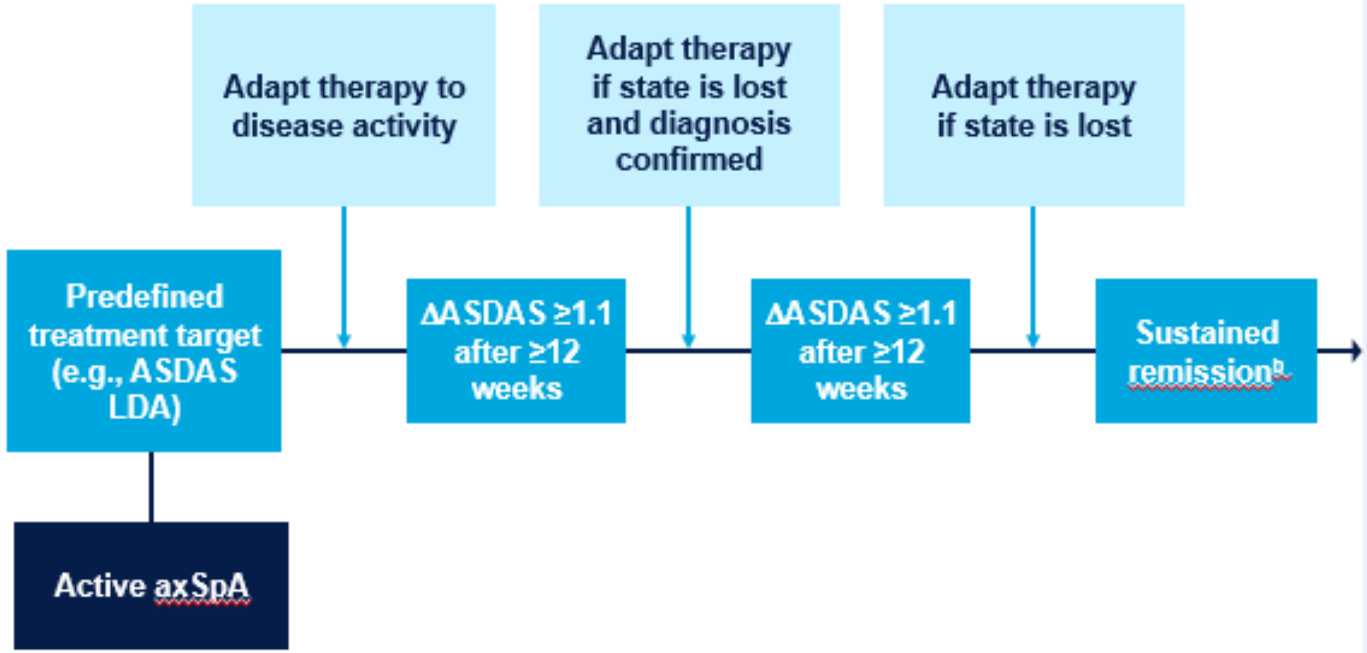
Speaker's opinion

axSpA is a chronic inflammatory disease with a complex and heterogeneous presentation



Percentages pertain to r-axSpA, except for inflammatory back pain, which applies to axSpA. axSpA=axial spondyloarthritis; IBD=inflammatory bowel disease; r=radiographic.**1.** Baraliakos X et al. *Clin Exp Rheumatol.* 2015;33(Suppl. 93):S31-35. **2.** Poddubnyy D et al. *Rheumatology (Oxford).* 2022;61(8):3299-3308 (and suppl. info). **3.** de Winter JJ et al. *Arthritis Res Ther.* 2016;18(1):196. **4.** van der Horst-Bruinsma IE and Nurmohamed MT. *Ther Adv Musculoskelet Dis.* 2012;4(6):413-422. **5.** Taurog JD et al. *N Engl J Med.* 2016;374(26):2563-2574. **6.** El Maghraoui A. *Eur J Intern Med.* 2011;22(6):554-560. **7.** Bergman MJ et al. *Arthritis Rheumatol.* 2018;70(Suppl. 10). Abstract 285.

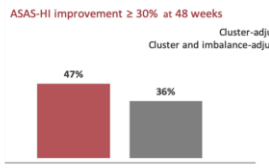
Treatment should be guided according to a predefined target and monitoring of disease activity[1,2]



- Treatment target (e.g., ASDAS LDA) should be predefined based on shared decision between patient and rheumatologist[a]
- Decision to continue or switch b/tsDMARDs should be based on achieving substantial improvement (ASDAS ≥1.1) after at least 12 weeks of therapy
- Monitoring disease activity with validated composite scores (e.g., ASDAS) at least twice a year

- Monitoring includes PROs, clinical findings, laboratory tests, and imaging
- ASDAS (CRP) considered to be the appropriate disease activity instrument
- Frequency of monitoring decided on an individual basis based on symptoms, severity, and treatment; ideally at least twice a year

TICOSPA



But..

✗

1. Ramiro S et al. *Ann Rheum Dis.* 2023;82(1):19-34. **2.** Kiltz U et al. *Ann Rheum Dis.* 2020;79(2):193-201.

Figure based on guidance/recommendations from ASAS-EULAR 2022 recommendations and the ASAS quality standards. [a]Use as a guidance. Intensify immunosuppressive treatment if physician and patient are convinced of presence of residual inflammatory activity and other factors (e.g., fibromyalgia and other comorbidities) do not impede such an intensification. [b]Consider bDMARD tapering. ASAS=Assessment of SpondyloArthritis international Society; ASDAS=Ankylosing Spondylitis Disease Activity Score; axSpA=axial spondyloarthritis; b/tsDMARD=biologic/targeted synthetic disease-modifying antirheumatic drug; CRP=C-reactive protein; LDA=low disease activity; PRO=patient-reported outcome.

The majority of patients with axSpA initiating bDMARDs are not achieving sustained stringent disease control

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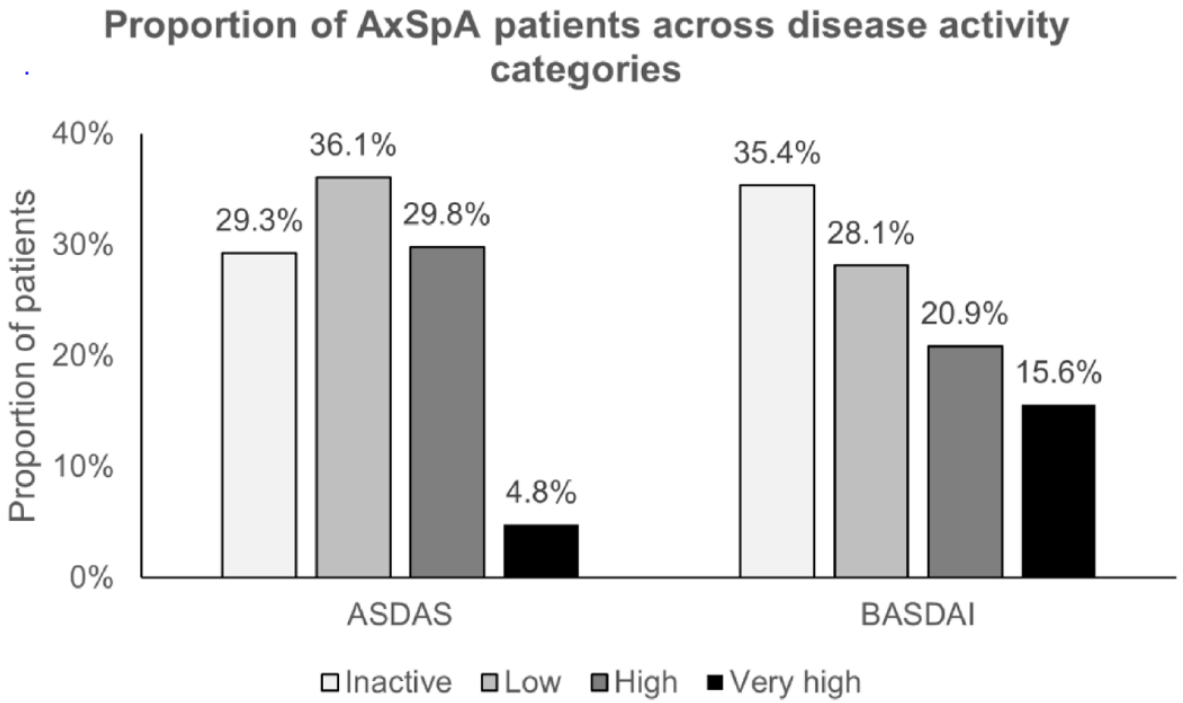
Disease characteristics, co-morbidities and treatment response in a contemporary axial spondyloarthritis cohort: Analysis of 717 patients from the Greek AxSpA registry



Despite the widespread use of bDMARDs, approximately 35 % of patients in our AxSpA cohort had still high or very high disease activity.

Table 1
Patient demographics and disease characteristics.

N	717
Current treatment	
No treatment, n (%)	86 (12)
NSAIDs only, n (%)	37 (5)
csDMARDs only, n (%)	38 (5)
bDMARDs only, n (%)	471 (66)
csDMARDs+bDMARDs, n (%)	83 (12)
*Current use of csDMARDs***	
Methotrexate, n (%)	95 (13)
Sulphasalazine, n (%)	18 (2.5)
Leflunomide, n (%)	6 (0.8)
Other, n (%)	2 (0.3)
Current use of bDMARDs	
Adalimumab, n (%)	171 (24)
Certolizumab pegol, n (%)	54 (7.5)
Etanercept, n (%)	61 (8.5)
Golimumab, n (%)	53 (7)
Infliximab, n (%)	155 (22)
Ixekizumab, n (%)	3 (0.4)
Secukinumab, n (%)	54 (7.5)
Ustekinumab, n (%)¶	3 (0.4)
Glucocorticoids, n (%)	30 (4)
Prednisolone dose, mg/day, median (IQR)	5 (2.5–7.5)
Miscellaneous*	2 (0.3)
No of prior bDMARDs (among current bDMARD users, n=554)	
0, n (%)	359 (65)
1, n (%)	103 (19)
2, n (%)	47 (8)
3, n (%)	29 (5)
≥4, n (%)	16 (3)
No of prior bDMARDs (among former bDMARD users, n=53)	
1, n (%)	28 (53)
2, n (%)	10 (19)
≥3, n (%)	15 (28)

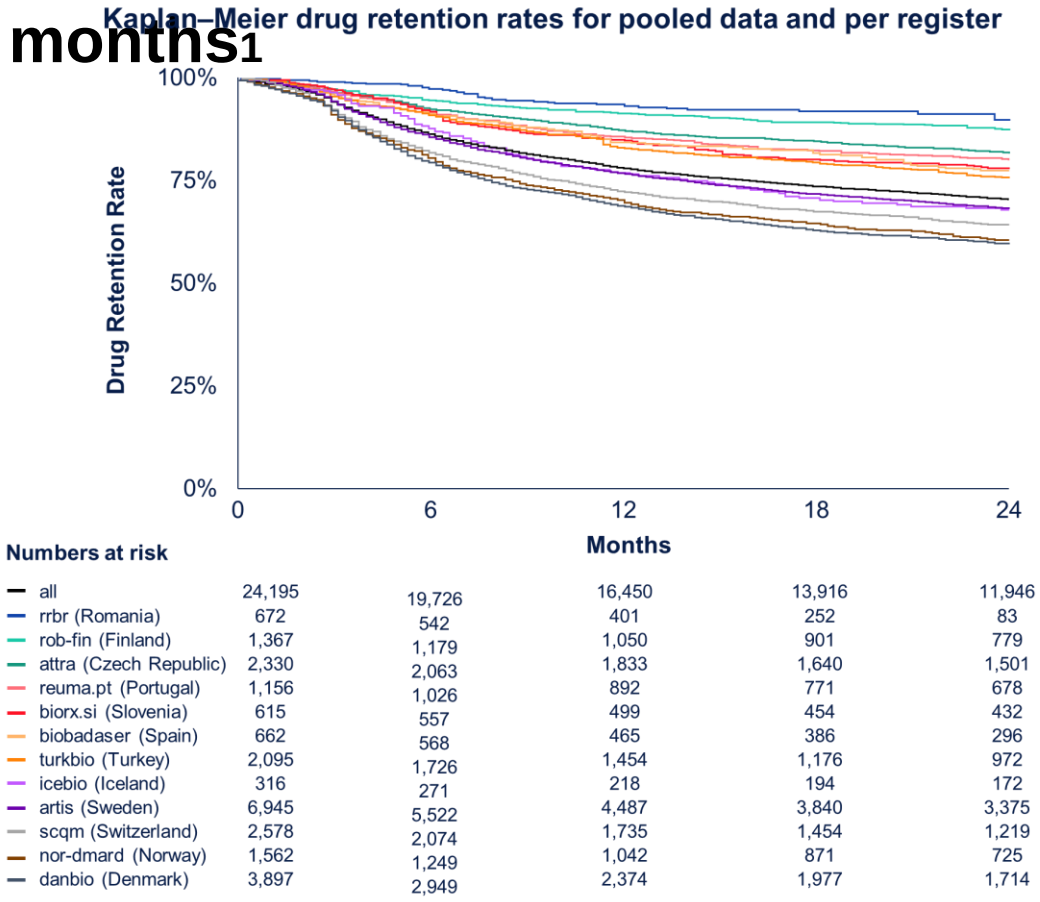
Papagoras et al., Seminars in Arthritis and Rheumatism 71 (2025) 152645

RWE shows that 80% of axSpA patients treated with first TNFi were still receiving the same TNFi after 1 year despite only ~25% achieving ASDAS ID at 6 months[1]

RWE: EuroSpA data from 12 registries

A large European database of 24,195 patients with axSpA initiating a first TNFi treatment in routine care, demonstrated that:

- The overall 12-month retention rate was 80% (95% CI: 79% to 80%)
- At 6 and 12 months, ASDAS ID was achieved by 33% (LUNDEX-adjusted 27%) and 35% (LUNDEX-adjusted 24%), respectively
- Patients with nr-axSpA showed numerically lower ASDAS ID rates (1/5 at 6 months) and 12-month retention rate (73% [95% CI: 70% to 76%]) vs patients meeting the ASAS classification criteria and those meeting the modified New York criteria for r-axSpA

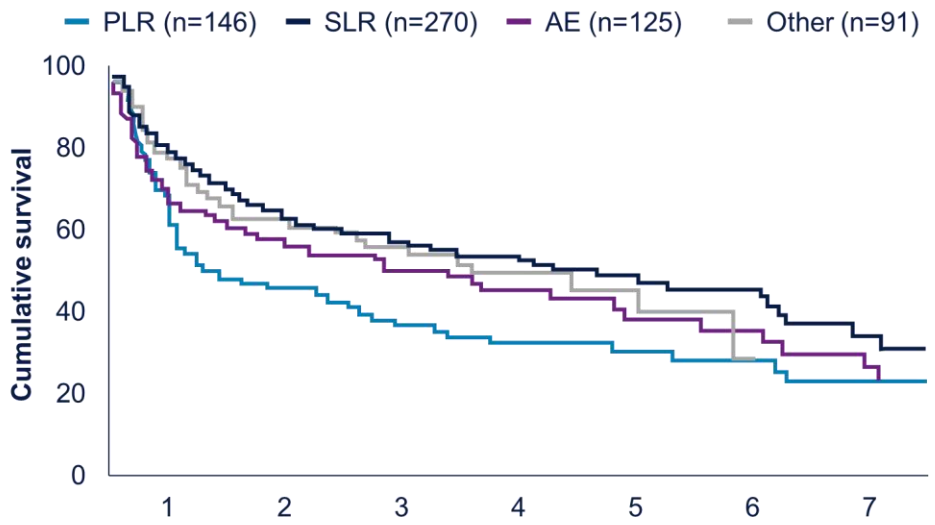


1. Ørnbjerg LM et al. Ann Rheum Dis. 2019;78(11):1536-1544.

Pooled data from 12 European registries. The present study included secondary use of data. Study Limitations: RWE is collected outside of controlled clinical trials and has inherent limitations including a lesser ability to control for confounding factors. ASAS40=≥40% improvement in Assessment of SpondyloArthritis international Society; ASDAS=Ankylosing Spondylitis Disease Activity Score; axSpA=axial spondyloarthritis; ID=inactive disease; nr=non-radiographic; RWE=real-world evidence; TNFi=tumor necrosis factor inhibitor

The effectiveness of a second TNFi is significantly impaired in patients with axSpA after primary failure to a first TNFi[1]

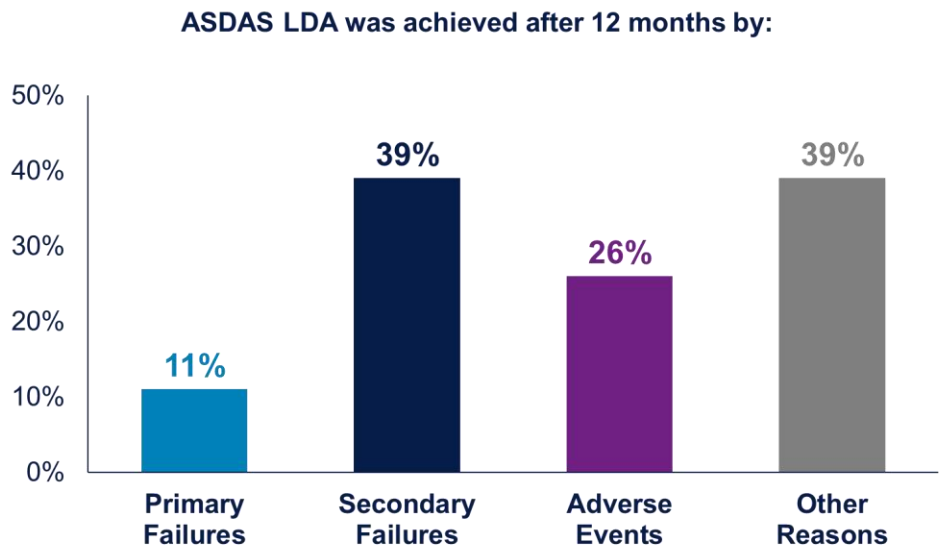
Low persistence to second TNFi following prior TNFi failure



Median survival of a second TNFi was (N=632)
- 1.1 years after primary failure
- 3.8 years after secondary failure (p=0.003)

Significant differences in retention rates were found between the four groups (p=0.001), with the shortest drug survival observed after previous primary lack of response

Fewer patients achieved LDA after first TNFi failure



ASDAS ID was achieved only in 4% of the primary failure patients, in comparison to 22% of those after secondary failure

Drug survival of the second TNFi, stratified by the reason for discontinuation of the first TNFi, in patients with a clinical diagnosis of axSpA. Other refers to reason for discontinuation other than lack of effect or intolerance.

1. Ciurea A et al. *Arthritis Res Ther*. 2016:18:71.

Longitudinal analysis of data collected annually from patients with a clinical diagnosis of axSpA, including r-axSpA, recruited in the ongoing Swiss Clinical Quality Management (SCQM) Cohort from January 2005 to September 2015 (N=632). AE=adverse event; DAS=Ankylosing Spondylitis Disease Activity Score; axSpA=axial spondyloarthritis; ID=inactive disease; LDA=low disease activity; PLR=primary lack of response; SCQM=Swiss Clinical Quality Management; SLR=secondary lack of response; TNFi=tumor necrosis factor inhibitor.

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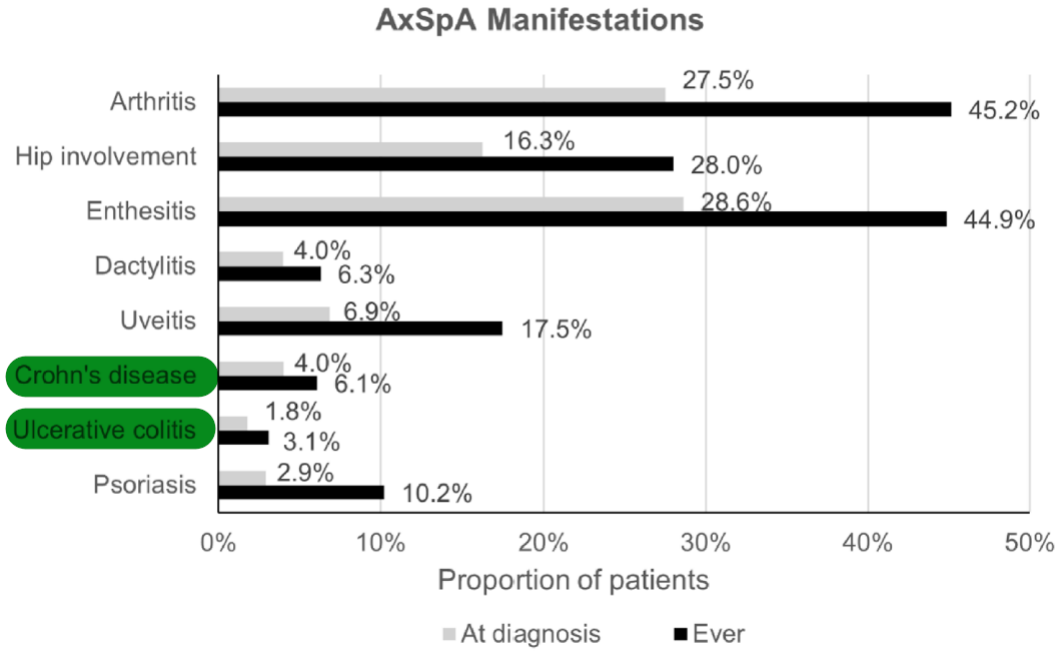

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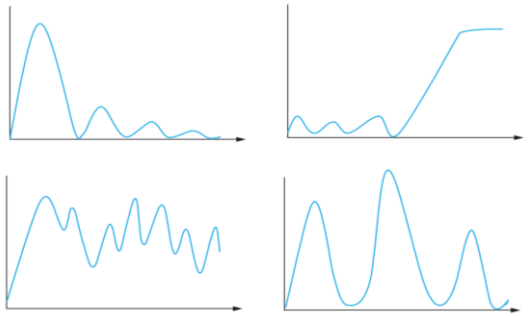
IBSEN cohort (20y FU): Η παρουσία AS συσχετίσθηκε με μακροχρόνια ενεργό νόσο

	Chronic back pain $n = 220$	Inflammatory back pain [ASAS] $n = 54$	Axial spondyloarthritis $n = 36$	Ankylosing spondylitis $n = 21$	Patients without back complaints $n = 242$
Females	129 [58.6]*	35 [64.8]*	17 [47.2]	8 [38.1]	102 [42.1]
Age, median [range]	53.7 [27.4–85.2]*	51.1 [36.6–72.2]	50.0 [32.7–85.2]	52.4 [32.6–83.2]	48.8 [28.8–94.0]
UC [$n = 314$]	145 [46.2]	31 [9.9]	19 [6.1]	13 [4.1]	164 [52.2]
UC extent					
Proctitis/left-sided	76 [52.4]	18 [58.1]	10 [52.6]	6 [46.2]	80 [48.8]
Extensive colitis	69 [47.6]	13 [41.9]	9 [47.4]	7 [53.8]	84 [51.2]
UC onset < 40 years	92 [63.4]	22 [71.0]	13 [68.4]	8 [61.5]	118 [72.0]
CD [$n = 156$]	75 [48.1]	23 [14.7]	17 [10.9]	8 [5.1]	78 [50.0]
CD onset < 40 years	54 [72.0]*	21 [91.3]	14 [82.4]	7 [87.5]	69 [88.5]
CD location					
Ileal	10 [13.3]	3 [13.0]	2 [11.8]	0	13 [16.7]
Colonic	21 [28.0]	6 [26.1]	3 [17.6]	1 [12.5]	22 [28.2]
Ileocolonic	44 [58.7]	14 [60.9]	12 [70.6]	7 [87.5]	43 [55.1]
CD behaviour					
Non-stricturing, non-penetrating	35 [46.7]*	9 [39.1]	7 [41.2]	5 [62.5]	21 [26.9]
Stricturing/penetrating	40 [53.3]*	14 [60.9]	10 [58.8]	3 [37.5]	57 [73.1]
IBD activity curves [C]					
C1	137 [62.3]	28 [51.9]	16 [44.4]*	10 [47.6]	168 [69.4]
C3/C4	68 [30.9]	20 [37.0]	16 [44.4]*	8 [38.1]	67 [27.7]
Medication ever used					
Corticosteroids	130 [59.1]	37 [68.5]	24 [66.7]	14 [66.7]	139 [57.4]
Biologics	22 [10.0]	9 [16.7]	6 [16.7]	3 [14.3]	23 [9.5]
Immunomodulators	51 [23.2]	16 [29.6]	13 [36.1]	7 [33.3]	61 [25.2]
HLA-B27 positive	30 [13.6]	14 [25.9]*	25 [69.4]*		
NOD 2	12 [5.5]	2 [3.7]	0		



Ossum AM et al, J Crohn's Colitis 2018:96-104

60% των ασθενών με SpA έχουν ενεργό φλεγμονώδη κολίτιδα ή υποκλινική φλεγμονή

Subclinical gut inflammation in axSpA is associated with[2–4]:

- Male sex
- High disease activity[a]
- Restricted spinal mobility[b]
- Younger age
- Early disease onset
- Radiographic sacroiliitis
- Bone marrow oedema of the SIJs[c]

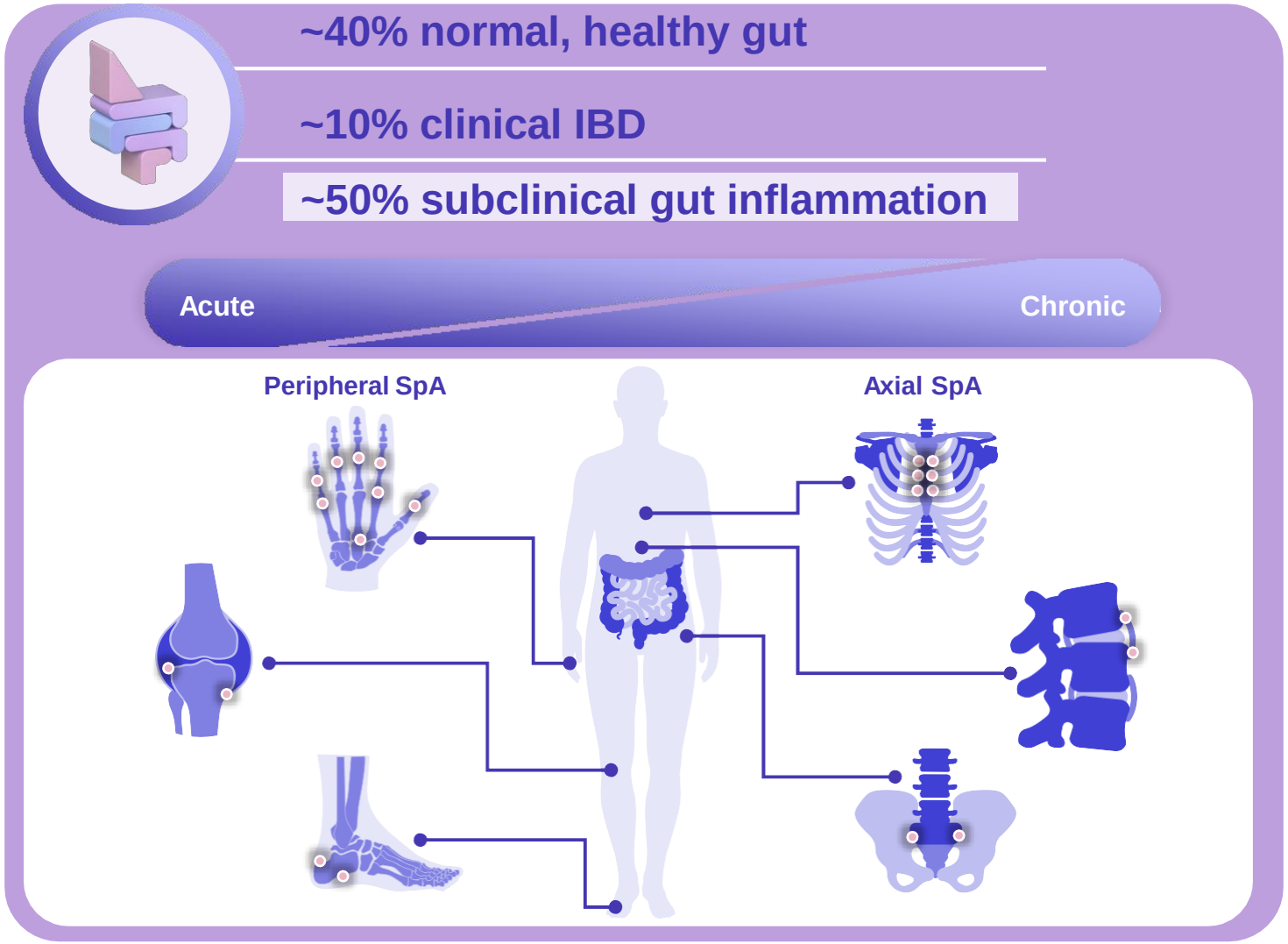


Figure adapted from Gracey E, et al. 2020.[1]

[a]Assessed by the Bath Ankylosing Spondylitis Disease Activity Index.[2] [b]Measured by the Bath Ankylosing Spondylitis Metrology Index.[2] [c]Measured by MRI; data show correlation between chronic gut inflammation and bone marrow oedema of SIJs.[4]

axSpA, axial spondyloarthritis; IBD, inflammatory bowel disease; MRI, magnetic resonance imaging; SIJ, sacroiliac joint; SpA, spondyloarthritis.

1. Gracey E, et al. *Nat Rev Rheumatol*. 2020;16:415–433. 2. Fragoulis G, et al. *World J Gastroenterol*. 2019;25:2162–2176. 3. Van Praet L, et al. *Ann Rheum Dis*. 2013;72:414–417. 4. Van Praet L, et al. *Ann Rheum Dis.* 2014;73:1186–1189.

Διαθέσιμες θεραπείες για ΙΦΝΕ & ΣπΑ

	Drug	Crohn's disease	Ulcerative colitis	Axial spondyloarthropathy	Peripheral spondyloarthropathy
COX-1 and COX-2	Long-term NSAIDs				
Conventional DMARDs	Sulfasalazine				
Conventional DMARDs	Methotrexate				
Conventional DMARDs	Leflunomide				
Conventional DMARDs	Azathioprine				
TNF	Infliximab and adalimumab				
TNF	Etanercept				
TNF	Golimumab				
α4β7	Vedolizumab				
IL-17A	Secukinumab, ixekizumab, and bimekizumab				
IL-12 and IL-23	Ustekinumab				
IL-23	Risankizumab				
IL-23	Guselkumab				
IL-23	Mirikizumab				
JAK1	Upadacitinib				
JAK1	Filgotinib				
JAK1 and JAK3	Tofacitinib				
S1P	Ozanimod				

Song K et al. Lancet Rheumatol 2024

Ποσοστά κλινικής ανταπόκρισης κατά ASAS40 των διαφορετικών θεραπευτικών επιλογών για την ΑΣ

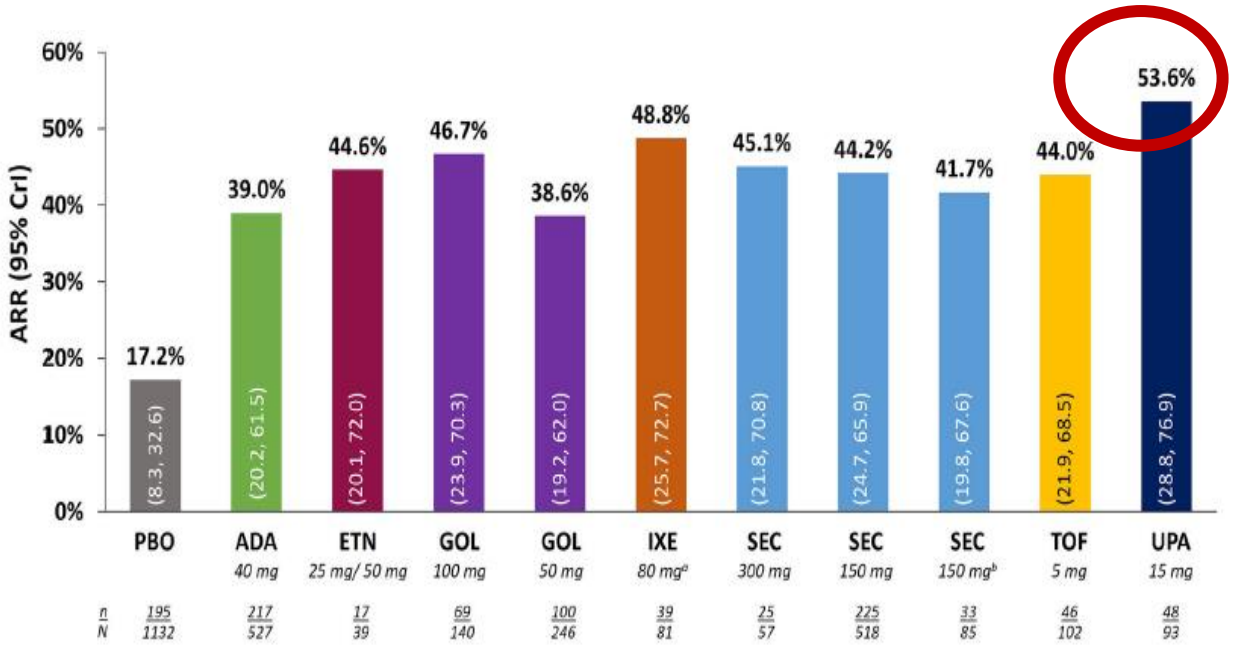
Rheumatol Ther
https://doi.org/10.1007/s40744-023-00586-6

ORIGINAL RESEARCH

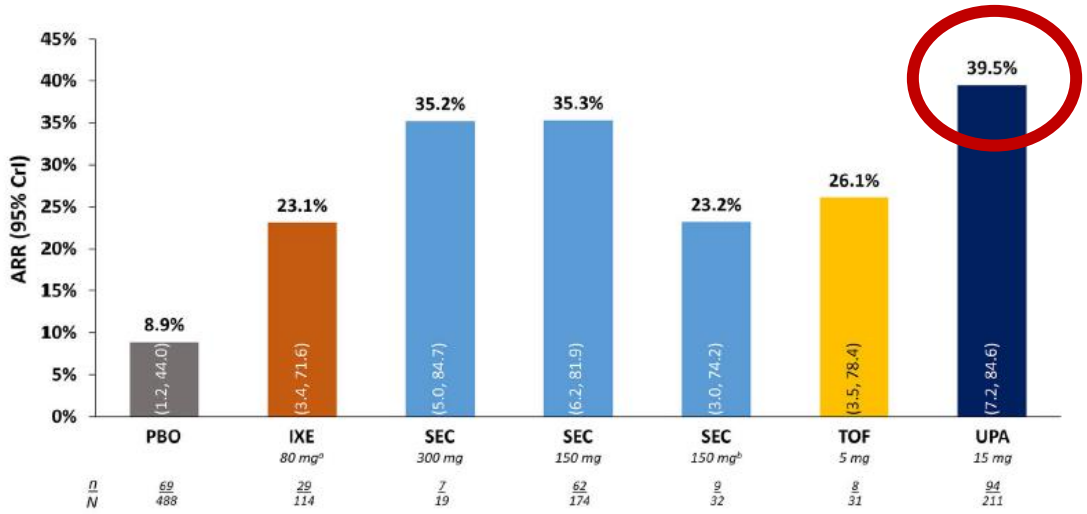
Real World

Clinical and Economic Benefit of Advanced Therapies for the Treatment of Active Ankylosing Spondylitis

Jessica A. Walsh · Christopher D. Saffore · Eric B. Collins · Andrew Ostor



Absolute ASAS40 response rates at week 12–16 in naive patients with AS.



Absolute ASAS40 response rates at week 12–16 in bio-IR patients with AS

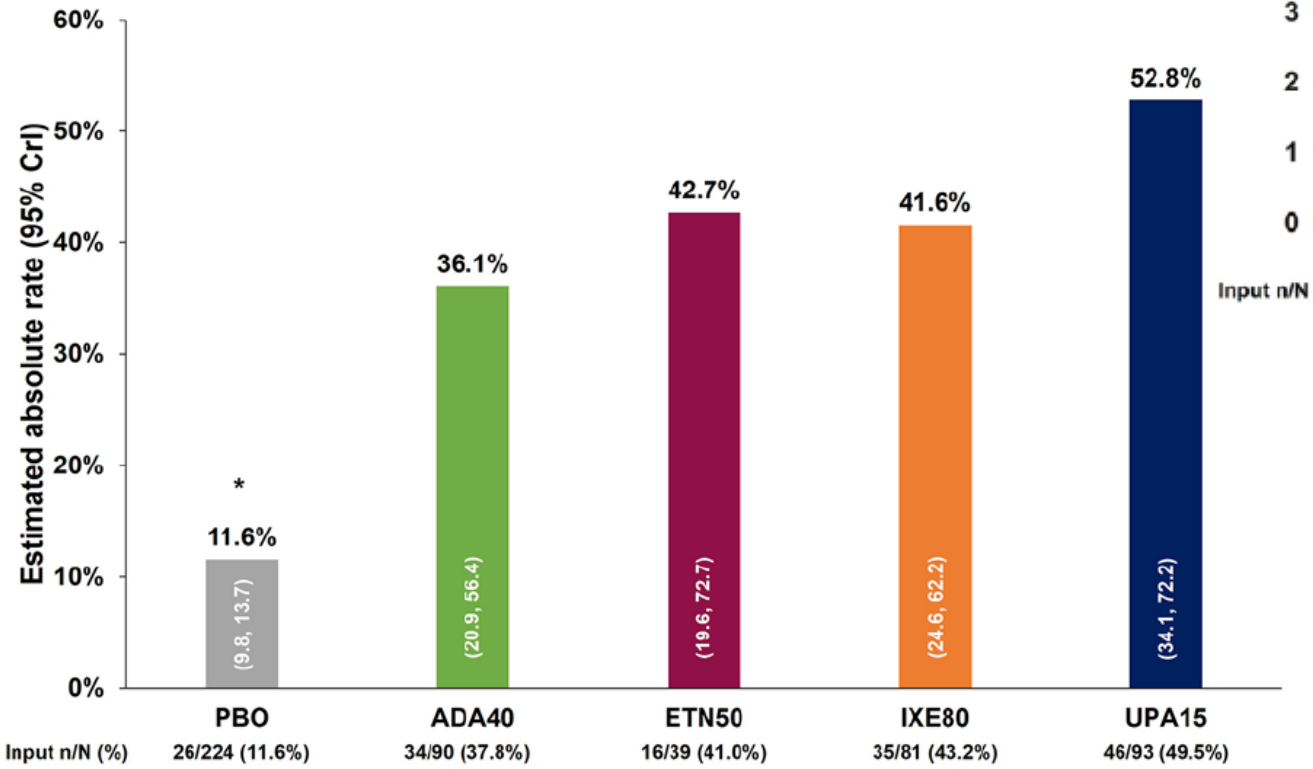
Walsh J.A. et al. Rheumatol Ther 2023

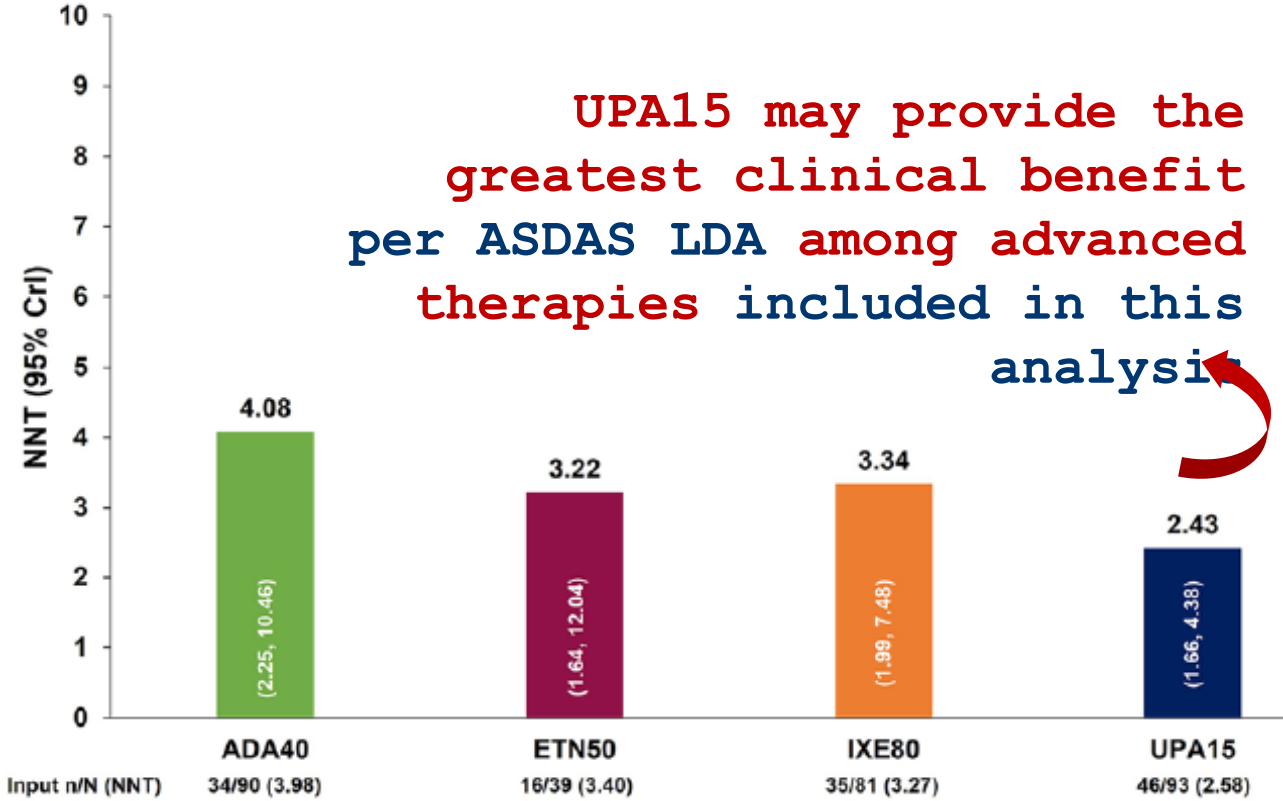
Rheumatol Ther (2024) 11:989–999
https://doi.org/10.1007/s40744-024-00685-y

ORIGINAL RESEARCH

Comparative Efficacy of Advanced Therapies in the Treatment of Radiographic Axial Spondyloarthritis or Ankylosing Spondylitis as Evaluated by the ASDAS Low Disease Activity Criteria

Xenofon Baraliakos · Christopher D. Saffore · Eric B. Collins · Bhumik Parikh ·



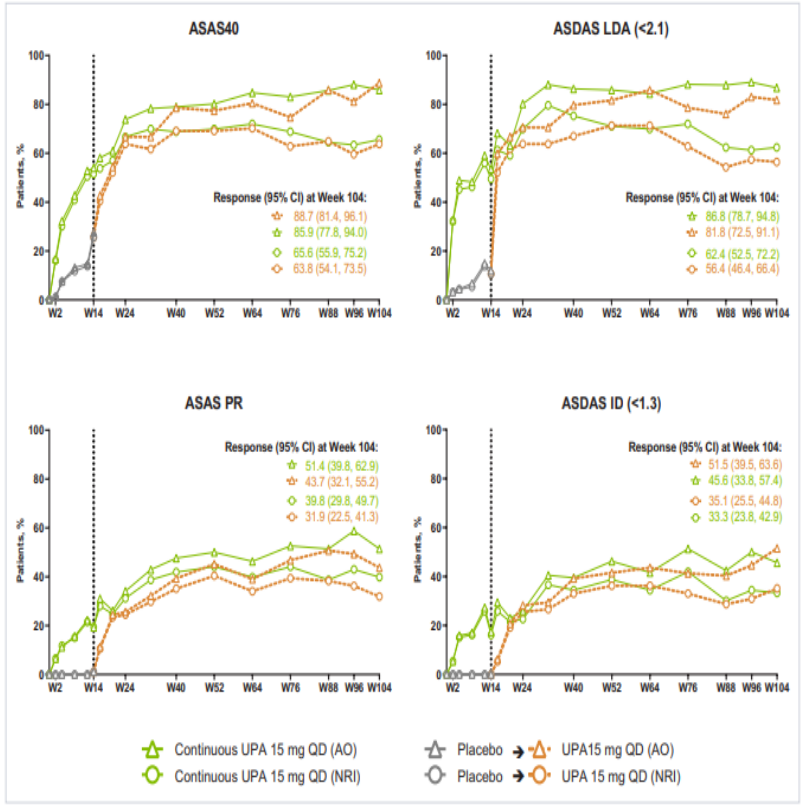


UPA15 may provide the greatest clinical benefit per ASDAS LDA among advanced therapies included in this analysis

Rates of ASDAS LDA were favorable for patients receiving UPA in both the TNFi-naïve and TNFi-IR

SELECT AXIS 1 & 2

- **Ταχεία έναρξη δράσης**
- 80% ASAS40 και ASDAS LDA στη 40η εβδομάδα
- **Παρόμοια αποτελεσματικότητα σε naïve ή bDMARDs-IR ασθενείς**
- **Σχεδόν 50% των ασθενών πέτυχαν πλήρη ύφεση στην 40η εβδομάδα**
- **Διατήρηση** της αποτελεσματικότητας στο τέλος του 2 έτους



van der Heijde D, et al. RMD Open 2022;8:e002280. doi:10.1136/rmdopen-2022-002280

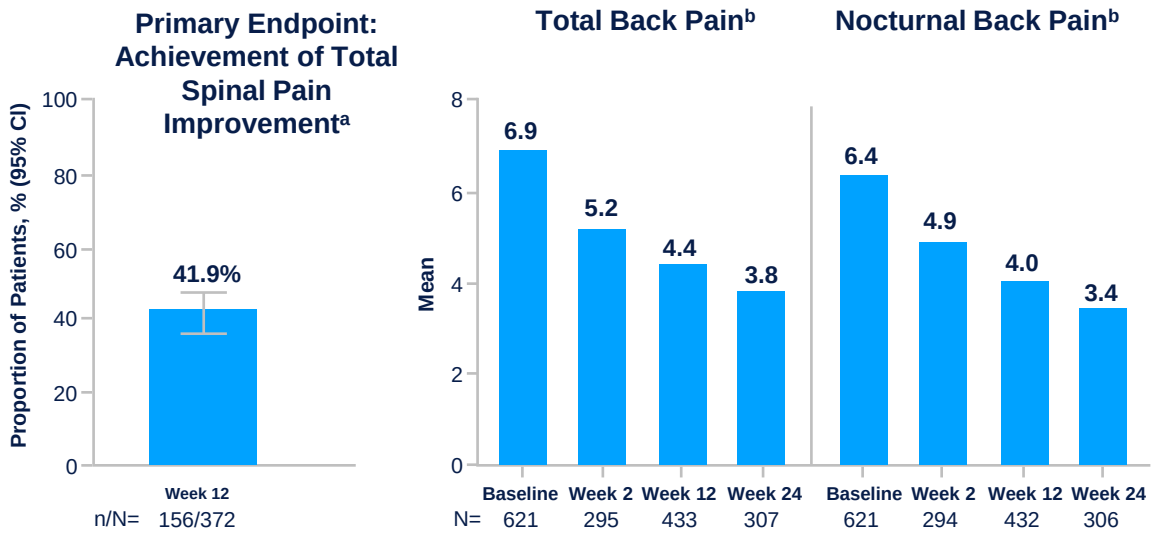
LDA: Low disease activity

In a real-world study, UPA demonstrated significant pain reduction in axSpA, including neuropathic pain

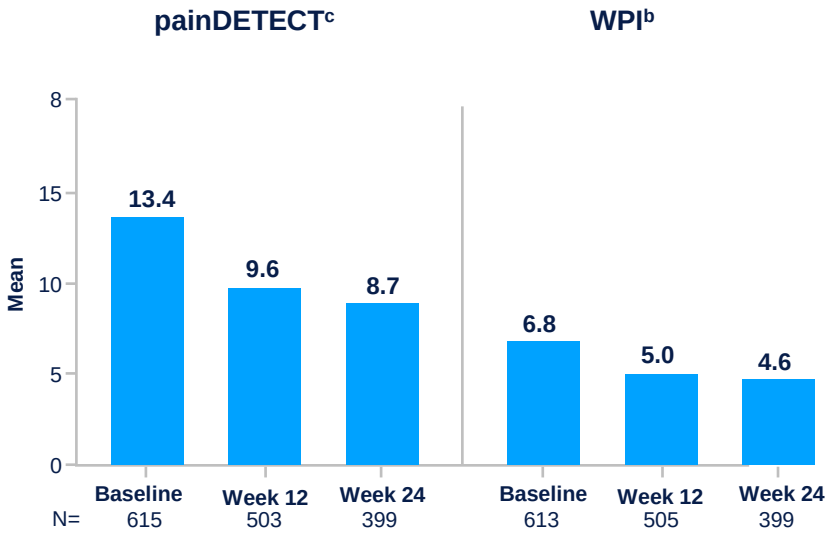
Real World

UPSTAND observational study in axSpA

Achievement of Total Spinal Pain Improvement at Week 12 and Measures of Total Back Pain and Nocturnal Back Pain Assessed Daily Through Week 2 and at Weeks 12 and 24



Additional Measures of Pain and Disease Activity at Baseline, Week 12, and Week 24



[a]Total spinal pain is the mean of total back pain and nocturnal back pain from the previous day, both measured 0 to 10 on the numeric rating scale and reported using observed cases. Improvement was defined as total spinal pain score <4 and ≥2 units improvement from baseline. [b]Both total back pain and nocturnal back pain were measured 0 to 10 on the numeric rating scale and analyzed using observed cases. [c]painDETECT scale: -1 (lowest pain) to 38 (highest pain). dWPI: 0 (lowest pain) to 19 (highest pain).
axSpA, axial spondyloarthritis; CI, confidence interval; dWPI, delta Wolf Pain Index; UPA, upadacitinib; WPI, widespread pain index.

Poddubnyy D, et al. EULAR 2025

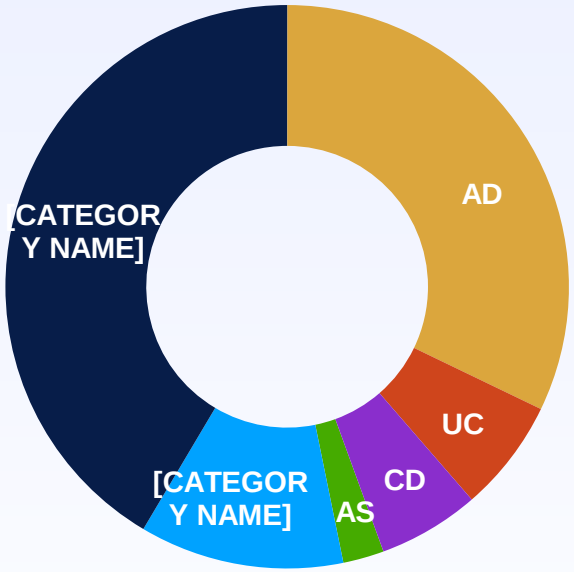
Overview of the UPA global safety data across indications

RA
(up to 5.5 yrs with UPA 15 mg)[1]

- **Higher rates of HZ, NMSC,** and **elevated CPK**
- MACEs, malignancies (excl. NMSC), and VTEs with UPA 15 mg were **generally similar to those reported with ADA + MTX and MTX monotherapy**
- The safety profile of UPA 15 mg **remained unchanged over long-term treatment compared with previous analyses**

PsA
(up to 3.9 yrs with UPA 15 mg)[1]

- **Differences in rates of serious and opportunistic infections, HZ, NMSC**, and **lymphopenia** were observed for UPA 15 mg vs ADA
- Rates for other events of **special interest** appeared **comparable between** UPA 15 mg and ADA



Percentage of patients from clinical trials included in safety analyses

AD
(up to 5 yrs with UPA 15 mg and UPA 30 mg)[2]

- **Numerically higher rates of serious and opportunistic infections as well as HZ** were seen with **UPA 30 mg vs 15 mg**
- **VTE, MACE, and malignancy (excl. NMSC) rates were numerically lower in AD** as compared to RA

UC & CD
(up to 1 yr with UPA 15 mg and UPA 30 mg)[3]

- **Rates of AEs of special interest** were **similar between UPA (15 and 30 mg doses)** and **PBO**
- **Dose-dependent increase** for **HZ, neutropenia,** and **CPK elevation** with **UPA**

AS
(up to 3.3 year with UPA 15 mg)[1]

- Rates of AEs were low with **no serious infections** reported

UPA is generally well tolerated with a safety profile that appears largely consistent across RA, PsA, AS, AD, UC, and CD populations, with some variations in AE rates due to differences in patient population and disease-associated comorbidities.

AD, atopic dermatitis; ADA, adalimumab; AE, adverse event; AS, ankylosing spondylitis; CD, Crohn's disease; CPK, creatine phosphokinase; HZ, herpes zoster; MACE, major adverse cardiovascular event; MTX, methotrexate; NMSC, nonmelanoma skin cancer; nr-axSpA, nonradiographic axial spondyloarthritis; PBO, placebo; PsA, psoriatic arthritis; PY, patient-years; RA, rheumatoid arthritis; UC, ulcerative colitis; UPA, upadacitinib; VTE, venous thromboembolism.

1. Burmester et al., RMD Open 2023;9:e002735;
2. Guttman-Yassky E, et al. J Allergy Clin Immunol. 2023;151:172-81;
3. Panaccione R, et al. Presented at the ACG Congress Oct 20-25, 2023 P3631.

Arthritis & Rheumatology
Vol. 76, No. 5, May 2024, pp 704–714
DOI 10.1002/art.42788

American College of Rheumatology
Empowering Rheumatology Professionals

Incidence of Uveitis in Patients With Axial Spondylarthritis Treated With Biologics or Targeted Synthetics: A Systematic Review and Network Meta-Analysis

Οι TNFis, Jakis, Il-17is, φαίνεται να προστατεύουν από την εμφάνιση πρόσθιας ραγοειδίτιδας σε ασθενείς με ΑΣ.

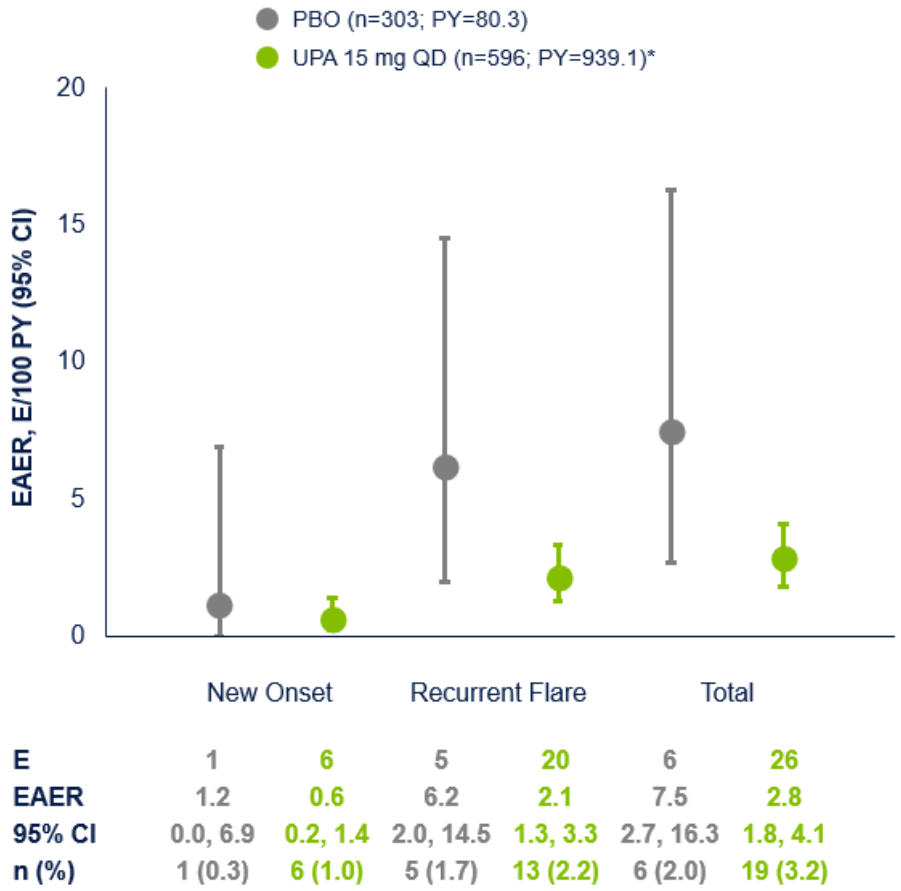
(iii)

Anti-TNF mAbs				
0.75 (0.18; 3.10)	Anti-IL17			
0.76 (0.10; 6.12)	1.01 (0.15; 6.86)	ETN		
1.01 (0.13; 7.56)	1.33 (0.21; 8.42)	1.32 (0.12; 14.31)	JAKi	
0.32 (0.10; 1.04)	0.43 (0.19; 0.98)	0.42 (0.08; 2.38)	0.32 (0.06; 1.67)	Placebo

No significant differences in risk of AU between treatments

SELECT-AXIS 1 Upadacitinib — bDMARD-naïve AS
SELECT-AXIS 2 Upadacitinib — bDMARD-IR AS

Uveitis in AS Studies



	New Onset		Recurrent Flare		Total	
E	1	6	5	20	6	26
EAER	1.2	0.6	6.2	2.1	7.5	2.8
95% CI	0.0, 6.9	0.2, 1.4	2.0, 14.5	1.3, 3.3	2.7, 16.3	1.8, 4.1
n (%)	1 (0.3)	6 (1.0)	5 (1.7)	13 (2.2)	6 (2.0)	19 (3.2)

*Includes any upadacitinib exposure, including patients who switched from placebo to upadacitinib up to data cutoff (15 August 2022). AS=ankylosing spondylitis; axSpA=axial spondyloarthritis; CI=confidence interval; E=events; EAER=exposure-adjusted event rate; nr-axSpA=non-radiographic axial spondyloarthritis; PBO=placebo; PY=patient-years; QD=once daily; UPA=upadacitinib.

1. Reddubnyy D et al. *Arthritis Rheumatol*. 2024. doi:10.1002/art.43069

Systematic Review and Meta-Analysis

Medicine

OPEN

Comparative of the effectiveness and safety of biological agents, small molecule drugs, and microbiome therapies in ulcerative colitis

Systematic review and network meta-analysis

Jie Gao, Master[a,b], Rui Nie, Master[a,b], Yalan Chen, Master[a,b], Wei Yang, Master[a,b,c], Qian Ren, PhD[a,b,c,*]

upadacitinib ranked highest for the induction of clinical remission and mucosal healing

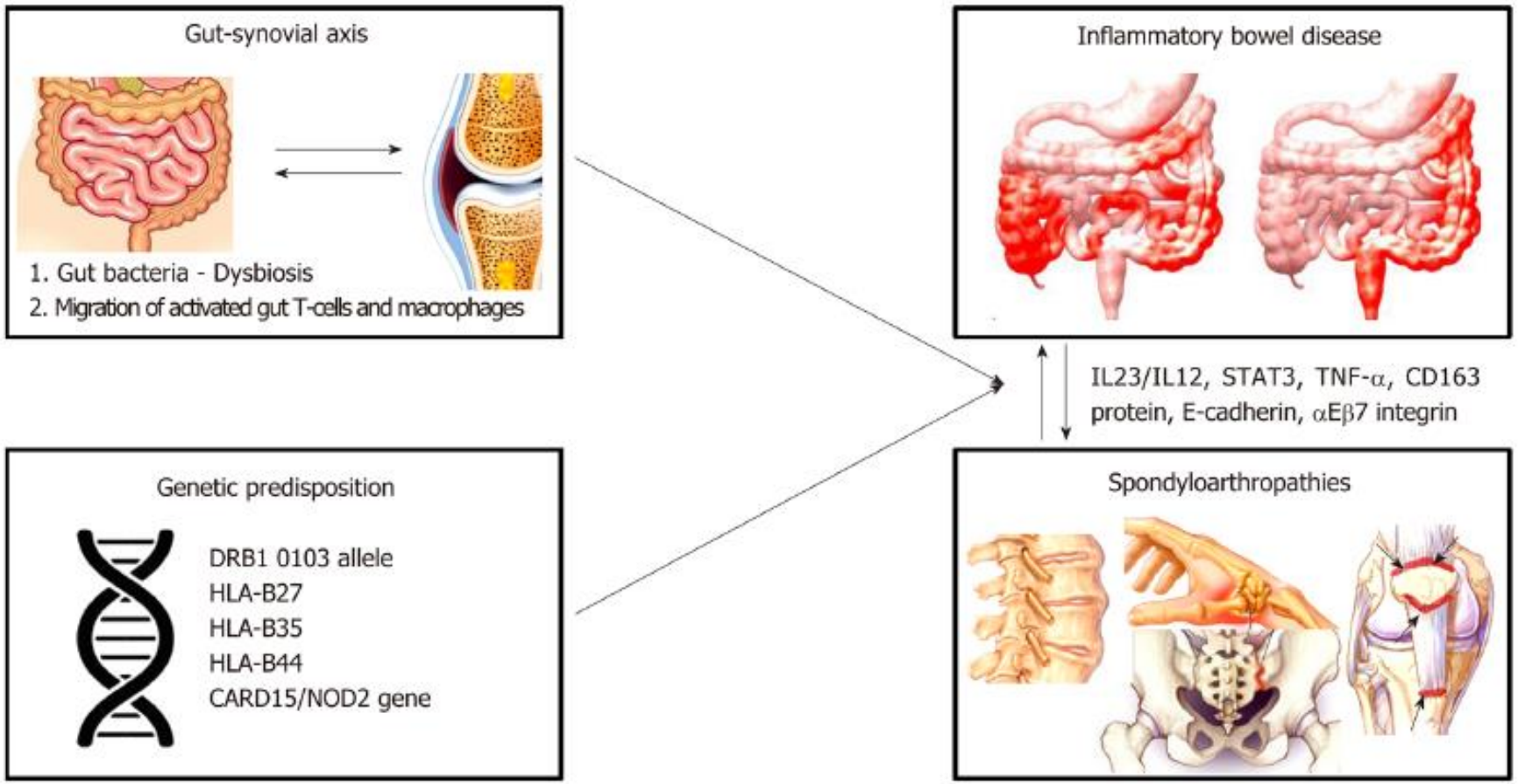
Adalimumab	0.38 (0.04, 3.83)	0.08 (0.00, 1.28)	0.28 (0.04, 1.89)	0.31 (0.05, 1.99)	0.64 (0.06, 6.92)	0.39 (0.04, 3.73)	1.24 (0.17, 8.62)	0.43 (0.04, 3.96)	0.16 (0.03, 0.83)	0.28 (0.04, 2.11)	0.32 (0.04, 3.00)
1.31 (0.55, 3.23)	Etrolizumab	0.20 (0.01, 3.19)	0.72 (0.10, 4.76)	0.81 (0.14, 4.78)	1.67 (0.16, 15.74)	1.02 (0.11, 9.07)	3.15 (0.46, 22.33)	1.10 (0.12, 9.79)	0.41 (0.08, 1.96)	0.72 (0.10, 5.30)	0.85 (0.10, 7.40)
0.82 (0.32, 2.22)	0.63 (0.25, 1.57)	FMT	3.66 (0.28, 50.08)	4.07 (0.37, 50.20)	8.33 (0.52, 152.95)	5.07 (0.33, 88.14)	15.84 (1.31, 225.62)	5.45 (0.35, 100.07)	2.04 (0.20, 22.62)	3.62 (0.29, 51.87)	4.26 (0.28, 69.54)
0.79 (0.26, 2.78)	0.60 (0.21, 1.97)	0.97 (0.35, 2.94)	Golimumab	1.12 (0.32, 4.41)	2.30 (0.33, 17.01)	1.40 (0.22, 9.08)	4.44 (0.93, 21.25)	1.53 (0.24, 10.50)	0.56 (0.19, 1.68)	1.00 (0.21, 5.11)	1.18 (0.19, 7.48)
0.88 (0.36, 2.23)	0.67 (0.32, 1.41)	1.07 (0.49, 2.35)	1.12 (0.38, 2.99)	Infliximab	2.06 (0.33, 11.97)	1.24 (0.23, 6.32)	3.92 (1.01, 14.25)	1.37 (0.23, 7.26)	0.50 (0.24, 0.99)	0.90 (0.22, 3.46)	1.04 (0.19, 5.31)
0.59 (0.15, 2.37)	0.45 (0.12, 1.71)	0.70 (0.18, 2.60)	0.75 (0.16, 3.02)	0.67 (0.18, 2.35)	Ozanimod	0.61 (0.06, 5.83)	1.92 (0.26, 13.52)	0.67 (0.07, 6.38)	0.24 (0.05, 1.25)	0.43 (0.06, 3.34)	0.51 (0.05, 4.49)
0.77 (0.26, 2.00)	0.58 (0.20, 1.41)	0.93 (0.35, 2.16)	0.97 (0.27, 2.66)	0.87 (0.34, 1.90)	1.30 (0.30, 4.77)	Tofacitinib	3.16 (0.47, 21.75)	1.09 (0.12, 9.29)	0.40 (0.09, 1.82)	0.71 (0.11, 5.07)	0.83 (0.10, 7.12)
0.21 (0.06, 0.69)	0.16 (0.05, 0.49)	0.25 (0.09, 0.75)	0.26 (0.07, 0.88)	0.24 (0.08, 0.64)	0.35 (0.08, 1.56)	0.27 (0.09, 0.91)	Upadacitinib	0.35 (0.05, 2.42)	0.13 (0.04, 0.39)	0.22 (0.05, 1.12)	0.26 (0.04, 1.76)
0.64 (0.16, 2.53)	0.48 (0.13, 1.86)	0.77 (0.21, 2.74)	0.80 (0.18, 3.32)	0.72 (0.21, 2.57)	1.07 (0.21, 5.60)	0.83 (0.23, 3.60)	2.98 (0.75, 13.22)	Ustekinumab	0.37 (0.08, 1.78)	0.65 (0.09, 4.66)	0.77 (0.09, 6.59)
2.12 (1.01, 4.61)	1.61 (0.81, 3.23)	2.55 (1.42, 4.72)	2.67 (1.04, 6.10)	2.39 (1.43, 4.03)	3.59 (1.13, 12.19)	2.76 (1.50, 6.05)	10.13 (4.19, 25.41)	3.35 (1.07, 10.46)	placebo	1.77 (0.58, 5.84)	2.09 (0.46, 9.13)
0.86 (0.29, 2.35)	0.65 (0.24, 1.73)	1.04 (0.40, 2.57)	1.08 (0.32, 3.12)	0.97 (0.38, 2.24)	1.44 (0.36, 5.74)	1.11 (0.44, 3.09)	4.13 (1.29, 12.56)	1.37 (0.32, 4.92)	0.41 (0.19, 0.80)	probiotic	1.17 (0.18, 7.52)
0.61 (0.26, 1.46)	0.46 (0.16, 1.36)	0.74 (0.24, 2.23)	0.77 (0.20, 2.60)	0.69 (0.24, 1.95)	1.04 (0.23, 4.68)	0.79 (0.27, 2.71)	2.94 (0.78, 10.77)	0.96 (0.21, 4.23)	0.29 (0.11, 0.72)	0.72 (0.22, 2.34)	vedolizumab

clinical remission

mucosal healing

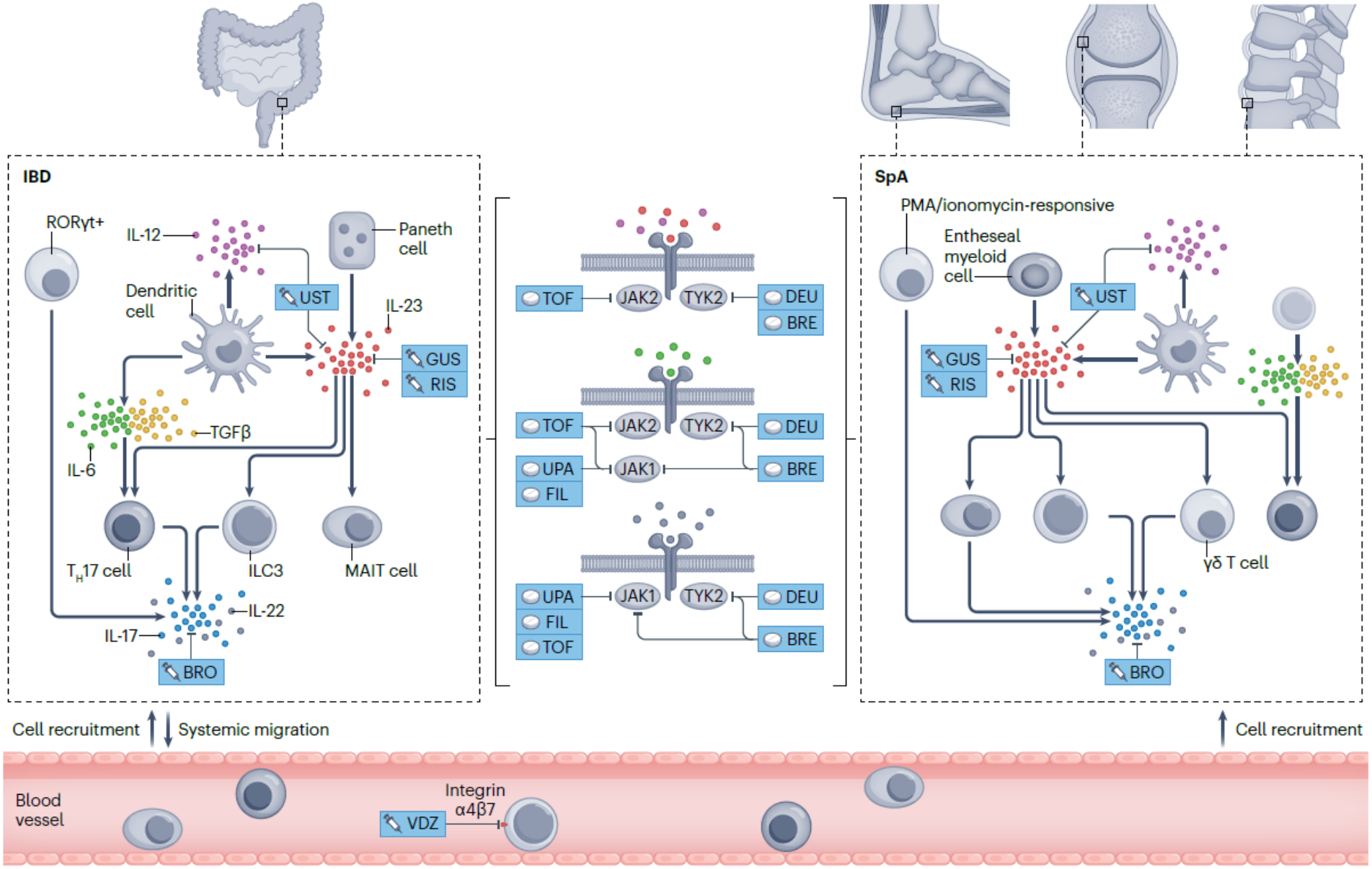
Figure 3. Indirect comparison for the induction of clinical remission and mucosal healing in patients with moderate-to-severe ulcerative colitis.

Pathogenic mechanisms linking gut and joint inflammation



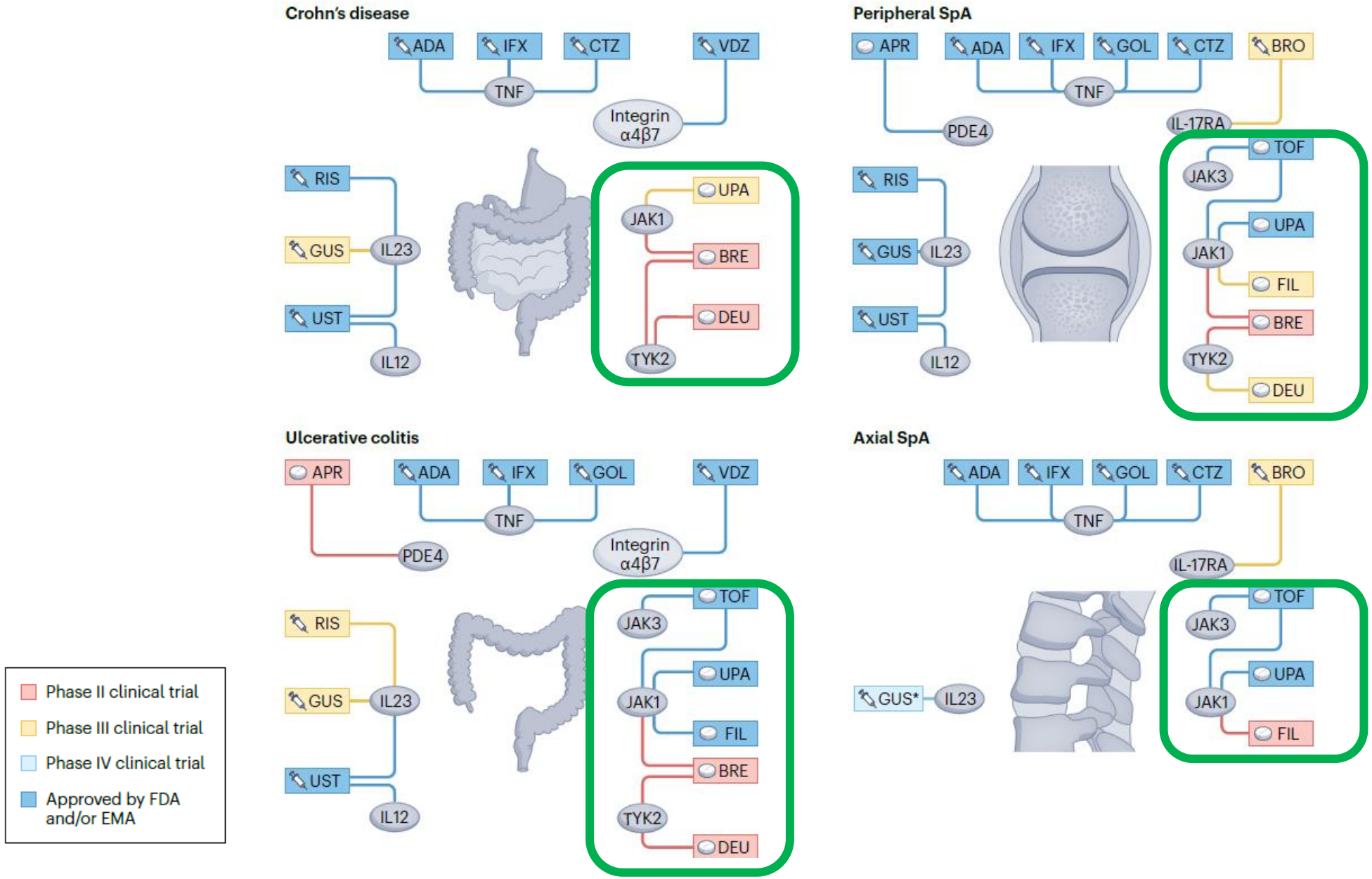
Fragoulis GE, Liava C, Daoussis D, Akriviadis E, Garyfallos A, Dimitroulas T. Inflammatory bowel diseases and spondyloarthropathies: From pathogenesis to treatment. *World J*

Common pathways & therapeutic targets in SpA and IBD



Cozzi, G., Scagnellato, L., Lorenzin, M. *et al.* Spondyloarthritis with inflammatory bowel disease: the latest on biologic and targeted therapies. *Nat Rev Rheumatol* **19**, 503–518 (2023). https://doi.org/10.1038/s41584-023-00984-8

Stages of development and targets of drugs in SpA & IBD



Cozzi, G., Scagnellato, L., Lorenzin, M. *et al.* Spondyloarthritis with inflammatory bowel disease: the latest on biologic and targeted therapies. *Nat Rev Rheumatol* **19**, 503–518 (2023). https://doi.org/10.1038/s41584-023-

AxSpA ♀

ΚΑΤΕΡΙΝΑ

45 ετών

Πρώην καπνίστρια (διέκοψε το 2010)

ΚΑΘΙΣΤΙΚΗ ΖΩΗ

Height	162 cm	Φαρμακευτικός αντιπρόσωπος, ταξιδεύει συχνά, δε γυμνάζεται
Weight	78 Kg	Μητέρα 2 τέκνων (2 και 5 ετών)
		Οικογενειακό ιστορικό: μητέρα με ΑΣ

Ιστορικό ασθενούς

- **2015** Αρθρίτιδα άκρων χειρών άμφω με προσβολή καρπών άμφω, ΜΚΦ και ΦΦ αρθρώσεων άμφω, γονάτων άμφω, και άκρων ποδιών άμφω, ενθεσίτιδα σε αχίλειο τένοντα άμφω και επικονδυλίτιδα άμφω
- Κόπωση, πρωινή δυσκαμψία για μια ώρα
- Κακή ψυχολογία
- **HLA-B27 θετικό**, Ro ιερολαγονίων αρθρώσεων χωρίς αλλοιώσεις
- Δυσλιπιδαιμία , υποθυρεοειδισμός υπό αγωγή

Εργαστηριακός έλεγχος

CRP (mg/dL)	5 (<5)
TKE	45
RF, anti-CCP , ANA, anti-ENA	Αρνητικά

Speaker’s opinion

AxSpA ♀

ΚΑΤΕΡΙΝΑ

45 ετών

Πρώην καπνίστρια (διέκοψε το 2010)

Table 1

- 2015: διάγνωση **περιφερικής SpA** σε ύφεση με δισκία μεθοτρεξάτης 15mg /εβδομάδα (είχε λάβει παραλληλα βραχύ σχήμα κορτικοστεροειδών κατά τη διάγνωση)

ΠΡΟΤΑΘΕΙΣΑ ΟΛΙΣΤΙΚΗ ΘΕΡΑΠΕΥΤΙΚΗ ΑΓΩΓΗ

- ➢ Διατροφή
- ➢ Γυμναστική με διατάσεις ΣΣ και ενδυνάμωση
- ➢ Φαρμακευτική Αγωγή
- ➢ Συζήτηση για πιθανή επαφή με ψυχολόγο!

Speaker's opinion

AxSpA ♀

ΚΑΤΕΡΙΝΑ

45 ετών

Πρώην καπνίστρια (διέκοψε το 2010)

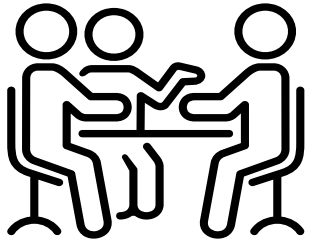
ΤΡΕΧΟΥΣΑ ΟΛΙΣΤΙΚΗ ΘΕΡΑΠΕΥΤΙΚΗ ΑΓΩΓΗ

- Ύφεση με MTX 15mg /εβδομάδα +
  - ➢ Διατροφή
  - ➢ Γυμναστική με διατάσεις ΣΣ και ενδυνάμωση

- **5/2020**: επισκέπτεται τον οικογενειακό Παθολόγο αναφέροντας ***αύξηση του αριθμού (από 1-2 σε 4-5) και ρευστοποίηση των κενώσεων με πρόσμειξη αίματος*** χωρίς επιτακτικότητα, πυρετό ή νυκτερινή αφύπνιση από 15μέρου. Δεν αναφέρει συμπτώματα από το μυοσκελετικό

Speaker's opinion

Ας συζητήσουμε …



Αν επισκεπτόταν τον Ρευματολόγο αντί του Παθολόγου, θα συστήνατε:

Α. Μικροβιολογικό έλεγχο κοπράνων & αιματολογικές εξετάσεις

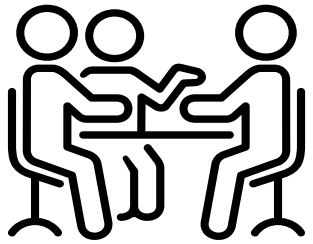
Β. Κολονοσκόπηση

Γ. CT Κοιλίας

Speaker’s opinion

- Καλλιέργεια & παρασιτολογική κοπράνων: χωρίς ανάδειξη παθογόνου
- Καλπροτεκτίνη κοπράνων: 1600 μg/g
- WBC: 10000 X 10^3
- Hgb: 11 mg/dL
- TKE: 60
- CRP: 2 mg/dL (<0.5)

Speaker's opinion



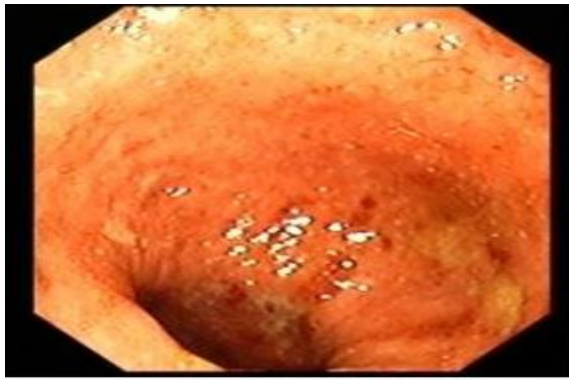
Ώρα για παραπομπή σε Γαστρεντερολόγο

Speaker’s opinion

Rheumatologist perspective on identifying and managing patients with SpA and IBD	SpA patients	IBD patients	Gastroenterologist perspective on identifying and managing patients with IBD and SpA
Early Identification	**Major criteria for IBD**	**Major criteria for SpA**	**Early Identification**
Multidisciplinary approach	1. Chronic diarrhoea 2. Rectal bleeding 3. Perianal fistula /abscess 4. Chronic abdominal pain 5. Nocturnal symtoms	1. Chronic low back pain 2. Dactylitis 3. Enthesitis 4. Peripheral joint pain / swelling	**Multidisciplinary approach**
Peripheral vs Axial SpA	**Minor criteria for IBD**	**Minor criteria for SpA**	**Calprotectin before starting IL-17?**
Type of IBD	1. Oral aphtosis 2. Fever 3. Anemia 4. Family history of IBD 5. Weight loss	1. Family history of SpA 2. Psoriasis 3. Anterior uveitis 4. Chest pain	**NSAIDS not an absolute contraindication**

Speaker's opinion

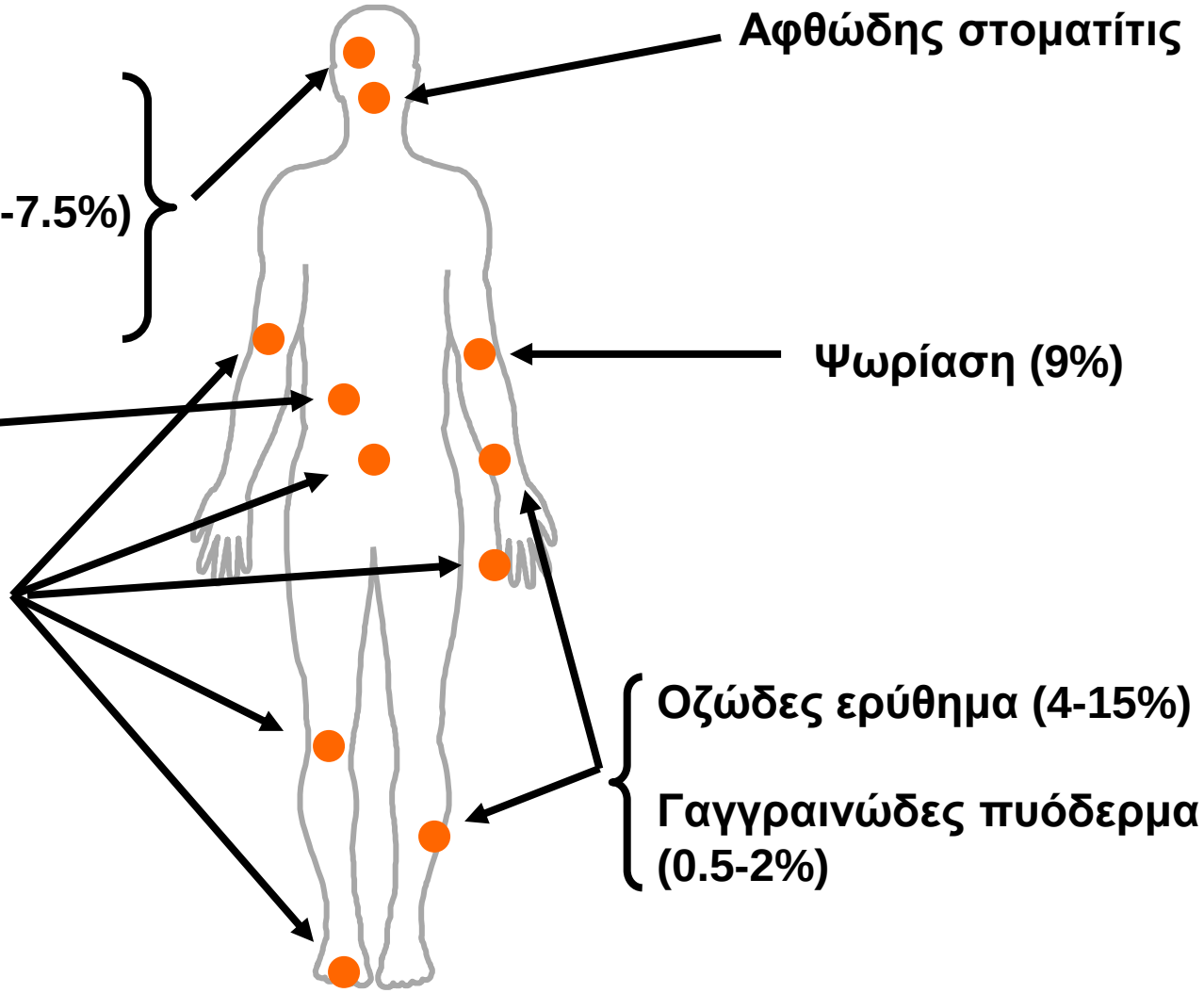
- 6/2020: παραπομπή σε Γαστρεντερολόγο οπότε και υποβάλλεται σε κολονοσκόπηση λόγω εμμένουσας συμπτωματολογίας



- Ενδοσκοπική εικόνα συμβατή με **αριστερόπλευρη ελκώδη κολίτιδα** μέτριας (**Mayo 2)** ενδοσκοπικής βαρύτητας

Speaker's opinion

Συχνές “τυπικές” εξωεντερικές εκδηλώσεις (ΕΕ) στις ΙΦΝΕ



Επισκληρίτιδα, σκληρίτιδα, πρόσθια (ιριδοκυκλίτιδα) & οπίσθια (υαλοειδίτιδα) ραγοειδίτιδα (2.5-7.5%)

Αφθώδης στοματίτις

Ψωρίαση (9%)

ΠΣΧ (2.5-7.5%)

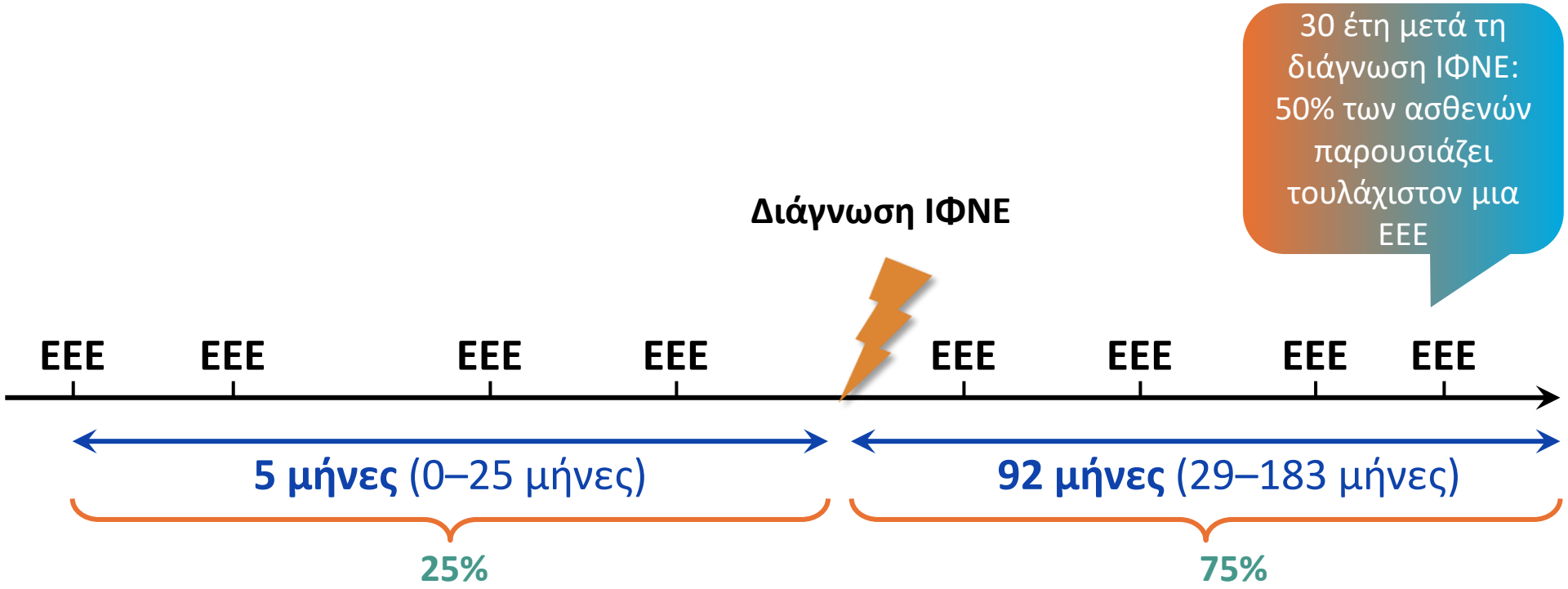
ΑΣ (2-8%), περιφερική αρθρίτιδα (5-20%)

Οζώδες ερύθημα (4-15%)

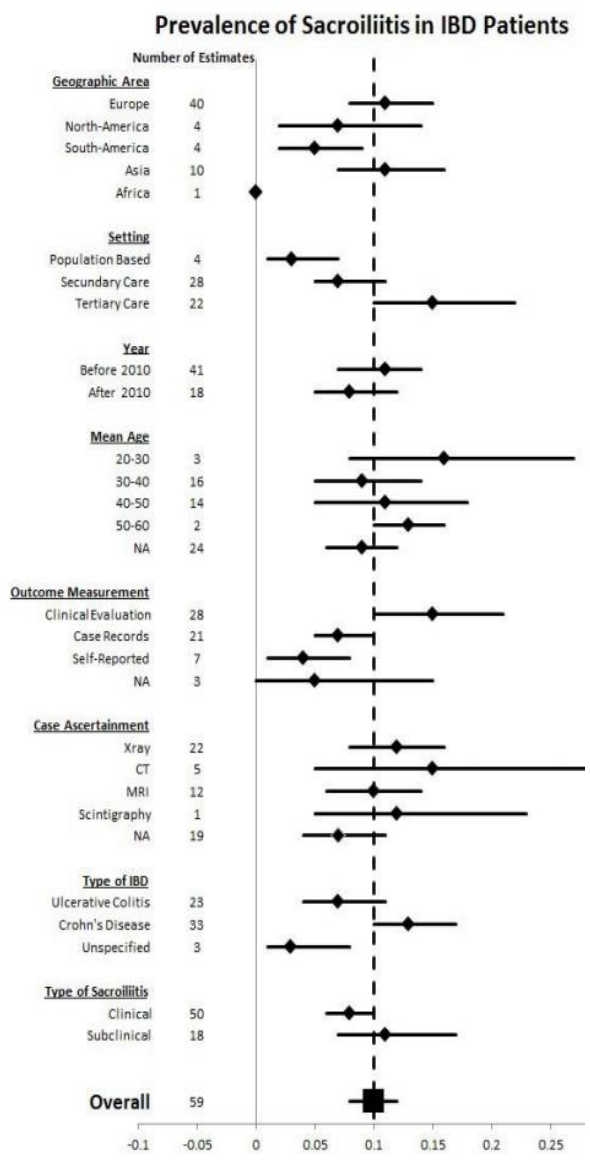
Γαγγραινώδες πυόδερμα (0.5-2%)

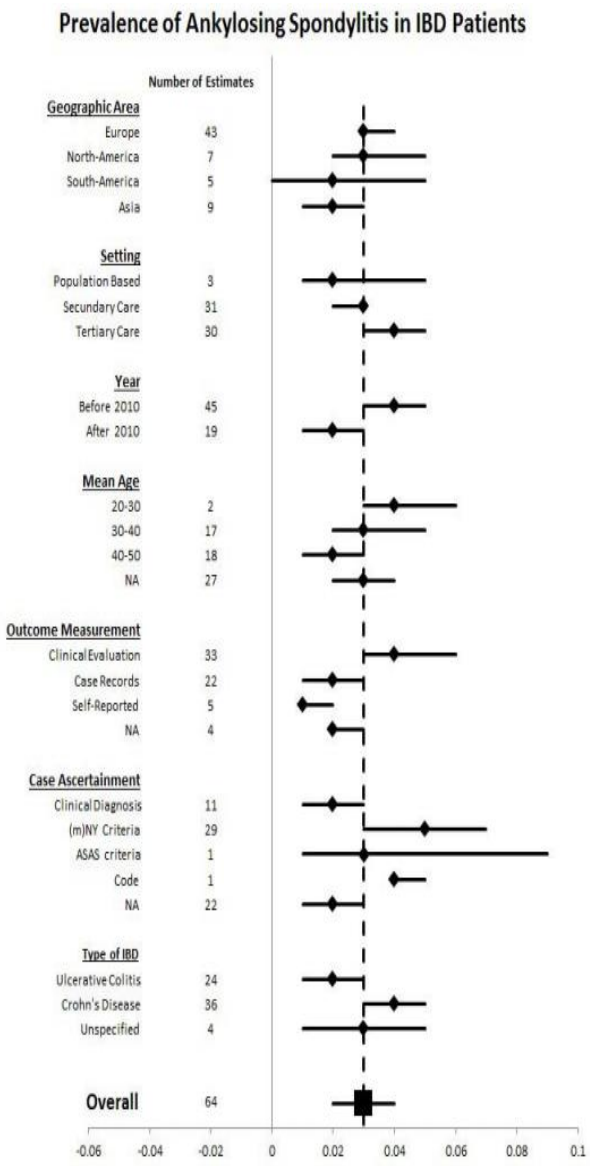
Ott C and Schölmerich J. Nat Rev Gastroenterol Hepatol 2013;10:585-595

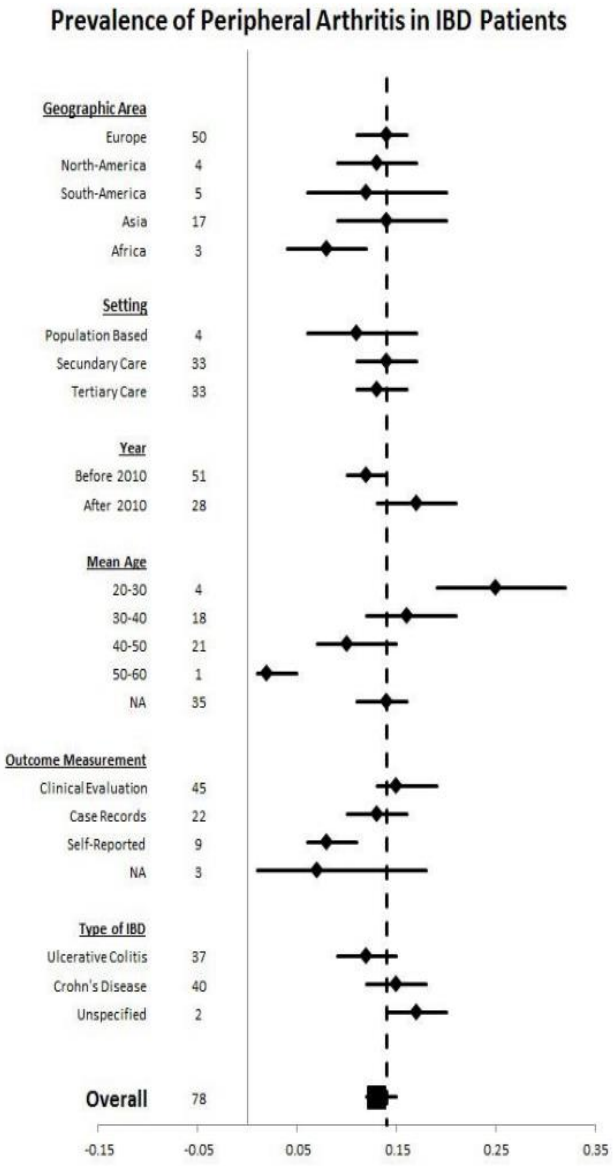
Οι ΕΕ μπορεί να παρουσιαστούν οποιαδήποτε χρονική στιγμή πριν ή μετά τη διάγνωση των ΙΦΝΕ



Gordon H, et al. J Crohns Colitis 2024;18:1-37
Vavricka SR, et al. Inflamm Bowel Dis 2015;21:1794–800
Ardizzone S, et al. Dig Liv Dis 2008;40S:S253–259







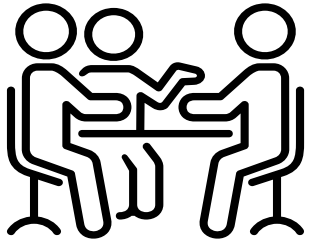
Spondyloarthritis occurs in up to 13% of patients with IBD. Ankylosing spondylitis is the least common [3%] followed by sacroiliitis [10%] and peripheral arthritis [13%]

Karreman MC, et al. J Crohns Colitis 2017;11:631-642

No Total cohort (%) EIMs cohort (%)	Total (n=1860) (n=615)	Males (n=1053) (n=272)	Females (n=807) (n=343)	OR (95%CI) [P value]	CD (n=1001) (n=407)	UC (n=859) (n=208)	OR (95%CI) [P value]
ARTHRITIC EIMs	434 (23.3) (70.6)	169 (16.0) (62.1)	265 (32.8) (77.3)	**0.5 (0.3-0.7) [<0.0001]**	308 (30.8) (75.7)	126 (14.7) (60.6)	**2.0 (1.4-2.9) [<0.0001]**
Arthralgia	311 (16.7) (50.6)	108 (10.3) (39.7)	203 (25.2) (59.2)	**0.5 (0.3-0.8) [0.005]**	218 (21.8) (53.6)	93 (10.8) (44.7)	NS
Peripheral arthritis	221 (11.9) (35.9)	74 (7.0) (27.2)	147 (18.2) (42.9)	**0.6 (0.4-0.9) [0.018]**	155 (15.5) (38.1)	66 (7.7) (31.7)	NS
Ankylosing spondylitis	39 (2.1) (6.3)	26 (2.5) (9.6)	13 (1.6) (3.8)	**3.5 (1.7-7.1) [<0.0001]**	34 (3.4) (8.4)	5 (0.6) (2.4)	**3.0 (1.1-7.8) [0.025]**
Sacroileitis	86 (4.6) (14.0)	39 (3.7) (14.3)	47 (5.8) (13.7)	NS	70 (7.0) (17.2)	16 (1.9) (7.7)	**2.0 (1.1-3.6) [0.017]**
DERMATOLOGIC EIMs	260 (14.0) (42.3)	120 (11.4) (44.1)	140 (17.3) (40.8)	NS	169 (16.9) (41.5)	91 (10.6) (43.8)	NS
Erythema nodosum	99 (5.3) (16.1)	39 (3.7) (14.3)	60 (7.4) (17.5)	NS	75 (7.5) (18.4)	24 (2.8) (11.5)	**2.2 (1.3-3.9) [0.005]**
Pyoderma gangrenosum	15 (0.8) (2.4)	7 (0.7) (2.6)	8 (1.0) (2.3)	NS	7 (0.7) (1.7)	8 (0.9) (3.8)	NS
Psoriasis	51 (2.7) (8.3)	23 (2.2) (8.5)	28 (3.5) (8.2)	NS	33 (3.3) (8.1)	18 (2.1) (8.7)	NS
Sweet's syndrome	4 (0.2) (0.7)	1 (0.1) (0.4)	3 (0.4) (0.9)	NS	2 (0.2) (0.5)	2 (0.2) (1.0)	NS
Hydradenitis suppurativa	5 (0.3) (0.8)	1 (0.1) (0.4)	4 (0.5) (1.2)	NS	4 (0.4) (1.0)	1 (0.1) (0.5)	NS
Aphthous stomatitis	114 (6.1) (18.5)	59 (5.6) (21.7)	55 (6.8) (16.0)	NS	69 (6.9) (17.0)	45 (5.2) (21.6)	NS

Karmiris K, et al. J Crohns Colitis 2016:429-436

Ας συζητήσουμε …



- **Ποια η βέλτιστη θεραπευτική προσέγγιση το 2020;**

Α. Χορήγηση μεσαλαμίνης συνδυαστικά με μεθοτρεξάτη

Β. Χορήγηση infliximab συνδυαστικά με μεθοτρεξάτη

Γ. Χορήγηση golimumab συνδυαστικά με μεθοτρεξάτη

Δ. Διακοπή της μεθοτρεξάτης και χορήγηση adalimumab

Speaker’s opinion

- Χορηγήθηκαν δισκία (4gr ημερησίως) και υποκλυσμοί (αρχικά ένας ημερησίως με προοδευτική αποκλιμάκωση) μεσαλαμίνης με καλή κλινική & εργαστηριακή ανταπόκριση

Speaker’s opinion

AxSpA + ελκώδης κολίτις

ΚΑΤΕΡΙΝΑ

45 ετών

Πρώην καπνίστρια (διέκοψε το 2010)

10/2021

Ραντεβού στο **ΡΕΥΜΑΤΟΛΟΓΟ**

- Προσέρχεται παραπονούμενη για εμμένουσες αρθραλγίες/έντονη δυσκαμψία σε άκρες χείρες και γόνατα από μηνός μη υφιόμενες με τη λήψη 2-3 βραχέων σχημάτων COX-2
- Δεν αναφέρει συμπτώματα από το πεπτικό

Κλινικά & εργαστηριακά ευρήματα

CRP (mg/dL)	5 (<5)
Αρθρίτιδα σε PIPs II,III,IV άμφω χωρίς άλλη προσβολή	
ΤΚΕ	35

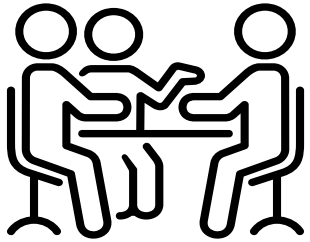
Speaker’s opinion

Η επίτευξη ύφεσης των ΕΕΕ δεν ακολουθεί πάντα παράλληλη πορεία με την επίτευξη ύφεσης της πεπτικής νόσου

ΕΕΕ	Παράλληλη πορεία με ΙΦΝΕ	Διακριτή πορεία από τις ΙΦΝΕ	Μεικτή σχέση με την ενεργό ΙΦΝΕ
Αξονική SpA		✓	
Περιφερική SpA	✓(ολιγοαρθρική)	✓(πολυαρθρική)	
Οζώδες ερύθημα	✓		
Γαγγραινώδεις πυόδερμα			✓
Σύνδρομο Sweet's	✓		
Αφθώδης στοματίτις	✓		
Επισκληρίτις	✓		
Ραγοειδίτις			✓
Πρωτοπαθής σκληρυντική χολαγγειίτιδα			✓

Speaker's opinion

Ας συζητήσουμε …



- **Ποια η βέλτιστη θεραπευτική προσέγγιση το 2021;**

Α. Χορήγηση infliximab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Β. Χορήγηση golimumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

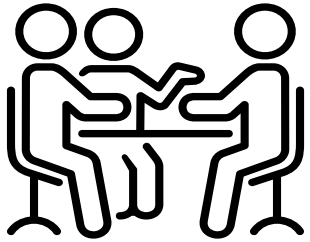
Γ. Χορήγηση σχήματος κορτικοστεροειδών επιπλέον της αγωγής που λαμβάνει

Δ. Διακοπή μεθοτρεξάτης και χορήγηση JAK αναστολέα

Speaker’s opinion

Χορηγήθηκε σχήμα πρεδνιζολόνης (δόση εφόδου: 40mg) με προοδευτική αποκλιμάκωση και καλή αρχικά κλινική & εργαστηριακή ανταπόκριση αλλά… υποτροπή όταν η δόση ελαττώθηκε στα 10mg

Speaker’s opinion



Ας συζητήσουμε … ξανά..

- **Ποια η βέλτιστη θεραπευτική προσέγγιση το 2021;**

Α. Χορήγηση infliximab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Β. Χορήγηση golimumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Γ. Χορήγηση ustekinumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Δ. Διακοπή μεθοτρεξάτης και χορήγηση JAK αναστολέα

Speaker’s opinion

- Χορηγήθηκε infliximab συνδυαστικά με τη MTX με καλή κλινική & εργαστηριακή ανταπόκριση

Speaker’s opinion

AxSpA + ελκώδης κολίτις

ΚΑΤΕΡΙΝΑ

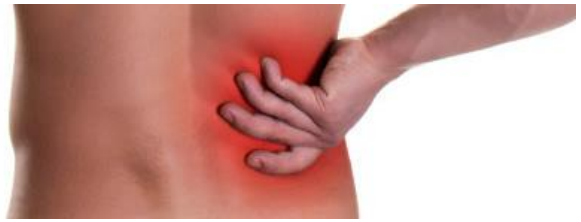
45 ετών

Πρώην καπνίστρια (διέκοψε το 2010)

10/2022

Ραντεβού στο **ΡΕΥΜΑΤΟΛΟΓΟ**

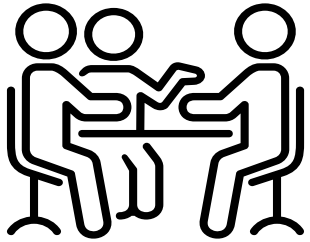
- **χαμηλή οσφυαλγία *προοδευτικά επιδεινούμενη από τριμήνου*** ενώ αναφέρει και **ρευστοποίηση των κενώσεων** χωρίς όμως ιδιαίτερη αύξηση του αριθμού τους (2-3 ημερησίως) ή παρουσία προσμείξεων αλλά σποραδική επιτακτικότητα χωρίς νυκτερινή αφύπνιση



Speaker’s opinion

- Καλλιέργεια & παρασιτολογική κοπράνων: χωρίς ανάδειξη παθογόνου
- Καλπροτεκτίνη κοπράνων: 300 μg/g
- WBC: 9000 X 10^3
- Hgb: 12.5 mg/dL
- TKE: 75
- CRP: 4 mg/dL (<0.5)

Speaker's opinion



Ας συζητήσουμε …

- **Ποια η βέλτιστη θεραπευτική προσέγγιση το 2022;**

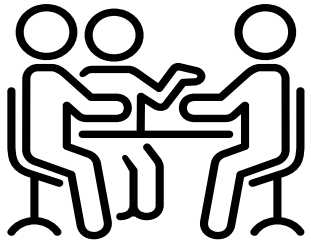
Α. Διακοπή του infliximab & χορήγηση adalimumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Β. Διακοπή του infliximab & χορήγηση ustekinumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Γ. Διακοπή του infliximab & χορήγηση upadacitinib με ή χωρίς μεθοτρεξάτη

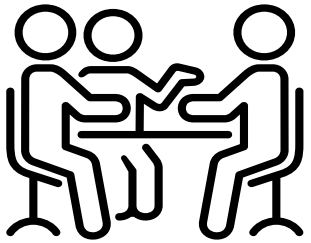
Δ. Διακοπή τόσο του infliximab όσο και της μεθοτρεξάτης και χορήγηση secukinumab

Speaker’s opinion



Anti-TNFα cycling vs out of class choice in ulcerative colitis with SpA?

Speaker’s opinion



ΣΥΝΕΝΝΟΗΣΗ-ΣΥΝΑΠΟΦΑΣΗ Γαστρεντερολόγου-Ρευματολόγου

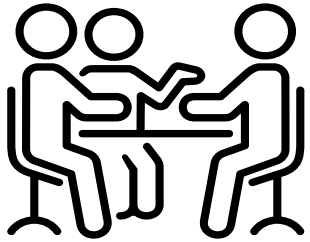
Οι νόσοι αλλάζουν…

Ο ασθενής αλλάζει και… ενημερώνεται

Οι ιατροί πρέπει να βρουν τη βέλτιστη θεραπευτική ισορροπία μεταξύ τους αλλά…και με τον ασθενή

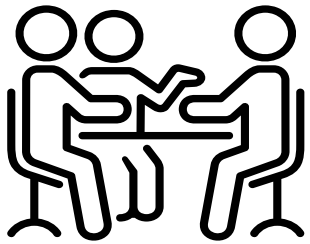
Speaker’s opinion

Ας συζητήσουμε …



Πώς εμπλέκεται ο ασθενής στην **από κοινού απόφαση** όταν συζητάμε για τις θεραπευτικές επιλογές???

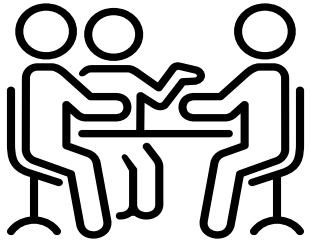
Speaker’s opinion



Συμμετοχή του ασθενή στην κοινή απόφαση !!!

- Discuss patient goals
- Provide options to patients
  Ask them what matters most
- Discuss safety transparently
  (risk assessment)
- Don’t assume patients are risk averse
- Compare with other options
  (how they are different)
- Explain the mechanism simply
- Set realistic expectations
- Discussing consequences of not treating or inadequate treatment

Speaker’s opinion



Ας συζητήσουμε …

- **Ποια η βέλτιστη θεραπευτική προσέγγιση το 2022;**

Α. Διακοπή του infliximab & χορήγηση adalimumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

Β. Διακοπή του infliximab & χορήγηση ustekinumab συνδυαστικά με μεθοτρεξάτη & μεσαλαμίνη

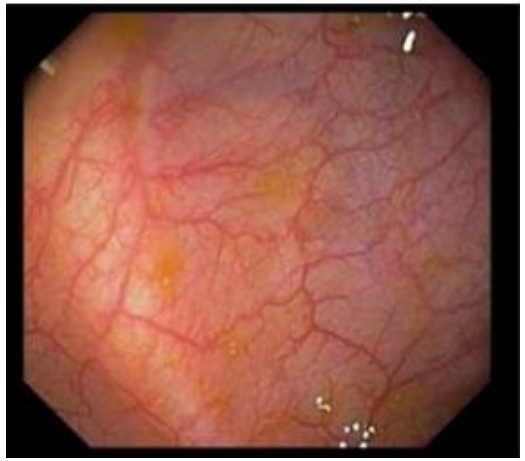
Γ. Διακοπή του infliximab & χορήγηση upadacitinib με ή χωρίς μεθοτρεξάτη

Δ. Διακοπή τόσο του infliximab όσο και της μεθοτρεξάτης και χορήγηση secukinumab

Speaker’s opinion

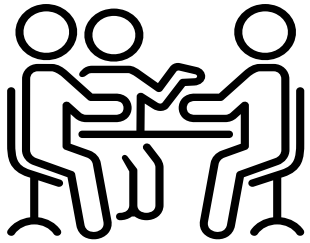
- Έγινε διακοπή της μεθοτρεξάτης και έναρξη δισκίων **upadacitinib 15mg** ημερησίως με καλή κλινική ανταπόκριση τόσο από το πεπτικό όσο και από το μυοσκελετικό

- 6/2023: 1-2 σχηματισμένες κενώσεις ημερησίως χωρίς προσμείξεις ή άλλη συμπτωματολογία, υποβλήθηκε σε ορθοσιγμοειδοσκόπηση



Speaker's opinion

Ελεύθερη συζήτηση



Συνδυασμοί βιολογικών παραγόντων /στοχευμένων θεραπειών το 2025??

Speaker’s opinion

Το 2025 οι προσδοκίες έχουν αλλάξει!!!

Μπορούμε σίγουρα καλύτερα!!!

Σας ευχαριστούμε !

Η γνώμη σας είναι πολύτιμη!

Παρακαλώ σκανάρετε το QR code