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INTERLAKEN, SEPTEMBER 3–4, 2026

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BEST ABSTRACTS

BA 1

Single-cell profiling of skin and synovial fibroblasts identifies opposing IFN alpha/beta pathway regulation in Psoriasis with Arthralgia and Psoriatic Arthritis.

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In most Psoriatic Arthritis (PsA) patients, psoriatic skin manifestation precedes articular involvement, with ~30% of psoriasis (PsO) patients developing PsA. Arthralgia – joint pain without overt arthritis – identifies patients at high risk of this transition. Fibroblasts are key stromal cells in both skin and synovium that regulate tissue structure, inflammation, and extracellular matrix dynamics and may play a crucial role in the transition from PsO to PsA; however, mechanisms and biomarkers of this transition are unknown. To address this, we profiled skin and synovial fibroblast populations from PsO-Arthralgia and PsA patients using scRNA-seq and compared their transcriptional programs to uncover shared pathogenic signatures. We performed scRNA-seq on skin (n = 34) and synovial biopsies (n = 22), including healthy controls for both tissue datasets. Unsupervised clustering identified fibroblasts, keratinocytes, melanocytes, endothelial cells, and infiltrating immune cells. Skin fibroblast subclustering revealed immune-interacting (CCL19+, PLA2G2A+), CXCL13+, Schwann-like, superficial (APCDD1+), universal (PI16+), and hair-follicle associated subpopulations. CCL19+ and PLA2G2A+ immune-interacting fibroblasts showed increased abundance in both PsA and PsO patients compared to healthy skin. Synovial fibroblast subclustering identified three lining and five sublining subpopulations, whose proportions were comparable across patient groups and healthy controls. Differential expression analysis showed that CCL19+ immune-interacting fibroblasts had the largest transcriptional differences between PsA and PsO-Arthralgia skin, while PI16+ fibroblasts showed distinct patterns between patient groups and healthy controls. Strikingly, IFN alpha/beta signalling was down-regulated in PsA skin fibroblasts compared to PsO-Arthralgia and healthy controls (NES = -2.04, p <0.001), most prominently in the CCL19+ subpopulation. In contrast, the same pathway was up-regulated in PsA synovial fibroblasts compared to PsO-Arthralgia (NES = 2.25, p <0.001). The core enriched genes – including HLA-A, HLA-B, BST2, STAT1, IFI6, and IFITM1 – showed divergent expression between skin and synovial tissue. Together, these findings identify fibroblast subpopulations with disease-specific transcriptional signatures, including opposing IFN alpha/beta pathway regulation in skin and synovium, that may represent early mechanistic drivers of progression from PsO-Arthralgia to PsA.

BA 2

Effect of Oral Glucocorticoids on Lung Function in Systemic Sclerosis-Associated Interstitial Lung Disease: A Target Trial Emulation Using the EUSTAR database.

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Objectives: To estimate the effect of low-dose oral glucocorticoids on 12-month lung outcomes among patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD) initiating ILD-modifying therapy.

Methods: We emulated a target trial using EUSTAR database. Eligible patients were adults with confirmed SSc-ILD who initiated an ILD-modifying treatment, with or without concomitant oral glucocorticoids at baseline (T0). Follow-up ended at the visit closest to 12 months within a 9 to 15-month window. The primary outcome was the between-group difference in change in FVC (% predicted). Secondary outcomes were the proportion of patients with progressive lung fibrosis or isolated DLCO decline ≥15%. We used multiple imputation for missing baseline covariates (m = 10) and stabilised inverse probability of treatment weighting. Weighted linear regression for the primary outcome and weighted Poisson regression for secondary outcomes, each with robust variance estimators, were pooled using Rubin 's rules. Prespecified subgroup and sensitivity analyses were performed.

Results: Of 443 patients with SSc initiating treatment for ILD, 185 (41.8%) received baseline oral glucocorticoids and 258 (58.2%) did not. In the primary analysis, adjunct glucocorticoids were not associated with improved 12-month FVC. The adjusted mean difference in change in FVC -1.51 percentage points (95% CI -3.56 to 0.55, p = 0.15). There was no between-group difference in the number of patients developing progressive lung fibrosis (RR 1.30, 95% CI 0.79 to 2.14, p = 0.30) or isolated DLCO decline ≥15% (RR 0.76, 95% CI 0.36 to 1.63, p = 0.49). Findings were consistent in the truncated-weight sensitivity analysis, and exploratory subgroup analyses did not identify a clear consistent benefit.

Conclusions: In SSc patients starting therapy for ILD, adjunct low-dose oral glucocorticoids were not associated with improved 12-month lung function or better secondary lung outcomes.

BA 3

High Serum Calprotectin Identifies Severe Rheumatoid Arthritis and Predicts Increased Mortality

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Purpose: Assessment of disease activity in inflammatory rheumatic diseases (IRDs) currently relies on acute-phase reactants such as C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR), which have limited sensitivity and may be suppressed by targeted therapies. Serum calprotectin (sCAL), a granulocyte-derived alarmin, may better reflect local synovial inflammation. This study evaluated the role of sCAL as a biomarker of disease activity and severity in rheumatoid arthritis (RA), axial spondyloarthritis (axSpA), and psoriatic arthritis (PsA), and compared its performance with CRP.

Methods: In this nested case-control study, patients with RA (n = 1475), axSpA (n = 768), and PsA (n = 432) from the Swiss Clinical Quality Management (SCQM) registry were included. sCAL was measured using an immunoturbidimetric assay (BÜHLMANN sCAL® turbo), with a cutoff of 4.2 µg/mL defined from healthy controls (HC, n = 248; 97.5th percentile), and compared with CRP. Disease activity was assessed using swollen joint counts and validated composite indices (CDAI, DAS28, BASDAI, BASFI, ASDAS, DAPSA). Disease severity included cardiovascular biomarkers, radiographic progression (Ratingen score in RA), and mortality. Diagnostic performance was evaluated using ROC curves and AUC comparisons. Associations with major adverse cardiovascular events (MACE) and all-cause mortality were analyzed using Kaplan–Meier and Cox models adjusted for age, sex, and disease duration.

Results: sCAL levels were significantly higher in RA compared with HC (2.5±2.9 vs 1.7±1.0 µg/mL, p<0.001) and other IRDs. Using the predefined cutoff, sCAL showed higher specificity than CRP for distinguishing RA from other IRDs (94% vs 75%), with a modest AUC advantage (0.56 vs 0.52, p<0.01). In RA, sCAL correlated with swollen joint counts and disease activity indices, outperforming CRP in identifying high disease activity (SJC>3 or CDAI>22; p<0.01). Elevated sCAL was associated with greater disease severity, including higher seropositivity, increased radiographic progression, and higher mortality (HR 3.04, 95% CI 1.0–4.85), particularly from cardiovascular and respiratory causes.

Conclusion: This study confirms the role of sCAL as a promising biomarker in RA, outperforming CRP in assessing disease activity and severity. Furthermore, high sCAL levels are associated with worse outcomes, supporting its role as a complementary or alternative marker in RA.

BEST CASES

BC 1

Eureka! Pleureka!

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We report the case of a 73-year-old man with a history of hypertension, chronic kidney disease and recurrent gout flares. Two months prior to hospital admission, he sustained a fall, after which he developed chest pain, dyspnoea, and tachycardia. One month before admission, he consulted his general practitioner. Initial investigations revealed markedly elevated inflammatory markers (CRP >200 mg/L), and imaging showed bilateral basal pulmonary infiltrates associated with pleural effusions. A 5-day course of co-amoxicillin was initiated, without clinical improvement. Two weeks later, laboratory findings showed worsening systemic inflammation. CT revealed a large pleural effusion, together with pericardial effusion and ascites. The patient was subsequently admitted because of progressive asthenia, weight loss, dyspnoea, tachycardia, and inflammatory polyarticular pain. On admission, examination revealed mild swelling of the mcp joints and the left knee, as well as bilateral basal hypoventilation. Laboratory tests confirmed persistent marked inflammation. An extensive infectious work-up was negative. Given the coexistence of polyarthritis and polyserositis, a broad differential diagnosis was considered, including autoimmune diseases, malignancy, as well as amyloidosis, sarcoidosis, and IgG4-related disease.

A PET-CT scan showed inflammatory polyserositis and increased metabolic activity in the shoulders, elbows, knees, and ankles, without evidence of malignancy or vasculitis. Haematological investigations, excluded a lymphoproliferative disorder. Autoimmune screening (RF, anti-CCP, ANA and ANCA antibodies) was negative. Musculoskeletal ultrasonography confirmed polyarthritis. Synovial fluid analysis from the knee joint revealed an inflammatory profile, with monosodium urate crystals. Serum urate was elevated at 448 µmol/L. In the absence of an alternative explanation for the polyserositis thoracocentesis was performed and crystals were searched. Pleural fluid analysis demonstrated an exudative effusion, with identification of monosodium urate crystals establishing the diagnosis of polyarticular gout associated with polyserositis. The patient was treated with colchicine, resulting in rapid improvement of articular, pericardial symptoms, and inflammatory markers. This case highlights that gout, although classically considered an articular disease, may present with systemic manifestations, including polyserositis.

BC 2

Severe Ureaplasma urealyticum–Associated Reactive Polyarthritis in a Young Man Four Years After Chemotherapy

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A 23-year-old Swiss man with a history of B-cell acute lymphoblastic leukemia diagnosed in 2021 and in remission, presented with a two-month history of recurrent, corticosteroid-resistant polyarthritis and systemic inflammation. Initial symptoms included peripheral polyarthritis with elevated inflammatory markers (CRP 82 mg/L). Synovial fluid analysis was initially non-diagnostic for a disseminated infection. Post-infectious reactive arthritis was suspected following a possible respiratory infection (germ not found), and prednisone (0.5 mg/kg) led to

partial improvement. Six weeks later, he developed a severe flare with fever and respiratory symptoms, requiring escalation of prednisone to 1 mg/kg and transfer to our center after 5 days of no response to treatment. On admission, he presented with a septic-like syndrome (fever 39°C, tachycardia, mild hypoxia) and extensive polyarthritis involving large and small joints associated with back pain. Bilateral granulomatous anterior uveitis was also present. Laboratory findings showed marked inflammation (CRP 235 mg/L, ferritin 1350µg/L) and lymphopenia (0.36 G/L). Blood cultures were sterile, whereas urine culture was positive for Ureaplasma urealyticum in an asymptomatic patient. PCR testing confirmed U. urealyticum in synovial fluid and aqueous humor (PCR: 292062069 and 2807 copies/ml, respectively). Other infectious and autoimmune investigations were negative. HLA-B27 was negative and HLA-B51 was positive, without clinical features suggestive of Behçet disease. Lumbosacral MRI showed no evidence of spondyloarthritis. Levofloxacin was initiated, leading to rapid clinical and biological improvement within 48 hours. Treatment continued for two weeks, and the patient was discharged with corticosteroid tapering. Given recent infections, an immunodeficiency was suspected, either primary or secondary post-chemotherapy (rituximab, asparaginase, daunorubicin). The immunological workup revealed mixed IgG, IgM and IgA hypogammaglobulinemia as well as low T-cells (T cells: 455/mm^3 (780-2240/mm^3) and CD4 cells 242/mm^3 (490-1640/mm^3). Further investigations are pending. This case illustrates a rare post-infectious, reactive arthritis with uveitis due to U. urealyticum that was detected in urine, synovial fluid and aqueous humor. It highlights the importance of thorough infectious evaluation in corticosteroid-refractory inflammatory arthritis and the need to consider underlying immunodeficiency in uncommon diagnosis.

BC 3

When the body turns black: a different face of degenerative disease

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Background: Alkaptonuria (AK) is an autosomal recessive metabolic disorder in which a deficiency of homogentisate 1,2-dioxygenase (HGD) leads to accumulation of homogentisic acid (HA). This substance is excreted in the urine, which turns black upon exposure to light. Ochronosis is deposition of this pigment in connective tissues, particularly in the cartilage of large joints and the spine, in the ears, sclerae, axillary and inguinal skin areas. Its toxic effect on chondrocytes results in accelerated ochronotic osteoarthritis of spine and large joints, periarticular calcifications and ankylosis. Other organ involvement includes cardiac manifestations (coronary calcification, aortic valvulopathy) and kidney stones. Imaging is virtually indistinguishable from primary osteoarthritis. Diagnosis is elevated urinary HA levels and mutations of HGD gene. Treatment is nitisinone, which inhibits the enzyme 4-hydroxyphenylpyruvate dioxygenase producing HA.

Case presentation: A 60-year-old Kurdish-Turkish man was referred for long-standing inflammatory polyarthralgia involving shoulders, hands, knees, and feet, with morning stiffness and nocturnal pain. He reported progressive spinal pain and functional impairment. The patient exhibited limited shoulder mobility, hand deformities, reduced hip range of motion, bluish pigmentation of the sclera and auricular cartilage. Laboratory showed marked ESR elevation without significant CRP elevation, high titers of RF and ACPA. Imaging revealed no erosive findings but marked osteopenia and severe multilevel degenerative spinal changes with atlanto-axial instability on dynamic X-rays. Seropositive non-erosive rheumatoid arthritis complicated by atlanto-axial instability was diagnosed. Methotrexate partially improve. Due to progressive cervical involvement with neurological symptoms, the patient underwent surgery (C4–C5 corpectomy and C3–C7 arthrodesis). Intraoperatively, black discolouration of intervertebral discs raise suspicion of ochronosis. Markedly elevated urinary HA levels suggest AK, and identifying compound heterozygous pathogenic variants in the HGD gene is pending.

Learning points: AK may mimic or coexist with inflammatory rheumatic diseases, contributing to severe degenerative spinal disease, complicating the clinical picture and delaying the diagnosis. Early recognition of characteristic features is essential, as disease-modifying treatment with nitisinone reduce HA production and potentially slow disease progression.

BC 4

Vaskulitis Overlap – Ein Diagnostisches und Therapeutisches Dilemma

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Hintergrund: ANCA-assoziierte Kleingefässvaskulitiden und Grossgefässvaskulitiden treten in der aller Regel getrennt auf. Ein Overlap beider Entitäten ist selten und diagnostisch wie therapeutisch herausfordernd.

Fallpräsentation: Wir präsentieren zwei Fälle eines Overlap-Syndroms zwischen ANCA-assoziierten Vaskulitiden (AAV) und Riesenzellarteriitis (RZA).

Bei einer 76-jährigen Patientin mit typischer Klinik und bildgebendem Nachweis einer Riesenzellarteriitis der Arteria temporalis wurden hoch-titrige MPO-ANCA nachgewiesen. Im Verlauf traten glomeruläre Erythrozyten auf, und eine Nierenbiopsie bestätigte eine pauci-immune Glomerulonephritis. Es wurde ein Overlap-Syndrom diagnostiziert und eine Remissionsinduktion mit Glukokortikoiden und Cyclophosphamid eingeleitet.

Eine 85-jährige Patientin mit bekannter MPO-ANCA-assoziierter Vaskulitis - damals histologisch gesichert in der Lungen - entwickelte nach 5 Jahren Remission ein Rezidiv mit renaler Beteiligung. Gleichzeitig wurde bildgebend und histologisch eine Riesenzellarteriitis gesichert, jedoch ohne typische klinische Symptomatik. Trotz Remission der AAV unter der Therapie mit Glukokortikoiden, Cyclophosphamid, Rituximab und Avacopan persistierte die Grossgefässbeteiligung, sodass eine Therapieanpassung mit Methotrexat und im Verlauf zusätzlich mit Tocilizumab erforderlich war.

Schlussfolgerung: Diese beiden Fälle illustrieren die seltene Koexistenz einer AAV und einer RZA. Sie unterstreichen die Bedeutung einer umfassenden diagnostischen Reevaluation bei Rezidiven sowie die Notwendigkeit individueller Therapieentscheidungen, insbesondere bei älteren Patienten mit erhöhtem Nebenwirkungsrisiko.

Schlagwörter: ANCA-associated vasculitis; giant cell arteritis; overlap syndrome; MPO-ANCA; cranial MRI; vasculitis diagnosis

BC 5

Severe Occlusive Vasculitis Associated with TET2-Mutated Myelodysplastic Syndrome and Clonal Hematopoiesis

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A 76-year-old male presented with a several-week history of recurrent blue fingers, splinter hemorrhages, typical palpable purpura on the feet, hands, and lower extremities, sensory disturbances of the feet, fatigue, and elevated CRP levels. He was admitted to the emergency department due to acute-onset abdominal pain radiating to the right testicle. Scrotal ultrasound demonstrated right testicular ischemia, necessitating urgent orchiectomy; histopathology revealed pauci-immune necrotizing vasculitis of small and medium-sized arteries and arterioles. Surprisingly, histology of the skin showed small vessel vasculitis with IgA deposits in vessel walls. Oscillography and duplex ultrasound of the hands demonstrated occlusion of the right radial and ulnar arteries with critically reduced perfusion of the right palmar arch and digital arteries. Anticoagulation and intravenous iloprost were initiated promptly. Transthoracic and transesophageal echocardiography showed no evidence of endocarditis. Repeated blood cultures and infectious serologies were negative. High-dose glucocorticosteroids were subsequently initiated. Flow cytometry revealed no evidence of neoplasia but demonstrated activated T-cell populations. Immunoserology for ANA and ANCA was negative. Bone marrow biopsy revealed dysplastic myelopoiesis consistent with myelodysplastic syndrome (MDS). Molecular genetic analysis identified a TET2 deletion with a clonal cell population, confirming clonal hematopoiesis. UBA1 was not mutated. TET2 is the most frequently mutated gene in clonal hematopoiesis and is commonly associated with clonal hematopoiesis of indeterminate potential (CHIP). TET2 mutations have been linked to chronic systemic inflammation, and emerging case series have reported associations with both small- and large-vessel vasculitis. This case of severe occlusive necrotizing vasculitis affecting the small and medium-sized arteries of the skin, testes, and distal extremities, with pauci-immune and immune-complex mediated features, underscores the importance of molecular diagnostics in atypical vasculitides that do not fit into standard disease categories. An etiological link to the TET2-mutated MDS with clonal hematopoiesis appears plausible.

BC 6

From erythroderma to arthritis, the eyes were the key

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A 68-year-old man was referred to my rheumatology clinic for one year of inflammatory arthralgia affecting the hands, feet, and knees, accompanied by a major skin rash. His medical history is unremarkable except for untreated gout. Clinical examination confirmed synovitis in multiple proximal interphalangeal (PIP), metacarpophalangeal (MCP) joints and wrists. Ultrasound confirmed radiocarpal, MCP and PIP joints synovitis, and tenosynovitis of sone flexor tendons in both hands. Hand X-rays revealed multiple erosions in the ulnocarpal and radiocarpal regions, as well as in the MCP, PIP, and distal interphalangeal (DIP) joints, without new bone formation or deformity. Dermatologically, he presented with an impressive erythroderma affecting all four limbs, the trunk, back, and face (sparing the eyelids). A skin biopsy showed granuloma annulare-like elastolysis with giant cells. Inflammatory markers were elevated (CRP 60.6 mg/l, ESR 41 mm/h), with hypergammaglobulinemia (IgG 20.3 g/l), positive rheumatoid factor (15 kU/l), negative anti-CCP antibodies, and ANA 1/320 without specificity. Tests for myositis and sclerodermy antibodies were negative. ACE levels were 22 UI/l, and soluble IL-2 receptor (CD25) was normal at 1429 pg/ml. HLA-B27 was negative. A chest-abdomen-pelvis CT scan showed only bilateral axillary lymph nodes, with no mediastinal lymphadenopathy or interstitial involvement. He was admitted to the dermatology department, but no specific diagnosis could be confirmed; he presented with symptoms consistent with idiopathic disseminated cutaneous granulomatosis, after neoplasia had been ruled out. Following the onset of red eyes, bilateral panuveitis was confirmed, consistent with sarcoidosis. The final diagnosis was multisystem sarcoidosis, characterized by erosive polyarthritis of the hands, erythrodermic granulomatous dermatitis, and bilateral granulomatous panuveitis. On February 20, 2025, ACE levels were 74.3 UI/l and CD25 was 4431 pg/ml. Methotrexate at 15mg then 20mg per week treatment was initiated in October 2025, leading to progressive improvement in skin, joint, and eye symptoms, alongside oral and topical corticosteroids. Due to recurrent eye condition of the posterior uveitis type, adalimumab will be added shortly.

I would like to express my sincere thanks to Dr Unal Azis and the Dermatology Department at the CHUV for their help and cooperation.

BASIC RESEARCH

BR 1

A Cooperative Release of Mitochondrial DNA From Platelets and Neutrophils Drives an Interferon Signature in Systemic Sclerosis

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Objective. Mitochondria are organelles with a hypomethylated circular genome. Mitochondrial DNA (mtDNA) in the systemic circulation has been implicated in inlammation. This study investigates the role of circulating DNA in systemic sclerosis (SSc) and the cellular mechanisms governing its release.

Methods. Total DNA was isolated from the plasma of healthy controls (HCs) and patients with SSc. Copy numbers were analyzed for mtDNA (ATP-6) and GAPDH abundance by quantitative real-time polymerase chain reaction. mtDNA was isolated from HCs and patients with SSc. Neutrophils and platelets were incubated with the plasma and mtDNA of patients with SSc, and neutrophil extracellular trap (NET) formation was assessed by SytoxGreen and immunostainings. Platelets were tested for mtDNA release propensity. DNA oxidation was evaluated by MitoSOX Red staining in vitro and 8-OHdG enzyme-linked immunosorbent assay (ELISA) of patient plasma. Plasma interferon (IFN) type 1 and chemokine (C-X-C motif) ligand 4

(CXCL4) were measured by ELISA. IFN signaling activation capacity was evaluated using THP-1 reporter cells and confirmed by a whole blood bulk RNA transcriptomic analysis.

Results. Median plasma mtDNA levels were 152-fold higher in patients with SSc compared with HCs, whereas nuclear DNA levels were similar. mtDNA from SSc plasma was highly oxidized. SSc-derived mtDNA efficiently promoted its own release by NETosis, most potently in the neutrophils of patients with SSc and by platelet activation. Oxidized mtDNA from SSc platelets in complex with CXCL4 further stimulated mtDNA release in both neutrophils and platelets. mtDNA plasma concentrations correlated with type I IFN concentrations in the blood of patients with SSc, and SSc blood exhibited elevated IFN-stimulated gene expression. SSc plasma-derived mtDNA-induced IFN signaling and NET formation via endosomal Toll-like receptors, cyclic GMP-AMP synthase/stimulator of IFN genes, and the JAK/STAT pathway. The type I IFN pathway further promoted NETosis and mtDNA release because IFN receptor and JAK inhibition antagonized the proNETotic effects of IFN.

Conclusion. SSc plasma is characterized by highly abundant mtDNA, which drives feedback loops amplifying its own release from both neutrophils and platelets. Thus, mtDNA contributes to in?ammation and tissue damage in SSc

BR 2

Divergent Effects of IL-23–IL-17A Pathway on Joint and Skin Inflammation in an Experimental Model of Arthritis

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Purpose: The development of autoimmune arthritis is recognized as a multi-stage process, involving initial loss of tolerance and the activation of multiple inflammatory triggers, ultimately resulting in arthritis. Pro-inflammatory cytokines such as interleukin-23 (IL-23) are key contributors of disease transition. Experimental models–including the arthritis-resistant C57BL/6 mouse strain in the context of collagen-induced arthritis (CIA)–provide a useful tool to identify potential pro-arthritogenic triggers. Here, we investigated whether IL-23 acts as a pro-inflammatory driver of arthritis development in the CIA model.

Methods: C57BL/6 mice were immunized with type II collagen emulsified in complete Freund's adjuvant on days 0 and 21. Sustained overexpression of IL-23 was achieved using an enhanced episomal vector (IL-23 EEV) delivered by hydrodynamic tail-vein injection; control mice received an empty vector. To assess downstream signaling, a neutralizing anti–IL-17A (BZN035, Novartis) antibody was administered in IL-23 overexpressing mice.

Results: IL-23 overexpression markedly exacerbated arthritis incidence and severity in type II collagen-immunized C57BL/6 mice, as evidenced by increased clinical and histological scores, weight loss, and elevated serum amyloid A levels, compared with mice receiving the empty vector. Plasmatic IL-23 concentrations (by ELISA) significantly correlated with arthritis severity. Despite the absence of strong arthritis phenotype in control group, the adaptive immune response remained intact, as shown by identical levels of anti-collagen II antibodies. In addition, IL-23 overexpression induced skin lesions with macroscopic and microscopic features resembling psoriasis. IL-17A blockade fully prevented arthritis development but did not alter the skin phenotype.

Conclusion: These preclinical findings indicate that the IL-23–IL-17A axis is essential for the development of autoimmune arthritis in the CIA model, whereas IL-23–driven skin inflammation appears to occur through IL-17A–independent mechanisms.

BR 3

Baricitinib hemmt Substanz P und Interleukin-6 in einem In-vitro-Modell für Schmerz und Entzündung

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Hintergrund: Baricitinib ist ein oraler Januskinase-Hemmer, der für die Behandlung der rheumatoiden Arthritis (RA) zugelassen ist. Klinische Studien bei RA-Patienten zeigen ausserdem eine stärkere Schmerzreduktion von Baricitinib im Vergleich zu TNF-Hemmern. Der molekulare Mechanismus ist jedoch weitgehend unbekannt. Bei der RA-Synovitis vermitteln Substanz P (SP) und Interleukin-6 (IL-6) Schmerz und Entzündung. Sie könnten daher Zielmoleküle für Baricitinib sein.

Studienziel: Anhand eines In-vitro-Modells wollten wir Mediatoren für Schmerz und Entzündung identifizieren, die möglicherweise durch Baricitinib supprimiert werden. Die Ratten-PC12-Phäochromozytom-Zelllinie exprimiert IL-6 als Reaktion auf den Nervenwachstumsfaktor (NGF). Letzteres Molekül ist ein nahezu ubiquitärer primärer Mediator bei schmerzhaften entzündlichen Erkrankungen, einschließlich der RA-Synovitis.

Methoden: PC12-Zellen wurden in mit Kollagen beschichteten Zellkulturschalen mit 100 ng/ml NGF in Abwesenheit oder Anwesenheit von 1 µM Baricitinib stimuliert. Das Neuritenwachstum als Reaktion auf NGF wurde mithilfe eines Färbekits (Molecular Probes A15001) bestimmt. ELISA-Assays wurden verwendet, um die Konzentrationen von IL-6 (Abcam ab234570) und SP (Abcam ab288318) in den Überständen zu bestimmen.

Ergebnisse: Zellviabilitätsassays zeigten keinen Unterschied zwischen den Behandlungsgruppen, einschließlich DMSO, das als Lösungsmittel für Baricitinib verwendet wurde. NGF führte in PC12-Zellen im Vergleich zu den Kontrollbedingungen erwartungsgemäss zu signifikant erhöhten Auswachsraten. NGF induzierte eine starke Überexpression von SP und IL-6. Dieser Effekt wurde durch Baricitinib gehemmt.

Schlussfolgerung: Die NGF-IL-6-SP-Achse spielt in der RA eine wichtige Rolle bei Schmerz und Entzündung. Baricitinib griff in unserem Kulturmodell stark in diesen Signalweg ein. Diese Beobachtungen könnten erste Hinweise für den durch Baricitinib induzierten analgetischen Effekt geben. Die genauen molekularen Mechanismen erfordern jedoch weitere Untersuchungen.

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BR 4

Altered Fibroblast NT-3/TrkC Signaling in Complex Regional Pain Syndrome Skin is Associated with Pain and Neuronal Remodeling

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Background: Complex Regional Pain Syndrome (CRPS) is a debilitating condition that typically develops after an injury, such as a fracture. Instead of normal healing, patients develop persistent pain accompanied by sensory disturbances, and skin alterations. Fibroblasts regulate inflammation, matrix remodeling, and neuroimmune interactions, but their role in CRPS remains poorly characterized. Neurotrophin-3 (NT-3) and its receptor TrkC are key mediators of neuronal survival and growth, but have not been studied in CRPS.

Objectives: 1. To characterize fibroblast alterations in CRPS skin. 2. To investigate NT-3/TrkC (NTF3/NTRK3) signaling in fibroblast–neuronal interactions.

Methods: Single-cell RNA sequencing was performed on skin biopsies from early unilateral CRPS patients (<6 months; affected and contralateral non-affected skin, n = 7 each), fracture controls (n = 6), and healthy controls (n = 6). Data were processed for ambient RNA and doublet removal, followed by Seurat-based downstream and CellChat analyses. NTF3 upregulation was validated in an independent chronic CRPS cohort (>6 months, n = 6) using total skin bulk RNA-seq and qPCR on cultured fibroblasts. Functional effects were assessed by transwell co-culture of fibroblasts with a neuronal cell line (SH-SY5Y). Neurite outgrowth was quantified over 9 days.

Results: Single-cell transcriptomic analysis revealed enrichment of neuron projection guidance pathways in CRPS fibroblasts, with NTRK3 among the top contributing genes (FDR<0.05). Expansion of pro-inflammatory (F3), papillary (F2), and neuron-associated (F5) fibroblast subsets was observed in CRPS skin. NTF3/NTRK3 were increased in CRPS fibroblasts and enriched in F2/F5 subsets. NTF3 expression correlated with maximum pain (r = 0.86, p = 0.02), and F2 abundance with CRPS Severity Score (r = 0.81, p = 0.03). CellChat predicted increased vascular/perivascular signaling toward fibroblasts in affected CRPS skin. Affected CRPS fibroblasts increased SH-SY5Y neurite outgrowth in vitro, which was reduced by TrkC blockade (p<0.05).

Conclusions: CRPS skin shows expansion of distinct fibroblast subsets representing potential disease-associated populations, with enhanced NT-3/TrkC pathway activity linked to pain severity. Functional co-culture data suggest that CRPS fibroblasts modulate neuronal outgrowth via NT-3/TrkC signaling. Predicted vascular/perivascular communication suggests that these fibroblast alterations may be shaped by the local neurovascular microenvironment.

BR 5

A single-cell atlas reveals shared fibroblast signature in pauci-immune arthritis across different chronic arthritides

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Background: In rheumatoid arthritis, synovial pathotypes are classified by immune cell composition into lympho-myeloid, diffuse-myeloid, and pauci-immune, the latter characterized by low immune infiltration and poor response to immunosuppression. These pathotypes are also observed across other arthritides. We hypothesize a shared pauci-immune endotype across joint diseases.

Objectives: To identify common fibroblast activation pathways across pauci-immune arthritides using single-cell RNA sequencing (scRNA-seq).

Methods: Synovial biopsies from arthritis patients and non-inflammatory controls were analyzed by scRNA-seq (10x Genomics). A fibroblast atlas comprising 43,693 cells from 42 samples across multiple diagnoses and pathotypes was generated. Fibroblast subtypes were annotated and analyzed for differential gene expression using MAST, with pathway overrepresentation assessed using clusterProfiler.

Results: In comparison to controls, pauci-immune fibroblasts showed upregulation of extracellular matrix (ECM) genes and enrichment of profibrotic pathways. These genes were mainly expressed by POSTN+COMP+ fibroblasts and were consistent across diseases, supporting a shared profibrotic signature. POSTN+COMP+ fibroblasts were enriched in both pauci-immune and diffuse-myeloid pathotypes. Compared with the diffuse-myeloid pathotype, pauci-immune synovium exhibited distinct ECM profiles: myeloid fibroblasts showed higher collagen expression, whereas pauci-immune fibroblasts were enriched in small leucine-rich proteoglycans (SLRPs) and COMP. Additionally, ferritin genes (FTH1, FTL) were among the most upregulated and were co-expressed in pauci-immune fibroblasts. These cells exhibited increased anti-ferroptotic and reduced pro-ferroptotic gene expression, indicating a shift toward an anti-ferroptotic state that may enhance fibroblast survival under stress.

Conclusion: Pauci-immune arthritis across various arthritides exhibits a shared fibroblast signature characterized by pro-fibrotic activation, expansion of POSTN+COMP+ subpopulation, and significant upregulation of SLRPs and COMP. In addition, POSTN+COMP+ fibroblasts exhibit an anti-ferroptotic state, characterized by elevated anti-ferroptotic gene expression and increased ferritin levels, warranting further investigation of ferroptosis in fibroblasts.

POSTERS SGR-SSR

P 1

Deciphering arthritis in systemic sclerosis: prevalence, clinical phenotype and prognosis in the EUSTAR cohort (CP 151)

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Background. Joint inflammation is a major determinant of disability and functional impairment in systemic sclerosis (SSc). In contrast to skin, lung and vascular manifestations, it remains poorly characterized, and no management guidelines are currently available. Improved characterization is crucial to define target populations for clinical trials and to inform the development of effective therapeutic interventions.

Objective. To provide the most comprehensive characterization of synovitis in SSc by determining its prevalence, clinical phenotype, and prognosis in the largest available cohort of SSc-patients.

Methods. SSc patients from the EUSTAR database fulfilling 2013 ACR/EULAR criteria with available data on joint involvement were included. Synovitis was defined by ≥1 swollen joint on clinical examination. Multivariable logistic regression identified factors associated with synovitis. Disease progression encompassed worsening skin/lung fibrosis, new pulmonary hypertension, left heart dysfunction, or scleroderma renal crisis. Prognostic factors for progression-free survival and mortality were assessed by multivariate Cox models. Missing data were handled by multiple imputation.

Results. Among 22,059 SSc patients, 4,612 (20.9%) experienced at least one episode of synovitis. Most had a single episode (83.3%) over a median follow-up of 57 months. Synovitis was oligoarticular (mean 2.0 ± 3.7 swollen joints) with moderate disease activity (DAS28-CRP 2.9). It was more frequent in females, younger patients, and those with shorter disease duration. Patients with synovitis had a more severe phenotype, including higher prevalence of anti-topoisomerase I/anti-RNA polymerase III antibodies, diffuse cutaneous form, ILD, elevated CRP, tendon involvement, and greater disability. In multivariate analysis, synovitis was independently associated with female sex, shorter disease duration, diffuse cutaneous form, anti-topoisomerase I positivity, elevated CRP, joint contractures, and tendon friction rubs. Longitudinal analysis showed synovitis was an independent predictor of mortality but not progression-free survival.

Conclusions. Synovitis affected >20% of SSc patients and was associated with a severe disease phenotype. Although synovitis often occurred as a single episode, it was active, disabling, and, for the first time, identified as an independent predictor of mortality. These findings underscore the urgent need for standardized assessment of SSc-arthritis.

P 2

Screening failure in systemic sclerosis randomized trials: reporting, rates, causes and trends over time

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Objectives: To evaluate the completeness of reporting of pre-randomization patient' flow in SSc randomized controlled trials (RCTs) and to estimate the extent and reasons for screening failure.

Methods: We searched SSc RCTs indexed in PubMed from 2000 to 2024. We recorded key trial features and checked whether they provided information on patient flow before randomization. We collected information on the adequacy of reporting of the pre-randomization phase, the number of patients screened and the extent and reasons of screening failure. Data were summarized as number (percentage) for qualitative variables and median (interquartile range) for continuous variables.

Results: Of the 127 SSc RCTs retrieved, 52.9% reported patient flow before randomization, 21.2% of those published before 2011 and 65.1% of those published after. The most commonly used terms were 'screened' in 33 studies (50%) and 'assessed for eligibility' in 29 studies (44%). Of 10 043 patients screened, 5147 (51%) were considered screening failure. The median proportion of screening failures was 36% (IQR 20-58), with higher rates in studies testing non-pharmacologic interventions, lacking industry funding, lacking double-blinding or not including a placebo arm. Reasons for screening failure and their frequency were detailed for 3510 screening failure patients (68.2%). The main reasons were not meeting the eligibility criteria and patient refusal, which accounted for 72.5% and 20.8% cases, respectively. Screening failure remained stable over time.

Conclusions: Reporting of screening procedures in SSc RCTs has improved over time but remains suboptimal. Most screening failures are due to patient ineligibility, followed by patient refusal, which continues to represent a significant barrier to enrolment.

P 3

Effects of non-pharmacological therapies in systemic sclerosis: A longitudinal observational study

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Introduction: Systemic sclerosis (SSc) causes substantial functional impairment and reduced quality of life. Evidence for non-pharmacological therapies is limited. This study establishes a database to document health status and non-pharmacological inpatient/outpatient interventions (e.g., hyperthermia, manual lymphatic drainage, physiotherapy, occupational therapy, speech and language therapy).

Methods: Patients meeting 2013 ACR/EULAR SSc criteria are assessed at admission and discharge from a 4-week rehabilitation programme. Outcomes include endurance (6-Minute Walk Test, 6MWT), perceived exertion (Borg Scale), hand function (Nine-Hole Peg Test, NHPT; Coin Rotation Test, CRT), hand strength (dynamometer), gait (3D gait analysis: stride length, step length, gait speed), mouth opening, patient-reported outcomes (Scleroderma Health Assessment Questionnaire; Hospital Anxiety and Depression Scale). Means and standard deviations are reported; pre–post changes are tested with paired t-tests.

Results: 25 patients were enrolled (mean age 63 ± 15 years; 74% female; mean mRSS 5.1, range 2–27). After a mean rehabilitation duration of 27 ± 7 days, improvements were observed in 6MWT (+34 m; p<0.001), Borg Scale score (2.7 to 2.3), hand strength on the right (18.4 to 20.1 kg; p = 0.060) and left side (18.5 to 19.9 kg; p = 0.044), NHPT on the right (27.8 to 25.0 s; p = 0.033) and left side (29.6 to 27.4 s; p = 0.156), and CRT on the right (23.9 to 18.5 s; p = 0.003) and left side (27.1 to 18.8 s; p = 0.002). Mouth opening increased from 33.3 to 38.2 mm (p = 0.039), and SHAQ Disability Index decreased from 1.2 to 0.9 (p = 0.020). HADS total score decreased from 16.0 to 14.8 (p = 0.665). In gait analysis, gait speed (p = 0.015) and step length (p = 0.009) improved significantly, while stride length remained unchanged (p = 0.860).

Conclusion: Preliminary results highlight the potential relevance of non-pharmacological therapies for improving multiple functional parameters in SSc. Systematic evaluation may help identify patient-specific factors to guide individualized rehabilitation strategies. Further data collection at planned follow-up visits is needed to assess long-term outcomes and sustainability of effects.

P 4

Healthcare resource utilisation in patients with Sjögren's disease included in the Swiss Sjögren Cohort: a cross-sectional analysis

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Introduction: Sjögren's disease (SjD) is associated with multidisciplinary healthcare needs. Characterising healthcare resource utilisation (HCRU) is essential for resource planning and understanding the multidisciplinary burden experienced by patients. We report real-world preliminary data from the Swiss Sjögren Cohort (SSC).

Methods: We performed a cross-sectional analysis of adult patients with SjD included in the SSC who completed a standardised HCRU questionnaire at cohort entry, which we developed for this study. The questionnaire captured self-reported HCRU during the preceding 12 months. Demographic, clinical, and disease-related characteristics were extracted from the SSC database.

Results: Forty-one patients were included between December 2024 and March 2026. The majority were female (90%), with a mean (SD) age of 60.9 (12.8) years and a median (range) disease duration of 8 years (1-46, n = 25). Anti-SSA antibodies were detected in 87% of the patients tested (n = 23). Among patients with available ESSDAI (n = 23), disease activity was low in 48%, moderate in 26%, and high in 26%; mean (SD) ESSDAI was 7.2 (6.8). During the previous year, 21% of patients reported at least one hospitalisation, and 18% at least one emergency department outpatient visit. The mean (SD) total number of physician visits was 15.8 (11.8) per year, including 4.3 (3.5) visits to general practitioners (GPs) and 11.4 (9.3) visits to specialists. Rheumatologists/immunologists were the most frequently consulted specialists, with 3.4 (3.1) visits per year. Healthcare professional services were also frequently used, particularly physiotherapy. Participants on sick leave or with an invalidity pension visited physicians more frequently than employed or retired patients (p = 0.005, n = 32, Kruskal-Wallis test). For comparison, the Swiss Health Survey 2022 conducted by the Federal Statistical Office reported 2.3 visits per year to GPs1 and 3 to 3.5 medical visits per year among patients older than 50 (all doctors)2.

Conclusion: Patients with Sjögren's disease included in the SSC showed substantial and multidisciplinary healthcare utilisation, including frequent specialist consultations. These preliminary data provide an initial Swiss national cohort-based overview of HCRU in SjD and may help identify priorities of future longitudinal analyses within the cohort.

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P 5

Raynaud-negative systemic sclerosis at disease onset: a phenotypic characterization of the Zürich EUSTAR cohort

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Introduction: Raynaud phenomenon (RP) represents one of the earliest manifestations of systemic sclerosis (SSc). The subset of patients presenting without RP is poorly characterized. Therefore, the aim of our study is to characterize RP-negative SSc patients and explore their longitudinal trajectories.

Methods: We conducted a longitudinal observational study on the EUSTAR cohort of our center, including patients with a clinical diagnosis of SSc. Baseline characteristics were summarized as counts (%) or medians (IQR). Differences between groups were quantified using standardized mean differences (SMDs).

Results: Among 851 patients, 42 (4.9%) were RP-negative at baseline. Median age was the same in the two groups (55.0 years), with a higher proportion of males among RP-negative patients (21.4% vs 16.7%, SMD = 0.12). Despite absence of RP, cutaneous subsets were similarly distributed between groups, including diffuse cutaneous SSc (23.1% vs 21.6%, SMD = 0.05). Interstitial lung disease (ILD) showed a higher prevalence in RP-negative patients (42.1% vs 33.6%, SMD = 0.17). Vasculopathy manifestations were less frequent among RP-negative patients: digital ulcers (3.1% vs 9.0%, SMD = 0.36) and pitting scars (9.4% vs 16.6%, SMD = 0.26). Puffy fingers were similarly prevalent in both groups (48.7% vs 56.8%, SMD = 0.12). SSc-specific capillaroscopy patterns had only a slightly lower prevalence in RP-negative patients (42.3% vs 53.8%, SMD = 0.23). The distribution of SSc-specific autoantibodies was similar: ACA (51.4% vs 49.6%; SMD = 0.04), Scl-70 (20.5% vs 22.2%; SMD = 0.04), and RNApol III (6.7% vs 10.7%; SMD = 0.14). Less RP-negative patients (35.1% vs 46.9%, SMD = 0.24) fulfilled the 2013 ACR/EULAR classification criteria for SSc. Longitudinally, 22/28 initially RP-negative patients developed RP during a median follow-up of 5 years, with a median time to conversion of 3.8 years. Among the 13 patients with available follow-up, 8 (61.5%) remained RP-positive and 5 (38.5%) became RP-negative.

Conclusion: RP-negative SSc represents a rare phenotype (4.9%), however including patients with clinically relevant fibrotic organ involvement (ILD, diffuse cutaneous subset). These data underline the importance of considering a diagnosis of SSc even in the absence of RP, when other suggestive signs are present. Moreover, given their potentially severe phenotype, patients with SSc without RP should be considered for recruitment in cohorts or clinical trials, especially when aiming at progressive disease.

P 6

Confusion in an elderly patient with treatment-refractory rheumatoid arthritis – an unexpected diagnosis

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Background: Rheumatoid arthritis (RA) in older adults is an increasingly important clinical challenge due to rising life expectancy and the growing incidence of elderly-onset disease. Treatment of this target population can be challenging. Comorbidity, polypharmacy, and frailty complicate management and predispose to atypical presentations. Acute confusion in hospitalized elderly patients is common and often multifactorial.

Case Presentation: A 67-year-old patient with long-standing, treatment-refractory seropositive RA and high disease activity (DAS 28: 6.5) was evaluated for therapy escalation to obinutuzumab after failure of multiple bDMARDs and tsDMARD. Shortly thereafter, his family noted progressive personality changes and confusion, leading to emergency admission. On presentation, he showed marked cognitive impairment, poor general condition, active polyarthritis, and elevated inflammatory markers. Initial findings suggested dehydration with hypernatremia, yet rehydration did not improve his symptoms. The next day a left sided hemiparesis was noted. Cranial CT revealed a right frontal hypodensity, raising suspicion of a subacute ischemic stroke. The patient's condition further deteriorated with increasing somnolence. Brain MRI subsequently demonstrated leptomeningeal enhancement suggestive of meningitis. Cerebrospinal fluid analysis was inconclusive, with mildly elevated leukocytes and total protein, but no signs of infectious or malignant etiology in the further diagnostic workup. Empirical antibiotic therapy was initiated but remained ineffective. Given the persistently high RA disease activity, systemic inflammation, and lack of response to anti-infective treatment, rheumatoid meningitis was suspected. High-dose intravenous glucocorticoid therapy was started, resulting in rapid and marked clinical improvement.

Learning points for clinical practice: Rheumatoid meningitis is a rare but severe extra-articular complication of RA presenting with non-specific neurological symptoms mimicking more common conditions such as stroke or infection. High-dose corticosteroids should be administered and maintenance therapy optimized. This case also highlights the importance of considering various differential diagnoses in elderly patients with difficult to treat RA and acute neuropsychiatric alterations.

P 7

Clinical Case of Severe Arthropathy Associated with Ochronosis

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The patient is a 56-year-old woman who presents with a long-standing history of severe arthrotic changes resulting in pronounced joint deformities. Multiple subluxations were observed, suggesting possible pre-existing hyperlaxity of the finger joints. Laboratory investigations showed no elevation of inflammatory markers. Immunoserological testing was negative except for ANA positivity at a titer of 1:80 with a fine granular pattern. Psoriasis capitis was confirmed; however, the pattern of joint involvement and deformities was not considered typical for psoriatic arthritis. Musculoskeletal ultrasound demonstrated isolated synovitides of the MCP and PIP joints, which may be explained in the context of advanced degenerative joint disease. In addition, dark discoloration of the fingernails and sclerae was observed, raising the possibility of ochronosis (alkaptonuria) as a differential diagnosis. Given the severe deformities and the presence of synovitis, differential diagnoses initially included psoriatic arthritis, rheumatoid arthritis, and other inflammatory arthropathies. However, the absence of significant inflammatory laboratory findings and the atypical pattern of joint involvement argued against a primary inflammatory rheumatic disease. The patient originates from Vietnam and reported travel to Cambodia during childhood. A history of malaria with possible quinine treatment could not be reliably confirmed; however, this may represent a potential cause of secondary ochronosis. Genetic testing was not performed, as it was not expected to influence therapeutic management. Furthermore,

the patient has no children, and therefore no implications regarding hereditary transmission were anticipated. This case highlights the importance of considering rare diseases as differential diagnoses in patients with severe joint deformities in the absence of a clear underlying inflammatory rheumatic disease.

P 8

Male excess in lifetime smoking prevalence and its discordance with seropositivity in rheumatoid arthritis: a Swiss nationwide study

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Background: Smoking is a major environmental contributor to RA pathogenesis.

Objectives: To compare the evolution of smoking prevalence patterns between patients with rheumatoid arthritis (RA) and the Swiss general population (2012-2022), and to assess sex- and serostatus-specific differences.

Methods: We conducted a repeated cross-sectional study using data from the Swiss Clinical Quality Management in Rheumatic Diseases (SCQM) registry and the Swiss Health Survey (2012, 2017, 2022). Current and ever smoking prevalence were compared between RA patients and the general population using indirect standardisation. Sex- and serostatus-stratified analyses were performed. Within the RA cohort, the association between smoking and seropositivity was assessed using multivariable logistic regression.

Results: A total of 5,523 visits from 3,983 patients with RA were analysed. Standardised prevalence ratios (SPRs) for current smoking consistently showed a lower-than-expected prevalence in RA. Conversely, ever smoking SPRs showed sex-specific differences. In men, SPRs exceeded expectations and increased over time, reaching significance in 2022 (SPR 1.19, 95% CI 1.04–1.36), driven by seropositive men. No excess was observed in women. Within the RA cohort, ever smoking was associated with higher odds of seropositivity (OR 1.29, 95% CI 1.09–1.53), with no significant interaction by sex.

Conclusion: Smoking patterns in RA differ from the general population in a sex-specific manner over 2012, 2017 and 2022. While current smoking is less prevalent in RA and might reflect disease-driven cessation, an excess lifetime smoking exposure is observed among men but not women. This discrepancy suggests that smoking may contribute differently to RA development across sexes but does not fully explain sex differences in seropositivity, highlighting the role of additional biological determinants. These findings also support continued efforts in smoking cessation strategies and highlight the importance of preventing smoking initiation overall, and particularly among men at increased risk of RA.

P 9

Subtype-specific cancer risk with JAK inhibitors and biologic DMARDs in rheumatoid arthritis: comparative analysis within the JAK-pot collaboration

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Following regulatory safety warnings based on the ORAL Surveillance trial, uncertainty remains regarding the reported malignancy risk associated with JAK inhibitors (JAKi) as only a single JAKi was assessed and bDMARDs with other modes of action (OMA) were not included. This study aim to evaluate the incidence of cancer subtypes in RA patients treated with JAKi compared to TNF inhibitors (TNFi) and bDMARDs-OMA in a real-world population. Data from 14 European and Québec rheumatoid arthritis (RA) registries of patients treated with JAKi (tofacitinib, baricitinib, upadacitinib, filgotinib), TNFi, or OMA were analysed. Cancer outcomes were assessed within an exposure window extending from treatment initiation until 5 years after treatment discontinuation, or until the occurrence of an adverse event (AE), loss to follow-up, or study end, whichever came first. The outcomes considered were stratified into overall cancers excluding non-melanoma skin cancer (NMSC), NMSC, haematologic malignancies, and specific solid tumors. The category "overall cancer excluding NMSC" comprised all solid and haematologic malignancies. Incidence rates (IR) per 1000 patient years (PY) and incidence rate ratios (IRR) between treatments were calculated using Poisson generalized estimating equations (GEE). Adjusted IRRs (aIRR) and confidence intervals (CIs) were calculated with propensity score weighting based on patient 's characteristic. Among 37559 patients with 60977 treatment courses, 792 cancers (217 NMSC), were recorded. Mean follow-up was 2.8 (SD 2.3) years. After adjustment, there was no significant higher risk with JAKi compared to TNFi for overall cancer excluding NMSC (aIRR = 1.17; 95%CI 0.92–1.48), NMSC (1.19; 0.81–1.74), haematologic malignancies (1.20; 0.62–2.31) or solid tumor subtypes, including breast (0.44; 0.22–0.86), colorectal (2.44; 0.88–6.72), genital (0.95; 0.36–2.49),

lung (1.77; 0.94–3.33), and prostate cancer (1.08; 0.44–2.64). In patients treated with OMA compared with TNFi, the aIRR for overall cancer excluding NMSC (1.31; 1.04-1.66), lung cancer (2.06; 1.06-4.01) and genital cancer (2.99; 1.25-7.15) was higher. In conclusion, while JAKi were associated with higher adjusted point estimate for overall cancer, they did not achieve statistical significance. No significant increase in risk was observed for any specific cancer subtypes. However, OMA use was associated with a significantly higher incidence of overall cancer excluding NMSC, lung and genital cancer.

P 10

Acute gout flare management and adherence to international guidelines: major drug-drug interactions and use of colchicine and NSAIDs in patients with severe chronic kidney disease and, evidence from an electronic health record-based gout register

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Background: Gout predominantly affects older patients with multiple comorbidities and polypharmacy. Acute gout flare management may be limited by contraindications, particularly clinically significant drug–drug interactions and severe chronic kidney disease (CKD). The 2016 EULAR recommendations advise against use of colchicine with strong cytochrome P450 (CYP) 3A4 or P-glycoprotein (P-gp) inhibitors, and against colchicine and non-steroidal anti-inflammatory drugs (NSAIDs) in severe CKD.

Objectives: To assess colchicine prescription during acute gout flares in patients receiving strong CYP3A4 or P-gp inhibitors, and prescription of colchicine and NSAIDs for acute gout flares in patients with severe CKD.

Methods: We used data from a validated electronic health record-based gout register (EHRMES) with excellent diagnostic performance (92.4% positive and 94.3% negative predictive value). CYP3A4 or P-gp inhibitors were classified as strong (clarithromycin, ritonavir, ketoconazole, ciclosporin, and related agents) or moderate/weak (erythromycin, verapamil, amiodarone, diltiazem, dronedarone). Colchicine prescription within ±3 days of inhibitor exposure was assessed using proportions and Jeffreys 95% confidence intervals. Prescription of NSAIDs or colchicine during acute gout flares was evaluated in patients with severe CKD (estimated glomerular filtration rate ≤30 ml/min/1.73 m² documented twice over 90 days).

Results: Among 7,225 patients with gout, we identified 4,194 acute gout flares among 2,920 patients. During flares, 121 patients were exposed to strong CYP3A4 or P-gp inhibitors (4.1%, 95%CI 3.5-4.9) and 93 to moderate/weak inhibitors (3.2%, 95%CI 2.6-3.9). Among patients exposed to any inhibitor during a flare, colchicine was prescribed in 5 cases (2.48%, 95%CI 0.96-5.37). Among 568 flares in severe CKD, NSAIDs were prescribed in 44 flares (7.7%, 95%CI 5.8-10.2), colchicine in 541 (95.7%, 95%CI 93.3-96.8), and both drugs in 17 (3.0%, 95%CI 1.8-4.6).

Conclusion: Co-prescription with strong CYP3A4 or P-glycoprotein inhibitors with colchicine was uncommon. Colchicine was frequently prescribed in severe CKD, and NSAIDs were also prescribed despite contraindications. These findings suggest partial adherence to recommendations, support further evaluation of colchicine safety in severe CKD, and highlight the need to reduce inappropriate NSAID prescription in this high-risk population.

P 11

Enhancing the appeal of specialist training in rheumatology and safeguarding the future of the discipline: an analysis and recommendations

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Background: The shortage of skilled staff in the Swiss healthcare sector is one of the most pressing, yet also most complex, problems that must be resolved to ensure that the high standard of care in Switzerland is not jeopardised. The future of rheumatological care in Switzerland is not secure. A key reason for this is the demographic trend in Switzerland: population aging is associated not only with an increasing number of older adults, but also with a rising prevalence of chronic musculoskeletal and inflammatory rheumatic diseases. Added to this are the age structure of the medical profession and changes in working time models, with an increasing proportion of part-time work, which further increases the pressure on the next generation. Furthermore, recruiting young physicians for specialist training in rheumatology remains a challenge, as rheumatology is still underrepresented in medical curricula and students frequently lack early clinical exposure to rheumatologic patients and practice. Ensuring sustainable rheumatological care requires targeted strategies to increase the attractiveness of the speciality and to support the next generation.

Methods: Data from surveys conducted by the Swiss Society for Rheumatology "Quo vadis?" (2021), AbbVie (2024) [1] and the "Young Rheumatologist" group (2025) were analysed. Qualitative interviews were conducted with representatives of the German Society for Rheumatology (DGRh) and the Austrian Society for Rheumatology (ÖGR) regarding the current situation, support measures and best-practice models.

Results: The literature and the analysed recruitment initiatives consistently demonstrate that structured, practice-oriented programs can sustainably increase medical students' interest in rheumatology. Successful initiatives combine interactive educational formats, such as hands-on-workshops, close interaction with experienced rheumatologist and direct patient contact. Their impact appears to be strongest among students in the final year of medical school. While short-term evaluations consistently report positive effect on students' interest, knowledge and perception of the specialty, assessing the long-term effectiveness of these initiatives remains challenging. The most appropriate indicator of long-term success is a positive trend in the number of physicians ultimately completing specialist training in rheumatology. Overall, these findings suggest that structured recruitment programs make an important contribution to strengthening the future rheumatology workforce and therefore represent a valuable investment in the long-term sustainability of the specialty.

Conclusion: The findings suggest that early and practice-oriented exposure to rheumatology is essential for promoting the next generation of rheumatologists. Professional societies can play a central role by providing medical students with direct exposure to the specialty and supporting their transition into post-graduate training. The experiences gained in Germany and

Austria may serve as a foundation for implementing comparable initiatives in Switzerland, thereby contributing to the long-term sustainability of the rheumatology workforce.

1 AbbVie (2024): Hügli N. Rheumatologie im Wandel: Der Nachwuchs, der die Zukunft in Bewegung hält, 07.12.2024

P 12

HLA-A*26:01 is associated with vertebral endplate bone marrow lesions (Modic changes): a novel immune-genetic link

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Objectives: Modic changes (MC) are vertebral endplate bone marrow lesions frequently observed in patients with chronic low back pain (CLBP). MC pathogenesis has an immunological component, and the accumulation of cytotoxic T cells in MC lesions suggests involvement of adaptive immunity. We therefore investigated whether specific HLA alleles predispose individuals to MC.

Methods: We studied HLA-association with MC across three independent samples with MC scoring (n = 325, n = 657, and n = 1092). Identified risk/protective alleles were further evaluated in twelve independent samples without MC scoring (total n = 9938). Age–allele interactions were examined in two cohorts spanning the adult lifespan (n = 325 and n = 657). Results were combined using random-effects meta-analysis.

Results: Random-effects meta-analysis across three cohorts with MC scoring identified HLA-A*26:01 as a risk allele for MC (OR = 2.30,95% CI 1.22–4.33; p = 0.01). Concordant effects across cohorts were supported using a directional Stouffer approach (FDR = 0.047). This association was independently supported by a higher OR for HLA-A*26:01 in CLBP patients with MC compared with ancestry-matched population reference datasets without MC scoring (OR = 1.95, 95% CI 1.05–3.04; FDR = 0.009). Age-interaction analyses demonstrated a significant age-dependent effect for HLA-A*26:01 (likelihood ratio test p = 0.01). While individuals carrying HLA-A*26:01 have a similar probability of MC development as non-carriers at younger ages, from the age of 43, the ORs increase above one, with lower 95% CIs crossing value of one at the age of 53 (OR = 2.58; 95% CI 1.01–6.53) and continuing to rise until the highest analysed age of 79 (OR = 23.52; 95% CI 1.88-321.29). Model-based estimates indicated that 95.1% (95% CI 86.53–99.84) of HLA-A*26:01 carriers had MC by age 59.7, compared with 50.5% (95% CI 46.44–54.85) of non-carriers; by age 66, this proportion reached 99.0% in carriers (95% CI 94.96–99.99), while 25.1% (95% CI 16.84–29.95) of non-carriers remained MC– up to age 79.

Conclusions: HLA-A26:01 exhibits a strong, age-dependent association with MC. Together with the known accumulation of cytotoxic T cells in MC lesions, these findings support a role for immune-mediated mechanisms in vertebral endplate pathology. HLA-A26:01 may help identify individuals at increased risk of MC and CLBP.

P 13

BAASIS-RA©: A Novel Instrument for Remote Assessment of Adherence to Disease-Modifying Antirheumatic Drug in Rheumatoid Arthritis

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Background: Accurate assessment of adherence to disease-modifying antirheumatic drugs (DMARDs) is essential for interpreting treatment effectiveness and optimising outcomes in rheumatoid arthritis (RA). Existing adherence instruments lack robust validation, do not capture all three phases of adherence (i.e., initiation, implementation and persistence), and fail to reflect the complexity of modern DMARD regimens, limiting their clinical and research utility. We aimed to adapt the Basel Assessment of Adherence to immunoSuppressive medIcations Scale (BAASIS©) to create a concise, patient-centred instrument for assessing DMARD adherence in RA.

Methods: A structured six-step adaptation approach was applied: (1) literature review; (2) interdisciplinary expert input (patients, pharmacists, rheumatologists, nurses); (3) algorithm development capturing DMARD complexity (routes, dosing, combinations, treatment changes); (4) RA-specific item generation with £ 6th grade reading level; (5) ISPOR-guided cognitive debriefing interviews (EN n = 5, DE n = 5, FR n = 3, IT n = 2); (6) ongoing integration into Swiss Clinical Quality Management (SCQM) registry and psychometric validation (e.g., reliability, construct validity).

Results: BAASIS-RA© is an 8-item instrument covering all three adherence phases. An algorithm customises implementation and persistence parameters, adjusting the recall period and acceptable timing deviations to enable a standardized yet personalised assessment. Cognitive debriefing interviews confirmed clarity, relevance, feasibility, as well as its brevity and ease of use. Available in multiple languages (EN, DE, FR, IT), it will be offered as an electronic Patient-Reported Outcome Measure (ePROM) via mySCQM, minimising clinician burden, with optional paper- or interview-based formats.

Conclusion: BAASIS-RA© is an instrument that enables the standardised assessment of DMARD adherence across all three phases: initiation, implementation, and persistence. In Switzerland, it will allow for remote, patient-level monitoring via mySCQM. By providing a concise, patient-centred measure of adherence, BAASIS-RA© has the potential to inform treatment decisions and strengthen real-world evidence generation in both clinical practice and research. Ongoing psychometric validation will further establish its measurement properties.

P 14

Incidence of infections in patients with rheumatoid arthritis treated with JAK inhibitors (including subtypes), TNF inhibitors and other bDMARDs: results from the JAK-pot collaboration

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A recent safety trial highlighted higher rates of infections (including serious) with tofacitinib, a JAKinhibitor (JAKi), compared with TNF-inhibitors (TNFi) in patients with rheumatoid arthritis (RA). However, real-world observational studies have reported heterogeneous results, leaving some important uncertainty regarding the infectious burden associated with JAKi in routine practice and compared to bDMARDs with other mode of actions (OMA). To address these uncertainties, we used the international JAK-pot collaboration to compare the risk of infections treated with TNFi, JAKi or OMA. Patients from 15 RA registries across Europe and Québec, starting a new treatment (JAKi, TNFi or OMA) were included. Tofacitinib, upadacitinib and baricitinib were also evaluated. Outcomes: all infections, serious infections (SI ; death, hospitalization, intravenous treatment), all infections excluding herpes zoster (HZ), HZ, and specific infections (skin, lung, digestive, osteoarticular, and systemic). Exposure period started at treatment initiation and stopped either 3 months after discontinuation (1 year for rituximab), or loss to follow-up, death or study end, whichever came first. Multiple imputations techniques and propensity score adjustment were performed using patient's characteristic. Adjusted Incidence Rate Ratios (aIRRs) were computed using Poisson generalized estimating equations, adjusted for country of registry. Over the 66 '492 treatment courses, in 42'541 patients (mean patient followup: 3.31 years), 11'375 incident infections were reported, including 2107 SI. Compared with TNFi, JAKi and OMA were associated with higher aIRRs for overall infections (1.18 [1.12;1.25] and 1.12 [1.06;1.18] respectively). We also found more infections excluding HZ with JAKi (1.12 [1.06;1.18] and with OMA 1.11 [1.05; 1.17]); and more SI with JAKi 1.15 [1.01; 1.32] and with OMA 1.26 [1.12;1.43]). Specifically, we obtain higher aIRRs for HZ with JAKi 2.96 [2.38;3.67] and with OMA 1.32 [1.01;1.72] and for lung infections with JAKi (1.21 [1.11;1.32] and with OMA 1.17 [1.07;1.27] when compared with TNFi. All JAKi subtypes demonstrated higher aIRRs for overall infections when compared with TNFi. Both OMA and JAKi (overall or for each subtypes) were associated with higher rates of overall infections, all infections excluding HZ, HZ, SI, and lung infections compared with TNFi. Our findings suggest an increased risk of infection with JAKi mainly during the first six months of treatment.

P 15

Selecting the right score: how disease activity composite scores influence treatment outcomes with IL-6-inhibitors, JAK-inhibitors and TNF-inhibitors in rheumatoid arthritis – insight from the 'JAK-pot' collaboration

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Disease activity scores such as Clincal Disease Activity Index (CDAI), Simplified Disease Activity Index (SDAI), Disease Activity Score 28 joints with Erythrocytes Sedimentation Rate and 4 variables (DAS-ESR) or with C-reactive protein and 4 variables (DAS-CRP) are essential to guide treatment decisions in rheumatoid arthritis (RA). Since these scores rely on different criteria, frequent discrepancies in disease activity classification occur. Moreover, scores that include acute-phase reactants may be influenced by treatment that modulate CRP or ESR independently of clinical improvement. This study aims to quantify how the choice of scores differs in capturing transitions between disease activity state (Remission, Low Disease Activity - LDA, Moderate Disease Activity -MDA, High Disease Activity - HDA) over time and how they are affected by treatment. Patients from 12 RA registers, starting JAK inhibitors (JAKi), Tumor Necrosis Factor inhibitors (TNFi), or Interleukin 6 inhibitors (IL-6i) were included.Treatment groups were propensity score–matched at the treatment course level at baseline.Only patients with more than one clinical visit and complete data for all four scores were included. Disease activity states and transitions were then compared using multistate Markov models. Among 13'498 patients contributing 78'864 medical visits (20'448 treatment courses), 7'009 patients were eligible for matching. 3'085 patients on IL-6i were matched to similar patients on JAKi and TNFi. Disease activity scores provided the same disease activity state for only 29.8% of all visits. Among the individual

scores, CDAI had the most visits with high agreement and the smallest difference in mean time spent in a particular state across all three classes of treatments while DAS-ESR displayed the greatest variation. When using DAS-ESR and DAS-CRP, the probabilities of reaching remission were much higher than when using CDAI and SDAI. Considering treatments, mean time spent in remission, hazard of transitioning in remission and probability of reaching remission at one year were all higher with IL6i (and to a lesser extent JAKi) when using scores with acute-phase reactants. Disease activity state should depend on patient 's disease evolution irrespective of the treatment administred. Disease activity scores provide very different evaluation of patient 's state. Given our findings, we suggest using a score independent of acute phase reactant, such as the CDAI.

P 16

Retractions in Rheumatology: Trends, Causes, and Implications for Research Integrity

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Objective: We aimed to describe the trends and main reasons for study retraction in rheumatology literature.

Methods: We reviewed the Retraction Watch database to identify retracted articles in rheumatology. We recorded the main study characteristics, authors ' countries, reasons for retraction, time from publication to retraction, and trends over time. Reasons for retraction were classified as scientific misconduct, data/figure errors, or other reasons. Main article features and cause of retractions in rheumatology were compared with a sample of articles from other medical specialties.

Results: A total of 381 (79.5% original articles) rheumatology articles were retracted between 1989 and 2024. Most originated from Asia (68.5%), particularly China (50.7%). Scientific misconduct accounted for 75.3% of retractions, followed by data errors (14.9%) and other reasons (7.6%). Common misconduct types included data fabrication, fake peer review, duplication, and authorship issues. The median time from publication to retraction was 18 months (interquartile range 9-46), with one-third of articles requiring more than 36 months to be retracted. Time to retraction did not improve over time. The number of retractions steadily increased over time from 18 in 2000-2009, 117 in 2010-2019, and 207 in 2020-2023 (P <0.001). Compared with other medical specialties, rheumatology exhibited similar retraction patterns, differing mainly in geographic distribution.

Conclusion: Retractions in rheumatology have risen substantially, largely due to misconduct. This trend may reflect an increase in questionable research practices or improved detection. Strengthening early-career education, institutional oversight, and ethical research culture is essential to enhance transparency and integrity in the field.

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Remission is a dynamic state: super-remitters and difficult-to-treat rheumatoid arthritis in a national multicentric registry (SCQM)

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Background: In clinical trials, remission rates in patients with established rheumatoid arthritis (RA) are around 6% [1], while approximately 12% develop difficult-to-treat (D2T) RA [2]. Long-term registry data on remission and D2T status in established RA remain scarce.

Objectives: To analyze remission rates and difficult-to-treat (D2T) status in a large real-world registry following initiation of b- or tsDMARD therapy.

Methods: This registry-based cohort study included patients with RA enrolled in the Swiss Clinical Quality Management in Rheumatic Diseases (SCQM) database between 2013 and 2026. Eligible patients were adults with a confirmed diagnosis of RA who initiated their first b- or tsDMARD on or after 2013. Boolean 2.0 remission and D2T status were defined according to ACR/EULAR criteria. Follow-up assessments were grouped at 6, 12, 24, and 60 months after baseline. Missing visit data were interpolated using the nearest available observation approach.

Results: A total of 2,833 patients initiating b- or tsDMARD therapy were included. Boolean remission 2.0 rates increased to month 24 (7% at 6 months, 13% at 12 months, 17% at 24 months), followed by a slight decline to 16% at 60 months. CRP was the most frequent limiting factor for achieving remission at every time point. Remission status was highly dynamic: between visits, 2-8% of all patients entered remission, while 7-9% transitioned out. From month 12 onward, only 6% of patients maintained sustained remission ("super-remitters"), whereas 11% fulfilled D2T criteria at 60 months. Descriptive statistics showed that super-remitters had lower weight [68.8 (13.8) versus 76.4 (17.6) kg], a later start of b- or tsDMARD therapy [6.3 (3.3) versus 2.8 (2.2) years], whereas seropositivity rates were comparable (72.7 versus 75%).

Conclusion: After 60 months, 16% achieved Boolean 2.0 remission and 11% met D2T criteria. Elevated CRP was the most frequent barrier to achieving remission across all time points. Remission was a dynamic state with frequent transitions, and only 6% of patients maintained sustained remission. Future studies should aim to better characterize super-remitters and identify predictors of sustained remission.

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Long-term remission and difficult-to-treat disease in established rheumatoid arthritis with concomitant Sjögren's disease: results from a multicentric national registry

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Rationale: Approximately 6% of patients with established rheumatoid arthritis (RA) achieve remission according to current ACR/EULAR criteria [1], while around 12% develop difficult-to-treat (D2T) RA [2]. Patients with RA and concomitant Sjögren's disease (RA/SjD) exhibit more severe RA, shorter drug retention times, and reduced treatment responsiveness [3,4]. Longitudinal data on the development of remission and D2T RA in patients with RA/SjD are lacking.

Objective: To longitudinally assess remission rates and progression to D2T RA in patients with RA/SjD compared with patients with RA alone.

Methods: This is an observational study analyzing patients enrolled in the SCQM registry between 2013 and 2025. Eligible patients were adults with a confirmed RA initiating their first b- or tsDMARD on or after 2013. Patients were stratified by sicca symptoms and physician-diagnosed SJD. ACR/EULAR-defined Boolean 2.0 remission and D2T criteria were assessed. Logistic regression models were used, adjusting for age at first b-/tsDMARD initiation and time from study start to first b-/tsDMARD.

Results: A total of 2,833 patients with RA initiating b- or tsDMARD therapy were analysed (2,024 RA without sicca, 441 RA with sicca, 67 RA/SjD). In patients with RA without or with sicca, remission rates increased steadily over the entire observation period (17-25% and 15-20%). In contrast, patients with RA/SjD showed an initial increase in remission rates up to 12 months (23%), followed by a decline to 10% at month 60, with the lowest remission rates overall. Based on our data we estimate an OR of 0.34, suggesting that participants with SjD are less likely to be in remission at 60 months ($\chi2 = 5.42$, df = 1, p = 0.02), whereas no effect was observed when looking at the entire follow-up period ($\chi2 = 0.09$, df = 1, p = 0.77). At month 60, 22% of RA/SjD patients fulfilled D2T criteria, compared with 11% in both non-SjD groups. Based on our data we estimate the OR for developing D2T RA associated with concomitant SjD as 2.22 (likelihood ratio test, $\chi2 = 3.20$, df = 1, p = 0.07), which did not reach statistical significance. However, the effect was significant over the whole course of the study (OR 2.3, $\chi2 = 4.37$, df = 1, p = 0.04).

Conclusions: Patients with RA/SjD showed lower remission rates and higher D2T rates following b/tsDMARD initiation, supporting the concept that concomitant SjD identifies a subgroup with a less favourable long-term prognosis.

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Risk of Multiple Lower Extremity Fractures in Methotrexate-Treated Patients: Evidence for 'Methotrexate Osteopathy'?

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Background: Case series have suggested an association between low-dose methotrexate (MTX) use and an increased risk of (multiple) insufficiency fractures of the lower extremities, often referred to as 'MTX osteopathy'.

Methods: This prospective, registry-based cohort study used data from the Swiss Osteoporosis Registry to assess fracture risk in individuals with a documented history of low-dose MTX therapy compared with those without MTX exposure. The outcomes included single and multiple lower extremity fractures (tibia, fibula, tarsals and metatarsals). Risks were analysed using pooled logistic regression models adjusted for age, sex, body mass index, lumbar spine and hip T-scores, prior fracture history, smoking status, glucocorticoid use and rheumatoid arthritis.

Results: Among 20,563 enrolled patients (85% female, median age 65 [IQR: 57–74]) between January 2015 and December 2023, 1,881 had a history of rheumatoid arthritis and/or glucocorticoid use. A total of 1,451 single and 71 multiple lower extremity fractures were documented. Overall, 733 patients received MTX during follow-up, corresponding to 4,099 patient-years of exposure. Single lower extremity fractures were not associated with MTX use (OR 0.73, 95% CI 0.48–1.11; p = 0.14). In univariable analyses, multiple lower extremity fractures were associated with both rheumatoid arthritis (OR 6.16, 95% CI 2.73–13.9; p<0.001) and MTX use (OR 10.7, 95% CI 5.15–21.1; p<0.001). In multivariable analyses, MTX use remained strongly associated with multiple lower extremity fractures (OR 7.95, 95% CI 2.93–21.6; p<0.001), whereas the association with rheumatoid arthritis was attenuated and no longer statistically significant (OR 1.19, 95% CI 0.43–3.29; p = 0.70).

Conclusion: Patients treated with MTX were at increased risk of multiple lower extremity fractures. Our findings support MTX use, rather than rheumatoid arthritis itself, as the principal factor associated with multiple lower extremity fractures; however, they should be interpreted cautiously given the observational design of the study.

POSTERS HPR

HPR 1

Transitional Care in Swiss Rheumatology: Findings from the HEROES Study in Adolescents and Young Adults

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BACKGROUND: Successful transition from pediatric to adult care in adolescents and young adults (AYAs) requires structured transitional care (TC) programs. In Swiss rheumatology clinics, TC practices vary considerably across centers. The Rheumatology Transition for Young People in Switzerland (HEROES) study aims to develop, implement, and evaluate a standardized TC program across Swiss rheumatology centers. The study is recruiting AYAs and collecting baseline data to inform program development and enable future evaluation of its effectiveness.

AIM: To describe baseline characteristics of participating AYAs.

METHODS: Data were collected using interviewer-administered questionnaires, including standardized and investigator-developed instruments. Health-related quality of life (HRQoL) was assessed using the EQ-5D-3L, and medication adherence using the Basel Assessment of Adherence to Immunosuppressive Medications Scale (BAASIS).

RESULTS: A total of 75 participants from seven pediatric rheumatology clinics in German-speaking Switzerland were included. Participants were aged 14–22 years (mean 17.0, SD 1.57). The majority of the participants were female (72%). Among 67 participants receiving medication, 25 (37.3%) reported missing at least one dose in the previous four weeks, and 9 (13.4%) reported missing three or more doses. School or work absenteeism in the past six months due to their rheumatic disease was reported by 69.3% of participants, with a mean of 8.9 days (range 0.5–80). The mean EQ-5D-3L utility score was 0.82 (SD 0.22; range 0.12–1.00), indicating overall good HRQoL with substantial variability. Problems were most frequently reported in the pain/discomfort (44%) and anxiety/depression (40%) dimensions. The mean EQ VAS score (self-rated health, 0–100) was 75.8 (SD 18.8; median 78).

CONCLUSION: Baseline findings highlight relevant challenges in medication adherence, disease burden, and HRQoL among AYAs with rheumatic diseases. These results provide important guidance for the development of a standardized TC program tailored to the needs of this population.

HPR 2

Umgang mit chronischen Schmerzen – aber wie? Ergotherapeutische Gruppeninterventionen zur Selbstmanagement-Förderung bei Erwachsenen mit chronischen Schmerzen

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Einleitung: Chronische Schmerzen können sich nachteilig auf verschiedene Lebensbereiche auswirken. Trotz klarer Hinweise auf den Nutzen von Ergotherapie bei chronischen Schmerzen ist ihre Beteiligung in multidisziplinären Schmerzmanagement-Programmen rückläufig. Dies könnte auf Unklarheiten bezüglich der Gestaltung ergotherapeutischer Interventionen bei der Behandlung chronischer Schmerzen zurückzuführen sein. Gleichzeitig zeigen insbesondere Gruppen- und Selbstmanagement-Interventionen verschiedene positive Effekte bezüglich chronischer Schmerzen.

Ziel: Es wird untersucht, welche evidenzbasierten inhaltlichen Komponenten in ergotherapeutischen Gruppeninterventionen zur Selbstmanagement-Förderung bei Erwachsenen mit chronischen Schmerzen in der Literatur empfohlen werden und wie diese in das ambulante ergotherapeutische Gruppenangebot im Inselspital Bern integriert werden können.

Methode: Mithilfe eines integrativen Reviews wurden anhand vordefinierter Ein- und Ausschlusskriterien sechs Hauptstudien eingeschlossen, zusammengefasst, kritisch gewürdigt und diskutiert. Die daraus gewonnenen Erkenntnisse dienten gemeinsam mit den erhobenen Bedürfnissen und Rückmeldungen von Betroffenen sowie der Checkliste „Machen wir Selbstmanagement-Förderung?“ (BAG, 2023) als Grundlage für die Entwicklung eines neuen Gruppenangebots.

Ergebnisse: In allen eingeschlossenen Hauptstudien des Reviews lassen sich wissensvermittelnde und interaktive sowie betätigungsbasierte Inhalte aus ergotherapeutischen Gruppeninterventionen zur Selbstmanagement-Förderung identifizieren. Ausserdem werden in mehreren Studien Zielsetzungs- oder Bedarfserhebungs-Komponenten sowie umweltbezogene Komponenten verwendet. Basierend auf den Ergebnissen wurde im Inselspital Bern ein Gruppenangebot mit acht Therapieeinheiten konzipiert und ein Arbeitsheft für die Patient:innen erstellt. Dieses enthält Theorie, Übungs- und Reflexionsaufgaben zu den einzelnen Interventionseinheiten.

Schlussfolgerung: Verschiedene inhaltliche Komponenten ergotherapeutischer Gruppeninterventionen können zur Selbstmanagement-Förderung bei chronischen Schmerzen eingesetzt werden. Die Erkenntnisse des Reviews führten zur Entwicklung eines neuen ambulanten Gruppenangebots am Inselspital Bern, welches derzeit in der Praxis umgesetzt und evaluiert wird. Zukünftige Untersuchungen sind notwendig, um die wirksamsten inhaltlichen Komponenten zu identifizieren und die Effektivität des gesamten Behandlungsangebots zu überprüfen.

HPR 3

Evaluation of a Supervised APN-Led Gout Clinic at a University Hospital

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Introduction: Gout is the most prevalent inflammatory arthritis worldwide, with the number of affected individuals projected to reach up to 96 million by 2050. Despite the availability of effective urate-lowering therapies, a substantial proportion of patients remain inadequately treated. Nurse-led models of care have been associated with high levels of treatment adherence. The involvement of Advanced Practice Nurses (APNs) has been shown to improve self-management, quality of life, patient satisfaction, and the sustained achievement of target serum urate (SU) levels. This study aimed to evaluate the effectiveness of a supervised APN-led gout clinic.

Method: This observational study included 69 patients with confirmed gout who were enrolled between May 2023 and January 2026. Based on disease severity, patients were assigned

to one of two target SU groups: ≤300 µmol/L (Group 1: severe gout) or ≤360 µmol/L (Group 2: non-severe gout). The APN provided patient education, counselling, and ongoing support regarding lifestyle modification, disease self-management, and medication adherence. Pharmacological treatment was initiated and adjusted under the supervision of a rheumatologist. Outcomes included changes in SU levels, treatment modifications, and medication adherence, with follow-up assessments conducted at six and twelve months. In addition, patients' perceptions and experiences of lifestyle changes were explored.

Result: Patients in Group 1 required significantly higher allopurinol doses than those in Group 2 to achieve target SU levels ($p \leq 0.01$). Target SU levels were achieved in 80% of treatment regimens in Group 1 and 68% in Group 2. Failure to achieve treatment targets was frequently attributable to treatment modifications made outside the APN-led clinic. Patients reported sustained lifestyle changes, which enhanced self-management and contributed to the maintenance of quality of life and successful disease control.

Conclusion: A supervised APN-led gout clinic effectively supports patients with gout through structured education, counselling, and guidance in self-management and medication adherence. Even in a clinically challenging patient population, this model of care contributed to improved quality of life and the sustained achievement of target serum urate levels.

HPR 4

Increased physical activity and health literacy through counselling? The importance of physical activity counselling in people with axSpA from patients' perspective

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Objectives: Physical Activity (PA) plays an important role in the management of axial spondyloarthritis (axSpA), yet many individuals experience difficulties engaging in PA. This study explored the perceived impact of PA counselling on PA engagement and on the perceived changes in the importance of PA in individuals with axSpA.

Methods: A qualitative design using Interpretative Phenomenological Analysis (IPA) was conducted. Semi-structured interviews were carried out with eight individuals with axSpA who had received PA counselling within the 'MyBeFit' programme. Data were analysed following the principles of IPA.

Results: Three group experiential themes (GETs) were identified. GET1: Enhancing understanding, confidence, and competence in PA through PA counselling described how PA counselling influenced the participants' understanding of and engagement in PA, GET2: Re-evaluating the meaning of PA in the context of the disease examined the participants' perceptions of PA and training and how these perceptions changed following diagnosis. GET3: Developing a competent and resource-oriented approach to PA explored the different aspects participants had to manage with PA integration.

Conclusion: PA counselling may represent a suitable intervention to support individuals with axSpA. Beyond increasing PA participation, it may also reduce uncertainty, enhance self-efficacy and support the development of a more confident and sustainable approach to PA engagement. Individualised counselling approaches may contribute to improved PA health literacy and long-term PA engagement despite fluctuating disease-related personal resources.

HPR 5

Interprofessional Education Meets Community Care: The MyBeFit@ZHAW Initiative Bridging Health Professions and Patient Needs in Rheumatology Care.

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Background: People with rheumatic diseases face challenges in translating physical activity (PA) recommendations into daily life and training due to pain, functional limitations and limited use of individualized support. Although PA is associated with improved symptoms and long-term outcomes, implementing in routine care remains challenging. Especially, younger adults may benefit from flexible, accessible services that can be integrated into work, study and family life as they are often physically active but may need guidance or small, tailored adjustments to their training.

Aim: The aim of MyBeFit@ZHAW is to implement interprofessional counselling and a training framework for people with rheumatic diseases, in collaboration with Zurich University of Applied Sciences (ZHAW) in Winterthur and Swiss Ankylosing Spondylitis Association (SVMB). The project strengthens self-management and self-efficacy, enhances collaboration between HCPs and patient organizations and establishes a structured training curriculum in chronic care management for Bachelor and Master students.

Methods: The project follows a human-centred, holistic and interprofessional approach through collaboration between ZHAW Unit of interprofessional teaching and education in HCPs, SVMB, and regional healthcare stakeholders. Building on existing services, an interprofessional teaching course is developed, integrating individualized assessment, counselling, PA support, and exercise instruction. The course is grounded in physiotherapy, occupational therapy and midwifery and tailored to individual needs and specialties across health professions. It is translated into a structured curriculum for MyBeFit counselling experts and delivered in a hybrid format. The programme is embedded within a regional network of HCPs and students.

Outcomes: Expected output includes an implementable interprofessional counselling model, a structured training programme for HCPs and students, an accessible entry point to PA support for people with rheumatic diseases and an informational video presenting the MyBeFit?concept.

Conclusion: MyBeFit@ZHAW bridges the gap between evidence-based PA recommendations and their implementation in routine care. By integrating HCPs', educational and community-based support, the project provides a potentially transferable framework for interprofessional counselling and self-management support in rheumatology. Furthermore, it teaches healthcare students in chronic care management support.

HPR 6

Implementation of auricular acupuncture according to the NADA Protocol for patients with chronic pain in the Rheumatology Department of the University Hospital of Zurich

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Introduction: Pain is a physically perceived phenomenon that may occur with or without tissue damage. Pain persisting for

three to six months is considered chronic and has a direct impact on quality of life (Borsca et al., 2016, p. 5). "Chronic pain disorder with somatic and psychological factors" is among the most common diagnoses in the Department of Rheumatology at Zurich University Hospital (USZ). Caring for these patients represents a daily challenge for nursing staff.

Objective: The aim of this project was to implement auricular acupuncture according to the NADA protocol as a complementary intervention alongside conventional medical and therapeutic treatments in the Department of Rheumatology at Zurich University Hospital.

Methods: The implementation process required the identification of relevant stakeholders and extensive collaboration to obtain approval for the practice development project. Discussions focused on the project launch, the selection of the target patient population, the location for treatment sessions, and the revision of the existing USZ guideline on auricular acupuncture. A dedicated working group was established within the department, and all members completed NADA training to acquire the necessary theoretical knowledge and practical skills. Treatment sessions were offered every Monday afternoon. Evaluation data were collected using a patient questionnaire administered immediately after the acupuncture session.

Results: Auricular acupuncture was well received by patients. Improvements were reported by 34.4% of patients in mood, 56.3% in overall well-being, 43.8% in stress levels, and 31.3% in pain levels. 30 of the 32 participating patients reported no adverse effects. Approximately 78% of patients indicated that they would choose to undergo auricular acupuncture again, and 87.5% considered it a meaningful complement to conventional medical and therapeutic interventions.

Conclusion: Auricular acupuncture according to the NADA protocol is a low-risk complementary treatment approach that helps patients relax, improves overall well-being, and may contribute to pain reduction. Furthermore, it expands the range of therapeutic services offered by the department, strengthens the professional role of nursing staff, and enhances the attractiveness of the nursing profession. Due to the positive response from patients and staff, auricular acupuncture is now offered twice weekly in the Department of Rheumatology.

HPR 7

Mind the Gap: Discrepancies in Transitional Care for AYAs with Rheumatic Diseases–Perspectives of Patients and Parents in Switzerland

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Background: High-quality transitional care (TC) is essential to support adolescents and young adults (AYAs) with rheumatic diseases in their transition from pediatric to adult healthcare. However, gaps between patients' needs and current care provision remain insufficiently understood.

Aim: This study aimed to identify discrepancies in TC by examining the perceived importance (i.e., ideal care) of specific aspects of TC and the extent to which these needs are currently met, from the perspectives of both AYAs and parents.

Methods: A cross-sectional study was conducted across Swiss pediatric and adult rheumatology clinics. AYAs aged 14–25 years with rheumatic conditions and their parents were recruited. Current and ideal TC were assessed using the validated Mind the Gap Scale. For each of the 21 items, differences between current experiences and perceived importance were analyzed using the Wilcoxon signed-rank test.

Results: A total of 48 AYAs and 42 parents from 10 clinics participated. The mean age of AYAs was 17.7 years (range 14–25), and of parents 50.1 years (range 33–59). Significant discrepancies between current and ideal TC were observed across most items, indicating unmet needs. Only one item, "gives me/my child the opportunity to be seen in the clinic alone," did not reach statistical significance for both AYAs ($p = 0.059$) and parents ($p = 0.273$). Among AYAs, no significant differences were found for "the healthcare team knows me well" ($p = 0.057$) and "knows me as a person and not just my condition" ($p = 0.086$), while all other 18 items showed significant differences of their perception of current vs. ideal TC. Among parents, no significant differences were observed for "allows my child to decide who should be in the consultation room" ($p = 0.117$), "is very well informed about my child's condition and most recent treatments" ($p = 0.094$), and "provides my child with honest explanations of their condition and treatment options" ($p = 0.206$). All remaining 17 items showed significant differences between current and ideal TC.

Conclusions: Substantial gaps exist between current and ideal TC in Swiss rheumatology settings, highlighting unmet needs from both AYA and parent perspectives. These findings provide a valuable basis to inform targeted improvements in TC. Addressing these gaps through more person-centered and developmentally appropriate approaches may enhance the transition experience and support a successful transition to adult care.

POSTERS INDUSTRY

IP 1

Site characteristics and patient selection criteria for romosozumab in routine clinical practice: insights from the PRIME European multi-country study

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Background: Romosozumab (Romo) is indicated for postmenopausal women with severe osteoporosis (OP) at high risk of fracture. We describe site characteristics, real-world prescribing and patient selection practices for Romo in the Prospective Romosozumab Investigation in Multiple European countries (PRIME).

Methods: PRIME is a non-interventional, primary data-collection study conducted in 8 European countries (final results expected Sept 2026), collecting patient-/site-/country-level data to describe patient characteristics, treatment patterns, persistence with and transition from Romo. To assess site characteristics, principal investigators completed a questionnaire.

Results: As of Nov 2025, all 99 currently enrolled centres, across 8 countries, completed the survey; 87% were outpatient clinics. Prescribing specialty varied: the most frequently reported specialties were rheumatology, endocrinology and multidisciplinary teams (26% of centres reported ≥2 specialties for OP care). Self-injection at home was most common (83%), except Switzerland where in-clinic administration was preferred (5/6 centres). Across sites, patient follow-up typically occurred approximately every 3 or 6 months (75%). 44% of centres were associated with a fracture liaison service (range: 10% [Greece] to 67% [Switzerland]). Respondents cited that when a bone mineral density T-score threshold was considered for starting Romo, it fell between ≤−2.5 and ≤−3.5; centres in Spain often used a lower threshold (≤−3.0). Most respondents rated recent (≤24 months; 75%), major osteoporotic (75%) and multiple fractures (78%) as being of high-to-very-high importance for consideration of Romo initiation. Variability was observed in willingness to prescribe in the presence of comorbidities, reflecting differences in local healthcare systems. Interpretation and extrapolation are limited by responses representing only the opinion of the principal investigator at each centre and the possibility of recall bias.

Conclusion: Preliminary results from the PRIME study provide real-world insights into Romo use in routine OP care in Europe. Findings show cross-country variation in care, Romo administration and patient selection, underscoring the influence of healthcare systems and policies.

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IP 2

Bimekizumab demonstrated sustained improvements in pain and fatigue following early control of inflammation in patients with axial spondyloarthritis over 3 years: results from 2 phase 3 studies and their open-label extension

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Introduction: Uncontrolled, chronic inflammation in axial spondyloarthritis (axSpA) leads to pain/fatigue. Symptom control is important to enhance health-related quality of life. Assessing treatment efficacy post 12 weeks (s) is suggested, highlighting importance of early disease control. Bimekizumab (BKZ) (selective inhibitor of IL-17F/IL-17A) demonstrated efficacy at Wk16, sustained to 3years in ph3 trials for non-radiographic (nr-)axSpA and radiographic (r-)axSpA, and their open-label extension (OLE). We evaluate if inflammation reduction measured by ASDAS or MRI at Wk16 BKZ treatment drives sustained improvements in pain/fatigue over 3years in axSpA patients (pts).

Methods: BE MOBILE 1 (nr-axSpA) and 2 (r-axSpA) included a 16wk double-blind, placebo-controlled and a 36wk maintenance period. From Wk16, all pts received BKZ 160mg every 4wks. Eligible pts entered the OLE at Wk52 and continued BKZ to Wk164. Pain/fatigue were measured by total spinal pain (TSP)/Bath Ankylosing Spondylitis Disease Activity (BASDAI) Q1 (0–10 scales), respectively. Proportions achieving mild pain (TSP<4)/fatigue (BASDAI Q1<4) are presented through Wk164 for BKZ-randomised pts (pooled) who achieved ASDAS <2.1 at Wk16. Results also reported for MRI sub-study pts with Wk16 MRI remission (SPARCC SIJ inflammation<2 [nr-axSpA]/Berlin spine≤2 [r-axSpA]). Data reported as OC.

Results: 128 nr-axSpA/221 r-axSpA BKZ-randomised pts were included in BE MOBILE 1/2 (N = 349). Of 293 entering the OLE, 133 (45.4%) achieved ASDAS<2.1 at Wk16. Most had mild pain scores (TSP<4) at Wks16/52/104/164 (87.2%/90.2%/92.2%/88.0%, respectively). Most had mild fatigue (BASDAI Q1<4) to Wk164 (82.0%/79.5%/93.0%/87.2% at Wks16/52/104/164, respectively). In those with available Wk16 MRI (n = 40), 26 (65.0%) BKZ-randomised pts with nr-axSpA achieved SPARCC SIJ<2 at Wk16; ≥50% had mild pain/fatigue at Wks16/52/104/164 (TSP <4: 50.0%/72.0%/70.8%/76.2%; BASDAI Q1<4: 57.7%/69.2%/70.8%/61.9%). In those with available Wk16 MRI (n = 27), 21 (77.8%) BKZ-randomised pts with r-axSpA achieved MRI Berlin spine≤2 at Wk16; achievement of mild pain/fatigue, at Wk16/52/104/164 was 38.1%/61.9%/57.1%/52.4% and 42.9%/47.6%/61.9%/57.1%, respectively.

Conclusion: BKZ demonstrated improvements in pain/fatigue to Wk164 in axSpA pts with controlled inflammation (ASDAS <2.1/MRI remission) at Wk16. Results suggest early inflammation reduction with BKZ is associated with long-term benefits.

Funding: UCB.

Previous submission: EULAR 2026.

Data to be shown in poster.

IP 3

Bimekizumab treatment resulted in rapid response that was associated with clinically important improvements in patient-reported outcomes up to 3 years in patients with psoriatic arthritis

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Introduction: Rapid response to psoriatic arthritis (PsA) symptoms helps reduce disease impact. We assessed if Week (Wk)16 treatment responses with bimekizumab (BKZ;inhibits IL-17F/IL-17A) relate to improvements in patient-reported outcomes (PROs) over 3 years (yrs).

Methods: BE OPTIMAL (bDMARD-naïve) & BE COMPLETE (TNFi-IR) assessed BKZ160mg every 4 wks (Q4W) in PsA patients (pts). Placebo-randomised pts switched to BKZ at Wk16. Completers entered BE VITAL (OLE;BKZ160mg Q4W). BKZ-randomised pts were evaluated on swollen joint count resolution (SJC = 0)/≥50% improvement from baseline in the American College of Rheumatology criteria (ACR50). PRO responses reported to 3yrs (BE OPTIMAL Wk160/148;BE COMPLETE Wk156), stratified by Wk16 SJC = 0/ACR50 response. PROs included ≥50% improvement in pain (Pain50), minimal clinically important difference (MCID) in Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-Fatigue) and remission/no symptom or disease impact based on 12-item Psoriatic Arthritis Impact of Disease (PsAID-12). Data reported as mNRI/OC. mNRI included visits post-discontinuation due to adverse events/lack of efficacy as non-response;other missing data:MI.

Results: Of 431 bDMARD-naïve/267 TNFi-IR pts, 48.3% (mNRI;OC:206/416[49.5%]) of bDMARD-naïve/45.9% (mNRI;OC:122/260[46.9%]) TNFi-IR pts achieved SJC = 0 at Wk16. 44.8% (mNRI;OC:189/414[45.7%]) of bDMARD-naïve/43.5% (mNRI;OC:115/260[44.2%]) of TNFi-IR pts achieved ACR50. Baseline mean ages of Wk16 SJC = 0 responders/non-responders were 46.3/50.6yrs (bDMARD-naïve) and 48.6/51.6yrs (TNFi-IR pts); 52.9%/41.4% (bDMARD-naïve) and 45.9%/50.7% (TNFi-IR) pts were male. Wk16 ACR50 responders/non-responders were 46.0/50.6yrs (bDMARD-naïve) and 47.2/52.7yrs (TNFi-IR); 59.3%/36.9% (bDMARD-naïve) and 52.2%/45.5% (TNFi-IR) pts were male. Wk16 SJC = 0 responders showed greater PRO improvements through yr3 vs non-responders. More SJC = 0 responders achieved Pain50 at yr3 (64.9% bDMARD-naïve/80.1% TNFi-IR) vs non-responders (47.4%/50.9%). Similar trends seen in FACIT- Fatigue MCID achievement/PsAID-12 score remission. Wk16 ACR50 responders showed greater PRO improvements to yr3 vs non-responders, including Pain50 (bDMARD- naïve:78.8% vs 33.3%; TNFi-IR:76.5% vs 44.2%; mNRI).

Conclusion: BKZ-treated PsA pts achieving ACR50/SJC = 0 at Wk16 showed sustained improvements in pain/fatigue/disease impact over 3yrs, supporting that rapid response predicts long-term improvements in PROs.

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Data to be shown in poster.

IP 4

Bimekizumab treatment resulted in long-term efficacy and safety in biological-naïve patients with active psoriatic arthritis: Week 192 end-of-trial results from the BE OPTIMAL phase 3 study and its open-label extension

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Introduction: Bimekizumab (BKZ; inhibits IL-17F/IL-17A) demonstrated efficacy and safety to 3 years in psoriatic arthritis (PsA) patients (pts) who were biological disease-modifying antirheumatic drug (bDMARD)-naïve/had prior inadequate response/intolerance to tumour necrosis factor inhibitors. We report end-of-trial efficacy/safety to Week (Wk) 192 from the phase 3 BE OPTIMAL study and BE VITAL OLE.

Methods: Pts were randomised 3:2:1 to BKZ 160mg every 4 weeks (Q4W), placebo (PBO) or adalimumab (ADA) 40mg Q2W (reference arm). PBO pts switched to BKZ at Wk16 (PBO/BKZ); ADA pts switched at Wk52 with no washout (ADA/BKZ). Wk52 completers could enter BE VITAL. Efficacy and safety reported to Wk192 (3.7 years) for BKZ total group (BKZ-randomised and PBO/BKZ; 192/176 weeks therapy duration, respectively). Missing data imputation: modified non-responder (mNRI)/multiple (MI)/worst-category (WCI) imputation. Safety data (treatment-emergent adverse events [TEAEs]) reported as exposure-adjusted incidence rates per 100 patient-years (EAIR/100 PY) to Wk192 for all BKZ-treated pts, (including PBO/BKZ and ADA/BKZ).

Results: 638/852 (74.9%) pts completed Wk192; 533/712 (74.9%) in the BKZ Total group completed Wk192. BKZ Total group pts showed sustained responses across all efficacy outcomes to end-of-trial. To Wk192 (2,472.1 total PY), EAIR/100 PY for BKZ-treated pts reporting ≥1 TEAE was 156.4 (95% CI:145.5; 167.9); serious TEAEs: 6.1 (5.1; 7.2). Most frequent TEAEs: COVID-19 (EAIR/100 PY:11.5[10.1; 13.0]), nasopharyngitis (7.4[6.3; 8.6]) and upper respiratory tract infection (6.0[5.0; 7.1]). Four deaths reported, all unrelated to treatment. Reported cases low for: adjudicated major adverse cardiovascular events (11), serious infections (33), adjudicated definite/probable inflammatory bowel disease (7), malignancies (excluding non-

melanoma skin cancer; 10), adjudicated suicidal ideation/behaviour (2). EAIR/100 PY of hepatic events was 5.0 (4.1; 6.0); most were transient liver enzyme abnormalities. EAIR/100 PY of Candida infections was 5.0 (4.1; 6.0), mostly oral candidiasis (3.9[3.1; 4.7]). Most Candida infections were mild/moderate, with one serious infection; no systemic Candida infections. Number of pts discontinuing due to Candida infections: 7 (EAIR/100 PY:0.3[95% CI:0.1; 0.6]).

Conclusion: BKZ provided sustained high clinical efficacy through 3.7 years with a safety profile consistent with previous data in bDMARD-naïve pts with PsA.

Funding: UCB.

Previous submission: EULAR 2026.

Data to be shown in poster.

IP 5

Long-Term Uveitis Rates with Bimekizumab Treatment Across Pooled Phase 2b and Phase 3 Studies in Patients with Axial Spondyloarthritis or Psoriatic Arthritis: 3-Year Update

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Introduction: Uveitis is a common manifestation in patients (pts) with spondyloarthritis (SpA); varying with SpA type/disease duration. IL-17 is implicated in uveitis pathogenesis. Data on IL?17A inhibition efficacy in uveitis are limited and conflicting. The exposure-adjusted incidence rate (EAIR) per 100 pt-years (PY) of uveitis was lower in pts with non-radiographic/radiographic axial SpA (axSpA) randomized to bimekizumab (BKZ; 1.8/100 PY), which selectively inhibits IL-17F/IL-17A, vs placebo (15.4/100 PY) after 16-wks in Ph3 studies. Previous long-term data over ~2 years (data cut-off: Jul 2023) showed uveitis rates remained low in BKZ-treated axSpA (1.3/100 PY) and psoriatic arthritis pts (PsA; 0.1/100 PY). We report updated uveitis incidence in BKZ-treated pts with axSpA/PsA in Ph2b/3 studies with an extra year of treatment in Ph3 studies (data cut-off: axSpA;Sep 2024, PsA;Aug 2024).

Methods: Data reported for 2 pools, each comprising 1 Ph2b and 2 Ph3 studies and their open-label extensions, in pts with axSpA and PsA, respectively. Uveitis events were identified using MedDRA v19.0 preferred terms "autoimmune uveitis", "iridocyclitis", "iritis" and "uveitis"; "acute anterior uveitis" not a specific preferred term in MedDRA v19.0. Uveitis rates and EAIR/100 PY for pts receiving ≥1 BKZ 160 mg every four weeks (Q4W) dose are reported.

Results: Pts with axSpA (N = 848)/PsA (N = 1,409) had mean (SD) ages of 40.3 (11.9)/49.3 (12.4) years, with mean (SD) time since diagnosis of 6.1 (7.8)/7.0 (8.0) years, respectively. 130 (15.3%) axSpA pts had a history of uveitis (PsA: 21 [1.5%]), and most were HLA-B27 positive (717/848 [84.6%]). In pooled Ph2b/3 axSpA data, BKZ exposure was 2,748.9 PY. Uveitis occurred in 33/848 (3.9%; EAIR [95% CI]: 1.2/100 PY [0.8, 1.7]) pts overall and in 20/130 (15.4%; 5.0/100 PY [3.0, 7.7]) pts with uveitis history. In pts without uveitis history, 13/718 (1.8%; 0.6/100 PY [0.3, 1.0]) had uveitis events. Most events were mild/moderate, one severe; two (0.2%) patients discontinued treatment due to uveitis. Incidence of uveitis in pts with PsA was low across pooled Ph2b/3 data (total BKZ exposure: 4,264.7 PY); uveitis occurred in 4/1,409 (0.3%; 0.1/100PY [0.0, 0.2]) pts; two had history of uveitis. No uveitis events led to treatment discontinuation.

Conclusion: Over three years of BKZ treatment, the incidence of uveitis in pts with SpA receiving BKZ long-term remained low.

Funding: UCB.

Previous submission: ACR 2025.

Data to be shown in poster.

IP 6

Bimekizumab treatment in routine clinical care for axial spondyloarthritis: interim observational evidence of patient-reported outcome improvements from the European, multicentre SPEAK study

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Introduction: Axial spondyloarthritis (axSpA) significantly impacts patients' (pts) health-related quality of life (HRQoL). Bimekizumab (BKZ) demonstrated sustained efficacy and patient-reported outcome (PRO) improvements to 3-years for pts with non-radiographic (nr-)/radiographic (r-)axSpA in clinical trials. SPEAK (first prospective observational BKZ study) interim data on PROs including HRQoL and disease activity in pts with axSpA in Europe are reported: pt characteristics at BKZ initiation and PROs to 24 weeks (wks), stratified by prior treatment history. Safety data also reported.

Methods: SPEAK is an ongoing 52-wk, multicentre/country observational study including axSpA pts commencing BKZ in routine clinical practice. Enrolment began 2023. axSpA primary outcome was change from baseline (CfB) in HRQoL, using Assessment of SpondyloArthritis international Society Health Index (ASAS HI) to Wk52. Baseline characteristics and CfB to Wk24 (observed cases) were reported for ASAS HI total score (0-17)/Patient Global Assessment of Disease Activity (PGADA;0–10[rescaled to derive ASDAS])/36-Item Short Form Health Survey Physical Component Summary (SF-36 PCS). Adverse events (AEs) were assessed. Outcomes stratified by prior b/tsDMARD exposure. Interim data reported to 2025.

Results: 197 pts had available baseline characteristics (nr-axSpA:78,r-axSpA:119). 77 (39.1%) had ≥2 prior b/tsDMARDs with distinct mechanisms; 63 (32.0%) received prior TNFi/IL-17A inhibitor therapy. Improvements in ASAS HI were observed 2wks after BKZ initiation regardless of treatment line, to Wk24. PGADA improved to Wk24 with similar responses regardless of prior treatment line. ASAS HI and SF-36 PCS improvements to

24wks greater in b/tsDMARD-naïve pts vs those with prior b/tsDMARDs. AEs reported in 62.9%; drug-related AEs in 33.0%. Reported were: 3 uveitis cases (1.5%); 16 Candida infections (7.6%; 12 were oral); 8 serious infections (4.1%); 1 inflammatory bowel disease (0.5%); 1 major adverse cardiovascular event (0.5%) (myocardial infarction; not drug-related). No venous thromboembolism, hypersensitivity, anaphylaxis, suicidal ideation/behaviour.

Conclusion: Pts with axSpA commencing BKZ showed PRO improvements from Wk2–24 across all prior treatment lines, greater in first-line BKZ pts. These data support effectiveness/safety of BKZ in axSpA; providing evidence that BKZ benefits may extend to routine clinical practice.

Funding: UCB.

Previous submission: EULAR 2026.

Data to be shown in poster.

IP 7

Bimekizumab treatment in routine clinical care for psoriatic arthritis: interim observational evidence of patient-reported outcome improvements from the European, multicentre SPEAK study

Baraliakos X[1], Kiltz U[1], de Vlam K[2], Ruyssen-Witrand A[3], Ramírez Garcia J[4], Walsh J[5], Poddubnyy D[6,7,8], Nicholls D[9], Oortgiesen M[10], Castagna F[11], Bonny MA[12], Korjagina M[13], Lambert J[14], Bajracharya R[15], Öhagen P[16], Ganz F[17], Tillett W[18,19]

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Introduction: Psoriatic arthritis (PsA) significantly impacts patients' (pts) health-related quality of life. Bimekizumab (BKZ; selectively inhibits interleukin [IL]-17F and IL-17A), has demonstrated sustained improvements in patient-reported outcomes (PROs) up to 3-years in PsA clinical trials. SPEAK (first prospective observational BKZ study) interim data on PROs in pts with PsA in Europe, are reported: pt characteristics at BKZ initiation and PROs to 24 weeks (wks), stratified by prior treatment history. Safety data also reported.

Methods: SPEAK is an ongoing 52-wk, multicentre/country study including adults with PsA commencing BKZ in routine clinical practice. Enrolment began in 2023. Baseline characteristics and change from baseline to Wk24 (observed cases) reported for PsA Impact of Disease 12-Item Questionnaire (PsAID-12) total score/Patient Global Assessment of Disease Activity score (PGADA)/36-Item Short Form Health Survey Physical Component Summary (SF-36 PCS). Adverse events (AEs) were assessed. Outcomes stratified by prior biological/targeted synthetic disease-modifying antirheumatic drug (b/tsDMARD) exposure. Interim data reported to April 2025.

Results: Overall, 376 pts had available baseline characteristics: 21.3% b/tsDMARD-naïve; 23.7% one prior b/tsDMARD; 55.1% ≥2 prior b/tsDMARDs (10.6% [22/207] of whom received ≥7 prior b/tsDMARDs). Baseline PRO scores were progressively worse with increasing number of prior treatment lines. Improvements in PsAID-12 total score and PGADA scores were observed 2wks after BKZ initiation, regardless of treatment line, and continued to improve to Wk24. For PsAID-12/PGADA/SF-36 PCS, improvements to 24wks were numerically greater in pts who were b/tsDMARD-naïve than those who had experienced one or ≥2 prior b/tsDMARDs. AEs reported in 61.4% of pts; 34.8% were drug-related. Reported: one uveitis case (0.3%); 43 Candida infections (11.4%); 15 serious infections (4.0%); One major adverse cardiovascular event (0.3%) (not drug-related). No cases of venous thromboembolism/inflammatory bowel disease/suicidal ideation or behaviour. No serious hypersensitivity or anaphylaxis reactions.

Conclusion: Pts with PsA treated with BKZ showed improvements in PROs as early as Wk2 through Wk24. Improvements were seen across all prior treatment lines, with greater changes in pts receiving BKZ as a first-line treatment. No additional safety concerns identified.

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