**Table of Contents**

Presidents, Honorary Chair, Committees ................................................................. 4
Welcome Address ........................................................................................................... 5
Scientific Programme .................................................................................................... 6
  Thursday, September 15 ............................................................................................. 6
  Friday, September 16 .................................................................................................. 7
  Saturday, September 17 ............................................................................................ 10
Poster List ..................................................................................................................... 12
  Poster Session 1 ........................................................................................................ 12
  Poster Session 2 ........................................................................................................ 19
  Poster Session 3 ........................................................................................................ 26
General information ..................................................................................................... 33
  Registration ............................................................................................................... 34
  Social Programme .................................................................................................... 35
  General Information ................................................................................................ 36
Sponsors ......................................................................................................................... 37
City Map ........................................................................................................................ 38
Welcome Address

Dear colleagues,

Welcome to the 10th International Congress on Spondyloarthritides. It is obvious that SpA research is blooming.

We think, over the years, the Gent SpA Congress has become the premier international research meeting focusing on all aspects of spondyloarthritides. The 10th International Congress on Spondyloarthritides will continue this strong tradition by convening researchers spanning clinical topics, such as imaging, treatment and prognostication, as well as basic and translational research, among which studies in molecular biology, cellular immunology, genetics and so on. The success of the meeting can be ascribed primarily to the high level of multidisciplinary interaction that takes place in a venue that encourages both social and scientific interactions.

The programme for the meeting includes the latest advances in clinical and epidemiological research, genetics, immunology, bone biology and inflammation in the gut, skin and eye, as well as in bone and joint. Internationally recognised specialists in their fields have been asked to provide state-of-the-art lectures about dedicated topics, clustered in themes. In our opinion, these themes reflect what is currently ‘hot’ in spondyloarthritides research.

New this year is the debate. We have planned a debate about a controversial topic and we look forward to hear provocative and opposing standpoints from the experienced debaters.

In addition, we have faced the submission of more than 200 abstracts from research groups from all over the world, and the scientific committee has meticulously scored the scientific content of these abstracts. We have the pleasure to be able to provide a podium to the best-of-the-best of these abstract presenters in two dedicated abstract sessions that will include a mixture of basic, translational and clinical research, all in the best spirit of the mission of the Gent Congress!

Furthermore, three poster sessions will facilitate animated scientific discussion during coffee breaks.

As Co-Presidents of the 10th Congress, we extend a warm welcome to this exciting meeting and to the warmth and charm of the host city of Gent.

Robert Landewé & Georg Schett
Presidents of the 10th International Congress on Spondyloarthritides
Wednesday, September 14

13.00 Welcome and Introduction
Robert Landewé & Georg Schett, Presidents

13.15 Opening Keynote Lecture: Basic
INV1 Innate lymphoid cells in the control of tissue homeostasis
Andreas Diefenbach, Germany

Session I: New mechanistic insights into the IL-17/23 pathway
Chairs: Robert Landewé & Georg Schett

14.00 INV2 IL-17/23 in transition from autoimmunity to inflammation
Gerhard Krönke, Germany

14.30 INV3 IL-17 as trigger for arthritis and joint destruction
Erik Lubberts, The Netherlands

15.00 INV4 The IL-17 pathway in spondyloarthritis
Dominique Baeten, The Netherlands

15.30 Coffee Break

16.00 Keynote Lecture: Clinical
INV5 Modern medicine: On the dangers of screening, overdiagnosis and public health advice
Luc Bonneux, Belgium

Session II: Treat-to-target concept in SpA
Chairs: Jürgen Braun & Percival Sampaio-Barros

16.45 INV6 Is the treat-to-target concept applicable to SpA?
Désirée van der Heijde, The Netherlands

17.15 INV7 Do we need to define remission in SpA?
Jochen Sieper, Germany

17.45 INV8 Can fibromyalgia be an obstacle for T2T?
Philip Mease, USA

18.15 Suprise Act: Gent and its unique heritage

18.30 Walking Dinner

Thursday, September 15

13.00 Welcome and Introduction
Robert Landewé & Georg Schett, Presidents

13.15 Opening Keynote Lecture: Basic
INV1 Innate lymphoid cells in the control of tissue homeostasis
Andreas Diefenbach, Germany

Session I: New mechanistic insights into the IL-17/23 pathway
Chairs: Robert Landewé & Georg Schett

14.00 INV2 IL-17/23 in transition from autoimmunity to inflammation
Gerhard Krönke, Germany

14.30 INV3 IL-17 as trigger for arthritis and joint destruction
Erik Lubberts, The Netherlands

15.00 INV4 The IL-17 pathway in spondyloarthritis
Dominique Baeten, The Netherlands

15.30 Coffee Break

16.00 Keynote Lecture: Clinical
INV5 Modern medicine: On the dangers of screening, overdiagnosis and public health advice
Luc Bonneux, Belgium

Session II: Treat-to-target concept in SpA
Chairs: Jürgen Braun & Percival Sampaio-Barros

16.45 INV6 Is the treat-to-target concept applicable to SpA?
Désirée van der Heijde, The Netherlands

17.15 INV7 Do we need to define remission in SpA?
Jochen Sieper, Germany

17.45 INV8 Can fibromyalgia be an obstacle for T2T?
Philip Mease, USA

18.15 Suprise Act: Gent and its unique heritage

18.30 Walking Dinner

FRIDAY, SEPTEMBER 16

08.30 INV9 Recent developments in inflammatory bowel disease
Raja Atreya, Germany

09.10 INV10 Pathophysiology and treatment of psoriasis
Paola Di Meglio, UK

09.50 INV11 Novel concepts in uveitis
Jim Rosenbaum, USA

10.30 Poster Session I and Coffee Break

Session IV: Gut homeostasis, microbiota and arthritis
Chairs: Francesco Ciccia & Robert Inman

11.30 INV12 Microbiota and development of arthritis
Jose Scher, USA

12.00 INV13 New concepts on the barrier function of the gut
Daniel Cua, USA

12.30 INV14 Modulating immune regulation in combined gut and joint
Dirk Elewaut, Belgium

13.00 Lunch

Session V: Challenges in assessing disease activity in SpA
Chairs: Xenofon Baraliakos & Atul Deodhar

14.00 INV15 Patient reported outcomes: Paradigm shift and new challenges
Helena Marzo-Ortega, UK

14.30 INV16 Advances in measuring disease activity of pSpA by ultrasound
Maria-Antonietta D’Agostino, France

15.00 INV17 Relation between clinical and MRI disease activity measures
Robert Lambert, Canada
Selected Oral Presentations I

15.30 O1 Anti-IL-17A treatment blocks inflammation, destruction and new bone formation in experimental spondyloarthritis in HLA-B27 transgenic rats
van Tok M.N., van Duivenvoorde L.M., Kramer I., Ingold P., Taurog J.D., Kolbinger F., Baeten D.L. (The Netherlands, Switzerland & USA)

15.40 O2 Effect of comedication with conventional synthetic DMARDs on retention of TNF inhibitors in patients with spondyloarthritis: A prospective cohort

15.50 O3 Deregulated expression of miRNAs in purified disease relevant blood cell populations in patients with spondyloarthritis
Miceli-Richard C., Bugge Tingaard A., Wang-Renault S.F., Busato F., Dougados M., Tost J. (France)

16.00 O4 Efficacy of golimumab in patients with active, very early peripheral spondyloarthritis: First results from the CRESPA trial
Carron P., Varkas G., Cypers H., Van Praet L., Elewaut D., Van den Bosch F. (Belgium)

16.10 O5 Killer immunoglobulin-like receptors are associated with ankylosing spondylitis

16.20 O6 Which is the most reliable imaging method for detection of structural changes in the SIJ in AS? Comparison of MRI, CT and radiographs
Baraliakos X., Hoffmann F., Deng X., Wang Y., Huang F., Braun J. (Germany)

16.30 Poster Session II and Coffee Break

Session VI: Understanding the functional role of HLA-B27
Chairs: Paul Bowness & John Reveille

17.15 INV18 The pathogenetic role of the HLA-B27 peptidome
Jose Lopez de Castro, Spain

17.45 INV19 The role of ERAP1 in spondyloarthritis in HLA-B27 transgenic rats
Bob Colbert, USA

18.15 INV20 Relationship between B27 and the gut microbiome
Maxime Breban, France

18.45 Scientific Committee Meeting

20.00 Gala Dinner at the ‘Oude Vismijn’ (Old Fish Market)
For details, see page 35
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.00</td>
<td>Debate: Is SpA genetics useful for the clinical community? Chairs: Walter Maksymowczy &amp; Martin Rudwaleit</td>
<td>Matthew Brown, Australia</td>
<td>Australia</td>
</tr>
<tr>
<td>08.00</td>
<td>Selected Oral Presentations II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09.00</td>
<td><em>O7</em> Adding MRI of the spine to the ASAS classification criteria for axial spondyloarthritis, redundant or beneficial?</td>
<td>Ez-Zaitouni Z., Bakker P., de Hooge M., van den Berg R., van Lunteren M., Reijnierse M., Fagerli K., Landewé R., van Oosterhout M., Ramonda R., van Gaalen F., van der Heijde D. (The Netherlands, Norway &amp; Italy)</td>
<td>Belgium</td>
</tr>
<tr>
<td>09.10</td>
<td><em>O8</em> IL-7 primes IL-17 in mucosal-associated invariant T (MAIT) cells, which contribute to the Th17-axis in ankylosing spondylitis</td>
<td>Gracey E., Qaiyum Z., Inman R. (Canada)</td>
<td>Canada</td>
</tr>
<tr>
<td>09.30</td>
<td><em>O10</em> HLA-B27 has major effects on the intestinal microbiome</td>
<td>Costello M.E., Asquith M., Le Cao K.A., Diamond S., Martin T., Rosenbaum J.T., Brown M.A. (Australia &amp; USA)</td>
<td>USA &amp; Australia</td>
</tr>
<tr>
<td>09.40</td>
<td><em>O11</em> Positive sacroiliac joint MRI in asymptomatic patients with recurrent acute anterior uveitis: A proof of concept</td>
<td>Oliveira T.L., Maksymowycz W.P., Lambert R.G., Muccioli C., Pinheiro M.M. (Brazil, Canada &amp; Brazil)</td>
<td>Brazil, Canada &amp; Brazil</td>
</tr>
<tr>
<td>10.00</td>
<td><strong>Poster Session III and Coffee Break</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Poster Session 1

Poster Session 1 is scheduled during the coffee break of 10.30 – 11.30 hrs on Friday, September 16. The presenters of posters P1 through P55 are requested to be present at their posters.

P1  ASDAS-based remission was less frequent than BASDAI-based remission, and both were related to CRP and smoking in early axial spondyloarthritis - The DESIR cohort
Wendling D., Guillot X., Gossec L., Prati C., Saraux A., Dougados M. (France)

P2  Evolution over thirty years of the profile of inpatients with reactive arthritis in a tertiary rheumatology unit
Brinster A., Guillot X., Prati C., Wendling D. (France)

P3  Work status and related variables in patients with ankylosing spondylitis
Sag S., Nas K., Sag M.S., Tekeoglu I., Kamanli A. (Turkey)

P4  Higher serum level of leptin might be responsible for less structural damage in the spine in female patients with ankylosing spondylitis
Podubnyy D., Hartl A., Hermann K.G., Rudwaleit M., Sieper J. (Germany)

P5  Are individual or country level socio-economic determinants related to disease activity and self-reported physical function in patients with spondyloarthritis? Results from multi-national cross-sectional study ASAS-COMOSPA

P6  Prevalence of peripheral and extra-articular disease in ankylosing spondylitis versus non-radiographic axial spondyloarthritis: A meta-analysis

P7  Assessment of the profile of joint involvement in the spondyloarthritides in regions of different ethnic background in Brazil
Ribeiro S.L.E., Campos A.P.B., Palominos P.E., Bortoluzzo A.B., Costa M.A.C., Ribeiro T.O., Sampaio-Barros P.D. (Brazil)

P8  Screening for antibody targets as novel candidate biomarkers for the diagnosis of ankylosing spondylitis using cDNA phage display
Quaden D.H.F., Vandormael P., De Winter L.M., Vanhoof J., Geusens P., Somers V. (Belgium & The Netherlands)

P9  Comparison of clinical characteristics between smoking and non-smoking patients with axial spondyloarthritis: A meta-analysis
Barnish M.S., Dean L.E., Jones G.T., Pathan E., Macfarlane G.J. (UK)

P10 Work instability is associated with increasing work absence and impairment in the short term: Results from the Scotland registry for ankylosing spondylitis (SIRAS)
Jones G.T., Dean L.E., Harkess J., Macfarlane G.J. (UK)

P11 Increased smoking exposure is associated with increased disease severity in axial spondyloarthritis: Results from the British Society for Rheumatology Biologics Register for Ankylosing Spondylitis (BSRBR-AS)
Zhao S., Jones G.T., Barnish M.S., Dean L.E., Macfarlane G.J., Sengupta R., Goodson N. (UK)

P12 Development and evaluation of the Combined Ankylosing Spondylitis Spine Score (CASSS) for the assessment of spinal radiographic outcome

P13 Assessing physical activity in axial spondyloarthritis patients: Modification of the SQUASH

P14 Serum-based soluble markers may differentiate psoriatic arthritis from osteoarthritis
Chandran V., Perruccio A.V., Li S., Abji F., Gandhi R., Gladman D.D. (Canada)

P15 Plasma calprotectin in Spa-patients, a biomarker for peripheral arthritis
Hansen I.M., Forre O.T., Bakland G. (Norway)

P16 ASDAS performance in patients with spondyloarthritides from different Brazilian regions

P17 DKK-1 levels are elevated in patients with enthesitis related arthritis without sacroiliac joint fusion
<table>
<thead>
<tr>
<th>Poster Session 1</th>
<th>Poster Session 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P18</strong></td>
<td><strong>P26</strong></td>
</tr>
<tr>
<td>IgA antibodies against CD74 are associated with structural damage in the axial skeleton in patients with ankylosing spondylitis</td>
<td>Regional registry as a tool for improvement of management of ankylosing spondylitis: Evaluation of psychological state</td>
</tr>
<tr>
<td><strong>P19</strong></td>
<td><strong>P27</strong></td>
</tr>
<tr>
<td>The association of extra-articular manifestations with disease duration in axial SpA: Results from the (Be-) Giant cohort and the ASPECT study</td>
<td>Fecal calprotectin as a new diagnostic tool in diagnosing spondyloarthropathies</td>
</tr>
<tr>
<td><strong>P20</strong></td>
<td><strong>P28</strong></td>
</tr>
<tr>
<td>InterSpA: Sensitivity and specificity of autoantibodies against CD74 in early axial spondyloarthritis</td>
<td>Prevalence of osteoporosis in an ankylosing spondylitis cohort</td>
</tr>
<tr>
<td><strong>P21</strong></td>
<td><strong>P29</strong></td>
</tr>
<tr>
<td>Sclerostin and anti-sclerostin antibodies serum levels predict the onset and site of articular involvement in enteropathic spondiloarthritis: Implications for the clinical practice</td>
<td>Serum amyloid A levels in psoriatic arthritis patients – A marker of disease activity?</td>
</tr>
<tr>
<td><strong>P22</strong></td>
<td><strong>P30</strong></td>
</tr>
<tr>
<td>Oxidative stress evaluated by disulfide/thiol homeostasis in patients with psoriatic arthritis</td>
<td>Low bone mineral density and its associated clinical features in spondyloarthritis</td>
</tr>
<tr>
<td><strong>P23</strong></td>
<td><strong>P31</strong></td>
</tr>
<tr>
<td>Rheumatological manifestations in inflammatory bowel disease patients: A cross-sectional study</td>
<td>Spondyloarthritis prevalence in Europe, a EULAR-endorsed survey</td>
</tr>
<tr>
<td><strong>P24</strong></td>
<td><strong>P32</strong></td>
</tr>
<tr>
<td>The prevalence of axial spondyloarthritis with MRI validation in patients presenting with acute anterior uveitis</td>
<td>HLA-B27/hB2m drosophila a new model to study HLA-B27 implication in spondyloarthritis</td>
</tr>
<tr>
<td><strong>P25</strong></td>
<td><strong>P33</strong></td>
</tr>
<tr>
<td>A prospective evaluation of the Dublin Uveitis Evaluation Tool (DUET) in UK clinical practice</td>
<td>HLA-B27-driven inflammation in the gut controls the central and peripheral monocyte compartments and their osteoclastic potential</td>
</tr>
<tr>
<td>Sykes M., Hamilton L., Gaffney K. (UK)</td>
<td>Ansalone C., Uttriainen L., Milling S., Goodyear C.S. (UK)</td>
</tr>
<tr>
<td><strong>P26</strong></td>
<td><strong>P34</strong></td>
</tr>
<tr>
<td><strong>P27</strong></td>
<td><strong>P35</strong></td>
</tr>
<tr>
<td>Regional registry as a tool for improvement of management of ankylosing spondylitis: Evaluation of psychological state</td>
<td>Modulator role of Inducible COSstimulator (ICOS) in spondyloarthritis animal model</td>
</tr>
<tr>
<td><strong>P28</strong></td>
<td><strong>P36</strong></td>
</tr>
<tr>
<td>Fecal calprotectin as a new diagnostic tool in diagnosing spondyloarthropathies</td>
<td>Regulation of inflammation by IL-27 in a rat model of spondyloarthritis</td>
</tr>
<tr>
<td>Poster Session 1</td>
<td>Poster Session 1</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| **P36** Wnt signaling modulators expression by FLS in inflammatory joint diseases  
| **P37** Window of opportunity: Circulating osteoblast precursors were decreased after infliximab therapy in patients with ankylosing spondylitis  
Kwon S., Park W., Son M., Lim M., Jung K., Park S. (Republic of Korea) | **P46** Performance of ASAS-, Berlin-, and Calin criteria of inflammatory back pain to detect axial spondyloarthritis  
Hermann J., Leitgeb Ch., Husic R., Dejaco Ch., Graninger W. (Austria) |
| **P38** Conditional disruption of the circadian molecular clock in mesenchymal cells causes Achilles tendon ossification and small joint arthropathy  
Ermann J. (USA) | **P47** Gender differences in ankylosing spondylitis patients treated with anti-TNF in daily practice with ten year follow up  
Rusman T., ten Wolde S., Euser S., van der Ploeg T., van Hall O., van der Horst- Bruinsma I.E. (The Netherlands) |
| **P39** Which cells correspond to typical signals for fatty and inflammatory lesions seen on MRI in AS?  
Baralikos X., Boehm H., Samir A., Schett G., Braun J. (Germany) | **P48** Quality of life in IBD patients is lower when having musculoskeletal complaints: Results of the cross-sectional AppSpA survey  
Karreman M.C., Hazes J.M.W., Weel A.E.A.M. (The Netherlands) |
| **P40** Association between improvement in enthesopathy and quality of life: Results from anti TNF-naïve patients with psoriatic arthritis in two phase 3 ustekinumab trials  
McInnes I.B., Puig L., Gottlieb A.B., Ritchlin C., You Y., Song M., Kafka S., Tang K.L., Morgan G.J., Rahman P., Kavanaugh A. (UK, Spain & USA) | **P49** Performance of the ASAS classification criteria for axial and peripheral spondyloarthritis - A systematic literature review and meta-analysis  
| **P41** Monitoring serologic response to HBV vaccination in spondyloarthritic patients treated with TNF blockers  
Valls Pascual E., Ybáñez García D., Vicens Bernabeu E., Vergara Dangond C., Aguilar Zamora M., María Martínez Ferrer M.A., Alegre Sancho J.J. (Spain) | **P50** Clinical disease activity measures are associated with radiographic spinal progression in early axial spondyloarthritis  
Poddubnyy D., Protopopov M., Haibel H., Braun J., Rudwaleit M., Sieper J. (Germany) |
| **P42** Ability of general practitioners to distinguish between inflammatory and non-inflammatory symptoms in patients at risk for spondyloarthritis: The AppSpA study  
Karreman M.C., Hazes J.M.W., Weel A.E.A.M. (The Netherlands) | **P51** Functional relevance of structural damage development in the spine in patients with early axial spondyloarthritis  
Poddubnyy D., Haibel H., Braun J., Rudwaleit M., Sieper J. (Germany) |
| **P43** The prevalence of axial and peripheral spondyloarthritis in inflammatory bowel disease: A systematic review & meta-analysis  
Karreman M.C., Luime J.J., Hazes J.M.W., Weel A.E.A.M. (The Netherlands) | **P52** Patient reported outcomes in spondyloarthropathies from Reuma.pt: Transitioning from paper to touch screen technology  
| **P44** Lack of information for patients at risk for spondyloarthritis: The AppSpA study  
Karreman M.C., Hazes J.M.W., Weel A.E.A.M. (The Netherlands) | **P53** Immune response to hepatitis B virus vaccination in patients with spondyloarthritis treated with anti-TNF therapy vs hemodialyzed patients  
Valls Pascual E., Ybáñez García D., Martínez Ferrer À., Vicens Bernabeu È., Vergara Dangond C., Aguilar Zamora M., Alegre Sancho J.J. (Spain) |
Poster Session 1

P54 In patients with spondyloarthritis anti-TNF therapy is not associated with an increase in neoplasias: Results of GISEA register

P55 Body mass index is related with the presence of syndesmophyte in axial spondyloarthritis: Data from Korean College of Rheumatology Biologics (KOBIO) registry cohort

Poster Session 2

Poster Session 2 is scheduled during the coffee break of 16.30 – 17.15 hrs on Friday, September 16. The presenters of posters P56 through P109 are requested to be present at their posters.

P56 Unmet needs in psoriatic arthritis: One third of the patients with quiescent disease according to the rheumatologist’s opinion do not achieve minimal disease activity
van Mens L., van Kuijk A., Baeten D. (The Netherlands)

P57 Subclinical atherosclerosis in ankylosing spondylitis - Does it really exist and which are the effects of treatments? A systematic review
Prati C., Demougeot C., Guillot X., Verhoeven F., Wendling D. (France)

P58 Validation of the ASAS health index: Results of a multicenter international study in 23 countries
Kiltz U., van der Heijde D., Boonen A., Braun J., on behalf of working group ‘ASAS HI international validation’ (Germany & The Netherlands)

P59 Study of prevalence and predictors of minimal disease activity (MDA) state in a Spanish population with psoriatic arthritis - MAAPs study

P60 Correlation of three enthesites indices with disease activity and function in Brazilian patients with spondyloarthritides

P61 Prevalence of minimal disease activity in “real life”: Cross sectional study in Brazilian patients with psoriatic arthritis and a literature review

P62 Long-term efficacy and tolerability of golimumab in active nonradiographic axial spondyloarthritis: Results of the open-label extension of a randomized, double-blind study
van der Heijde D., Dougados M., Maksymowycz W.P., Braun J., Bergman G., Curtis S.P., Tzontcheva A., Philip G., Huyck S., Sieper J. (The Netherlands, France, Canada, USA & Germany)
P63 Does change in disease activity over one year result in change in health-related quality of life in axial spondyloarthritis patients? 

P64 The association between disease activity and illness perceptions in early axial spondyloarthritis patients in the space cohort 

P65 Is disease activity associated with work productivity loss, presenteeism, and absenteeism in patients with early axial spondyloarthritis? Results from the SPACE cohort 

P66 Illness perceptions and health-related quality of life in patients with axial spondyloarthritis and other forms of chronic back pain in the SPACE-cohort 

P67 Comorbidities are associated with worse clinical outcomes and quality of life in patients with spondyloarthritis - Results from multi-national ASAS-COMOSPA study 

P68 Long-term (up to 156 weeks) safety profile of oral apremilast in patients with psoriatic arthritis: Pooled analysis of PALACE 1-3 
Mease P.J., Gladman D.D., Gomez-Reino J.J., Hall S., Kavanaugh A., Lespessailles E., Schett G., Shah K., Teng L., Wollenhaupt J. (USA, Canada, Spain, Australia, France & Germany)

P69 Treatment with golimumab or infliximab reduces healthcare resource utilization (HCRU) and increases work productivity in patients with ankylosing spondylitis (AS) in the QUO-VADIS study 
Sarzi-Puttini P., Van Den Bosch F., Claudepierre P., Sajjan S., Vastesaeger N., Govoni M., Kachroo S. (Italy, Belgium, France, USA & Italy)
Efficacy and safety of apremilast and switch from etanercept in patients with moderate to severe psoriasis: 52-week results from the LIBERATE study
Reich K., Soung J., Gooderham M., Zhang Z., Nogales K., Day R.M., Ferris L., Goodfield M. (Germany, USA, Canada & UK)

Multidisciplinary management improves disease activity and quality of life in patients affected by enteropathic spondyloarthritis: A prospective observational study
Benfaremo D., Ciccia F., Bolognini L., Ciferri M., Rossini M., Capeci W., Farinelli A., Fava G., Mosca P., Luchetti M.M., Triolo G., Gabrielli A. (Italy)

Burden of disease in axial spondyloarthritis and the potential influence of coexisting neuropathic pain component
Gok K., Cengiz G., Erol K., Ozgocmen S. (Turkey)

A comparison of depression and anxiety levels in patients with non-radiographic axial spondyloarthropathy with those in patients with ankylosing spondylitis
Barisan E., Solmaz D., Akar S. (Turkey)

Comparison of clinical features in patients with psoriatic and non-psoriatic spondylitis
Ozgocmen S., Cengiz G., Erol K., Gok K., Dagli A.Z., Çevik R., Nas K. (Turkey)

Performance of disease activity measures in juvenile spondyloarthritis in a placebo controlled trial with infliximab
Ramiro S., Casasola-Vargas J.C., van der Heijde D., Landewé R., Burgos-Vargas R. (The Netherlands & Mexico)

Food intake, healthy eating index and dietary inflammatory index in patients with psoriatic arthritis
Leite B.F., Morimoto M.A., Genaro P.S., Shivappa N., Hébert J., Pinheiro M.M. (Brazil & USA)

Higher adiposity, fat intake and cholesterol serum levels are associated with higher disease activity in psoriatic arthritis patients: Is there a link among joint, skin and fat?
Leite B., Morimoto M., Genaro P.S., Damasceno N., Pinheiro M.M. (Brazil)

Relationship between work disability and fatigue, anxiety, depression and comorbidities in patients with psoriatic arthritis: A preliminary report
Nas K., Sağ S., Dağılı A.Z., Erkorkmaz U., Solak B., Tekoçğlu I., Kamanlı A. (Turkey)

Feet biomechanics in PsA patients

Determinants of quality of life, healthcare services demand and labor-market status in radiographic axial spondyloarthritis patients
Pimentel-Santos F.M., Pryroteo I., Branco J.C., Pita-Barros P. (Portugal)

Patterns of clinical assessment of general practitioners when facing a patient suspected for spondyloarthritis - A study with unannounced standardized patients in daily practice
Van Onna M.G.B., Gorter S.L., Maiburg H.J.S., Waagenaar G., Van Tubergen A.M. (The Netherlands)

Family matters: Is a positive family history of spondyloarthritis of value in patients with chronic back pain?
Ez-Zaitouni Z., van Lunteren M., Berg I.J., Landewé R., Lorenzin M., van der Heijde D., van Gaalen F. (The Netherlands, Norway & Italy)

Ethnicity and disease severity in ankylosing spondylitis

Comparison of the imaging and clinical arms of ASAS axial spondyloarthritis classification criteria in patients with non-radiographic axial spondyloarthritis

Functional interaction of the ankylosing spondylitis associated endoplasmatic reticulum aminopeptidase 2 (ERAP2) with the HLA-B*27 peptidome in human cells

Epigenetic and expression analysis of ankylosing spondylitis association loci point to key cell types driving disease
Li Z., Haynes K., Thomas G.P., Kenna T., Leo P., Brown M.A. (Australia)

Identification of differentially methylated genes in purified disease relevant blood cell populations in patients with spondyloarthritis
Miceli-Richard C., Bugge Tingaard A., Wang-Renault S.F., Busato F., Dougados M., Tost J. (France)
**Poster Session 2**

**P95** ERAP1 differentially shapes the two major subpeptidomes of HLA-B*51:01: Implications for the pathogenesis of Behçet’s disease

**P96** Functional interaction of ERAP1 with HLA-B*27 subtype-bound-peptidome

**P97** Presence of the HLA-B27+/HLA-B*40:01+ high risk ankylosing spondylitis genotype in early back pain patients (results from the DESIR and SPACE cohort)

**P98** Increased toll like receptor 2 (TLR2) expression on peripheral blood monocytes from patients with ANTI-TNF induced psoriasis suggests a role for a Gram-positive inflammatory trigger

**P99** Increased lymphocyte GM-CSF production is a hallmark of spondyloarthritis
Al-Mossawi M.H., De Wit J., Ridley A., Bowness P. (UK)

**P100** Position 97 (P97) of HLA-B, implicated in ankylosing spondylitis pathogenesis, affects cell surface free heavy chain expression - Evidence of interaction with Beta 2 microglobulin
Chen L., Shi H., Yuan J., Bowness P. (UK)

**P101** Molecular size profile of surfactant protein-D in spondyloarthritis

**P102** Genetic association of ankylosing spondylitis with TBX21 influences T-bet and pro-inflammatory cytokine expression in humans and SKG mice as a model of spondyloarthritis

**P103** Tissue deficiency of the atypical chemokine receptor D6 is associated with the selective increase of gut-derived pro-inflammatory CXCR1highLy6highTL1A+IL-23+CCR7+ cells in the peripheral blood, synovial fluids and bone marrow of AS patients
Ciccia F., Guggino G., Haroon N., Ranganathan V., Rizzo A., Alessandro R., Triolo G. (Italy & Canada)

**P104** Biomechanical stress as primary driver for inflammatory arthritis
Cambré I., Schryvers N., Verheugen E., Lambrecht S., Jacques P., Elewaut D. (Belgium)

**P105** Analysis of granzyme and perforin in ankylosing spondylitis implicates CD8+ T cell perforin-deficiency in joint inflammation
Yao Y., Gracey E., Qaiyum Z., Ranganathan V., Inman R. (Canada)

**P106** S100A8/S100A9: Drivers of disease in arthritis by myeloid deficiency of A20?
Debusschere K., Cypers H., Vogl T., Roth J., Van Loo G., Drennan M., Elewaut D. (Belgium & Germany)

**P107** GM-CSF+ Th17 cells are enriched in psoriatic arthritis and are down-regulated by IL-23
Stober C., Goodall J., Gaston H. (UK)

**P108** A20 inhibition of STAT1 expression in myeloid cells: A novel endogenous regulatory mechanism preventing development of enthesitis

**P109** Invariant natural killer T cells dominate Tregs in controlling arthritis in TNFΔARE mice
Venken K., Decruy T., Jacques P., Sparwasser T., Kollias G., Elewaut D. (Belgium, Germany & Greece)
Poster Session 3

Poster Session 3 is scheduled during the coffee break of 10.00 – 11.00 hrs on Saturday, September 17. The presenters of posters P110 through P162 are requested to be present at their posters.

P110  No radiological sacroiliac joint progression after 2 years of etanercept treatment in non-radiographic axial spondyloarthritis: Data from the EMBARK study
Dougados M., Maksymowych W., van der Heijde D., Pedersen R., Bonin R., Logeart I., Bukowski J., Jones H. (France, Canada, The Netherlands & USA)

P111  Quantification of sacroiliac joint inflammation using diffusion-weighted imaging in young people: Biological validation in enthesitis-related arthritis

P112  The natural history of sacroiliitis in young people with enthesitis-related arthritis on biologic therapy

P113  Quantitative apparent diffusion coefficient measurements are a more repeatable measure of sacroiliitis than visual scoring in young people with enthesitis-related arthritis

P114  Enthesitis, synovitis and tenosynovitis detected by ultrasonography in patients with psoriasis: Diagnostic value of PASE and EARP questionnaires and predictors variables
Reina D., Vidal D., Cerda D., Estrada P., García Díaz S., Navarro V., Peramiquel L., Roig D., Torrente V., Corominas H. (Spain)

P115  About half of the patients with ankylosing spondylitis already have radiographic changes in T spine at the point of diagnosis - Cross sectional study, by whole spine CT
Lee S.H., Choi J.Y., Song R., Lee Y.A., Hong S.J., Yang H.Y. (South Korea)

P116  Back pain is related to MRI-lesions in patients included in the SPACE-cohort

P117  The characteristics of Andersson lesions (spondylodiscitis) based on whole spine magnetic resonance imaging in ankylosing spondylitis
Kim T.H., Nam S.W., Lee S.W., Kim S.K., Shin K.C., Song Y.A., Lee S.H. (Republic of Korea)

P118  Current smoking, its intensity and duration, is associated with fat metaplasia on MRI in patients with spondyloarthritis

P119  What predicts absence of spinal damage in patients with spondyloarthritis after prolonged disease?

P120  The detection of sacroiliitis by CT enterography may be useful in the evaluation of Crohn’s disease
Lage R.C., Tavares W.C., Resende G.G., Kakehasi A.M. (Brazil)

P121  The prevalence of inflammatory and structural lesions on MRI of the sacroiliac joints in patients with very early peripheral spondyloarthritis
Varkas G., Carron P., Cypers H., Van Praet L., Elewaut D., Jans L., Van den Bosch F. (Belgium)

P122  Predictors of sustained remission on TNF-alpha inhibitor in an observational cohort of patients with ankylosing spondylitis: The role of MRI parameters of inflammation and structural damage

P123  Predictors of survival on TNF-alpha inhibitor in an observational cohort of patients with ankylosing spondylitis: The role of MRI parameters of inflammation and structural damage

P124  Can structural progression on MRI of sacroiliac joints in patients with spondyloarthritis be reliably detected and what type of calibration is necessary to achieve this?
Pedersen S.J., van den Berg R., Navarro V., Wichuk S., Marin J., de Hooge M.S.M., Lambert R.G., van der Heijde D., Maksymowych W.P. (Denmark, The Netherlands, Spain, Canada & Argentina)
<table>
<thead>
<tr>
<th>Poster Session 3</th>
</tr>
</thead>
</table>
| **P125** | **Response to treatment with nonsteroidal anti-inflammatory drugs in patients with ankylosing spondylitis and non-radiological axial spondyloarthritis**  
Cherentsova I.A., Otteva E.N. (Russia) |
| **P126** | **Use of conventional systemic disease-modifying antirheumatic drugs before, during, and after TNFi therapy for psoriatic arthritis in the UK: CAPTURE study**  
Bishop-Bailey A., Coope H., McHugh N. on behalf of the CAPTURE Study Investigators (UK) |
| **P127** | **Secukinumab improves minimal disease activity response rates in patients with active psoriatic arthritis: Data from phase 3 FUTURE-2 study**  
Mease P., Coates L.C., Kirkham B., McLeod L.D., Mpofu S., Karyekar C., Gandhi K. (USA, UK & Switzerland) |
| **P128** | **Is it possible to interrupt anti-TNF therapy using a tapering strategy in patients with ankylosing spondylitis achieving clinical response?**  
Navarro-Compán V., Plasencia C., Monjo I., Peiteado D., Villalba A., Balsa A., Martin-Mola E., de Miguel E. (Spain) |
| **P129** | **Is the pattern of patients with axial spondyloarthritis starting biological therapy changing overtime? Results from REGISPONSERBIO?**  
| **P130** | **Impact of aerobic fitness on axial spondyloarthritis activity: A meta-analysis of controlled studies**  
Verhoeven F., Guillot X., Prati C., Tordi N., Demougeot C., Wendling D. (France) |
| **P131** | **Certolizumab pegol for the treatment of axial spondyloarthritis: 4-year outcomes from the RAPID-axSpA trial**  
| **P132** | **Certolizumab pegol for the treatment of psoriatic arthritis: 4-year outcomes from the RAPID-PsA trial**  
Mease P.J., Fleischmann R., Wollenhaupt J., Deodhar A., Gladman D., Hoepken B., Peterson L., van der Heijde D. (USA, Germany, Canada, & The Netherlands) |
P142 **Enteropathic spondyloarthritis: Treatment and outcome in a 2-years prospective study**
Chimenti M.S., Coniglio P., Triggianese P., Cedola F., Onali S., Calabrese E., Petruzzello C., Ruffa A., Biancone L., Perricone R. (Italy)

P143 **Efficacy of golimumab for nonradiographic axial spondyloarthritis (nr-axSpA): Subgroup analysis by baseline MRI and C-reactive protein status**
Sieper J., van der Heijde D., Maksymowych W.P., Braun J., Bergman G., Curtis S.P., Tzontcheva A., Philip G., Huyck S., Dougados M. (Germany, The Netherlands, Canada, USA & France)

P144 **Patient-reported quality of life in patients with baseline objective signs of inflammation and active nonradiographic axial spondyloarthritis treated with golimumab: Results of the open-label extension of a randomized, double-blind study**

P145 **Effect of secukinumab on spinal radiographic changes through 2 years in patients with active ankylosing spondylitis: Results of the phase 3 study, MEASURE-1**
Braun J., Baraliakos X., Deodhar A., Baeten D., Sieper J., Emery P., Talloczy Z., Martin R., Richards H.B. (Germany, USA, The Netherlands, UK & Switzerland)

P146 **Secukinumab for the treatment of psoriatic arthritis: Comparative effectiveness results versus adalimumab up to 48 weeks using a matching-adjusted indirect comparison**
Mclnnes I.B., Nash P., Mease P., Thom H., Hunger M., Gandhi K., Mpofu S., Jugl S. (UK, Australia, USA, Germany & Switzerland)

P147 **Secukinumab for the treatment of ankylosing spondylitis: Comparative effectiveness results versus adalimumab using a matching-adjusted indirect comparison**
Maksymowych W., Strand V., Baeten D., Nash P., Thom H., Hunger M., Gandhi K., Richards H., Jugl S. (Canada, USA, The Netherlands, Australia, UK, Germany & Switzerland)

P148 **Secukinumab provides sustained improvements in the signs and symptoms of active ankylosing spondylitis: 2-year results from a phase 3 trial with subcutaneous loading and maintenance dosing (MEASURE-2)**
P157  Influence of sulfasalazine comedication in switching and response to anti-tumoral necrosis factor in ankylosing spondylitis
Shimabuco A.Y., Gonçalves C.R., Moraes J.C.B., Waisberg M.G., Ribeiro A.C.M., Sampaio-Barros P.D., Goldenstein-Schainberg C., Bonfa E., Saad C.G.S. (Brazil)

P158  Latent tuberculosis screening and treatment in ankylosing spondylitis patients under anti-TNF therapy in endemic area
Moraes J.C.B., Saad C.G.S., Miossi R., Bonfiglioli K.R., Ribeiro A.C.M., Bonfá E. (Brazil)

P159  Anti-TNF therapy in axial spondyloarthritis: Prediction of therapeutic responses using immunological signatures
Menegatti S., Latis E., Yahia H., Leloup C., Ménagé N., Moltó A., Miceli-Richard C., Dougados M., Bianchi E., Rogge L. (France)

P160  Significantly reduced recurrence rate of acute anterior uveitis in ankylosing spondylitis during treatment with golimumab

P161  Smoking related with disease response and age at diagnosis in ankylosing spondylitis
Rusman T., Nurmohamed M.T., Visman I., van der Horst-Bruinsma I.E. (The Netherlands)

P162  Development of recommendations on the content, organisation and positioning of exercise therapy for axial spondyloarthritis in The Netherlands
van Weelij S.F.E., van der Giesen F.J., Kat Y., de Jong S., Vliet Vlieland T.P.M. (The Netherlands)
Registration

As of 15/09/’16

- Participant MD: € 700,00
- Participant Non-MD: € 800,00
- Researcher Non-MD with Abstract*/Student: € 400,00

Gala Dinner** on Friday: € 50,00

*Presenting author only
**If seats are available

The registration includes
The registration fee includes access to all lectures, coffee breaks, lunches and the Opening Reception and Farewell Lunch as indicated in the programme. Participants also have free access to the exhibition.

Separate registration for the Gala Dinner is mandatory.

Participation in the Opening Reception & Walking Dinner is free but pre-registration is mandatory.

Payment
Payment is to be made by credit card. All major credit cards are accepted.

Cancellations
Cancellations received no later than August 31, 2016, entitle registered persons to a 50% refund. In order to cancel your registration and/or hotel booking please contact Yvienne Hoorne: yvienne@medicongress.com.

Social Programme

Opening Reception and Walking Dinner on Thursday, September 15
This Opening Reception and Walking Dinner will take place at Flanders Opera House and is included in the registration fee. Pre-registration however is required.

Gala Dinner on Friday, September 16
The Gala Dinner will take place at the ‘Oude Vismijn’ (Old Fish Market). Separate registration and payment is required to participate in the Gala Dinner.

Here centuries-old history and high-tech facilities go hand in hand. Opposite the Castle of the Counts lies the monumental gateway (1689) to the Old Fish Market. Neptune keeps watch over the Scheldt (male) and the Lys (female).

Access via the bridge in the Jan Breydelstraat.

Access the ‘Old Fish Market’ via the bridge in the Jan Breydelstraat
**General Information**

**Venue**
**Flanders Opera House – Vlaamse Opera**
Schouwburgstraat 3 - 9000 Gent - https://vlaamseopera.be/en

Flanders Opera House – Vlaamse Opera is located in the city centre, within walking distance from the hotels.

For security reasons backpacks, large bags and coats are not allowed in the meeting room. There is a cloakroom on-site.

It is strictly forbidden to take drinks/food into the meeting room.

**Dates**
Thursday, September 15 - Saturday, September 17, 2016

**Language**
The official congress language is English.

**Exhibition**
A medical exhibition is held on the occasion of the Congress and is located on the 2nd floor. Access is free for registered participants. The exhibition is not accessible for non-MDs.

**Catering**
Coffee breaks and lunches will be served in the exhibition and poster area located on the 2nd floor.

**Evaluation**
In order to evaluate the 10th Congress, all participants will receive a short questionnaire at the end of each congress day (link sent by email). This daily questionnaire will take max 5 minutes to complete. Your opinion is valuable for the future of the Congress.

**WiFi**
Free WiFi is offered to all participants and exhibitors.
Internet connection: spondylo2016 - Password: spondylo10

**Liability**
Neither the organisers nor Medicongress accept liability for damages and/or losses of any kind which may be incurred by Congress participants during the Congress. Participants are advised to take out insurance against loss, accidents or damage which could be incurred during the Congress.

**Organisation and Administration**
MEDICONGRESS
Noorwegenstraat 49 - B-9940 Evergem, Belgium
Phone: +32 (0)9 218 85 85
E-mail: congresses@medicongress.com
The only oral PDE4 inhibitor that modulates a network of cytokines involved in PsA

- Effective in the management of swollen and tender joints and enthesitis manifestations of enthesitis and dactylitis
- Provides broad and sustained efficacy in multiple manifestations of PsA, as well as in psoriasis
- Has a proven and favorable long-term safety profile in PsA

Is a convenient oral therapy — No label-required laboratory monitoring and no TVS screening required

**Method of administration:** Otezla is for oral use. The film-coated tablets should be swallowed whole, and can be taken either with or without food.

**Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients listed in section 6.1 of the SPC. Pregnancy (see section 4.6 of the SPC). Undesirable effects: Summary of the safety profile: The most commonly reported adverse reactions included gastrointestinal (GI) disorders including diarrhea (15.7%) and nausea (13.9%). These GI adverse reactions were mostly mild to moderate in severity. The most common adverse reactions leading to discontinuation during the first 16 weeks of treatment were diarrhea (17.5%) and nausea (15.7%).

**Otezla®:** AN ORAL THERAPY THAT MAY CHANGE THE WAY YOU TREAT PSORIATIC ARTHRITIS

Otezla is an oral PDE4 inhibitor which modulates a network of cytokines involved in the pathogenesis of PsA. It is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy (see section 4.3 of the SPC). Otezla is indicated for the treatment of moderate to severe plaque psoriasis in adult patients (see section 4.3 of the SPC). Otezla is not recommended for use in children aged 18 years of age and younger.

**Notes:**

- The safety of apremilast was not evaluated in PsA or PsOR patients with moderate or severe renal impairment in the clinical studies. Reporting of suspected adverse drug reactions were based on data from the apremilast clinical development programme. The frequencies of adverse drug reactions are those reported in the apremilast arms of Phase III clinical trials.
- No dose adjustment is necessary in patients with mild and moderate renal impairment. The dose of apremilast should be reduced to 30 mg once daily in patients with severe renal impairment.
- The treatment of psoriatic arthritis (PsA) has been shown to be effective in improving signs and symptoms of disease activity, including pain, physical function, and general well-being. In a network meta-analysis of randomized controlled trials comparing oral and injectable agents for the treatment of PsA, Otezla was found to be as effective as conventional synthetic and biological DMARDs in improving signs and symptoms of disease activity, including pain, physical function, and general well-being.

**References:**

1. Summary of Product Characteristics OTEZLA® (07/2016)

**Table 1: Dose titration schedule:**

- Day 1: AM: 10 mg, Day 2: AM: 10 mg, Day 3: AM: 10 mg, PM: 10 mg, Day 4: AM: 20 mg, PM: 20 mg, Day 5: AM: 30 mg, PM: 30 mg.
- The additional dose of 10 mg can be administered if the patient's condition improves.
- The recommended dose of Otezla is 20 mg once daily taken orally, morning and evening, approximately 12 hours apart, without food restrictions. An initial titration schedule is required as shown in Table 1. No re-titration is required after initial titration. Table 1: Dose titration schedule: Day 1: AM: 10 mg, Day 2: AM: 10 mg, Day 3: AM: 10 mg, PM: 10 mg, Day 4: AM: 20 mg, PM: 20 mg, Day 5: AM: 30 mg, PM: 30 mg.
- The dose should be titrated upward by 10 mg every 24 hours until the desired therapeutic effect is achieved.

**Notes:**

- The safety and efficacy of Otezla in children aged 0 to 17 years have not been established. No data are available.
- The method of administration: Otezla is to be used. The film-coated tablets should be swallowed whole, and can be taken either with or without food.
- The oral PDE4 inhibitor Otezla is indicated for the treatment of active psoriatic arthritis (PsA) in adults with an inadequate response or who have been intolerant to a prior DMARD therapy.
Janssen’s established track record of bringing innovative treatments for chronic illnesses to patients makes us a leader in the discovery, research and development of immunotherapies.

The foundations built from our pioneering work in developing monoclonal antibodies allow us to expand our portfolio to include novel, oral, small molecules, new biologic platforms and inhaled therapies.

We look forward to working with you to continue to transform the field of immunology.
Transforming patients’ lives

For your aXpPa patients across all stages of their disease

Free from neutralising antibodies

over 15 years of partnership and experience

Established safety profile

Proven long-term efficacy

As immunogenicity analyses are product-specific, comparison of antibody rates with those from other products is not appropriate. Many factors such as patient’s disease activity and history of biologics or how an individual patient responds to these treatments.

The immunogenicity of a therapeutic agent is one of the factors that should not be considered in isolation when evaluating the overall efficacy and safety of a drug. The emergence of anti-drug antibodies is also influenced by several factors including the co-treatment with immunosuppressive drugs such as MTX. Anti-drug antibodies can be neutralising or non-neutralising and both may impact the biactivity and safety of the drug. Neutralising antibodies bind to the binding site of the therapeutic protein and therefore these antibodies would bind to the therapeutic protein but do not neutralise it. Antibodies to Enbrel have not been detected in the sera of some subjects treated with Enbrel. These antibodies have all been non-neutralising and are generally transient.

© Pfizer Inc.

Pfizer

Full SmPC and bibliography available at the stand.
It begins with a promise
to discover medicines that make life better.

For 140 years, we have worked tirelessly to develop and deliver trusted medicines that meet real needs, finding ways to come through no matter the odds. From the development of insulin to treatments in rheumatology, we have pioneered breakthroughs against some of the most stubborn and devastating diseases. We bring this same determination to our work today, uniting our expertise with the creativity of research partners across the globe to keep finding ways to make life better.

To find out more about our promise, visit [www.lilly.be](http://www.lilly.be)

Lilly

www.spa-congress.org
For more than 150 years, a very special passion has driven the people of MSD. Our goal is to develop medicines and animal health innovations that will improve the lives of millions. Still, we know there is much more to be done. And we’re doing it, with a long-standing commitment to research and development. We’re just as committed to expanding access to healthcare and working with others who share our passion to create a healthier world. Together, we’ll meet that challenge. Promise.

To learn more about our efforts, visit www.msd-belgium.be
SOLVING THE WORLD'S TOUGHEST HEALTH CHALLENGES TAKES ALL OF US.

It takes the will to find a new way forward. And no one gets there alone.

That’s why AbbVie teams with peers, academics, clinical experts and others to take on the most complex health challenges.

Uniting the best of pharma with the boldness of biotech, together we’re going beyond conventional thinking to innovate end-to-end approaches that make a real difference.

Starting with science, we arrive at solutions that help millions of patients around the world live better.

abbvie.com
This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See full leaflet for how to report adverse reactions. Name: Cosentyx 150 mg solution for injection in pre-filled syringe / Cosentyx 150 mg solution for injection in pre-filled pen Composition: Each pre-filled syringe contains 150 mg secukinumab* in 1 ml. Each pre-filled pen contains 150 mg secukinumab* in 1 ml. * Secukinumab is a recombinant fully human monoclonal antibody selective for interleukin-17A. Secukinumab is of the IgG1/k-class produced in Chinese Hamster Ovary (CHO) cells. For the full list of excipients, see full leaflet. Pharmaceutical form: Solution for injection in pre-filled syringe (injection). The solution is clear and colourless to slightly yellow / Solution for injection in pre-filled pen (SensoReady pen). The solution is clear and colourless to slightly yellow. Therapeutic indications: Plaque psoriasis: Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. Psoriatic arthritis: Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. Ankylosing spondylitis: Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. Posology: Cosentyx is intended for use under the guidance and supervision of a physician experienced in the diagnosis and treatment of conditions for which Cosentyx is indicated. Plaque psoriasis: The recommended dose is 300 mg of secukinumab by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. Psoriatic arthritis: For patients with concomitant moderate to severe plaque psoriasis or who are anti-TNFα inadequate responders (IR), the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. For other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Ankylosing spondylitis: The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response by 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. Special populations: Elderly patients (aged 65 years and over): No dose adjustment is required. Renal impairment / hepatic impairment: Cosentyx has not been studied in these patient populations. No dose recommendations can be made. Paediatric population: The safety and efficacy of Cosentyx in children below the age of 18 years have not yet been established. No data are available. Contraindications: Severe hypersensitivity reactions to the active substance or to any of the excipients. Clinically important, active infection (e.g. active tuberculosis). Undesirable effects: Summary of the safety profile: see full leaflet. List of adverse reactions: ADRs from clinical studies clinical are listed by MedDRA system organ class. Within each system organ class, the ADRs are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000). List of adverse reactions in clinical studies 1): Infections and infestations: Very common: Upper respiratory tract infections; Common: Oral herpes; Rare: Oral candidiasis; Rare: Tinea pedis; Uncommon: Otitis externa. Blood and lymphatic system disorders: Uncommon: Neutropenia. Immune system disorder: Rare: Anaphylactic reactions. Eye disorders: Uncommon: Conjunctivitis. Respiratory, thoracic and mediastinal disorders: Common: Rhinorrhea. Gastrointestinal disorders: Common: Diarrhoea. Skin and subcutaneous tissue disorders: Uncommon: Urticaria. Placebo-controlled clinical studies (phase III) in plaque psoriasis, PsA and AS patients exposed to 300 mg, 150 mg or placebo up to 16 weeks (psoriasis) or 16 weeks (PsA and AS) treatment duration. Description of selected adverse reactions - see full leaflet. Reporting of suspected adverse reactions: Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system. Mode of delivery: Medicinal product subject to medical prescription. Marketing authorisation holder and numbers: Novartis Europharm Limited, Frimley Business Park, Camberley GU16 7SR, United Kingdom; EU/1/14/980/001- EU/1/14/980/007 Date of revision of the text: 01.04.2016