mediated by the CB1 receptor induced by an increased cell viability and reduction of caspase activity after combined treatment with CBD and CB1 antagonist AM251. Since CBD induced Erk1/2 phosphorylation seems to be independent of CB1 signalling, the involvement of other signalling pathways and/or a crosstalk with other Ca2+ channels or receptors seems likely and will be the focus of further investigations.

REFERENCES:

Disclosure of Interests: None declared


SAFETY AND EFFICACY OF LENABASUM IN AN OPEN-LABEL EXTENSION OF A PHASE 2 STUDY IN DIFFUSE CUTANEOUS SYSTEMIC SCLEROSIS SUBJECTS (dcSSc)

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Background: Lenabasum is a synthetic, non-immunosuppressive, selective cannabinoid receptor type 2 agonist that activates resolution of innate immune responses and limits fibrosis in animal models of SSC. Lenabasum had acceptable safety and tolerability, and improved efficacy outcomes in the 16-week, double-blind, randomized, placebo-controlled Part A of Phase 2 trial JBT101-SSc-001 (NCT02465437) in dcSSc subjects.

Objectives: To provide long-term open-label safety and efficacy data in dcSSc subjects in study JBT101-SSc-001.

Methods: Subjects who completed Part A were eligible to receive oral lenabasum 20 mg BID in an open-label extension (OLE) that assessed safety and efficacy at 4 weeks, then every 8 weeks.

Results: 36/38 (95%) eligible subjects enrolled in the OLE, with mean interval of 134 (range 33-392) days or 19.1 weeks from end of dosing in Part A to start of OLE when subjects received only standard-of care drugs. 34/36 (94%) subjects experienced at least 1 AE; 229 AEs have occurred during the OLE to date. Seven (19%) subjects had > 1 AE considered related to lenabasum in the OLE. Only fatigue (1 subject) was considered definitely-related, none of the related AEs were serious or severe. Most subjects experienced AEs that were mild (n = 6, 17%) to moderate (n = 24, 67%) in maximum severity. Four (11%) had severe AEs and 1 (3%) had a life-threatening AE of renal crisis caused by high-dose steroids. AEs in > 10% of subjects: upper respiratory tract infection (n = 11, 31%), skin ulcer and arthralgia (each n = 6, 17%), urinary tract infection (n = 5, 14%), and diarrhea, nasopharyngitis, and cough (each n = 4, 11%). Dizziness and fatigue occurred in 3 (8.3%) subjects each. At the time of efficacy data cut-off, 30/36 (83%) subjects had completed > 18 months in the OLE. Improvement was seen in multiple physician- and patient-reported efficacy outcomes; selected outcomes are shown in Figure 1. Compared to Baseline at study start, the CRISSS median score (primary efficacy outcome) was 0.99 (0.43 IQR) at Week 76 and mRSS declined by mean (SD) = -10.7 (7.2) points. HAG-DI, Physician Global Assessment, Patient Global Assessment, skin symptoms, itch, and multiple PROMIS-29 domains also improved. FVC% predicted was relatively stable during the OLE; mean (SD) FVC% predicted decreased by 2.5% from study start.

Conclusion: Lenabasum continues to have a favorable safety and tolerability profile in the OLE of Phase 2 trial JBT101-SSc-001 with no lenabasum-related serious AEs or study discontinuations. Only 7 (19%) subjects had an AE related to lenabasum in > 18 months of OLE dosing. ACR CRISSS score, mRSS, Physician Global Assessment, and multiple patient-reported outcomes showed continued improvement, although background therapy, potential for spontaneous improvement, and open-label dosing limit what can be definitely attributed to lenabasum.

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Figure 1. Change from Baseline in Selected Efficacy Outcomes in OLE of Phase 2 Trial JBT101-SSc-001
Background: Results from individual data collections on drug safety during pregnancy and outcomes of pregnancy in patients with inflammatory rheumatic diseases (IRD) are often limited due to small numbers of cases. Joint data analyses from different data sources could solve this problem.

Objectives: The aim of this EULAR task force was to define a core data set to facilitate joint analysis of pregnancy registers in rheumatology.

Methods: Scope and core areas of the core data set have been developed according to COS-STAD recommendations by consensus. An initial list of data items possibly relevant for pregnancy registers was generated based on (i) a systematic literature search, (ii) data items already collected by European pregnancy registers and (iii) a survey among patient representatives. Consensus about the importance of each data item to be included in a core data set was reached by applying a 2-round Delphi survey where each item was rated on a numeric scale (1-3 = low importance, 4-6 = important but not critical, 7-9 = critical importance). Any data item that was considered as ‘critical important’ by at least 70% of respondents in Delphi round 2 was included in the core set. During a face-to-face meeting of the EULAR task force, the inclusion or exclusion of data items with no consensus was finally decided.

Results: The scope was defined as follows: ‘To develop a standardized core data set for data collection in prospective observational research and clinical care of pregnant women with IRD including the neonatal phase. All interventions the pregnant women with IRD including the neonatal phase. All interventions the pregnant women with IRD including the neonatal phase. All interventions the pregnant women with IRD including the neonatal phase.’

Conclusion: The consensus process resulted in an extensive list of data items recommended by experts to be collected as a minimum by pregnancy registers in rheumatology. This core data set applies to all pregnant women irrespective of the underlying IRD. The EULAR task force plans to find consensus on additional disease-specific advice.