SATURDAY, 15 JUNE 2019

12:00:00 – 13:30:00

Novel treatments and old challenges: where do we stand in the management of antiphospholipid syndrome

SP0200 TARGETED TREATMENTS: WHAT'S ON THE HORIZON FOR OBSTETRIC ANTIPHOSPHOLIPID SYNDROME?

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Pregnancy in women with APS and/or lupus is dangerous both for mother and offspring, and, in the past, patients were advised not to have children. Among complications frequently seen in women with lupus are preeclampsia (also known as toxemia of pregnancy), preterm birth, markedly underweight newborns, and fetal death. Identifying women destined for complications remains challenging and limits our ability to counsel and care for pregnant lupus patients.

There is currently no effective treatment for women with these high-risk pregnancies; treatments to prevent poor pregnancy outcomes require an understanding of mechanisms of injury. Our research in an animal model that mimics the human condition shows that blockade of well-established mediators of inflammation, specifically complement and TNF-alpha, prevents adverse outcomes. To translate these discoveries to lupus patients, we launched the **PROMISSE** Study (Predictors of pRegnancy Outcome: bioMarkers In antiphospholipid antibody Syndrome and Systemic lupus Erythematosus) to determine which pregnancies were at highest risk for adverse outcomes. Over 20% of pregnancies in patients with SLE resulted in an adverse pregnancy outcome. We discovered that the presence of a lupus anticoagulant which can be detected in the blood before pregnancy or in the first trimester, confers a 10-fold increase in risk of complications. Furthermore, we found that early in pregnancy, measurable alterations in the balance of angiogenic factors (proteins that circulate in blood, promote proper placenta development, and are required to maintain the health of the mother's vascular system) are highly predictive of preeclampsia and other pregnancy complications.

The results of the PROMISSE Study provide models for early risk stratification to allow physicians to identify patients early in pregnancy who are at low risk and reassure them that their pregnancies were likely to be uncomplicated and their babies healthy. Conversely and importantly, we can reliably predict which patients are destined to have poor pregnancy outcomes, and we conducting a trial with a TNF-alpha inhibitor that does not cross the placenta in patients at highest risk an experimental therapy to prevent placental dysfunction. Treatments to prevent poor pregnancy outcomes require an understanding of mechanisms of injury. Experiments in mouse models have enabled us to embark upon a trial of a potential treatment.

Disclosure of Interests: Jane E. Salmon Shareholder of: Biogen-Idec, BMS, Johnson & Johnson, Regeneron, Merck, Grant/research support from: UCB, Consultant for: BMS, Ionis

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SP0201 CATASTROPHIC APS TREATMENT GUIDELINES

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The current recommendation for specific therapy of catastrophic antiphospholipid syndrome (CAPS) is the triple therapy with anticoagulation, glucocorticoids, plasma exchange and/or intravenous immunoglobulins. Of note, only anticoagulation had a significant effect improving the vital prognosis of these patients. From the experimental point of view, there is only indirect evidence to advocate the use of these immunomodulatory therapies in CAPS.

Recently, two monoclonal antibodies, rituximab and eculizumab, have been successfully used in some cases of severe or refractory CAPS. The first decreases the generation of pathogenic autoantibodies such as antiphospholipid. The second prevents the generation of C5b-C9 complex.

The current presentation will describe the conventional and recent modalities of CAPS treatment, discussing the rationale for each one.

REFERENCES:

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How low should you go? What is the relevant target in T2T in rheumatoid arthritis?

SP0202 WHAT DOES REMISSION MEAN FOR PHYSICIANS?

Laure Gossec. Sorbonne Université and Pitié-Salpêtrière Hospital, Rheumatology, Paris, France

Remission is the announced objective in rheumatoid arthritis. However, there are several definitions of remission. In this talk, we will review different health professional based definitions of remission, the components of these definitions, and their advantages and drawbacks.

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SP0203 WHAT DOES REMISSION MEAN FOR PATIENTS?

Ruth Williams. Kings College London, Department of Inflammation Biology, London, United Kingdom

What does remission in Rheumatoid arthritis mean to patient?

This session discusses what remission means to patients. Remission holds different meaning for researchers, clinicians and patients. In addition it holds different meaning for individual patients and for individual patients at different points of time in their lives. I shall reflect on over fifty years living with Rheumatoid arthritis, as both a patient and a doctor. To consider the changes in my care, my therapy and in my own and my clinicians objectives and treatment aims, at different points in time. Looking at how things have progressed from pain relief, splinting, physical therapy, rehabilitation and surgery. To progressively more effective DMARD's, anti-TNF's & Biologics and an aim of complete 'clinical remission'.

However commonly 'clinical remission' can conflict with a patients concept of remission, as patients are individuals and the tools used to define remission are research based and consider populations not people. 'Disease activity scoring' and 'Treat to Target' has had significant impact on patients, clinicians and their rheumatology consultations. The absence of inflammation does not equal remission for many patients and it is important to consider the differing needs of patients who were diagnosed pre and post- biologic therapies and those with refractory disease. Currently maximal energy appears to be concentrated on the newly diagnosed and even pre-diagnosis, but has this been at the detriment of those with long established disease?

I will share my own and different patients viewpoints of what 'remission' means and consider the benefits of progress in effective 'therapies' but also to reflect upon some of the important things that may have been lost from clinical 'care' along the way. To list simple things that can help patients achieve remission that can easily be forgotten. I will explain the phenomenon of 'DAS blindness' and the potential failings it can lead to. Discuss how improved shared decision making of treatment aims might improve outcomes for patients whilst reducing risk and possibly costs; aiming to increase patient autonomy and improve the doctor patient dynamic.

In order to achieve 'remission' for patients we need to have a clear shared understanding of what 'remission' means to each individual and only then can we aim to achieve it.

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