con il patrocinio di

APPROCCI INTERDISCIPLINARI IN REUMATOLOGIA

5ª edizione

REUMATOLOGIA E MALATTIE NEOPLASTICHE

Torino, 13-14 ottobre 2017

OPEN ACCESS

EXTENDED REPORT

Treating rheumatoid arthritis to target: 2014 update of the recommendations of an international task force

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A. The treatment of rheumatoid arthritis must be based on a shared decision between patient and rheumatologist

B. The primary goal of treating patients with rheumatoid arthritis is to maximise long-term health-related quality of life through control of symptoms, prevention of structural damage, normalisation of function and participation in social and work-related activities

C. Abrogation of inflammation is the most important way to achieve these goals

D. Treatment to target by measuring disease activity and adjusting therapy accordingly optimises outcomes in rheumatoid arthritis

1. The primary target for treatment of rheumatoid arthritis should be a state of clinical remission
2. Clinical remission is defined as the absence of signs and symptoms of significant inflammatory disease activity
3. While remission should be a clear target, low-disease activity may be an acceptable alternative therapeutic goal, particularly in long-standing disease
4. The use of validated composite measures of disease activity, which include joint assessments, is needed in routine clinical practice to guide treatment

[illegible]) measure of disease activity and the target value [illegible]orbidities, patient factors and drug-related risks

[illegible]must be obtained and documented regularly, as [illegible]tients with high/moderate disease activity or less [illegible]months) for patients in sustained low-disease

[illegible]l impairment and comorbidity should be [illegible]ical decisions, in addition to assessing composite

[illegible]arget is reached, drug therapy should be adjusted

[illegible] should be maintained throughout the remaining course of the disease

10. The rheumatologist should involve the patient in setting the treatment target and the strategy to reach this target

Recommendations for the use of biologic therapy in rheumatoid arthritis: update from the Italian Society for Rheumatology II. Safety

E.G. Favalli[1], R. Caporali[2], L. Sinigaglia[3], N. Pipitone[4], I. Miniati[5], C. Montecucco[2], M. Matucci-Cerinic[5]

Recommendations

- In patients undergoing biological treatment for RA an accurate medical and family history should be taken to assess the risk of developing solid or haematopoietic malignancies (grade of recommendation C).
- Considering the timing of oncologic remission of 5 years, TNF inhibitors should be avoided in patients with a recent history of malignancy (<5 years) (grade of recommendation D).

Clin Exp Rheumatol 2011; 29 (Suppl. 66): S15-S27.

Arthritis Care & Research
Vol. 64, No. 5, May 2012, pp 625–639
DOI 10.1002/acr.21641

SPECIAL ARTICLE

2012 Update of the 2008 American College of Rheumatology Recommendations for the Use of Disease-Modifying Antirheumatic Drugs and Biologic Agents in the Treatment of Rheumatoid Arthritis

JASVINDER A. SINGH,[1] DANIEL E. FURST,[2] ASEEM BHARAT,[1] JEFFREY R. CURTIS,[1]

Malignancies. For patients who have been treated for solid malignancies more than 5 years ago or who have been treated for nonmelanoma skin cancer more than 5 years ago, the panel recommends starting or resuming any biologic agent if those patients would otherwise qualify for this RA management strategy (Table 4).

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SPECIAL ARTICLE

2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis

JASVINDER A. SINGH,[1] KENNETH G. SAAG,[1] S. LOUIS BRIDGES JR.,[1] ELIE A. AKL,[2] RAVEENDHARA R. BANNURU,[3] MATTHEW C. SULLIVAN,[3] ELIZAVETA VAYSBROT,[3] CHRISTINE MCNAUGHTON,[3] MIKALA OSANI,[3] ROBERT H. SHMERLING,[4] JEFFREY R. CURTIS,[1] DANIEL E. FURST,[5] DEBORAH PARKS,[6] ARTHUR KAVANAUGH,[7] JAMES O'DELL,[8] CHARLES KING,[9] AMYE LEONG,[10] ERIC L. MATTESON,[11] JOHN T. SCHOUSBOE,[12] BARBARA DREVLOW,[13] SETH GINSBERG,[14] JAMES GROBER,[13] E. WILLIAM ST.CLAIR,[15] ELIZABETH TINDALL,[16] AMY S. MILLER,[17] AND TIMOTHY MCALINDON[3]

Past history of treated or untreated malignancy[4]		
Previously treated or untreated skin cancer (non-melanoma or melanoma)	*Use DMARDs over biologics in melanoma (PICO F.1).* *Use DMARDs over tofacitinib in melanoma (PICO F.2).* *Use DMARDs over biologics in non-melanoma (PICO F.3).* *Use DMARDs over tofacitinib in non-melanoma (PICO F.4).*	*Very low (104-106)*
Previously treated lymphoproliferative disorder	**Use rituximab over TNFi (PICO G.1).**	**Very low (105,107)**
Previously treated lymphoproliferative disorder	*Use combination DMARD or abatacept or tocilizumab over TNFi* (PICO G.2, G.3 and G.4).	*Very low (105,107)*
Previously treated solid organ malignancy	*Same recommendations as in patients without this condition (PICO H.1).*	*Very low (105,108)*

Accepted Manuscript

Novel risk factors related to cancer in scleroderma

David Bernal-Bello, Jaime García de Tena, Alfredo Guillén-del Castillo, Albert Selva-O'Callaghan, Eduardo L. Callejas-Moraga, Ana María Marín-Sánchez, Vicent Fonollosa-Pla, Carmen Pilar Simeón-Aznar

PII: S1568-9972(17)30082-4
DOI: doi:10.1016/j.autrev.2017.03.012
Reference: AUTREV 1991

To appear in: *Autoimmunity Reviews*

Received date: 3 February 2017
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6. Conclusions

The search of risk factors related to cancer emergence might have prognostic implications taking into account that the diagnosis of tumor significantly decreased the probability of survival in our patients with scleroderma. To our knowledge, this is the first time that anti-PM/Scl antibodies were independently associated with a higher risk of cancer among patients with SSc. These antibodies could be unexplored players in the immune response against tumor, wherein exosomes are closely involved. In contrast, the use of aspirin was related to a lower risk of malignancy in our series,

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Rheumatology INTERNATIONAL

OBSERVATIONAL RESEARCH

Mortality and prognostic factors in idiopathic inflammatory myositis: a retrospective analysis of a large multicenter cohort of Spain

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