**EULAR 2021 PRESS CONFERENCE AGENDA**

**Date:** Tuesday, 25 May, 2021  
**Time:** 08:30 – 09:45  
**Chairpersons:** Ms Carina Haupt *EULAR Research Manager*  
Mrs Diana Rodrigues *EULAR Scientific Project Coordinator*  
**Location:** Online - Microsoft Teams meeting  
(Link to be provided upon attendance confirmation)

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| 08:30  | **Introduction**                                                            | Ms Carina Haupt  
*EULAR Research Manager and EULAR 2021 Press Conference Chair* |
| 08:40  | **Capacity building for researchers across Europe: The new EULAR Research Centre**  
(*See manuscript*) | Prof Iain McInnes, OBE  
*EULAR President, Director of Institute of Infection, Immunity and Inflammation, University of Glasgow, Scotland/UK*  
Curriculum vitae: [https://orcid.org/0000-0002-6462-4280](https://orcid.org/0000-0002-6462-4280) |
| 09:00  | **Lessons learned from the Pandemic: The EULAR COVID-19 and COVAX registries**  
(*See manuscript*) | Prof Pedro Machado  
*EULAR lead for the COVID-19 registries, Chair of the EULAR Standing Committee of Epidemiology and Health Services Research, University College London (UCL), London, UK*  
Curriculum vitae: [https://orcid.org/0000-0002-8411-7972](https://orcid.org/0000-0002-8411-7972) |
| 09:10  | **Remote care for people with RMDs**  
(*See manuscript*)  
*Emargo: Thursday, 03 June 2021 (0:01 CEST)* | Prof Dr Thea Vliet Vlieland  
*EULAR Vicepresident representing HPR*  
Curriculum vitae: [https://orcid.org/0000-0001-6322-3859](https://orcid.org/0000-0001-6322-3859) |
### 09:20 Lifestyle and RMDs

- OP0203: Gene-Diet Interaction on the Risk of Incident Gout among Women – Prospective Cohort Study over 32 Years
  Embargo: Friday, 04 June 2021 (0:01 CEST)

- OP0012: Association between passive smoking in childhood and adulthood, and rheumatoid arthritis: results from the French E3N-EPIC cohort study
  Embargo: Wednesday, 02 June 2021 (0:01 CEST)

- POS0644: Air pollution is a predictor of poor response to biological therapies in chronic inflammatory arthritis
  Embargo: Wednesday, 02 June 2021 (0:01 CEST)

  *(See manuscript)*

### 09:30 Vaccinations in children with RMDs

- OP0166: Disease Activity in Children with Juvenile Idiopathic Arthritis after Simultaneous PCV13 and Hib Vaccination: A Cohort Study
  Embargo: Wednesday, 02 June 2021 (0:01 CEST)

  *(See manuscript)*

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**Chairs:**
- Ms Carina Haupt, EULAR Research Manager, EULAR Office
- Mrs Diana Rodrigues, EULAR Scientific Project Coordinator, EULAR Office
Capacity building for researchers across Europe

The new EULAR Research Centre

Founded in 2020, the EULAR Research Centre aims to provide an information hub to help accelerate research into rheumatic and musculoskeletal diseases (RMDs) across Europe and worldwide by bringing together and mobilizing a multidisciplinary research community interested in pursuing RMD research. The Centre does this by providing a research roadmap that highlights unmet needs as well as research resources, infrastructure, services, and training. To advance its mission, the centre also develops broad coalitions and partnerships at the local, national, and international level to integrate existing resources, support research that addresses the needs of people with rheumatic and musculoskeletal diseases, and foster innovation in the field.

The first service that launched under the umbrella of EULAR Research in December 2020 is the Research Consultation Service for clinical and translational sciences, which provides expert advice to RMD investigators with the goal of improving the quality of their research. Requestors are matched with successful and highly experienced consultants who help them in their area of need. Service areas range from advice on study design to data analysis, the reporting of research results, study protocol design, scientific communication, as well as accessing patient/human materials, and using methods and technologies to perform translational science-related analyses such as biomarker testing. During its current pilot phase, the service is available and free for researchers in EULAR-affiliated countries.

Since its launch, the Centre has supported a total of 11 consultation requests from researchers in 9 different European countries, ranging from junior-level PhD students to Professors and department heads. This diversity of requests and the feedback received from all participants indicates a growing demand for this service. EULAR therefore constantly works on expanding its offer and will soon provide additional consultation services for questions related to patient engagement, health services research and implementation science. With the launch of the European Commission’s Horizon Europe research funding programme in 2021, the Research Centre will also provide support to RMD investigators to help them prepare successful, competitive proposals for EU grants.

Through the EULAR School, the Research Centre will further provide training opportunities and webinars for a highly qualified, diverse rheumatic and musculoskeletal disease workforce from researchers, clinicians, and other health professionals to patient researchers. Topics will include research methods, digital health, and data science with a focus on research into rheumatic and musculoskeletal diseases.
To address the challenge of limited funding opportunities, EULAR Research is aiming to launch dedicated programmes to provide further support to RMD researchers across Europe. Besides the research grants offered through the FOREUM Foundation for Research in Rheumatology, the Research Centre will offer more research-oriented and smaller scale funds to help investigators initiate pilot studies or review research methodologies, for example.

Visit the Centre’s website for more information: EULAR Research Centre

Lessons learned from the pandemic: The EULAR COVID-19 and COVAX registries

What is the question about?

There is a lack of robust data to inform our understanding of outcomes following SARS-CoV-2 infection in people with rheumatic and musculoskeletal diseases (RMDs), leading to uncertainties regarding chronic disease management, especially for those taking immunosuppressant or immunomodulatory drugs. Whether people with RMDs belong to a vulnerable, higher risk population for SARS-CoV-2 infection and have poorer outcomes is unclear.

Continuation of immunomodulatory or immunosuppressive therapy is essential for controlling RMD activity, avoiding disease progression and preventing joint or organ damage related to sustained inflammation. Withdrawal of effective treatments should be based on sound evidence, even during a pandemic.

EULAR is committed to collecting data to inform our understanding of COVID-19 disease in people with RMDs as well as outcomes following COVID-19 vaccination. This is being achieved through two parallel, physician-reported registries: The COVID-19 Registry, capturing cases of COVID-19 in people with RMDs (established in collaboration with the COVID-19 Global Rheumatology Alliance, GRA, in March 2020), and the COVAX Registry, capturing vaccine outcomes (established in February 2021).

Here, we share new research data and information on factors associated with COVID-19-related death (analysis of 3729 patients), as well as vaccination outcomes, in people with RMDs (analysis of 1519 patients).

What are the most important core statements/points?

- In common with the general population, older age was more closely linked to COVID-19-related death in people with RMDs. Of those who died, over two-thirds were over 65 and the risk was higher for men compared to women.
- Most RMD medications were not associated with COVID-19-related death, therefore people with RMDs should continue taking their medication unless told otherwise by the rheumatologists and other health professionals managing their care.
• People with lower RMD disease activity or in remission were less likely to die from COVID-19 compared with those with higher disease activity, highlighting the importance of adequate disease control.

• Comorbidities were also more common in people who died from COVID-19: 21% of people looked at by the study had three or more comorbidities. For those that died, 43% had three or more comorbidities. Hypertension combined with cardiovascular disease and chronic lung disease were the most relevant comorbidities.

• People with RMDs under certain medications (Rituximab, some immunosuppressants, glucocorticoids – more than 10 mg per day, and possibly Sulfasalazine) may have a higher risk of severe COVID-19 disease, although disease severity and comorbidities may have also contributed to these reported associations.

• As of 21 May, 2505 cases from 32 countries had been reported to the COVAX Registry. At EULAR, in a late-breaking abstract, data from the first 1519 patients are being reported.

• The safety profiles for COVID-19 vaccines in RMD patients was reassuring. Most adverse events were the same as in the general population (short-term non-serious symptoms).

• The overwhelming majority of patients tolerated their vaccination well with rare reports of inflammatory RMD flare and very rare reports of severe adverse events.

• These initial findings should provide reassurance to rheumatologists and vaccine recipients and promote confidence in COVID-19 vaccine safety in RMD patients.

What is new about it?

The EULAR/GRA COVID-19 registry study described the largest collection of COVID-19 cases amongst people with RMDs, with 3729 cases from >60 countries. It provides information about the outcome of COVID-19 in people with RMDs and, for the first time, it informs about risk factors for COVID-19-related death.

Among people with RMDs, COVID-19-related death was associated with known general factors (older age, male sex and specific comorbidities) and disease-specific factors (disease activity and specific medications). The association with moderate/high disease activity highlights the importance of adequate disease control with DMARDs, preferably without increasing glucocorticoid dosages. Caution may be required with rituximab, sulfasalazine and some immunosuppressants.

Initial findings from the EULAR COVAX Registry provide reassurance to rheumatologists and vaccine recipients, and promote confidence in COVID-19 vaccine safety in RMD patients, namely those with inflammatory RMDs and/or taking immunomodulatory treatments.

What significance do the findings have for patients in Europe/Worldwide? Have they already reached the clinic?

These results will inform the management of people with RMDs in the context of SARS-CoV-2/COVID-19 and are therefore relevant to all rheumatologists and physicians/health care professionals treating people with RMDs and COVID-19 worldwide.
This study demonstrated that most RMD medications are not associated with COVID-19-related death which should provide some reassurance to patients. Therefore, it is important for people with RMDs to continue taking their medication to control disease activity. Withdrawal of effective treatments should be based on sound evidence, even during a pandemic.

Throughout history vaccines have contributed in a major way to protecting the health and the safety of the population. Vaccines protect against >25 diseases and an estimated 3-4 million deaths are being prevented every year. RMD patients are not the exception and should be vaccinated as soon as possible with any of the currently available COVID-19 vaccines. Increasing immunisation globally will have a major impact in the number of COVID-19 deaths prevented in the general population and in patients with RMDs in particular.

Figures, data, facts, background information, scientific publications on the topic

- [Lay summary](#) and [infographic for patients](#) of the above mentioned publication.
- EULAR COVID-19 Registry [webpage](#) and EULAR COVAX Registry [webpage](#).

Further aspects regarding the EULAR registries

The experience of setting up and managing these registries has emphasised the importance of the ‘what, who and why’ of data collection that we will take forward to future projects. However, these considerations are not just applicable to rapid-response disease-specific research, but to all data collection projects in all specialties, regardless of region.

The balance between easy and comprehensive data collection is delicate. We created quick, easy, anonymous surveys while knowingly sacrificing a more robust, complex longitudinal data collection process. Ensuring the data also gives enough meaningful context around the outcomes one is analysing is, while easier to state in retrospect, vital.

These registries demonstrated the strength in collaboration across Europe and beyond and we should look to strengthen these networks and pipelines further. As for the future of the EULAR COVID-19 and COVAX registries, these now sit within the EULAR Virtual Research Centre, which will act as a catalyst to build on these collaborations, for both COVID-19 and other RMD research.
Remote management of RA

What is the question about?

Rheumatoid arthritis (RA) is an autoimmune inflammatory disease. This means the immune system – which is supposed to defend against invaders such as bacteria and viruses – instead attacks the body’s own tissues, causing inflammation and damage. In RA, this is commonly in the joints, but it can also affect the internal organs. RA affects both men and women, and people of all ages, although it is more common in women. People with RA may have stiffness and joint pain, and feel very tired and unable to do activities.

People with RA need regular follow-up to track their disease activity and change treatments if they are not working for them. Traditionally, this has been done with face-to-face clinic visits, but remote management is a new option. However, it is unclear how patients’ self-reporting relates to treatment decisions. This study compared decisions made by clinicians in clinic to those made by a health professional remotely using questionnaire information from the patient.

What are the most important core statements/points and why?

- In this study, 72 RA patients starting a new biologic therapy continued with their usual care and usual clinic monitoring – but they also completed monthly questionnaires at home. The questionnaires were sent to a health professional who was asked to make virtual treatment decisions. This allowed a comparison to be made between the two models of care – the outpatient clinic decisions and the remote virtual decisions.
- Remote treatment decisions were made by an independent health professional, based on the monthly questionnaires. This clinician did not have the same information as the clinician at the routine hospital visits – for example, they did not have blood results and in-person joint assessments.
- The results showed that there were 57 matched decisions between the independent remote health professional and the outpatient clinician, which was important because it showed there was fair agreement.
- In the matched decisions, there was only 1 adverse event that needed treatment to be stopped, and this was identified by both the remote and the outpatient clinicians, suggesting that remote management does not increase safety risks.
- Overall, remote RA monitoring using patient self-assessment and outcome measures was feasible, and there was fair agreement on treatment decisions in both models.
What is new about it?

Using remote monitoring is a new idea in medicine. Traditionally, people with RA have been monitored in face-to-face clinic visits, but remote management using patient self-assessment of disease and patient-reported outcomes has the potential to inform timely clinical decisions on disease management, reduce the burden on busy rheumatology services and promote effective self-management.

What significance does this have for patients in Europe/Worldwide?

Over the past 18 months, many medical appointments have been done remotely, rather than in person. The COVID-19 pandemic has forced this change, but there may be benefits to both patients and healthcare professionals to this new way of interacting. If people with RA can be safely managed remotely, this could free up time for both patients and healthcare services. Remote monitoring could be especially useful in rural or remote areas where getting to the clinic is difficult, or where services are very limited.

These results showed that there was fair agreement between the remote and in-person clinicians, suggesting that patient questionnaires reporting their disease activity and symptoms can be used to help make treatment decisions. This might not be the case for everyone. Some people may struggle to complete the questionnaires, or might not notice changes that would be picked up in an in-person examination. More work will need to be done to inform who is suitable for remote monitoring, and how often in-person visits should still be scheduled.

Figures, data, facts, background information on the topic

- Globally, almost 20 million people have RA, and treat-to-target strategies recommend that each person’s therapy is reviewed every 3–6 months.
- In this study, the questionnaires included self-reported measures of joint stiffness and flare, which are usually collected as part of routine clinical practice.
- The patients also used a visual analogue scale to report their pain, global health and fatigue.
- The pre-categorised remote decisions that the clinicians could make were: no change to biologic, stop biologic, add concomitant disease-modifying antirheumatic drug (DMARD), reduction/removal of a concomitant DMARD and bring in for review.
- The outpatient clinician made 7 changes to biologic and 18 non-biologic therapy changes, while the remote health professional made 1 change to biologic and 17 changes to a non-biologic DMARD, including bringing the patient in for review.
- During the COVID-19 pandemic, data from a registry database in Switzerland showed that a short interruption of in-person care had no major detrimental impact on the disease course of rheumatic disease in 666 people, as assessed by patient-reported outcomes.
- Another recent study showed that using an App to document patient-reported outcomes in people with RA was useful for disease surveillance.
Further reading


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Lifestyle and RMDs

What is the question about?

Rheumatic and musculoskeletal diseases (RMDs) are a group of over 200 different conditions that share similar features – often involving the joints, bones, muscles, and connective tissues such as ligaments and tendons. One of the common symptoms is joint pain. RMDs can also affect internal organs. Some RMDs are autoimmune – which means the immune system is imbalanced for some reason, and attacks the body’s own tissues.

Some RMDs are triggered by lifestyle and environmental factors. For example, there is a link between smoking and the development of rheumatoid arthritis (RA). When cigarette smoke is inhaled, chemicals and by-products are absorbed into the body through the lungs. This is thought to affect the immune system by causing antibodies to develop, and may be one of the causes of the autoimmune disease developing.

Diet can also play a role. Gout is a common RMD that is caused by the build up of urate crystals in the joints, often in the big toe. The urate crystals form when there are high levels of uric acid in the blood from a diet rich in red meat, seafood, alcohol, and sugar. The affected joints become red, swollen, and very tender. Symptoms of gout can come and go, but if left untreated severe gout can cause joint destruction and kidney stones. Traditionally, gout is more common in men than women.

What are the most important core statements/points and why?

Lifestyle: diet
- Women who eat diets rich in fruits, vegetables, nuts, legumes, whole grains, low-fat dairy, and who have low intake of saturated fat and sugar-sweetened beverages are less likely to develop
gout that those who consume diets high in red and processed meats, sugary drinks, desserts, and refined grains.

- The links with diet were true regardless of a person’s individual genetic risk for gout.

**Lifestyle: passive smoking**

- Smoking is a known risk factor for RA – but there is also an increased risk of developing RA in people regularly exposed to passive smoke as children or adults.
- Smoking by-products – whether actively or passively inhaled or absorbed – could generate autoimmunity, at least towards antigens involved in the development of RA.

**Environment: air pollution**

- Air pollution has also been shown to be associated with the development of types of chronic inflammatory arthritis.
- There is a relationship between exposure to air pollutants and markers of inflammation in the blood of people with chronic inflammatory arthritis, which is important because it shows that air quality affects the development of disease.

**What is new about it?**

The gout diet study used a very large population of women, and the latest genetic risk information from genome-wide association studies.

In the smoking study, the authors examined the risk of developing RA in people who had been exposed to passive smoking either in childhood or adulthood. This has been shown before – the first time was in 2017 in an abstract shared at the annual EULAR congress.

For the air pollution study, until now evidence linking higher concentrations of air pollutants with inflammation in chronic arthritis has been missing.

**What significance does this have for patients in Europe/Worldwide?**

These large data sets very clearly show the impact that certain lifestyles and environments can have on the development of RMDs. To avoid gout, choosing a DASH-style diet can help to avoid the build up of uric acid in the blood, and thereby stop urate crystals forming in the joints.

Smoking too is a modifiable risk factor. Although some damage may have already been done, overall risks will decrease over time after quitting. As well as being involved in RMDs developing, smoking can also stop treatments for those diseases working as well. Quitting smoking is a positive step that people with or at risk of developing RMDs can take for their health – and the health of those around them.
The data around smoking and air quality emphasise the need to avoid exposure to tobacco smoke and air pollutants, especially in children and those with a family history of RMDs who may be more at risk of developing these diseases themselves.

Figures, data, facts, background information on the topic

- A study examining the role of genes and diet on the risk of gout in 18,512 women found 523 cases of the disease.
- Analysis showed the DASH diet was associated with a lower risk of developing gout.
- The DASH diet emphasizes fruit, vegetables, nuts, legumes, whole grains, low-fat dairy, and reduced intake of saturated fat and sugar-sweetened beverages.
- The Western diet is one with high intake of red and processed meats, sugary drinks, desserts, and refined grains.
- 79,806 women were included in the passive smoking study, and 698 developed RA.
- 1,286 patients with chronic inflammatory arthritis were included in the air pollution study, and 13,636 daily air pollution records were retrieved.
- Concentrations of pollutants were grouped by levels per cubic metre of air, and inflammation was measured using the levels of C-reactive protein (CRP) in people's blood.
- At exposures of >50 μg/m³ and >40 μg/m³ there was a 150% and 65% higher risk of having CRP above a 5 mg/L threshold.
- Even if the air pollution threshold was set at >30 μg/m³ (below the European Union health protection limit) there is still a 38% higher risk of having altered markers of inflammation.

Further reading

Vaccination on children with RMDs

What is the question about?

Rheumatic and musculoskeletal diseases (RMDs) are a group of over 200 different conditions that share similar features – often involving the joints, bones, muscles, and connective tissues such as ligaments and tendons. One of the common symptoms is joint pain. RMDs can also affect internal organs. Some RMDs are autoimmune, which means the body’s immune system – which is supposed to fight off infection – is attacking its own tissues. This causes inflammation, with swelling, redness, and warmth in the affected areas. People with RMDs are more at risk of infection, both due to the underlying disease, and some of the drugs that are used to treat it.

RMDs can affect both men and women, and people of all ages. Juvenile idiopathic arthritis (JIA) is a type of RMD. JIA is diagnosed when children under the age of 16 have arthritis (joint inflammation) of unknown origin in one or more joints for 6 weeks or more.

Vaccination prevents against infectious diseases caused by bacteria or viruses. There are different types of vaccines, but most work by training the immune system to recognise a specific invader, so that when it encounters it for real it has the tools to defeat it. The two main types are live and non-live vaccines. Non-live vaccines use dead pathogens, or just parts of them that trigger an immune response. Live vaccines use a weakened or modified version of the real virus or bacteria to prime the immune system. Live vaccines give a strong immune response, but they might not be suitable for people whose immune systems do not work properly – either due to illness, or medicines they are taking. This is the case for people with RMDs, and it is recommended that people with RMDs do not receive live vaccines. Many routine childhood vaccines are non-live. Two examples are the PCV13 and Hib vaccines, which protect against pneumococcal and Haemophilus influenzae type b infections.

What are the most important core statements/points and why?

- The safety of vaccination in RMDs is determined not only by the risk of adverse events but also by the risk of worsening the RMD, or causing a disease flare.
- The simultaneous administration of several vaccines at once can increase the likelihood of these events.
- This study looked at 430 children with JIA who received their PCV13 and Hib vaccines at the same time to see what happened with their JIA afterwards.
- Two-thirds of the children were taking biologic disease-modifying antirheumatic drugs (bDMARDs), and a similar proportion were taking conventional synthetic (csDMARDs) such as methotrexate. Just over 10% were taking steroids. All these medicines can suppress the immune system.
- The results showed that simultaneous vaccination against pneumococcal and Hib-infections in children with JIA did not negatively affect their JIA disease activity as measured by joint activity, eye inflammation, and a marker of inflammation (erythrocyte sedimentation rate or ESR).
• However, 3 weeks after vaccination a small number of children (less than 10%) had increases in two markers of inflammation: high-sensitivity C-reactive protein (hsCRP), and the concentration of calprotectin – which shows there is intestinal inflammation.

*What is new about it?*

This study looked specifically at how receiving two common childhood vaccines at the same time might affect JIA disease activity.

*What significance does this have for patients in Europe/Worldwide?*

It is important for children to receive their childhood vaccinations to protect them against preventable diseases. Children with RMDs such as JIA are at increased risk of infections, due to both the immunosuppressive effect of the disease and some of the drugs used to treat it. EULAR recommend that children with RMDs using corticosteroids, DMARDs and/or a type of bDMARD called anti-tumour necrosis factor alpha (anti-TNF or TNF inhibitor therapy) receive non-live vaccines according to the normal vaccination schedule for their country. This includes the pneumococcal and Hib vaccines used in this study, as well as those against tetanus, diphtheria, pertussis, and meningococci.

After vaccination, some children may experience an increase in levels of underlying inflammation, although the majority will not have any increased disease activity. Patients, their parents or carers, and healthcare providers should be alert to the development or worsening of disease flare so that it can be treated.

*Figures, data, facts, background information on the topic*

• About 1 in 1000 children develop chronic arthritis, although this varies by region.
• This study included 430 children between the ages of 2 and 18 with JIA.
• All the children were hospitalized with JIA, but did not have any serious comorbidities or other diseases.
• The vaccines were administered concurrently by subcutaneous injection into the deltoid area of the upper arm.
• Worldwide, guidelines for vaccination vary widely.
• EULAR has published recommendations on vaccination in both adults and children with RMDs based on published evidence and clinical studies.
• If pneumococcal and Hib vaccines are not included in the national vaccination programme, EULAR recommends these for children with RMDs and low complement levels or functional asplenia. These vaccinations can also be considered in patients on high-dose immunosuppressive drugs or bDMARDs before starting therapy.
Further reading


About EULAR

EULAR is the European umbrella organisation representing scientific societies, health professional associations and organisations for people with rheumatic and musculoskeletal diseases (RMDs). EULAR aims to reduce the burden of RMDs on individuals and society and to improve the treatment, prevention and rehabilitation of RMDs. To this end, EULAR fosters excellence in education and research in the field of rheumatology. It promotes the translation of research advances into daily care and fights for the recognition of the needs of people with RMDs by the EU institutions through advocacy action.

About the EULAR European Congress of Rheumatology

Since its introduction in 2000, the annual EULAR European Congress of Rheumatology has become the primary platform for exchange of scientific and clinical information in Europe. It is also a renowned forum for interaction between medical doctors, scientists, people with arthritis/rheumatism, health professionals and representatives of the pharmaceutical industry worldwide. The EULAR congress is usually held in June in one of the major cities in Europe (see previous congresses).

The scientific programme at the congress covers a wide range of topics on clinical innovations, clinical, translational and basic science. Meetings set up by associations of people with arthritis/rheumatism, health professionals and the health care industry complement the programme. The poster sessions, offering lively interaction between presenters and participants, are regarded by many as the heart of the congress.
Over the years, the EULAR Congress has gained a reputation of being a most innovative platform for the practicing physician particularly with respect to the acquisition of information on novel clinical research. The congress attracts more than 18,000 delegates from more than 130 countries.

The aim of the EULAR European Congress of Rheumatology is to provide a forum of the highest standard for scientific, both clinical and basic, educational, and social exchange between professionals involved in rheumatology, liaising with patient organisations, in order to achieve progress in the clinical care of people with rheumatic diseases.

Contact
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