EULAR 2026

DO NOT MISS HIGHLIGHTS IN PSORIATIC DISEASE

JUNE 2026



This special edition of the Y-GRAPPA Newsletter features a curated selection of notable abstracts in psoriatic disease, selected by our members ahead of the EULAR Congress in London. Explore what's new, what's relevant, and what deserves your attention.



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CLINICAL HIGHLIGHTS



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TREATMENT HIGHLIGHTS

TABLE OF CONTENTS

Schedule at a glance - **p2**

GRAPPA adjacent to EULAR - **p3**

DNM abstracts:

Basic science - **p4**

Clinical - **p9**

Treatment - **p 18**

GRAPPA Virtual Highlight of EULAR 2026 - **p25**

EULAR Schedule at a **Glance:**

PsA related sessions

Scientific sessions

Date	Room	Session Type	Topic
Wednesday, 3 June, 10:30 -12:30 BST	Crowne Plaza London Docklands	**GRAPPA Adjacent to EULAR**	
Wednesday, 3 June, 14:15 - 15:00 BST	Plenary	What is New (WIN)	What is **new** in psoriatic arthritis
Wednesday, 3 June, 16:30 - 17:45 BST	George V Room 4	Basic and Clinical Abstract - Oral Presentations	**Unconventional targets** in Psoriatic Arthritis
Thursday, 4 June, 08:15 - 09:30 BST	N3	Basic and Clinical Abstract – Oral Presentations	**Optimising care** in Psoriatic Arthritis
Friday, 5 June, 08:15 - 09:30 BST	Victoria Room 3	Basic Abstract – Oral Presentations	**Hidden circuits** in Psoriatic Arthritis and Spondylarthritis
Friday, 5 June, 13:30 - 14:30 BST	Poster Tour V	Clinical Poster Tours	Advances in Psoriatic Arthritis **management**

Meet the experts and hands-on sessions

Date	Room	Session Type	Topic
Thursday, 4 June, 10:30 - 11:45 BST	Hands-on 2	HPR Hands-on Sessions	Assessment of disease **activity** in Psoriatic Arthritis
Thursday, 4 June, 13:30 - 14:45 BST	Hands-on 2	HPR Hands-on Sessions	Assessment of disease **activity** in Psoriatic Arthritis
Friday, 5 June, 09:45 - 10:15 BST	Meet the EULAR Expert 3	Meet the EULAR Expert	Psoriatic Arthritis
Saturday, 6 June, 10:45 - 11:15 BST	Meet the EULAR Expert 3	Meet the EULAR Expert	Psoriatic Arthritis

GRAPPA

Group for Research and Assessment of Psoriasis and Psoriatic Arthritis

ADJACENT TO EULAR 2026

WEDNESDAY JUNE 3

CROWNE PLAZA LONDON DOCKLANDS

Western Gateway Royal Victoria Dock, London, E16 1AL, GB

10:30 AM - 12:30 PM

FACULTY INCLUDES:



Artie Kavanaugh
University of California San Diego (USA)



Joseph Merola
UT SOUTHWESTERN (USA)



Walter P. Maksymowych
UNIVERSITY OF ALBERTA (CANADA)



Dylan McGagh
UNIVERSITY OF OXFORD (UK)



Rodrigo Garcia-Salinas
HOSPITAL ITALIANO DE LA PLATA (ARGENTINA)



Stephanie Lembke
GERMAN RHEUMATOLOGY RESEARCH CENTER (GERMANY)

BASIC SCIENCE



Isaac T Cheng, PhD
Postdoctoral Fellow
Subcommittee of Newsletter Group
Clinical interests: Radiographic damage in inflammatory arthritis

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SINGLE-CELL PROFILING OF SKIN AND SYNOVIAL FIBROBLASTS IDENTIFIES OPPOSING IFN ALPHA/BETA PATHWAY REGULATION IN PSORIASIS WITH ARTHRALGIA AND PSORIATIC ARTHRITIS

Aleksandra Khmelevskaia (Zurich, Switzerland)

Friday, 5 June, 08:25 - 08:35 BST
Basic Abstract Sessions: Hidden circuits in Psoriatic Arthritis and Spondylarthritis
Victoria Room 3
OP0266

This study profiled skin and synovial fibroblasts in PsO-Arthralgia and PsA using scRNA-seq, with comparison to healthy controls.

Immune-interacting fibroblasts (CCL19⁺, PLA2G2A⁺) were enriched in both PsO-Arthralgia and PsA compared to healthy skin. Among skin fibroblasts, the CCL19⁺ subset showed the greatest transcriptional differences between PsA and PsO-Arthralgia, while PI16⁺ fibroblasts distinguished diseased from healthy samples. Notably, IFN-α/β signalling was downregulated in skin fibroblasts in PsA, most prominently in the CCL19⁺ subset.

In synovium, COMP⁺ sublining fibroblasts displayed the largest transcriptional changes across disease groups. IFN-α/β signalling was also altered in synovial fibroblasts but, in contrast to skin, was upregulated in PsA compared to PsO-Arthralgia.

Why important?

Distinct fibroblast subsets show disease-specific signatures, with opposing IFN-α/β regulation in skin and synovium, suggesting a tissue-specific mechanism underlying transition from PsO-Arthralgia to PsA.

Polling Question

Would understanding tissue-specific pathways (e.g. IFN signalling) influence the future practical approach to early PsA detection or prevention?

FROM DISEASE-CENTRED TO TISSUE-CENTRED CARE IN PSORIATIC ARTHRITIS: CLINICAL IMPACT OF SYNOVIAL BIOPSY-DRIVEN THERAPEUTIC STRATIFICATION

Simone Parisi (Turin, Italy)

Wednesday, 3 June, 17:00 - 17:10 BST
Basic and Clinical Abstract Sessions: Unconventional targets in Psoriatic Arthritis
George V Room 4

OP071

This study compared a biopsy-driven therapeutic strategy with standard clinician-guided treatment in PsA, and evaluated whether a myeloid CD117⁺ synovial pathotype predicts differential response to biologic therapies.

Synovial biopsies were graded using the Krenn score and classified into three pathotypes: myeloid, lympho-myeloid, and pauci-immune. Fifteen patients with a myeloid CD117⁺ pathotype received targeted biologic therapy (IL-17 inhibitors n=9, IL-23 inhibitors n=3, TNF inhibitors n=3). A matched control group of 20 patients received biologics based on standard clinical decision-making without biopsy guidance.

The biopsy-driven group demonstrated higher treatment retention at 6 and 12 months with DAPSA low disease activity or remission achieved in 68% of patients compared with 45% in controls (p=0.04). In CD117⁺ myeloid cases, IL-17 and IL-23 inhibitors were associated with greater DAPSA reduction than TNF inhibitors. Higher Krenn synovitis scores were also associated with clinical response.

Taken together, these data indicate that both the qualitative characteristics of synovial inflammation (myeloid CD117 pos pathotype) and the quantitative degree of synovitis (Krenn score) can help predict the therapeutic response in PsA.

Why important?

This study supports a move towards precision medicine in PsA by showing that synovial pathotype and inflammatory burden may guide biologic selection and improve outcomes.

Polling Question

How do you view the use of synovial biopsies to guide therapy in routine clinical practice?

PERIPHERAL IMMUNE-CELL SIGNATURES PREDICT CLINICAL RESPONSE IN PSORIATIC ARTHRITIS: INTEGRATED FLOW CYTOMETRY AND SINGLE-CELL RNA SEQUENCING FROM THE COLIPSO COHORT

Shannon Gunawardana
(Oxford, United Kingdom)

Thursday, 4 June, 09:48 - 09:54 BST
Poster Tour IV
Basic Poster Tours: Cracking the immune code in PsA and SpA
POS0083

This study used integrated flow cytometry and scRNA-seq to identify peripheral immune-cell signatures associated with treatment response in PsA.

Higher baseline frequencies of regulatory T cells, activated CD4⁺ effector T cells, Th22, and Th9 cells were associated with greater reductions in DAPSA, BSA, and swollen joint counts, with strong posterior probabilities supporting these associations.

At the transcriptional level, scRNA-seq revealed differences at baseline between patients who later achieved MDA and those who did not, particularly within CD4⁺ memory T helper cells. Lower baseline expression of IL18RAP was observed in patients who subsequently reached MDA. At follow-up, remission was associated with upregulation of ribosomal gene RPS26 and persistently low IL18RAP expression.

Why important?

Circulating immune-cell profiles at treatment initiation may help predict clinical response, supporting the development of blood-based biomarkers to guide treatment selection in PsA.

Polling Question

How do you view the use of circulating immune-cells to guide therapy in routine clinical practice?

BASIC SCIENCE



Hanna Johnsson, MBChB PhD
Consultant Rheumatologist, NRS Clinical Researcher Fellow.
Y-GRAPPA Newsletter subcommittee chair
Clinical interest: Psoriatic arthritis

CIRCULATING PRE-OSTEOCLASTS ARE PRIMED FOR OSTEOCLAST FATE AND SYNOVIAL TISSUE HOMING IN PSORIATIC ARTHRITIS.

Joe Hutton
(Cambridge, United Kingdom)

Friday, 5 June, 09:05 - 09:15 BST
Basic Abstract Sessions: Hidden circuits in Psoriatic Arthritis and Spondylarthritis
Victoria Room 3
OP0270

Bone destruction in PsA is driven by osteoclasts derived from circulating monocyte precursors but the specific precursor population and mechanisms guiding their infiltration into the synovium remain unclear. This study aimed to identify circulating pre-osteoclast (preOC) cells in humans and define their role in PsA pathophysiology.

Tc99m-labelled CD14⁺ monocytes were tracked in vivo by SPECT imaging, revealing selective recruitment to inflamed PsA joints. A distinct preOC population was identified, characterised by NFATC1 enrichment and transcriptional similarity to in vitro osteoclast intermediates. Functionally, these cells generated multinucleated osteoclasts in vitro.

Circulating preOCs were expanded in PsA compared with PsO and healthy individuals and exhibited synovial homing signatures. Spatial and single-cell analyses confirmed their enrichment in PsA synovium, alongside matching endothelial ligands. Fate-mapping approaches demonstrated preferential migration of preOCs from blood into inflamed joints.

Why important?

This work provides mechanistic insights into how aberrant preOC trafficking drives structural damage in PsA and identifies a novel cellular therapeutic target.

Polling Question

Which mechanism best explains structural bone damage in PsA?

SYNOVIAL LINING FIBROBLAST MOLECULAR ENDOTYPES RELATE TO DIVERGENT PHENOTYPES IN RHEUMATOID AND PSORIATIC ARTHRITIS

Shing Law
(Oxford, United Kingdom)

Saturday, 6 June, 10:21 - 10:27 BST
Poster Tour II
Basic Poster Tours: Another one BITes the CAR-T

POS0348

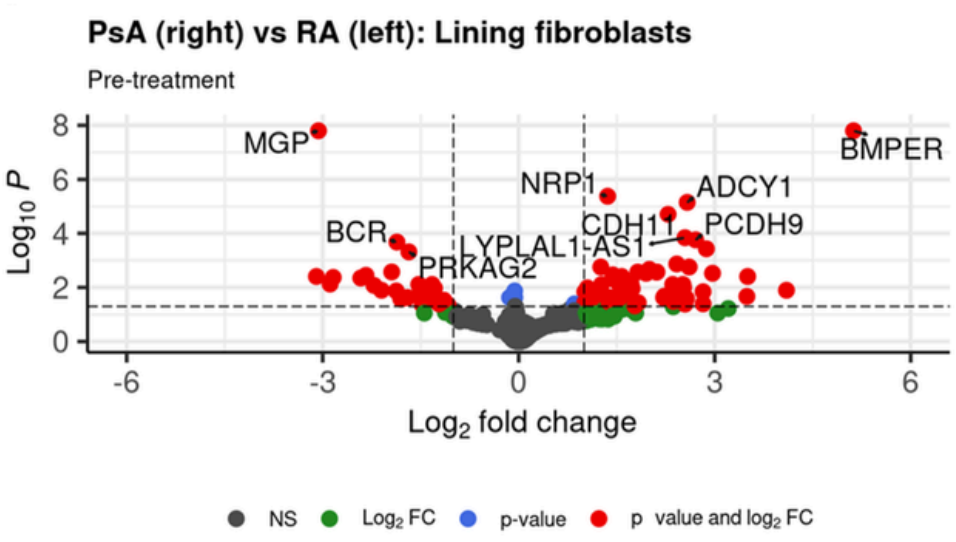
This study examined differences in synovial tissue gene expression by single-nucleus RNA sequencing between PsA (N=4) and RA (N=4) before and four weeks after an intra-articular methylprednisolone injection.
After quality control, 26,453 nuclei were analysed, with cell types identified using established marker genes and differential expression assessed per cell type.
The treatment response was consistent with known glucocorticoid effects, including reduced TIMP1 expression in lining fibroblasts.
Differences between PsA and RA were observed only in pre-treatment lining fibroblasts, with no significant distinctions post-treatment. In these pre-treatment cells, 27 genes had higher expression in RA and 56 had higher expression in PsA. The differentially expressed genes were enriched in pathways linked to development and morphogenesis.
The most differentially expressed genes were BMPER which was upregulated in PsA and MGP which was upregulated in RA (Figure). BMPER and MGP have opposing effects on bone morphogenetic proteins (BMP) - while BMPER promotes BMP activity, MGP inhibits it.

Why important?

Differential expression of BMPER and MGP may contribute to the distinct synovial phenotypes in PsA and RA with new bone formation and tortous blood vessels in PsA, and erosions and straight blood vessels in RA.

Polling Question

What role do you think synovial fibroblasts have in synovial pathologies?



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CLINICAL HIGHLIGHTS



Daniela B. Tovar-Bastidas, MD
Rheumatologist at ReumaMedic and Clínica Tezza, Lima, Peru
Social Media Subcommittee chair, and Subcommittee of Newsletter Group
Clinical Interests: PsA prevention, axial disease in PsA.

Daniela Tovar Bastidas
@dani.reumatologa

Interception of psoriatic arthritis in psoriasis: real-world evidence across biologic classes from a long-term clinical cohort

Nikolaos Kougkas
(Thessaloniki, Greece)

Wednesday, 3 June, 17:10 - 17:20
George V *Room 4*
Basic and Clinical Abstract Sessions: Unconventional targets in Psoriatic Arthritis

OP072

This retrospective real-world study explored whether biologic treatment class in psoriasis may be associated with the subsequent development of PsA. The concept is highly relevant to PsA "interception": identifying whether treatment during the psoriasis stage could modify the risk of progression to clinically evident PsA.

The study included 394 patients with psoriasis treated with biologic DMARDs and without PsA at baseline, followed longitudinally for up to 17 years in two dermatology-rheumatology centers. During follow-up, 86 patients, or 22%, developed PsA. In patients exposed to a single biologic class, incident PsA was more frequent among those treated with TNF inhibitors than among those receiving IL-17, IL-23, or IL-12/23 inhibitors. After adjustment for methotrexate exposure, IL-17i, IL-23i, and IL-12/23i were associated with lower odds of developing PsA compared with TNFi. Overall, this study provides an intriguing real-world signal supporting the concept of PsA interception and raises the possibility that biologic class may influence PsA risk in patients with psoriasis. However, as a retrospective observational study, these findings should be interpreted with caution and do not establish causality.

Why important?

This study brings PsA interception closer to clinical discussion, suggesting that treatment decisions in psoriasis may eventually consider not only skin control, but also the risk of progression to PsA.

Polling Question

When treating psoriasis, should future therapeutic decisions consider the potential risk of developing PsA?

Interception of psoriatic arthritis in psoriasis: real-world evidence across biologic classes from a long-term clinical cohort

Nikolaos Kougkas, Greece

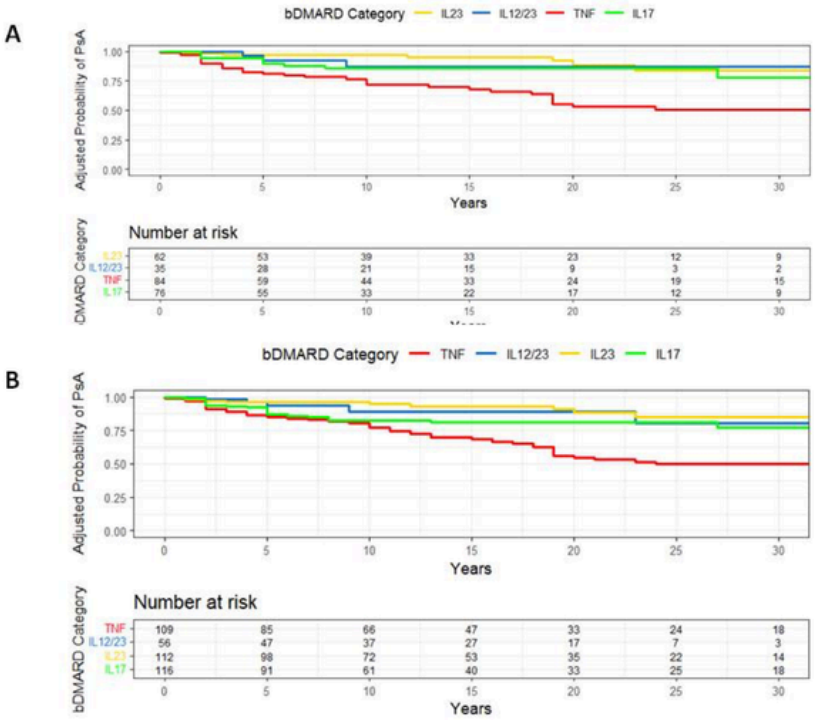
Wednesday, 3 June, 17:10 - 17:20 BST

George V R*oom 4*

Basic and Clinical Abstract Sessions: Unconventional targets in Psoriatic Arthritis

OP072

Figure 1. Adjusted PsA-free survival curves from multivariable Cox models for (A) single bDMARD exposure and (B) bDMARD class used for the longest duration.



DOI: 10.1136/annrheumdis-2026-eular.B.686

THE DEVELOPMENT AND VALIDATION OF A DIAGNOSTIC ULTRASOUND ENTHESITIS SCORE (DUET THE DEVELOPMENT AND VALIDATION OF A DIAGNOSTIC ULTRASOUND ENTHESITIS SCORE FOR PSORIATIC ARTHRITIS DUET) FOR PSORIATIC ARTHRITIS

Sibel Aydin (Canada)

Thursday, 4 June, 08:15 - 08:25
Room N3
Basic and Clinical Abstract Sessions: Optimising care in Psoriatic Arthritis

OP0180

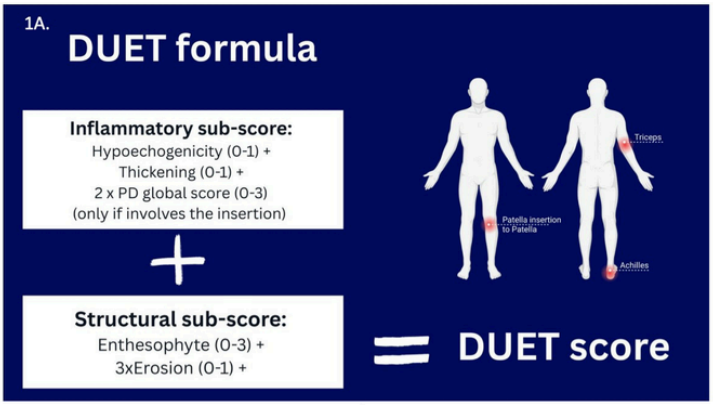
DUET is a newly developed ultrasound score designed to support the diagnosis of enthesitis in PsA. The study addressed an important clinical challenge: entheseal pain is common in PsA, but it can also be seen in psoriasis without arthritis, mechanical pain, obesity, and other non-inflammatory conditions. Therefore, a standardized ultrasound tool may help clinicians interpret enthesitis more consistently. In this multicenter study, patients with early PsA, psoriasis alone, and non-inflammatory musculoskeletal symptoms underwent ultrasound assessment of 16 entheseal sites. The final DUET score was not based on all sites, but on the combination that best distinguished PsA from controls: Achilles tendon, patellar tendon insertion, and triceps tendon. It included both inflammatory lesions — hypoechogenicity, thickening, and power Doppler — and structural lesions — enthesophytes and erosions. The score showed moderate diagnostic performance. In the development cohort, age-specific cut-offs achieved 73-74% specificity and 47-49% sensitivity. In the validation cohort, specificity improved to 74-100%, with comparable sensitivity of 49-52%. Sensitivity increased up to 63% among patients with clinically tender entheses. Overall, DUET provides a PsA-specific ultrasound framework for enthesitis assessment, while also suggesting that large-joint enthesitis is not a universal feature of early PsA.

Why important?

DUET may help standardize ultrasound assessment of enthesitis in suspected PsA, especially in patients with entheseal tenderness.

Polling Question

In patients with psoriasis and musculoskeletal symptoms, when do you find ultrasound most useful for assessing enthesitis?



DOI: 10.1136/annrheumdis-2026-eular.B.544

QUANTIFYING THE OBESITY-PSORIATIC ARTHRITIS NEXUS: PREVALENCE, INCIDENCE, AND COMORBIDITIES FROM 19.9 MILLION US PATIENTS (2018-2024)

Jeffrey R Curtis
(United States of America)

Friday, 5 June, 13:54 - 14:00 BST
Poster Tour V
Clinical Poster Tours: Advances in Psoriatic Arthritis management

POS0291

This large real-world study explored the relationship between body mass index and PsA using electronic health record data from 19.9 million adults in the United States between 2018 and 2024. The authors compared patients with PsA with individuals without psoriasis or PsA, assessing BMI distribution, cardiovascular-risk-related comorbidities, treatment patterns, and incident PsA according to BMI category.

The study highlights obesity as a highly relevant and potentially modifiable factor in PsA. In 2024, 81.8% of patients with PsA had overweight or obesity, compared with 73.4% of individuals without psoriatic disease. Among patients with PsA, the burden of cardiovascular-risk-related comorbidities increased progressively with BMI, affecting 59.5% of those with normal BMI, 69.1% with overweight, and 74.8% with obesity. Overall, these findings support the concept that PsA management should extend beyond control of skin and joint inflammation, incorporating weight management and cardiovascular risk assessment as part of an integrated, multidisciplinary approach. However, these findings should be interpreted with caution, as the EHR-based design does not establish causality.

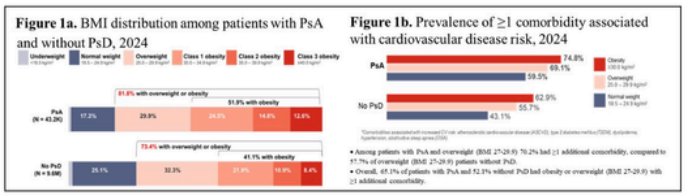
Why important?

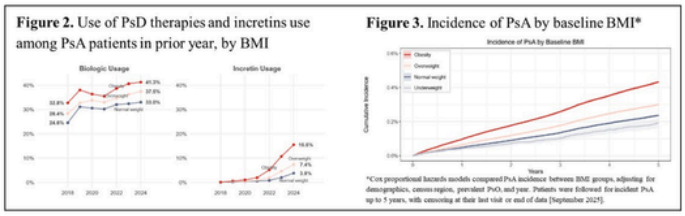
This study reinforces that obesity and cardiometabolic risk are not secondary issues in PsA, but key components of disease burden that should be addressed as part of comprehensive care.

Polling Question

In your PsA practice, how often is weight management discussed as part of the treatment plan?

Image, graphic, or table 1





DOI: 10.1136/annrheumdis-2026-eular.B.1049

GLOBAL EXPLORATION OF PSORIATIC ARTHRITIS DISEASE ACTIVITY ASSESSMENT: RESULTS FROM THE EXPLORE-PSA STUDY

A. Ribeiro, M. L. M. Mulder, et al.

Published only
AB0732 (2026)

The EXPLORE-PsA study, developed by Young-GRAPPA, assessed how rheumatologists evaluate PsA disease activity in routine practice worldwide. This 15-minute online survey included 699 rheumatologists and trainees from 64 countries, representing all major geographic regions. It explored the use of composite scores, treat-to-target strategies, skin and axial assessment, payer requirements, and barriers to implementation.

DAPSA and DAS-28 were the most frequently used instruments, each reported by 36.6% of respondents, followed by MDA and full 66/68 swollen and tender joint counts. Patterns differed by geography and GRAPPA membership. GRAPPA members were more likely to use PsA-specific tools, including DAPSA, MDA, and full 68/66 joint counts, while non-GRAPPA clinicians relied more often on DAS-28. Treat-to-target strategies were commonly reported, but uptake was higher among GRAPPA members. The study also showed major geographic and structural variation, including high rates of payer-mandated disease activity measures in South America and Africa.The main barriers to using PsA activity scores were lack of time, patient questionnaire burden, lack of consensus on tools, and poor integration into electronic medical records. Overall, EXPLORE-PsA highlights a global gap between PsA assessment recommendations and everyday clinical implementation.

Why important?

This study shows that standardized PsA assessment remains highly variable worldwide, with practical barriers limiting implementation. It identifies clear opportunities for education, simplified tools, and better workflow integration

Polling Question

How often do you use PsA-specific disease activity scores in your routine practice?

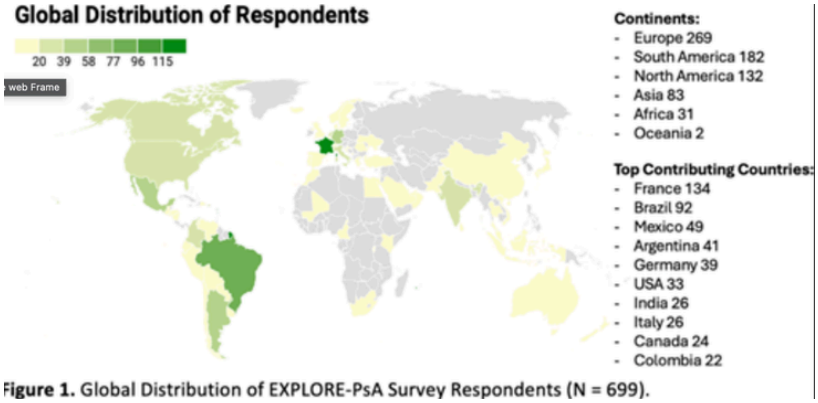


Figure 1. Global Distribution of EXPLORE-PsA Survey Respondents (N = 699).

DOI: 10.1136/annrheumdis-2026-eular.B.1013

CLINICAL HIGHLIGHTS



Guillermo Arturo Guaracha-Basañez, MD, MSc
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Coordinator of the Spondyloarthritis and Psoriatic Disease Clinic.
DNM Newsletter Clinical Highlights contributor.
Clinical Interests: Psoriatic disease, spondyloarthritis, patient-reported outcomes, diagnostic pathways, sexual health, quality of life, and patient-centred care in rheumatic diseases.

Guillermo Guaracha Basañez
@dr.guaracha

Clinical and Imaging Features of Subclinical and Early Psoriatic Arthritis Reveal Synovio-Entheseal Inflammation as a Marker of Psoriatic Arthralgia Progression

Alen Zabotti (Udine, Italy)

Thursday, 4 June, 08:45-08:55
Basic and Clinical Abstract Sessions: Optimising care in Psoriatic Arthritis
Room N3

OP0183

Among 183 patients, clinical features alone did not distinguish stable from progressing subclinical PsA. Tender joint count, pain, BASDAI, and HAQ substantially overlapped between groups. In contrast, ultrasound findings were more informative: progressing subclinical PsA was associated with active synovitis and active enthesitis, suggesting that synovio-entheseal inflammation may identify patients at higher risk of progression.

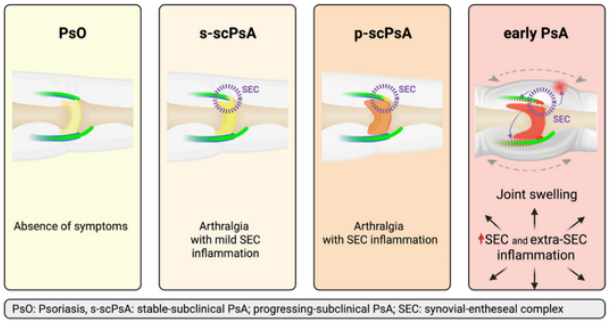
Early PsA showed both greater inflammatory burden and broader tissue involvement. Compared with progressing subclinical PsA, early PsA was characterized by swollen joints and more frequent power Doppler-positive tenosynovitis and peritendinitis, supporting the idea that clinical onset reflects both amplification and diversification of inflammation.

Why important?

Ultrasound may help identify which psoriasis patients with arthralgia are truly progressing toward PsA, beyond what symptoms or clinical examination alone can show.

Polling Question

In patients with psoriasis and new-onset arthralgia, when would you use ultrasound to assess risk of PsA progression?



DOI: 10.1136/annrheumdis-2026-eular.B.3414

DEFINING REMISSION IN PSORIATIC ARTHRITIS FROM THE PATIENT PERSPECTIVE: FINDINGS FROM THE REMIPPSA INTERNATIONAL QUALITATIVE STUDY

Clementina López-Medina
(Cordoba, Spain)

Friday, 5 June, 14:12
Poster Tour V
Clinical Poster Tours: Advances in Psoriatic Arthritis Management
POS0294

Current definitions of remission in PsA are largely based on composite disease activity scores, but these may not fully capture what remission means to patients. The RemiPPsA study explored patient perspectives through 19 focus group discussions conducted across 11 countries and four continents. A total of 123 patients with PsA participated, most with long-standing disease and prior biologic exposure.

The concept of "remission" did not resonate equally with all participants. Some associated it with "cure," which they felt was unrealistic in PsA. Many considered "low disease activity" a more honest and achievable term. Patient-defined remission extended beyond symptom control and was strongly linked to daily functioning, participation, social life, and overall well-being.

Pain was the most frequently cited element of remission, followed by visible psoriasis, daily activities, stiffness, fatigue, and swelling. Mild non-limiting pain, limited non-visible psoriasis, or residual stiffness could still be compatible with remission for some patients

Why important?

This study reminds us that remission in PsA is not only a composite score. For patients, remission means less pain, better function, participation in daily life, and a sense of control over their disease.

Polling Question

Which domain should carry more weight when defining remission in PsA from the patient perspective?

Definitions of remission		Definitions of low disease activity
'being able to do what I want to do without being in pain' (Brazil)	*'being controlled, with a bit of pain, but not enough to stop me from doing things'* (Spain)	*'having pain at times, but not affecting daily life'* (Hong Kong)
'being able to do anything without pain' (Romania)	*'the disease has gone'* (Singapore)	*'having pain, but not a flare'* (France)
'putting the disease to sleep' (Argentina)	*'being fully controlled'* (Singapore)	*'still having pain and reduced joint function'* (Italy)
'not feeling the disease' (Germany)	*'not having flares'* (France)	*'less inflammation, less stiffness; the disease calms down a bit, and you get back to daily life'* (France)
'being able to live normally again' (Egypt)	*'recovery'* (Argentina)	*'there's still something going on, even if it's low'* (France)
'going back to normal' (France)	*'rebirth, living again'* (Italy)	*'a kind of disease control that gives us a breather'* (France)
'a normal life' (Italy)	*'being back to 100% of my possibilities'* (Italy)	*'being able to work while still having mild joint pain'* (Egypt)

Footnote – orange is related to arthritis; green to skin disease; yellow to arthritis & skin disease; blue to social and other aspects.

DOI: 10.1136/annrheumdis-2026-eular.B.1844

LIGHTEN THE LOAD: ARTIFICIAL INTELLIGENCE REVEALS BODY MASS INDEX OUTRANKS TREATMENT IN ONE-YEAR PSORIATIC ARTHRITIS OUTCOMES - FINDINGS FROM THE SPEED TRIAL

Alexandre Garaïman
(Bucharest, Northern Ireland)

Thursday, 4 June, 09:25-09:35
Room N3
Basic and Clinical Abstract Sessions:
Optimising care in Psoriatic Arthritis
OP0187

This analysis from the SPEED trial used machine learning to identify predictors of one-year outcomes in early PsA. The study included 192 patients with early PsA and poor prognostic factors randomized to standard step-up csDMARD therapy, combination csDMARD therapy, or early TNF inhibitor induction. The outcome was PASDAS response at 48 weeks.

Using recursive partitioning modelling, BMI emerged as the strongest baseline predictor of PASDAS at one year, ranking above treatment allocation. Patients with BMI <25 kg/m^2 and lower baseline disease activity had the best predicted outcomes, regardless of treatment strategy. Among patients with higher baseline disease activity and BMI <27 kg/m^2, early TNF inhibitor therapy was associated with better outcomes than csDMARD-based approaches.

The poorest outcomes were seen in patients with higher BMI, longer disease duration, and polyarticular disease, particularly among those aged 51-74 years. These findings suggest that obesity, chronicity, and disease burden interact to shape treatment response and support weight management as part of personalized PsA care.

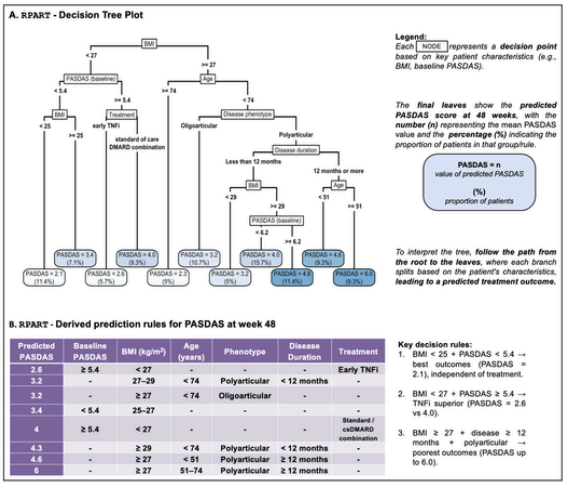
Why important?

BMI may be a stronger predictor of one-year PsA outcomes than treatment allocation. This reinforces weight management as a core, modifiable component of personalized PsA care.

Polling Question

How should weight management be integrated into PsA care?

Figure 1. Depicting Prediction Rules for One-Year PASDAS Based on BMI and Other Baseline Characteristics.



DOI: 10.1136/annrheumdis-2026-eular.B.1875

EFFICACY AND SAFETY OF PROBIOTIC SUPPLEMENTATION IN PSORIATIC ARTHRITIS - A RANDOMIZED CONTROLLED TRIAL

Philipp Bosch (Graz, Austria)

Friday, 5 June, 13:48 - 13:54
Poster Tour V
Clinical Poster Tours: Advances in Psoriatic Arthritis Management

POS0290

PsA has been associated with subclinical gut inflammation and alterations in the intestinal microbiome, supporting the concept of a gut-joint axis. The MEDIPSA trial evaluated whether multispecies probiotic supplementation could improve clinical and biological outcomes in PsA.

This single-centre, randomized, double-blind, placebo-controlled trial included adults with PsA fulfilling CASPAR criteria, moderate disease activity, and stable immunomodulatory therapy. Participants received either a Lactobacillus/Bifidobacterium-containing probiotic or placebo for 12 weeks. The primary endpoint was achievement of low disease activity or remission, defined as PASDAS ⩽3.2 without treatment escalation.

Sixty-six patients were randomized and 56 were included in the primary analysis. Treatment response at week 12 occurred in 43% of the probiotic group and 65% of the placebo group, with no statistically significant difference. PASDAS improved over time in both groups, but without between-group differences. No significant effects were observed on gut permeability markers, immune cell profiles, or microbiome composition. Safety was comparable between groups.

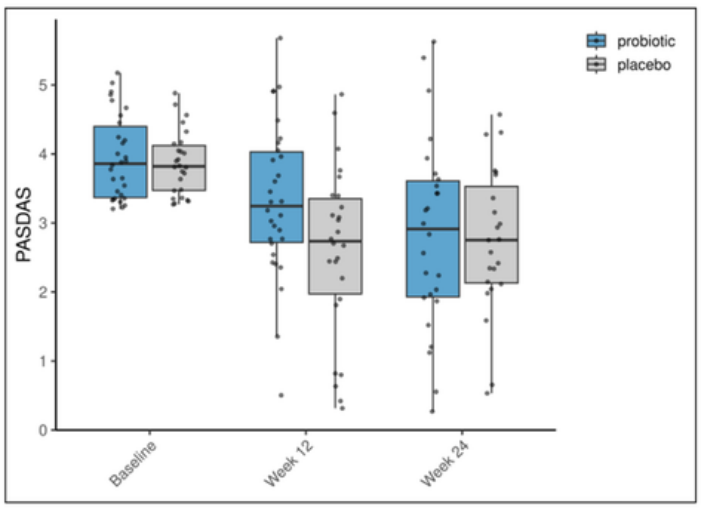
Why important?

This first randomized controlled trial of probiotics in PsA provides an important negative result: despite strong interest in the gut-joint axis, probiotic supplementation was not superior to placebo over 12 weeks.

Polling Question

Would you recommend probiotic supplementation as part of PsA management based on current evidence?

Figure 1. Changes in PASDAS Over Time With Probiotic Supplementation Versus Placebo.



DOI: 10.1136/annrheumdis-2026-eular.B.818

TREATMENT HIGHLIGHTS



André Lucas Ribeiro, MD MSc
Attending Rheumatologist and Clinical Research Investigato
Chair of Young-GRAPPA, Steering Committee Member
Research focus: Psoriatic arthritis, with a focus on musculoskeletal ultrasound, difficult-to-treat disease, transition of psoriasis to psoriatic arthritis, and metabolic commorbidities

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Bimekizumab efficacy and safety versus risankizumab in patients with active psoriatic arthritis: 16-week results from the head-to-head phase 3b BE BOLD study

Joseph F. Merola
(Dallas, United States of America)

Saturday, 6 June, 12:00-12:10 BST
Session: Late Breaking Abstracts
Room: N3

LB0001

BE BOLD is an ongoing phase 3b, multicentre, randomised, double-blind, active-comparator head-to-head trial comparing bimekizumab, a dual IL-17A/F inhibitor, with risankizumab, an IL-23 inhibitor, in patients with active PsA. Patients were bDMARD-naïve or had inadequate response/intolerance to one prior TNF inhibitor and were randomised 1:1 to approved-dose bimekizumab or risankizumab. At Week 16, bimekizumab was superior to risankizumab for the primary endpoint of ACR50, achieved by 49.1% versus 38.4% of patients, respectively (p=0.0078). MDA was numerically higher with bimekizumab but did not reach statistical significance (43.0% vs 39.9%; p=0.4408), stopping the hierarchical testing sequence. Additional outcomes also numerically favoured bimekizumab, including ACR50 at Week 4, ACR50 plus PASI100, PASI100, and DAPSA low disease activity/remission. Safety profiles were comparable, although Candida infections were more frequent with bimekizumab.

Why important?

BE BOLD is the first head-to-head biologic trial in PsA to show superiority for a joint-focused endpoint.

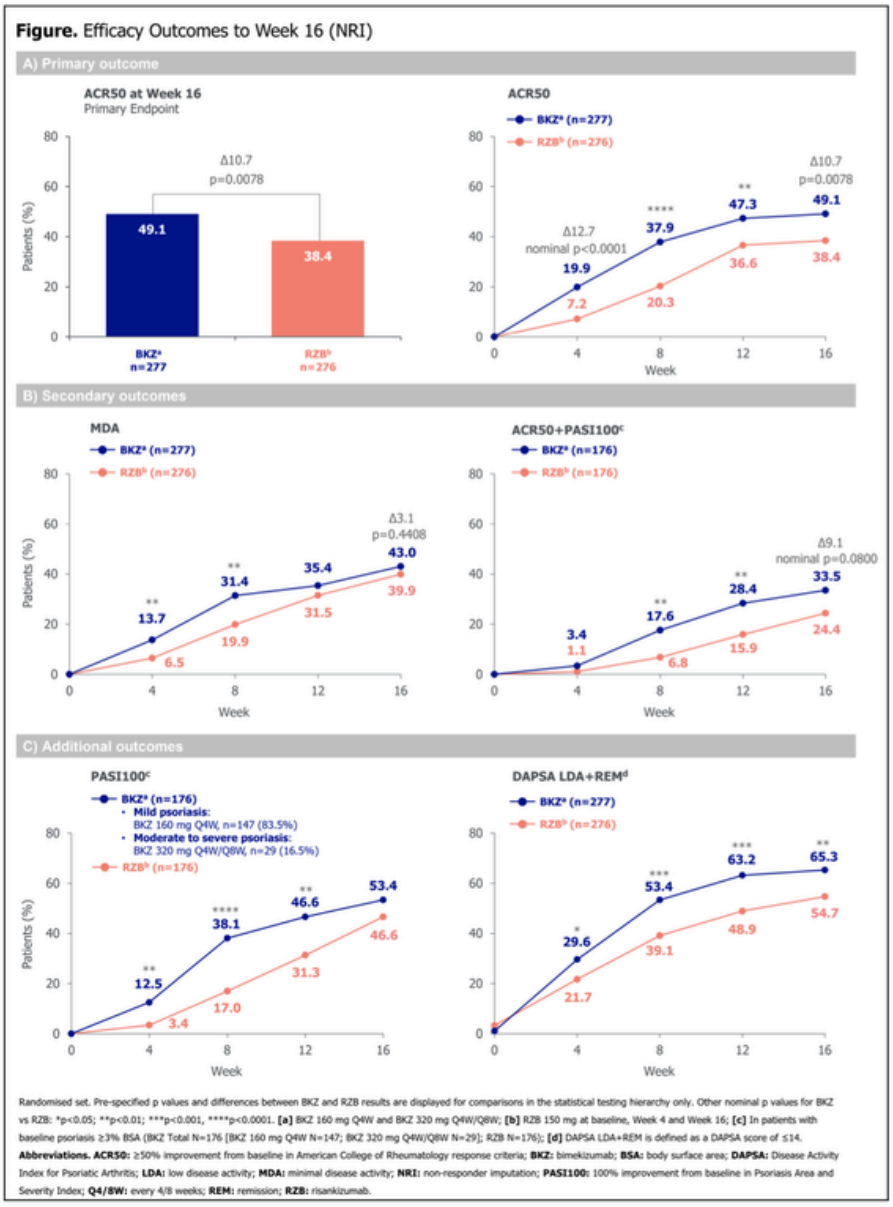
Polling Question

In a patient with active PsA and clinically relevant psoriasis, would these head-to-head data influence your choice between IL-17A/F and IL-23 inhibition?

Bimekizumab efficacy and safety versus risankizumab in patients with active psoriatic arthritis: 16-week results from the head-to-head phase 3b BE BOLD study

Joseph F. Merola.

Saturday, 6 June, 12:00–12:10 BST Session: Late Breaking Abstracts
Room: N3
LB0001



DOI: 10.1136/annrheumdis-2026-eular.LBA_B.10

IXEKIZUMAB AND CONCOMITANT TIRZEPATIDE ACHIEVED EARLY DISEASE CONTROL IN ADULTS WITH PSORIATIC ARTHRITIS AND OBESITY/OVERWEIGHT: PHASE 3B TOGETHER-PSA TRIAL

Laura C. Coates
(Oxford, United Kingdom)

Wednesday, 3 June, 16:40-16:50 BST
Session: Basic and Clinical Abstract Sessions: Unconventional targets in Psoriatic Arthritis
Room: George V Room 4

OP069

TOGETHER-PsA is a phase 3b, randomized, multicentre, assessor-blinded, open-label trial evaluating ixekizumab plus concomitant tirzepatide versus ixekizumab alone in adults with active PsA and obesity or overweight with at least one weight-related comorbidity. Patients were randomized 1:1 and all received individualized diet and exercise counselling. The primary endpoint was the combined achievement of ACR50 and ⩾10% weight reduction at Week 36. Baseline disease burden was high, with mean BMI approximately 37-38 kg/m^2, with high DAPSA and frequent prior bDMARD exposure. At Week 36, 31.7% of patients receiving ixekizumab plus tirzepatide achieved the primary endpoint versus 0.8% with ixekizumab alone (p<0.001). ACR responses separated as early as Week 4 (ACR50 IXE+TZP 11.1% vs. IXE 3.9%; p=0.029) and were maintained through Week 36 (ACR50 IXE+TZP 33.5% vs. IXE 20.4%; p=0.02). DAPSA improvement, DAPSA low disease activity/remission, and MDA also favoured combination treatment by later time points. Adverse events were mostly mild or moderate and consistent with the known profiles of both agents.

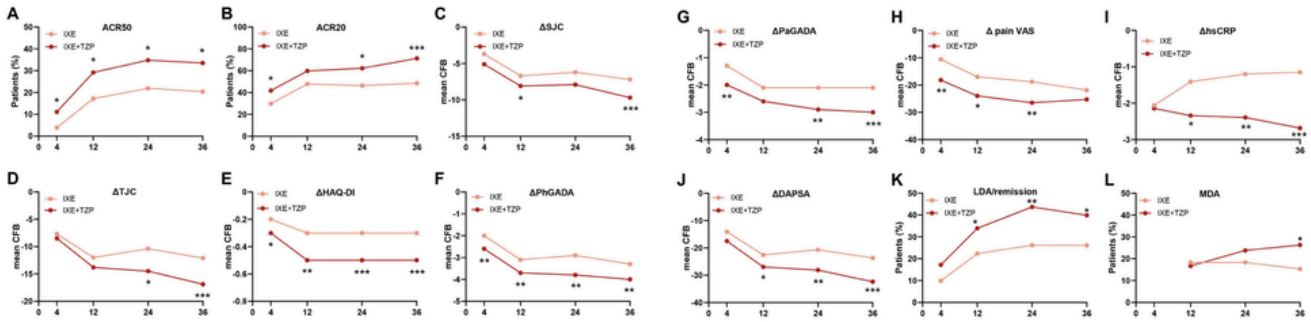
Why important?

This study moves obesity in PsA from a "comorbidity to acknowledge" toward a therapeutic target that may modify the probability of achieving disease control. It also provides randomized evidence supporting a more integrated PsA strategy, where inflammatory and metabolic pathways are treated in parallel rather than sequentially.

Polling Question

In patients with active PsA and obesity, should pharmacologic weight-loss therapy be considered part of a treat-to-target strategy?

Figure 1: ACR50 and component scores, DAPSA LDA/remission and MDA for IXE+TZP and IXE cohorts.



Significant difference between IXE+TZP and IXE was observed: ACR50 at W4 (7.2%[95%CI: 0.8%, 13.6%], p=0.029), W12 (12.1%[95%CI: 2%, 22.2%], p=0.019), W24 (12.9%[95%CI: 2.0%, 23.8%], p=0.02) and W36 (multiplicity controlled) (13.1%[95%CI: 2.1%, 24.1%], p=0.02); ACR20 at W4 (11.9%[95%CI: 0.4%, 23.5%], p=0.042), W24 (16.0% [95%CI: 3.3%, 28.6%], p=0.014) and W36 (22.8%[95%CI: 10.0%, 35.6%], p<0.001); SJC at W12 (-1.4(0.68) [95% CI: -2.7, -0.1]; p=0.041) and W36 (-2.5(0.72) [95% CI: -3.9, -1.1]; p<0.001); TJC at W24 (-4.1(1.64) [95% CI: -7.3, -0.8]; p=0.014) and W36 (-4.8(1.4) [95% CI: -7.6, -2.1]; p<0.001; HAQ-DI at W4 (-0.1(0.04) [95%CI: -0.2, -0.0], p=0.047), W12 (-0.2(0.05) [95%CI: -0.3, -0.1], p=0.003), W24 (-0.2(0.06) [95%CI: -0.3, -0.1], p<0.001) and W36 (-0.2(0.06) [95%CI: -0.3, -0.1], p<0.001); PhGADA at W4 (-0.6(0.22) [95%CI: -1.1, -0.2], p=0.005), W12 (-0.6(0.21) [95%CI: -1.0, -0.2], p=0.005), W24 (-0.9(0.26) [95%CI: -1.4, -0.4], p=0.001) and W36 (-0.7(0.27) [95%CI: -1.2, -0.2], p=0.009); PaGADA at W4 (-0.7(0.22) [95%CI: -1.1, -0.3], p=0.002), W24 (-0.9(0.27)[95%CI: -1.4, -0.3], p=0.002) and W36 (-1.0(0.28) [95%CI: -1.5, -0.4], p<0.001); pVAS at W4 (-7.5(2.57) [95%CI: -12.6, -2.5], p=0.004), W12 (-6.9(2.68) [95%CI: -12.2, -1.7], p=0.01) and W24 (-7.7(2.84) [95%CI: -13.3, -2.1], p=0.007); hsCRP at W12 (-0.7(0.33) [95%CI: -1.35, -0.04], p=0.027), W24 (-1.35(0.44) [95%CI: -2.21, -0.48], p<0.001) and W36 (-1.35(0.38) [95%CI: -2.1, -0.61], p<0.001); DAPSA at W12 (-4.4(1.97) [95%CI: -8.2, -0.5], p=0.027), W24 (-7.3(2.5) [95%CI: -12.3, -2.4], p=0.004) and W36 (-8.7(2.03) [95%CI: -12.7, -4.7], p<0.001); LDA/remission at W12 (11.5% [95%CI: 0.8%,22.3%], p=0.036), W24 (17.4% [95% CI: 6.0%,28.8%], p=0.003), and W36 (13.8% [1.7%, 25.9%], p=0.025; MDA at W36 (11.0% [95%CI: 1.3%, 20.6%], p=0.026). *p<0.05, **p<0.01, ***p<0.001.

DOI: 10.1136/annrheumdis-2026-eular.B.3012

DIETARY INTERVENTIONS IN PSORIATIC ARTHRITIS (DIPSA): A RANDOMIZED CONTROLLED CLINICAL TRIAL

Lihi Eder (Toronto, Canada)

Wednesday, 3 June, 16:50-17:00 BST
Session: Basic and Clinical Abstract Sessions: Unconventional targets in Psoriatic Arthritis
Room: George V Room 4

OP070

DIPSA was a multicentre randomized controlled trial evaluating two personalized dietary interventions versus standard dietary advice in adults with moderately active PsA, BMI 25-40 kg/m^2, and stable pharmacologic therapy. Ninety-two patients were randomized to a Mediterranean diet (Med), a low-calorie DASH diet targeting weight reduction, or standard-of-care printed dietary advice (CTL). Interventions included dietitian-led consultations and structured telephone follow-up over 24 weeks. Baseline disease activity was moderate, with mean DAPSA 20, mean BMI 33 kg/m^2, and 72% receiving biologic or targeted synthetic DMARDs. All groups achieved modest weight loss by Week 12 (in kilograms, (Med: -1.36; DASH-LC: -2.47; CTL: -1.88) with additional loss by Week 24 (Med: -0.94; DASH-LC: -2.64; CTL: -2.28), with no significant between-group differences. DAPSA improved in all arms by Week 24, again without significant differences between dietary strategies (Med: -4.87; DASH-LC: -5.42; CTL: -6.53). MDA rates were numerically higher with DASH-LC and Mediterranean diet at Week 12, but converged by Week 24. Across the cohort, greater weight loss was associated with greater improvement in DAPSA, pain, fatigue, PsAID, and tender joint count, independent of treatment arm (Figure 2).

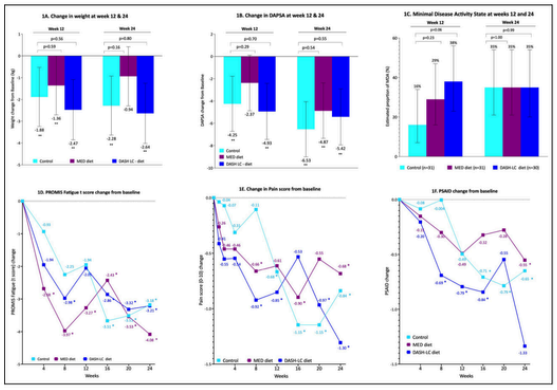
Why important?

DIPSA provides rare randomized evidence on diet in PsA and suggests that weight loss may be a clinically relevant adjunctive target for residual disease activity. However, it does not establish superiority of a specific dietary pattern over structured standard advice.

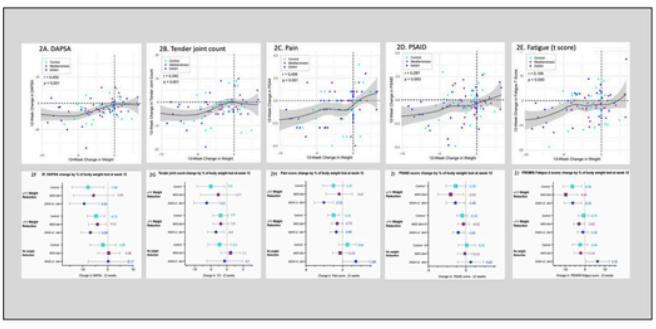
Polling Question

How would you integrate dietary intervention into PsA treat-to-target care?

Change in study outcome by study arm. 1A. Weight; 1B. DAPSA; 1C. Minimal disease activity; 1D. PROMIS Fatigue (t score); 2E. Pain score; 1F. PSAID;. * indicates p<0.05 compared to baseline. DAPSA - Disease activity index for Psoriatic Arthritis; PSAID - Psoriatic Arthritis Impact of Disease.



2A-E. The correlation between study outcomes and weight change from baseline with splines; 2F-3J. The estimated mean change (95% CI) in study outcomes by the extent of weight reduction (none, <5% and >5% reduction in body weight) for each study arm.



DOI: 10.1136/annrheumdis-2026-eular.B.545

EFFECT OF GUSELKUMAB AND GOLIMUMAB COMBINATION THERAPY ON MRI-DETECTED INFLAMMATION AND DAMAGE IN PHALANGEAL JOINTS AND HEEL ENTHESES IN ACTIVE PSA: FINDINGS FROM THE PHASE 2A AFFINITY STUDY

Mikkel Østergaard
(Glostrup, Denmark)

Thursday, 4 June, 09:15-09:25 BST
Session: Basic and Clinical Abstract Sessions: Optimising care in Psoriatic Arthritis
Room: N3

OP0186

AFFINITY was a phase 2a randomized, double-blind, proof-of-concept trial evaluating guselkumab plus golimumab versus guselkumab monotherapy in patients with active PsA and inadequate response to one or two TNF inhibitors. This exploratory imaging subanalysis assessed MRI inflammation and damage using PsAMRIS in hand and forefoot phalangeal joints and HEMRIS in heel entheses. At Week 24, dual therapy showed a larger numerical reduction in hand joint inflammatory burden than monotherapy, although this difference was not statistically significant and its clinical meaningfulness remains uncertain (-5.55 vs -0.44;nominal p =0.181). In the forefoot, the reduction in total PsAMRIS inflammation with dual therapy, contrasted with numerical worsening on monotherapy, reached nominal statistical significance (-3.56 vs 2.76; nominal p =0.019). However, validated minimal clinically important difference thresholds for these MRI scores in PsA are not well established. Structural damage scores remained largely unchanged in both arms, which is reassuring but difficult to interpret over only 24 weeks. Heel enthesitis MRI scores showed no clear treatment separation.

Why important?

This AFFINITY subanalysis provides exploratory MRI evidence that rational dual blockade of IL-23 and TNF may reduce joint inflammatory burden beyond IL-23 inhibition alone in TNFi-IR PsA. The findings are hypothesis-generating, but highly relevant to the emerging discussion on difficult-to-treat PsA, efficacy ceilings, and whether selected patients with objective inflammatory burden despite sequential monotherapies may benefit from dual therapy.

Polling Question

In difficult-to-treat PsA with persistent objective inflammation after TNF inhibitor failure, would you consider dual targeted therapy in selected patients?

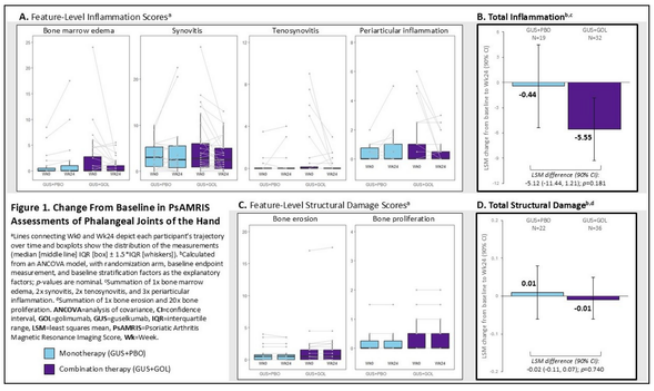


Figure 1. Change From Baseline in PsAMRIS Assessments of Phalangeal Joints of the Hand

*Lines connecting W0 and Wk24 depict each participant's trajectory over time and boxplots show the distribution of the measurements (median [middle line] IQR [box] ± 1.5 *IQR [whiskers]). [b]Calculated from an ANCOVA model, with randomization arm, baseline endpoint measurement, and baseline stratification factors as the explanatory factors; p-values are nominal. [c]Summation of 1x bone marrow edema, 2x synovitis, 2x tenosynovitis, and 3x periarticular inflammation. [d]Summation of 1x bone erosion and 20x bone proliferation. **ANCOVA**=analysis of covariance, **CI**=confidence interval, **GOL**=golimumab, **GUS**=guselkumab, **IQR**=interquartile range, **LSM**=least squares mean, **PsAMRIS**=Psoriatic Arthritis Magnetic Resonance Imaging Score, **Wk**=Week.

	Monotherapy (GUS+PBO)	Combination therapy (GUS+GOL)	*P* value
PsAMRIS - Forefoot			
Total Inflammation[a]	N=19 2.76 (-0.63, 6.14)	N=31 -3.56 (-6.19, -0.93)	0.019
Total Structural Damage[b]	N=22 0.00 (-0.04, 0.04)	N=36 0.01 (-0.02, 0.04)	0.776
HEMRIS			
Inflammatory Score	N=21	N=35	
Achilles Tendon[c]	-0.28 (-0.56, -0.00)	-0.03 (-0.25, 0.18)	0.247
Plantar Fascia[d]	-0.15 (-0.32, 0.01)	0.00 (-0.13, 0.13)	0.223
Structural Damage Score	N=22	N=35	
Achilles Tendon[e]	-0.03 (-0.10, 0.04)	0.02 (-0.03, 0.08)	0.280
Plantar Fascia[f]	-0.02 (-0.05, 0.00)	0.00 (-0.02, 0.02)	0.204

Table 1. Change from Baseline in Composite Indices of Inflammation and Structural Damage From PsAMRIS Forefoot and HEMRIS Assessments

Data shown are LSM (90% CI) change from baseline to Wk24 for all participants with available assessments (N; complete case analysis) and all reported *p*-values for combination therapy vs monotherapy comparisons are nominal. Data calculated from an ANCOVA model, with randomization arm, baseline endpoint measurement, and baseline stratification factors as the explanatory factors. [a]Summation of 1x bone marrow edema, 2x synovitis, 2x tenosynovitis, and 3x periarticular inflammation. [b]Summation of 1x bone erosion and 20x bone proliferation. [c]Summation of intra-tendon hypersignal, peri-tendon hypersignal, bone marrow edema, and retrocalcaneal bursitis. [d]Summation of intra-fascia hypersignal, peri-fascia hypersignal, and bone marrow edema. [e]Summation of tendon thickening, calcaneal enthesophyte, and calcaneal bone erosion. [f]Summation of scores of fascia thickening, calcaneal enthesophyte, and calcaneal bone erosion. **ANCOVA**=analysis of covariance, **CI**=confidence interval, **GOL**=golimumab, **GUS**=guselkumab, **HEMRIS**=Heel Enthesitis Magnetic Resonance Imaging Score, **LSM**=least squares mean, **PsAMRIS**=Psoriatic Arthritis Magnetic Resonance Imaging Score, **Wk**=Week.

DOI: 10.1136/annrheumdis-2026-eular.B.37

TREATMENT HIGHLIGHTS



Dennis Neuen, MBBS (Hons I), FRACP Research Rheumatologist, Royal Prince Alfred Hospital, Sydney, Australia
Y-GRAPPA domain leader for nail disease treatment recommendations update
Clinical Interests: Musculoskeletal and enthesitis in PsO and PsA

PLACEBO-ARM RESPONSE RATES AND ADVERSE EVENT RATES IN PSORIATIC ARTHRITIS CLINICAL TRIALS BETWEEN 2005-2025: A SYSTEMATIC REVIEW AND META-REGRESSION

Mark Gibson
(London, United Kingdom)

Poster View
Wednesday, 3 June, 15:30 - 16:30 BST

POS0454

This systematic review and meta-regression examined whether placebo-arm outcomes in PsA randomised controlled trials have shifted over two decades. Placebo-arm responder counts at the primary endpoint were extracted from 45 phase II/III placebo-controlled trials (2005-2025; 7,147 placebo participants) identified via MEDLINE and EMBASE, and modelled against calendar year using weighted binomial logistic meta-regression. Each additional year was associated with higher odds of placebo joint response: ACR20 (OR 1.071), ACR50 (OR 1.060) and ACR70 (OR 1.049; all $p<0.001$), equating to roughly +7%, +6% and +5% odds per year, or about one percentage point per year in absolute terms. Placebo response also rose significantly for PASI75 (OR 1.013), enthesitis resolution (OR 1.081) and dactylitis resolution (OR 1.027; all $p<0.001$), whereas higher-threshold PASI90 remained broadly static (OR 0.997; $p=0.007$). Conversely, placebo adverse events declined: serious AEs (OR 0.957) and non-serious AEs (OR 0.928; both $p<0.001$). The authors conclude that placebo outcomes have drifted steadily, most markedly for joint and entheseal endpoints, raising the baseline against which new therapies are judged and challenging the validity of indirect comparisons and network meta-analyses spanning different eras.

Why important?

Placebo ACR20 has risen from roughly 14% in the original ADEPT adalimumab trial to as high as 40% in 2025, now coming close to the active-arm ACR20 of the original etanercept trials (50% ACR20). This steadily rising bar forces the question of whether our threshold for "efficacy" is now too high, or simply appropriate because standard care has improved and patients expect more.

The drivers are worth reflecting on - a Hawthorne effect of modern pharma-sponsored trials, the subjectivity of patient and physician global assessments versus objective measures, and more severe enrolled patients prone to regression to the mean - a reminder that the placebo arm deserves as much scrutiny as the headline curve.

Polling Question

Is the efficacy bar in modern PsA trials set too high?

PHOSPHODIESTERASE-4 INHIBITION WITH APREMILAST MODULATES SUBCLINICAL INFLAMMATION MEASURED BY MRI IN PSORIASIS PATIENTS AT RISK OF DEVELOPING PSORIATIC ARTHRITIS - RESULTS FROM THE PROSPECTIVE, INTERVENTIONAL EPOS STUDY

Arnd Kleyer (Berlin, Germany)

Wednesday 3rd June 15:40-16:30
Poster view Presentations
POS0467

EPOS was a phase 4, prospective, single-arm, open-label, interventional trial assessing whether PDE-4 inhibition with apremilast can modulate subclinical joint and enthesealinflammation in psoriasis patients at risk of developing PsA. Twenty biologic-naive psoriasis patients with arthralgia, moderate-to-severe skin disease, and subclinical inflammatory or structural changes on hand MRI and/or high-resolution peripheral quantitative CT (HR-pQCT) were enrolled; those with current or prior PsA were excluded. All received apremilast 30 mg twice daily for 24 weeks, with change in HR-pQCT structural entheseal lesions as the primary endpoint. At baseline, subclinical MRI lesions were present in 9 of 19 evaluable patients, most frequently synovitis (6/19) and tenosynovitis (4/19); mean total PsAMRIS was 2.74. After 24 weeks, subclinical inflammation did not progress: total PsAMRIS remained stable (2.8; p=0.384), tenosynovitis and periarticular inflammation were no longer detectable, and HR-pQCT confirmed no progression of structural entheseal lesions. Skin disease improved significantly (PASI 10.9 to 5.2; p=0.013), as did tender joint count (3.2 to 0.8; p=0.006). A modest increase in MRI erosions occurred without accompanying inflammatory progression. As a small, single-arm, uncontrolled study with surrogate imaging endpoints and no conversion-to-PsA outcome, results require confirmation in larger, randomised trials.

Why important?

PsA interception - treating at-risk psoriasis patients before joint disease develops - is one of the hottest topics in PsA research, and prior interventional studies have used biologics (IL-17 in IVEPSA; IL-23 in the ongoing PAMPA RCT). EPOS is one of the few, if not the only, study to test an oral, non-biologic agent in this space, which is particularly important given that biologics, while effective, carry significant cost and access barriers; building an evidence base for affordable, accessible oral therapies in the pre-disease setting is an exciting and clinically meaningful step. As a small, single-arm study with surrogate imaging endpoints and no conversion-to-PsA outcome, results require confirmation in larger trials.

Polling Question

Your psoriasis patient has active skin disease and subclinical musculoskeletal inflammation on imaging.

Which agent do you choose?

- A) Apremilast
- B) Methotrexate
- C) Deucravacitinib
- D) Biologic (presuming access)

GRAPPA

VIRTUAL CONGRESS HIGHLIGHTS

OF PSORIATIC DISEASE

EULAR 2026

FEATURING:



Marleen van de Sande
Netherlands



Ennio Lubrano
Italy



Philippe Carron
Belgium



Isaac Cheng
Hong Kong



Andre Ribeiro
Brazil



Daniela Tovar
Peru / Venezuela

MODERATORS:



Maria-Angeliki Gkini
UK



Fabian Proft
Germany

PRP:



Wendy Wagenaar
Netherlands

ONLINE EVENT

June 17	10:00-11:30 AM EST 4:00-5:30 PM CEST

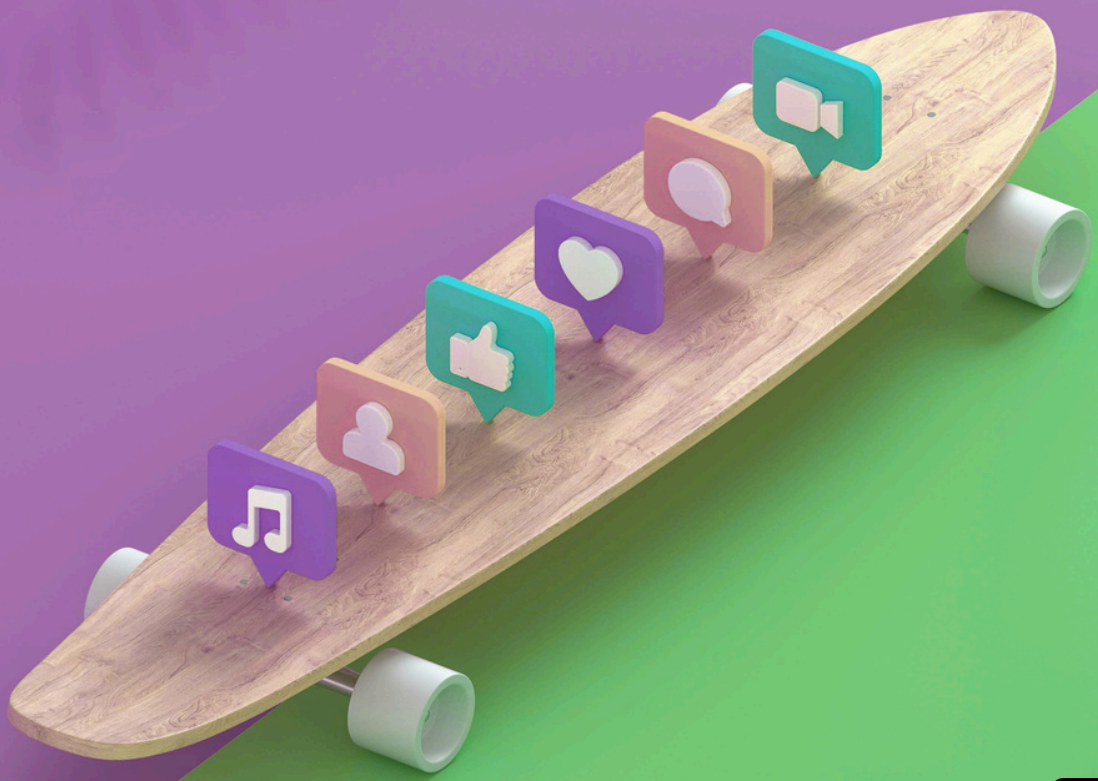
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Y-GRAPPiANs
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