ACR 2026

DO NOT MISS HIGHLIGHTS IN PSORIATIC DISEASE

NOVEMBER 2026



Explore must-see highlights and unmissable sessions on psoriatic disease at ACR Convergence 2026 in Orlando. This newsletter presents a handpicked collection of abstracts, selected and commented on by the following Y-GRAPPA members:



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BASIC SCIENCE



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REGULATORY ROLE OF IL-32Γ IN PATHOGENESIS OF PSORIATIC ARTHRITIS: A NEW THERAPEUTIC TARGET

Siba Raychaudhuri
Abstract number: 1034

Monday, November 9th 2026, 10:30AM-12:30PM
Poster Session B: Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster B
Room: TBC

Full Abstract here

Interleukin-32 (IL-32) is a pro-inflammatory cytokine and this abstracts offers new insights into its role in psoriatic disease.

The study assessed total amount of IL-32 (IL-32γ/IL-32α) in synovial fluid (SF) from patients with PsA, RA and OA (n=10 each). Synovial fibroblasts (FLS) from 5 patients with PsA were then cultured with IL-32γ/ IL-32α and other cytokines to assess their effect on proliferation and FLS supernatant was assessed for cytokines/ endopeptidase using ELISA.

The total amount of IL-32 (IL-32γ/IL-32α) in SF was significantly higher in PsA (980±30 pg/ml) and RA (430±50 pg/ml) than in SF of OA (70±30 pg/ml). Stimulation of FLS with recombinant IL-32γ significantly ($p< 0.001$) induced proliferation of FLS and this was enhanced when IL-32γ was combined with IL-17A. In addition, PsA FLS stimulated with rIL-32γ induced upregulation of RANK-L (475±25 pg/ml) compared to media (96±5 pg/ml; $p< 0.001$)

Results suggest proinflammatory properties of IL-32 establishing a positive feedback loop and a role of IL-17A/IL-32γ on FLS proliferation/pannus formation. IL-32 may represent a novel therapeutic target for inflammatory arthritis.

Why important?

IL-32 establishes a positive inflammatory feedback loop and may contribute to pannus formation, synovial inflammation, and osteoclast activation, making it a promising new therapeutic target.

Polling Question

How useful would a therapeutictarget be that treats both inflammatory arthritis and osteoporosis?

DEFINING A SIGNATURE OF AUTOREACTIVE CD8+ T CELLS IN HLA-B27-ASSOCIATED AUTOIMMUNE DISEASE

Isabel Risch

Abstract number: 1850

Monday, November 9 2026, 8:00AM-8:15AM
Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science
Room: TBC

Full Abstract here

This mechanistic study characterizes autoreactive CD8+ T cells in patients with acute anterior uveitis (AAU), ankylosing spondylitis (AS) and HLA-B27+ Crohn's Disease, and compared findings to publicly available datasets, including. psoriatic arthritis (PsA).

Using paired single-cell TCR and gene expression sequencing (scRNA/TCR-seq) and paired scRNA/scTCR-seq on sorted CD8+ T cells from gut and peripheral blood of HLA-B27+ individuals with Crohn's Disease and/or AAU, distinct transcriptional signatures were seen in YeiH-reactive CD8+ T cells. These cells exhibited an effector-like profile, expressing KLRB1, CCR6, CEBPD, LTK, and IL4I1. Functional enrichment analysis showed significant ($p < 0.01$) transcriptional similarity between IL-17-producing CD8+ T cells and gut-resident CD161intCD8+ T cells.

Autoreactive T-cell receptor sequences in intestinal samples from HLA-B27-positive individuals with Crohn's disease showed transcriptional profiles similar to peripheral blood. CD8+ T-cell populations were comparable across inflamed tissues in AS, AAU, and PsA, suggesting a conserved transcriptional immunological phenotype.

A key finding is identifying a molecularly distinct CD8+ T-cell population with a conserved type 17-like signature across diseases and tissues, supporting the role of microbial antigen recognition, gut immunity, and inflammation in HLA-B27-associated diseases. Their origin, migration patterns, and causal contribution remain unclear. This work advances our understanding of CD8+ T-cell homogeneity in spondyloarthritis.

Why important?

This study identifies an autoreactive CD8+ T-cell signature that's preserved through tissues and diseases.

Polling Question

Can CD8+ cells affect inflammation through other pathways ?

BASIC SCIENCE



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Roberta Foti

MICROBIAL BIOMARKERS IN LESIONAL AND NON-LESIONAL SKIN ACROSS AUTOIMMUNE DISEASES IN THE AMP AIM CONSORTIUM

Kevin Bu
Abstract number: 0133

Sunday, November 8th 2026, 10:30AM-12:30PM
Poster Session A: Genetics, Genomics & Proteomics Poster A
Room: TBC

Full Abstract here

As part of the AMP AIM consortium, this study characterized the skin microbiome across three immune-mediated diseases using long-read PacBio sequencing, which allows species-level identification. A total of 371 lesional and non-lesional skin samples were analyzed from 93 patients with psoriatic arthritis (PsA, n=36), psoriasis (PsO, n=38) or lupus erythematosus (LE, n=19), and from 7 healthy controls.

Lesional skin showed a trend towards higher alpha diversity than non-lesional skin ($p=0.051$), whereas non-lesional and control skin were comparable ($p=0.92$). Patients with PsO had the highest diversity at lesional sites and the lowest at non-lesional sites. Beta diversity did not differ significantly between patients and controls, between lesional and non-lesional sites, or across diagnoses.

At species level, lesions were enriched in Staphylococcus epidermidis and S. aureus and depleted in Cutibacterium acnes, C. namnetense, S. hominis and S. capitis compared with non-lesional skin. S. epidermidis was higher in PsA and PsO than in LE ($p<0.01$), while C. acnes tended to be more abundant in LE ($p=0.09$). The small control group and cross-sectional design limit interpretation, and whether these shifts drive or follow skin inflammation remains unknown.

Why important?

By comparing several diseases at species-level resolution, the study suggests that some features of skin dysbiosis, such as the loss of Cutibacterium species, may be shared across autoimmune skin involvement rather than being disease-specific.

Polling Question

Do you think changes in the skin microbiome are more likely to drive cutaneous inflammation in psoriasis and PsA, or to be a consequence of it?

DUAL IL-17A/IL-17F INHIBITION MODULATES ENTHESEAL STROMAL INFLAMMATORY NETWORKS AND REVEALS A ROLE FOR IL-17F IN NEUTROPHIL RECRUITMENT IN HUMAN ENTHESEAL INFLAMMATION

Thomas Macleod

Abstract number: 0070

Sunday, November 8th 2026, 10:30AM-12:30PM
Poster Session A: Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster A
Room: TBC

Full Abstract here

This translational study explored the contribution of IL-17F to entheseal inflammation using human spinal peri-entheseal bone (PEB; n=6) and entheseal soft tissue (n=3) obtained during corrective spinal surgery. The authors compared sonelokimab (SLK), a nanobody that binds IL-17A and IL-17F with similarly high affinity and is designed for tissue penetration, with the IL-17A inhibitor secukinumab (SEC).

Under IL-17-inducing conditions, PEB T cells produced 3- to 5-fold more IL-17F than IL-17A. In entheseal stromal cells stimulated with TNF plus IL-17A and IL-17F (ratio 1:4), IL-17F did not significantly increase inflammation. However, dual blockade with SLK regulated more genes and had a greater effect on inflammation-associated pathways than IL-17A blockade alone, with stronger downregulation of neutrophil-associated chemokines and CSF3 (G-CSF).

When neutrophils from healthy donors (n=3) were exposed to conditioned stromal media, SLK, but not IL-17A blockade alone, significantly reduced neutrophil chemotaxis and degranulation. These are in vitro findings with small sample sizes from spinal tissue, and their relevance to peripheral enthesitis in PsA has not yet been established.

Why important?

The study suggests that IL-17F contributes to stromal-driven neutrophil recruitment in the enthesis and that IL-17 pathway redundancy may limit the effect of IL-17A blockade alone. Clinical studies are needed to determine whether dual inhibition leads to better control of enthesitis.

Polling Question

Would you expect dual IL-17A/IL-17F inhibition to offer clinically meaningful advantages over IL-17A inhibition alone for enthesitis in PsA?

SEX-SPECIFIC BIOMARKERS IN THE TRANSITION TO PSA: LONGITUDINAL METABOLOMIC ANALYSES

Semini Beragama Jathunga

Abstract number: 0076

Sunday, November 8 2026, 10:30AM-12:30PM
Poster Session A: Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster A
Room: TBC

Full Abstract here

This longitudinal study investigated serum metabolic changes during the transition from psoriasis without arthritis (PsC) to psoriatic arthritis (PsA), and whether they differ by sex. One hundred serial serum samples collected before and after PsA onset (CASPAR criteria) from 50 patients with psoriasis at three North American rheumatology clinics were profiled using untargeted liquid chromatography-mass spectrometry.

Of 1219 metabolites retained for analysis (29.1% unannotated), 63 changed significantly from PsC to PsA (FDR <0.01). These were mainly related to pro-inflammatory lipid signaling, mitochondrial dysfunction and exposure to perfluorochemicals. Sex differences were observed in several trajectories (p<0.1): males showed greater perturbations in amino acid metabolism and females in lipid metabolism. The interval between PsC and PsA sampling did not differ by sex (p=0.6).

In network analysis, a densely connected lipid subnetwork, comprising over half of the PsA network, suggested coordinated changes in membrane remodeling, fatty acid mobilization and mitochondrial beta-oxidation. The sex-specific findings used a lenient significance threshold, and results for xenobiotics were limited by high exposure-driven variability; independent validation is needed.

Why important?

Serial sampling before and after PsA onset offers a rare view of the biochemical changes that accompany the transition from psoriasis to PsA, and points to environmental chemical exposure and sex as factors to consider in future biomarker studies.

Polling Question

Should sex be systematically taken into account when developing biomarkers to predict progression from psoriasis to PsA?

CLINICAL HIGHLIGHTS



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INCIDENCE OF PSORIATIC ARTHRITIS AMONG PATIENTS WITH PSORIASIS TREATED WITH TARGETED SYNTHETIC AND BIOLOGIC THERAPIES: A PROPENSITY SCORE-MATCHED REAL-WORLD COHORT STUDY

Uyen Nguyen
Abstract number: 1320

Monday, November 9th 2026, 10:30AM-12:30PM
Poster Session B: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster B
Room: TBC

Full Abstract here

Using the TriNetX network, this study identified adults with psoriasis and no prior PsA who started a targeted therapy, and evaluated incident PsA (⩾90 days after treatment start) after 1:1 propensity score matching for demographics, comorbidities, inflammatory burden and psoriasis severity proxies. Pooled tsDMARDs and bDMARDs showed no difference in PsA incidence (4.0% vs 3.9%; HR 1.05, 95% CI 0.92–1.20). In pairwise comparisons, IL-23 inhibitors were associated with a lower PsA incidence than IL-17 inhibitors (2.8% vs 3.8%; HR 1.51, 95% CI 1.19–1.91) and TNF inhibitors (2.7% vs 3.8%; HR 1.60, 95% CI 1.30–1.97), while TNF and IL-17 inhibitors did not differ (HR 0.98). Strengths: large multicentre cohort, propensity matching and consistent results across analyses. Limitations: reliance on diagnostic coding, no CASPAR criteria, psoriasis severity or HLA-B27 data, residual confounding and no assessment of subclinical PsA. Prospective studies are needed.

Why important?

Whether systemic therapy for psoriasis can change progression to PsA is still unresolved; these data suggest a possible advantage of IL-23 inhibition in patients at high risk, although they remain hypothesis-generating.

Polling Question

In this TriNetX analysis, which class was associated with the LOWEST incidence of PsA in patients with psoriasis?

A) TNF inhibitors
B) IL-17 inhibitors
C) IL-23 inhibitors
D) No difference between classes

FREQUENCY AND PREDICTORS OF DRUG FREE REMISSION IN PSORIATIC ARTHRITIS: INSIGHTS FROM A LONGITUDINAL COHORT

Neethu Maria Kunjumon

Abstract number: 1342

Monday, November 9 2026, 10:30AM-12:30PM
Poster Session B: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes Poster B
Poster Hall WB1&2

Full Abstract here

Remission is the main treatment target in PsA, but data on drug-free remission (DFR) are limited. The authors analysed a large, prospectively enrolled longitudinal PsA cohort. Sustained DFR was defined as ⩾12 months of remission without csDMARDs, bDMARDs or tsDMARDs (NSAIDs allowed), using two definitions: physician-determined (0 swollen joints and PASI ⩽1 or BSA ⩽3%) and minimal disease activity (MDA). Predictors were explored with multivariable Cox models. Sustained physician-determined DFR was reached by 197 of 1,519 patients (13.0%) and MDA-based DFR by 97 of 1,550 (6.3%). Patients reaching DFR had lower baseline inflammatory burden, lower disease activity, less radiographic damage and better function. A lower likelihood of physician-determined DFR was associated with higher BMI (HR 0.94), greater structural damage (HR 0.98) and HLA-B27 positivity (HR 0.39); older age was associated with a higher likelihood (HR 1.02). For MDA-based DFR, male sex was an independent predictor (HR 2.22). DFR is attainable in a distinct subgroup with limited structural damage, favourable metabolic profile and older age.

Why important?

Guidelines support cautious tapering in sustained remission, but it is unclear who can actually stop all therapy; this study describes the profile of patients in whom drug-free remission is realistic.

Polling Question

What proportion ofPsA patients achieved sustained physician-determined drug-free remission (⩾12 months) in this cohort?

A) About 1%
B) About 13%
C) About 35%
D) More than 50%

BIOLOGIC PERSISTENCE AND TREATMENT SEQUENCING IN AXIAL SPONDYLOARTHRITIS FROM A REAL-WORLD COHORT STUDY

Antoni Chan

Abstract number: 0352

Sunday, November 8 2026, 10:30AM-12:30PM
Poster Session A: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster A
Room: TBC

Full Abstract here

Evidence on long-term persistence and sequencing of advanced therapies in axSpA is limited. This retrospective longitudinal cohort included axSpA patients who received at least one b/tsDMARD between January 2003 and December 2025. Therapies were grouped as TNFi, IL-17A inhibitors, IL-17A/F inhibitors, IL-12/23 inhibitors and JAK inhibitors; persistence was assessed by cumulative treatment duration and sequences were mapped.

Of 431 patients, 74.0% stayed on a single advanced therapy, 19.0% received two, 6.0% three and 0.9% four; only 26.0% needed several agents. TNFi accounted for most exposure and showed the greatest persistence; adalimumab and etanercept had the longest mean durations (1,620 and 1,584 days). Secukinumab was the most prescribed IL-17Ai (mean 791 days). Within-class TNFi cycling was the dominant strategy (189 transitions), about threefold more frequent than TNFi-to-IL-17Ai switching (57). Switches involving IL-17A/F inhibitors, IL-12/23 inhibitors or JAK inhibitors were uncommon. TNFi remained the backbone of advanced therapy.

Why important?

Real-world data on how long biologics last and what clinicians choose after a failure are scarce in axSpA; most patients needed only one agent and, when switching, cycling within the TNFi class was the most common path.

Polling Question

In this 22-year axSpA cohort, what was the most common treatment sequencing strategy?

A) Cycling to another TNF inhibitor
B) TNF inhibitor to IL-17A inhibitor
C) Switch to a JAK inhibitor
D) Switch to an IL-12/23 inhibitor

CLINICAL HIGHLIGHTS



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DIFFICULT-TO-TREAT PSORIASIS IDENTIFIES PATIENTS AT INCREASED RISK OF INCIDENT PSORIATIC ARTHRITIS: A POPULATION-BASED TIME-VARYING COHORT STUDY

Paula David, MD
Abstract number: 0881

Sunday, November 8th 2026, 9:15AM-9:30AM
Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes I
Room W311A-D

Full Abstract here

A national registry-based retrospective cohort study followed 2,251 adults with psoriasis who initiated biologic therapy between 2002 and 2022 and had no prior psoriatic arthritis (PsA). Difficult-to-treat (D2T) psoriasis was defined as failure of biologics from at least two mechanistic classes before PsA onset. Investigators modeled D2T status as a time-varying exposure to limit immortal time bias. Of 2,251 patients, 305 (13.5%) met D2T criteria and 580 developed PsA. D2T psoriasis was associated with increased PsA risk (adjusted hazard ratio [HR] 1.42, 95% CI 1.01-2.00), with similar results in competing-risk analysis (HR 1.44, 95% CI 1.02-2.03). The association was stronger among patients with obesity (HR 1.90, 95% CI 1.18-3.05). A small subgroup refractory to all four biologic classes (n=11) had a higher, but imprecisely estimated, HR of 3.25 (95% CI 0.78-13.6).

Why important?

D2T psoriasis may serve as a readily identifiable clinical marker of increased PsA risk, particularly in patients with obesity. These findings support more vigilant musculoskeletal screening and timely rheumatology referral among patients with repeated biologic treatment failure.

Polling Question

Should patients with psoriasis who fail two or more biologic classes undergo more intensive screening for psoriatic arthritis?

IMPROVING PSORIATIC ARTHRITIS REFERRALS FROM DERMATOLOGY TO RHEUMATOLOGY THROUGH ELECTRONIC HEALTH RECORD–INTEGRATED DIGITAL SCREENING

Zheni Stavre, MD

Abstract number: 1345

Monday, November 9th 2026, 10:30AM–12:30PM
Poster Session B: Spondyloarthritis Including Psoriatic Arthritis – Diagnosis, Manifestations, & Outcomes Poster B
Poster Hall WB1&2

Full Abstract here

Investigators integrated the Psoriasis Epidemiology Screening Tool (PEST) into Epic dermatology workflows for patients with psoriasis, initially during clinic visits and later through six-monthly previsit MyChart questionnaires. A score of at least 3 prompted a recommendation for rheumatology referral. Provider surveys, interrupted time-series analysis, and chart review evaluated adoption and outcomes. Before implementation, 90% of surveyed dermatology providers did not use a validated PsA screening tool. Afterward, 90% reported PEST use and 89% reported more frequent screening. During the first year of digital implementation, patients completed 676 questionnaires (36% screening rate). Of 71 patients with positive screens, 31 had documented PsA, yielding a positive predictive value of 44%. Monthly referrals for suspected PsA increased by an estimated 2.6 patients, although the change was not statistically significant (p=0.23). No-show rates among new PsA referrals decreased from 5.3% to 2.5% following implementation.

Why important?

Integrating validated PsA screening tools into routine dermatology workflows may facilitate earlier identification and referral of patients with previously unrecognized joint disease. Although clinician adoption was encouraging, limited patient screening completion and the nonsignificant increase in referrals demonstrate the need for continued implementation efforts.

Polling Question

What is the greatest barrier to implementing routine PsA screening in dermatology: patient completion, clinician workflow, or access to rheumatology care?

DATA-DRIVEN CLINICAL SIGNATURES SHAPE DISTINCT LONGITUDINAL DISEASE TRAJECTORIES IN PSORIATIC ARTHRITIS

Alexandre Garaïman, Jr, MD, PhD

Abstract number: 0880

Sunday, November 8th 2026, 9:00AM-9:15AM
Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes I
Room W311A-D

Full Abstract here

Investigators used latent class analysis to identify clinical profiles among 326 patients with newly diagnosed psoriatic arthritis (PsA) enrolled in the UK multicenter MONITOR-PsA prospective cohort. Baseline joint and extra-articular features, body mass index, and sex informed three profiles: axial/enthesitis-dominant (n=127), peripheral polyarticular/ metabolic (n=137), and oligoarticular/nail-predominant (n=62). Over 48 weeks of treat-to-target care, disease activity and patient-reported outcomes generally improved, but trajectories differed after adjustment for time-varying treatment. The peripheral polyarticular/metabolic group retained the greatest residual multidomain disease burden, while the oligoarticular/nail- predominant group achieved the most favorable outcomes. The axial/enthesitis-dominant group demonstrated the least improvement. A significant interaction between profile, time, and treatment for the Psoriatic Arthritis Disease Activity Score (PASDAS; p=0.039) suggested differences in treatment-associated trajectories between groups. The findings support further investigation of clinically informed PsA stratification but require external validation.

Why important?

Identifying distinct clinical phenotypes at PsA diagnosis may improve risk stratification and help clinicians anticipate differences in disease progression and treatment response. These findings support further development of individualized, phenotype-informed treatment strategies rather than relying exclusively on composite disease activity measures.

Polling Question

Should baseline clinical phenotyping guide initial treatment selection in newly diagnosed psoriatic arthritis?

TREATMENT HIGHLIGHTS



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SEX-RELATED DIFFERENCES IN EFFICACY AND SAFETY OF ADVANCED THERAPIES IN PSORIATIC ARTHRITIS RANDOMIZED CLINICAL TRIALS: AN UPDATED SYSTEMATIC LITERATURE REVIEW AND META-ANALYSIS FOR THE GRAPPA TREATMENT GUIDELINES

Gizem Ayan
Abstract number: 2309

Tuesday, November 10th 2026, 10:30AM-12:30PM
Poster Session C: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster C
Room: TBC

Full Abstract here

This updated systematic review and meta-analysis examined whether responses to advanced therapies differ by sex in randomized psoriatic arthritis (PsA) trials. Eleven additional studies were included alongside studies from the previous analysis to inform the GRAPPA treatment guidelines.

Overall, men had higher odds than women of achieving ACR20 (OR 1.42; 95% CI 1.24-1.63), ACR50 (1.74; 1.54-1.96) and minimal disease activity (MDA; 1.94; 1.68-2.25). These male-versus-female odds ratios do not represent absolute response rates or treatment effects versus placebo.

For ACR20, odds ratios were 1.55 for TNF inhibitors, 1.70 for IL-17 inhibitors, 1.46 for IL-23 inhibitors and 2.66 for IL-12/23 inhibitors. No statistically significant difference was found for ACR20 with JAK inhibitors (1.21; 0.97-1.51) or TYK2 inhibitors (0.76; 0.46-1.26). However, men had higher odds of ACR50 (1.45; 1.12-1.87) and MDA (2.10; 1.58-2.80) with JAK inhibitors. Placebo ACR20 responses did not differ significantly; sex-disaggregated safety data were limited.

Why important?

The findings highlight differences in the attainment of standard treatment targets between males and females and the need for consistent sex-disaggregated reporting. The analysis does not establish the causes of these differences or demonstrate that one drug class should be selected over another based on sex.

Polling Question

How should sex-related differences in treatment outcomes influence the assessment of treatment targets in patients with PsA?

TREATMENT WITH GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS IS ASSOCIATED WITH LOWER DISEASE ACTIVITY AND PAIN IN PSORIATIC ARTHRITIS INDEPENDENT OF WEIGHT CHANGE

Pankti Mehta

Abstract number: 0373

Sunday, November 8th 2026, 10:30AM-12:30PM
Poster Session A: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster A
Room: TBC

Full Abstract here

This longitudinal cohort study assessed psoriatic arthritis (PsA) outcomes in 74 patients receiving a GLP-1 receptor agonist or dual GLP-1/GIP agonist and 74 controls matched by body mass index (BMI), cDAPSA and calendar year. Diabetes was more common in the treated group at baseline (58.1% vs 12.2%).

At 12 months, weight loss exceeding 5% was more frequent in treated patients (44.4% vs 12.8%; p<0.001). Forty-five treated patients had assessments available at 12 months. After adjustment for BMI change, each month of treatment was associated with lower cDAPSA (β -0.43; 95% CI -0.80 to -0.06), DAPSA (-0.62; -1.18 to -0.06) and patient-reported pain (-0.13; -0.24 to -0.02).

No significant associations were observed for C-reactive protein, swollen or tender joint counts, or PASI. The authors reported more pronounced associations in patients not receiving a biologic DMARD. Residual confounding and missing follow-up assessments may affect interpretation; BMI adjustment does not establish causality or prove a weight-independent effect.

Why important?

The study raises a clinically relevant hypothesis about pain and composite disease activity in patients receiving GLP-1-based therapy. Prospective interventional studies are needed before these findings can inform treatment specifically for PsA.

Polling Question

In patients with PsA who start GLP-1-based therapy for obesity or diabetes, have you observed changes in pain or joint symptoms?

CLASS-LEVEL AND DRUG-LEVEL PERSISTENCE OF IL-17AI VERSUS IL-23 INHIBITORS IN PSORIATIC ARTHRITIS: RESULTS FROM THE PPD COREVITAS PSA/SPA REGISTRY

Philip Mease

Abstract number: 2288

Tuesday, November 10th 2026, 10:30AM-12:30PM
Poster Session C: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster C
Room: TBC

Full Abstract here

This observational CorEvitas registry study compared treatment persistence in patients with psoriatic arthritis (PsA) initiating their first IL-17A inhibitor (n=385) or IL-23 inhibitor (n=233). Before weighting, previous biologic or targeted synthetic DMARD exposure was more frequent in the IL-17A group (60.5% vs 48.9%). Inverse probability of treatment weighting was used to balance measured baseline characteristics.

At 12 months, estimated class-level persistence was 56.2% for IL-17A inhibitors and 57.4% for IL-23 inhibitors; switching to another drug within the same class was allowed. Persistence on the original drug was 48.9% and 54.1%, respectively. The hazard ratios for discontinuation with IL-17A versus IL-23 inhibitors were 1.06 (95% CI 0.78–1.46) at class level and 1.19 (0.88–1.60) at drug level. Neither comparison showed a statistically significant difference, but the intervals include potentially meaningful differences. Persistence was assessed only up to 12 months; whether the pattern continues during the second year is unknown.

Why important?

Persistence provides information on treatment continuity in routine care and can complement, but not replace, assessments of effectiveness, safety and patient preferences. Longer follow-up is needed to determine whether the observed pattern persists beyond one year.

Polling Question

How important is long-term real-world treatment persistence when choosing between IL-17A and IL-23 inhibitors for patients with PsA?

REAL-WORLD COMPARATIVE RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS AND VENOUS THROMBOEMBOLISM WITH BIOLOGICS VERSUS JAK INHIBITORS IN PSORIATIC ARTHRITIS

Milad Heydari-Kamjani

Abstract number: 2304

Tuesday, November 10th 2026, 10:30AM-12:30PM
Poster Session C: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster C
Room: TBC

Full Abstract here

This retrospective TriNetX study compared a composite of myocardialinfarction, stroke, deep vein thrombosis and pulmonary embolism among 21,569 adults with psoriatic arthritis (PsA) initiating one biologic or JAK inhibitor. Patients had no previous biologic or JAK inhibitor exposure and at least one year of follow-up; those with prior specified cardiovascular or thromboembolic events or events within 30 days of initiation were excluded. Baseline characteristics were balanced using inverse probability of treatment weighting.

No statistically significant differences were found between JAK inhibitors and any of the biologic classes during the first two years of treatment. During years 2-5, TNF inhibitors (HR 0.50; p=0.01) and IL-17 inhibitors (HR 0.45; p=0.024) were associated with a lower hazard of the composite outcome than JAK inhibitors; differences for IL-23 and IL-12/23 inhibitors were not statistically significant.

In the weighted Kaplan-Meier analysis restricted to years 2-5, cumulative incidence was 9.5% for JAK inhibitors, 4.5% for TNF inhibitors, 4.0% for IL-17 inhibitors, 4.0% for IL-23 inhibitors and 5.5% for IL-12/23 inhibitors. Selection criteria and residual confounding limit causal interpretation; nonsignificant comparisons do not establish equivalent risk.

Why important?

This study adds comparative real-world data on cardiovascular and thromboembolic outcomes in PsA, particularly beyond two years of treatment.

Polling Question

How does a patient's cardiovascular and thromboembolic risk influence your choice of advanced therapy for PsA?

TREATMENT HIGHLIGHTS



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Research focus: Musculoskeletal US, transition from PsO to PsA, enthesitis

ONE-YEAR AND THREE-YEAR COMPARATIVE OUTCOMES AMONG PATIENTS WITH PSORIASIS TREATED WITH BIMEKIZUMAB VERSUS SECUKINUMAB: A PROPENSITY SCORE-MATCHED REAL-WORLD STUDY

Maya Khasho
Abstract number: 2339

Tuesday, November 10th 2026, 10:30AM-12:30PM
Poster Session C: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes Poster C
Room: TBC

IL-17A and dual IL-17A/F inhibitors work differently, but whether that translates into different real-world outcomes is less clear. This retrospective study used the TriNetX Global Collaborative Network to compare adults with psoriasis starting bimekizumab or secukinumab, propensity score-matched for demographics, comorbidities and prior medications (1,992 patients per cohort). Outcomes were new psoriatic arthritis (PsA), candidiasis and all-cause hospitalisation at 1 and 3 years.

At 1 year, PsA and hospitalisation rates were similar, but candidiasis was more common with bimekizumab (5.5% vs 2.1%). By 3 years, bimekizumab was associated with less PsA (6.4% vs 11.0%) and fewer hospitalisations, while candidiasis remained more common, though the absolute gap had narrowed to under 2 percentage points.

The authors suggest a possible longer-term benefit with bimekizumab balanced against candidiasis risk, with residual confounding and differential follow-up as key caveats.

Full Abstract here

Why important?

We know IL-17A andIL-17A/F inhibitors are different, but do treatment outcomes differ? We may never see a head-to-head RCT, so this is a decent attempt using the frequently used TriNetX database. No surprises that candidiasis was more common with bimekizumab. If you're a glass half full person, around 94% did not get candidiasis! More interesting is the lower PsA rate with bimekizumab at 3 years, so dual IL-17A/F blockade might matter. With data suggesting IL-23 inhibition is probably the best choice to prevent psoriasis progressing to PsA, the next step in the IL-17 vs IL-23 battle is how bimekizumab goes against IL-23 inhibitors.

Polling Question

Yourpatientwithmoderate-to-severe psoriasis and no arthritis is starting a biologic. Which class would you choose to reduce their risk of developing PsA?

A) IL-17A inhibitor
B) IL-17A/F inhibitor
C) IL-23 inhibitor
D) TNF inhibitor

EFFECTIVENESS OF GUSELKUMAB VS GOLIMUMAB IN PARTICIPANTS WITH ACTIVE PSORIATIC ARTHRITIS AND INADEQUATE RESPONSE TO ONE PRIOR TUMOR NECROSIS FACTOR INHIBITOR: INTERIM RESULTS AT 6 MONTHS IN A PHASE 3B, RANDOMIZED, OPEN-LABEL, PRAGMATIC TRIAL

Alexis Ogdie

Abstract number: 0358

Sunday, November 8th 2026, 10:30AM-12:30PM
Poster Session A: Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster A
Room: TBC

Full Abstract here

Cycle or switch? After a first TNF inhibitor fails in PsA, it is still unclear whether to try another TNF inhibitor or change mechanism. EVOLUTION is a phase 3b, open-label, pragmatic trial randomising TNFi inadequate responders to golimumab 50 mg every 4 weeks, guselkumab 100 mg every 4 weeks, or guselkumab at approved dosing (every 8 weeks after induction). The primary endpoint, cDAPSA low disease activity/remission plus IGA 0/1, is at 12 months; this is a descriptive 6- month interim look at 57 participants, with no statistical testing. So far, no clear winner. The combined endpoint was reached by 26.3% on golimumab, 23.5% on 4-weekly guselkumab and 19.1% on approved-dose guselkumab. Four-weekly guselkumab had the largest cDAPSA improvement and the highest MDA rate, while approved- dose guselkumab trailed on MDA (9.5%). Patient-reported impact (PsAID-12) improved similarly across groups. The authors suggest both mechanism and dosing frequency may matter, with 12-month results to come.

Why important?

A negative study (at least at this interim point), which is disappointing. Four-weekly guselkumab may show some signal, but 8-weekly is regular dosing where I'm from in Australia and, I understand, in many other countries. You can ask the company for extra doses, but that supply isn't unlimited, so the real day-to-day comparison is 8-weekly guselkumab versus golimumab. You can see why the company ran this, as they make both: if guselkumab wins, great; if it's a draw, it's because their golimumab is so good!
Old-schoolers will like this one: one TNF fails, go to another and get some benefit. But the contemporary shift, especially among younger rheumatologists, is that TNF doesn't have to be used first and can go straight to IL-17 or IL-23, so this study anchors us back in old-school thinking. And what if bimekizumab had been used instead, given its recent superiority over risankizumab in BE BOLD?

Polling Question

Your PsA patient has had an inadequate response to their first TNF inhibitor. What next?

A) Cycle to another TNFi

B) Switch to an IL-23 inhibitor

C) Switch to an IL-17 inhibitor

D) Switch to a JAK inhibitor

CLINICAL AND ECONOMIC OUTCOMES OF PSORIATIC ARTHRITIS PATIENTS WITH OVERWEIGHT OR OBESITY TREATED WITH IXEKIZUMAB AND WITH TIRZEPATIDE: A MODELING STUDY

Russel Burge

Abstract number: 2715

Tuesday, November 10th 2026, 10:30AM-12:30PM
Poster Session C: Health Services Research
Poster C
Room: TBC

Full Abstract here

Can a weight-loss drug pay its own way? Overweight and obesity are common in PsA (81.8% in a recent analysis), and in the phase 3b TOGETHER-PsA trial, adding tirzepatide (a dual GIP/GLP-1 receptor agonist) to ixekizumab (an IL-17A inhibitor) improved ACR50 (33.5% vs 20.4%) alongside weight loss. This modelling study took those results and ran the numbers over a lifetime, from societal and US payer perspectives, by combining existing pharmacoeconomic models for each drug.

Clinically, the combination came out ahead: better PsA response, longer time on ixekizumab (2.07 vs 1.57 years), fewer heart attacks, strokes and cardiovascular deaths, far fewer diabetes-related complications, and more QALYs. Then came the bill. Tirzepatide added $93,209 in acquisition costs and clawed back only $19,532 through fewer obesity-related complications. Even so, the authors concluded the combination was cost-effective, more so at higher BMI and over longer horizons, with results most sensitive to the ixekizumab discontinuation rate.

Why important?

Economic studies are not sexy at all for clinicians (broadly speaking), but regulators find them attractive, and we need more of them to persuade governments to fund treatments that deliver excellent outcomes for our patients. Many of us assume the cost of these drugs is completely offset by fewer obesity-related complications. I don't know enough about the modelling to critique it, but it was a bit of a shame: $93,000 in tirzepatide costs against $19,500 in savings isn't tremendous, and you get a bit pessimistic when the company that makes both drugs shows these results in theoretical modelling.

Don't get me wrong, fewer heart attacks and strokes is fantastic. But at the end of the day costs matter, and as more studies come out and patents run out, I'm sure the cost/benefit pendulum will shift.

Polling Question

What is the biggest barrier to adding GLP-1-based therapy in PsA with obesity?

A) Cost and access
B) Tolerability and side effects
C) Not my role as a rheumatologist
D) Not enough evidence yet

Where to Find **PsA Science** at ACR 2026

Key ScientificSessionsandDiscussions

Sunday, 8 Nov

0878-0883: **Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes I.** W311A-D 8:30am - 10:00am

0069-0077: **Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster A.** Poster Hall 10:30am - 12:30pm

0344-0373: **Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster A.** Poster Hall 10:30am - 12:30pm

0374-0408: **Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes Poster A.** Poster Hall 10:30am - 12:30pm

0890-0895: **Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Axial Spondyloarthritis Imaging Advances.** 1:00pm - 2:30pm

Monday, 9 Nov

1850-1855: **Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science.** 8:00am - 9:30am

1027-1034: **Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster B.** Poster Hall 10:30am - 12:30pm

1301-1330: **Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster B.** Poster Hall 10:30am - 12:30pm

1331-1365: **Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes Poster B.** WB1&2 10:30am - 12:30pm

Tuesday, 10 Nov

2008-2015: **Spondyloarthritis Including Psoriatic Arthritis - Basic and Translational Science Poster C.** Poster Hall 10:30am - 12:30pm

2284-2314: **Spondyloarthritis Including Psoriatic Arthritis - Treatment Poster C.** Poster Hall 10:30am - 12:30pm

2315-2350: **Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes Poster C.** Poster Hall 10:30am - 12:30pm

2875-2880: **Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Diagnosis, Manifestations, & Outcomes III.** 1:00pm - 2:30pm

Wednesday, 11 Nov

2941-2946: **Abstracts: Spondyloarthritis Including Psoriatic Arthritis - Treatment.** 9:30am - 11:00am

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ADJACENT TO ACR 2026

GRAPPA Soapbox Presentations & Young GRAPPA Research Spotlight

Hyatt Regency Orlando
Barrel Spring, Level 2 (Lobby Level)
9801 International Drive, Orlando, Florida, USA
Across the street from the Orange County Convention Center

JOIN US IN-PERSON

Sunday
November 8
6:00-8:00 PM ET

FEATURING:

ARTIE KAVANAUGH, MD
UniversityofCalifornia,SanDiego, USA
Welcome, GRAPPA Leadership Update & Closing

JOSEPH MEROLA, MD, MMSC
UT Southwestern, USA
Welcome, Psoriasis Update & Closing

GURJIT KAELEY, MD
University of Florida, USA
Ultrasound in Psoriatic Arthritis: Current Applications and Emerging Insights

ANDRÉ RIBEIRO, MD, MSC
Hospital de Clínicas de Porto Alegre, Brazil
Psoriasis Update: Key Highlights from EADV and AAD

NIKOLAOS KOUGKAS, MD, PHD
Aristotle University of Thessaloniki, Greece
Methotrexate First in PsA: Tradition or Evidence?

JEAN-GUILLAUME LETAROUILLY, MD, PHD
Université de Lille, France
Heart Failure with Preserved Ejection Fraction in Psoriatic Disease

DANIEL XIBILLE-FRIEDMAN, MD, PHD
Hospital General de Cuernavaca, Mexico
Life's Essential 8 as a Screening Tool for Cardiovascular Risk in Psoriatic Disease

ROBERTA FOTI, MD
AOU Policlinico, Italy
IL-23 Inhibition in Axial PsA: Current Evidence, Real-World Experience and MRI Assessment

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Peru



Dennis Neuen
Australia

MODERATORS:



Lourdes Perez Chada
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Fabian Proft
Germany

PRP:



Arnon Katz
Israel

ONLINE EVENT

SCAN ME

December 2	10:00-11:30 AM EST 4:00-5:30 PM CEST

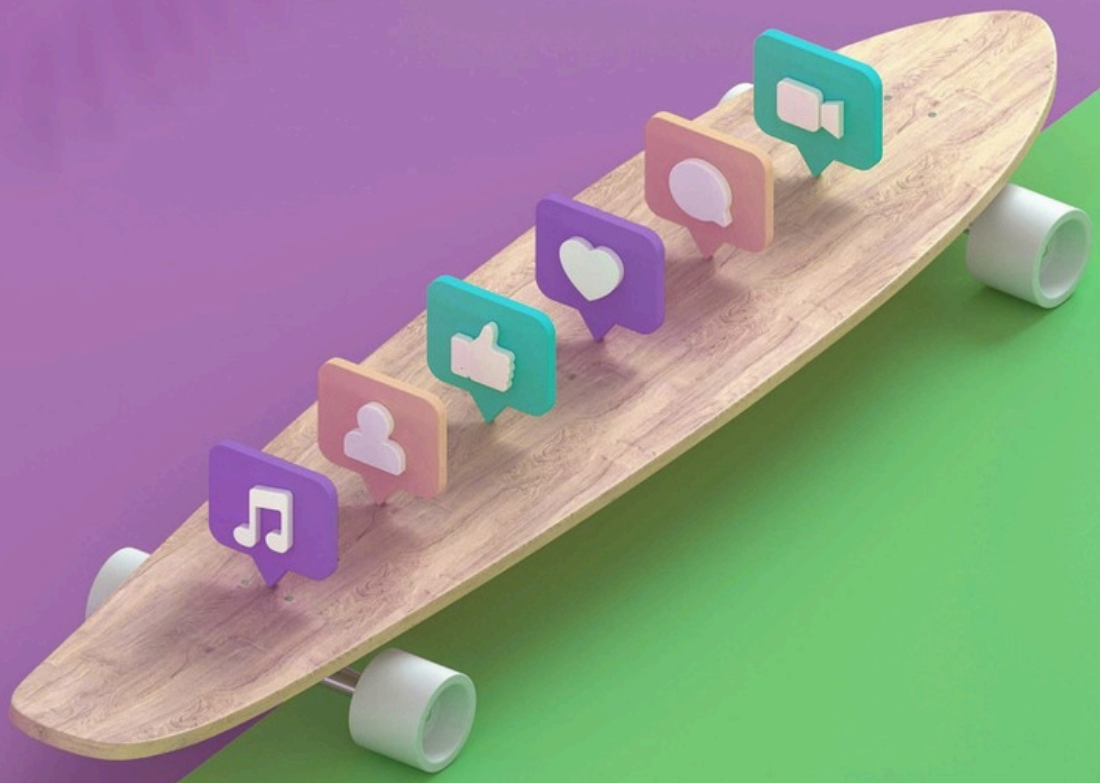
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