Updates from the European Alliance of Associations for Rheumatology (EULAR) 2025 Congress

Author: *Antoni Chan[1]

1. University Department of Rheumatology, Royal Berkshire NHS Foundation Trust and University of Reading, UK
*Correspondence to antoni.chan@nhs.net

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THE European Alliance of Associations for Rheumatology (EULAR) 2025 Congress was held in Barcelona, Spain, from the 11th–14th June. Important abstracts covering updates in axial spondyloarthritis (axSpA), lupus nephritis (LN), psoriatic arthritis (PsA), and rheumatoid arthritis (RA) were presented over the course of the meeting and this feature covers the highlights.

PSORIATIC ARTHRITIS: LATEST INSIGHTS

Combination Treatment in Psoriatic Arthritis

The use of dual biologic disease-modifying antirheumatic drug (bDMARD) with JAK inhibitor (JAKi) or tyrosine kinase 2 (TYK2) inhibitor (TYK2i) for treating PsA was explored in an abstract presented by Ribeiro AL et al.[1] This observational study, with short-term follow up, reviewed patient charts to assess the efficacy and safety of this combination treatment. There were 22 patients in the study, equally split between males and females, with a total exposure of 8.5–10.5 patient-years. The most common combination was IL-17 inhibitor (IL-17i)+TYK2i, followed by IL-23 inhibitor (IL-23i)+TYK2i and IL-17i+JAKi. There were also some patients on combinations of bDMARD+apremilast (APR), such as IL-17i+APR, IL-23i+APR, and TNF inhibitor (TNFi)+APR. Short-term responses were observed in both musculoskeletal and skin domains, including tender and swollen joint counts, Disease Activity in Psoriatic Arthritis (DAPSA) index, Psoriasis Area and Severity Index (PASI), body surface area, and patient-reported outcomes (numerical rating scale for pain, skin, and patient global assessment). The overall safety profile of combination bDMARD with JAKi, TYK2i, and APR was favourable. Infections, such as upper respiratory infections and stomatitis, were manageable, did not require hospitalisation, or withdrawal of treatment.

Early Intensive Treatment in Psoriatic Arthritis

The concept of early, aggressive medical intervention to manage PsA was also discussed during the event. The results of the Severe Psoriatic arthritis - Early intervEntion to control Disease (SPEED) trial were reported on by Coates LC et al.[2] The trial compared

the Psoriatic Arthritis Disease Activity Score (PASDAS) responses in patients with PsA and poor prognostic factors, treated with standard step-up conventional systemic disease-modifying anti-rheumatic drugs (csDMARD), combination csDMARDs, or early TNF inhibitor (TNFi) induction therapy. A total of 192 patients were included in the study, 52% of whom were male. The mean PASDAS was lower in both the early TNFi (3.7) and combination csDMARDs (4.1) groups compared to the step-up csDMARDs (4.8) group. Early TNFi was superior to step-up csDMARDs by –1.09 on the PASDAS and this benefit was sustained at 48 weeks. Combination csDMARDs were also superior to step-up therapy by –0.69 in the PASDAS.

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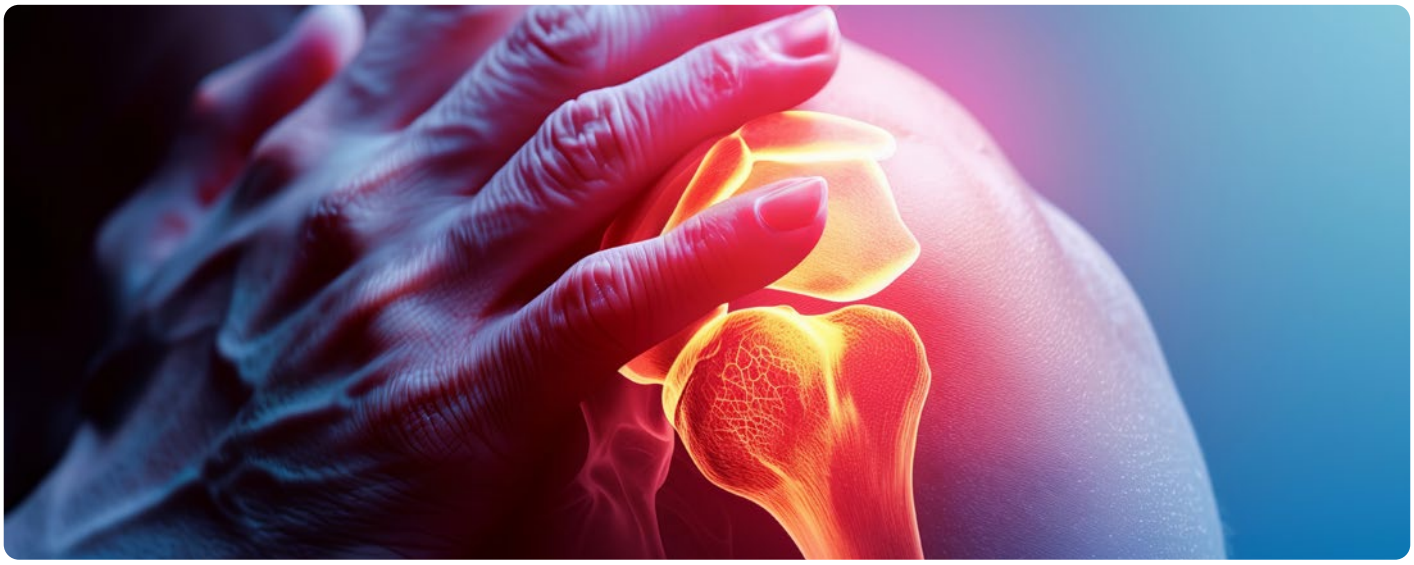
Complex to Manage and Difficult to Treat Psoriatic Arthritis

Discussing difficult-to-treat disease, Fabian Proft, Charité – Universitätsmedizin Berlin, Germany, reported on the GRAPPA definition of complex-to-manage and difficult-to-treat PsA.[3] Complex-to-manage PsA was defined as a disease state characterised by persistent symptoms despite at least one adequate trial of a biologic and targeted synthetic disease-modifying antirheumatic drug. This category extends beyond pure biological non-response to also include factors like comorbidities, overlapping conditions, and treatment-related challenges. Difficult-to-treat, or treatment resistant disease, was defined as failure to respond to ≥3 treatments for PsA with different modes of action (including ≥2 biologic and targeted synthetic disease-modifying antirheumatic drug), persistent symptoms perceived as problematic by both the treating clinician and the patient, and the presence of objective evidence of ongoing inflammation. These definitions were endorsed by 95% of the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) membership, with 89–100% agreement across items.

Whole-Body MRI in Psoriatic Arthritis

The TIGERS study explored the use of whole-body MRI (WB-MRI) to monitor treatment response in patients with PsA receiving different biologic therapies.[4] In this randomised controlled trial, 32 patients with PsA were assigned to receive adalimumab (TNFi), guselkumab (IL-23p19 inhibitor), or ustekinumab (IL-23i). Imaging was performed using WB-MRI with the MRI Whole-body score for Inflammation in Peripheral joints and Entheses (MRI-WIPE) scoring system, and standard clinical assessments were collected, including 66/68-swollen and tender joint count (SJC66/TJC68), DAPSA, and Leeds enthesitis index (LEI). The results demonstrated that adalimumab led to a significant reduction in MRI-WIPE scores (median decrease of 39 units) and joint synovitis scores (median decrease of 23 units), while guselkumab and ustekinumab did not show significant imaging changes. All three treatments improved clinical scores, but only adalimumab achieved significant



reductions in both imaging and clinical measures. There was a strong correlation between MRI synovitis and SJC66 changes (rho: 0.78; p=0.023), suggesting that WB-MRI can capture inflammation not fully reflected in clinical scores.

UPDATES IN AXIAL SPONDYLOARTHRITIS AND LUPUS NEPHRITIS

AI in Axial Spondyloarthritis

The Bechterew-App Trial[5] presented important new data on Axia, a novel AI-powered digital therapeutic developed for axSpA. To rigorously test Axia's efficacy, the research team conducted a randomised, controlled, crossover trial across Germany. The trial included 200 patients with axSpA on stable pharmacotherapy. Individuals were randomised 1:1 to receive either Axia or treatment as usual for 12 weeks. Evaluation of disease activity, functional status (BASFI), and quality of life were the primary endpoints. Secondary outcomes included Assessment of Spondyloarthritis International Society (ASAS) 20 and 40 response rates, reflecting clinically meaningful improvements. The key findings were significant improvements across multiple domains at 12 weeks. In terms of disease activity, the mean improvement with Axia was –1.66 (SD: 1.41) compared to –0.11 (SD: 1.15) with the control (p<0.001). Regarding functional status (BASFI), Axia resulted in a –1.12 (SD: 1.40) improvement, compared to the control group, who experienced an increase in BASFI (+0.06 [1.31]; p<0.001). For quality of life, the Axia group saw a –2.51 (SD: 2.55) improvement compared to –0.16 (SD: 2.26) in the control group (p<0.001). In terms of ASAS20 response rates, 51% achieved this in the Axia group, compared to 9% in the control group (p<0.001). Finally, 23% of individuals in the Axia group achieved an ASAS40 response rate, compared to 3% in the control group (p<0.001). No safety concerns emerged, highlighting Axia's suitability as a well-tolerated adjunct to standard care.

Updated European Alliance of Associations for Rheumatology Guidelines on Lupus Nephritis

The updated EULAR recommendations on the management of lupus nephritis (LN) were also presented.[6] Kidney biopsy is vital for the assessment of suspected LN. Similar to the recent American College of Rheumatology (ACR) guidelines for LN, EULAR also recommends early use of quadruple therapies (glucocorticoids[GC] + hydroxychloroquine + immunosuppressant [mycophenolate mofetil or low-dose cyclophosphamide] + calcineurin inhibitor or biologics [belimumab or obinutuzumab]). EULAR did not distinguish the choice of calcineurin inhibitor or biologics based on renal histology class. Following intravenous methylprednisolone pulses for remission induction, oral GC (0.3–0.7 mg/kg/day) tapered to ≤5mg/day by 4–6 months were recommended. Other treatments to be considered for nephroprotection (low salt diet and blood pressure control with renin-angiotensin-aldosterone system blockade and sodium–glucose cotransporter 2 [SLGT2]) if residual proteinuria after 12 months), as well as management of dyslipidaemia, vaccinations, and bone health, were also discussed.

RESEARCH INSIGHTS IN RHEUMATOID ARTHRITIS AND PALINDROMIC RHEUMATISM

Cancer Risk in Rheumatoid Arthritis

The results from a prospective, multicentre cohort study from using a national registry of targeted therapies investigating cancer (excluding non-melanoma skin cancer [NMSC]) and NMSC (basal cell carcinoma and squamous cell carcinoma) were reported on during the congress.[7] Over 23 years, among a total of 4,635 patients with RA, 187 incident cancers were detected. When divided in groups according to treatment, and using TNFi as a reference, the adjusted overall hazard ratio for cancer excluding NMSC was 1.1 for IL6 inhibitor, 0.8 for CD20i, 1.2 for JAKi, and 1.1 for CTLA4-A. The adjusted overall hazard ratio for NMSC was 0.5 for IL6 inhibitor, 0.6 for cluster of differentiation 20 (CD20) inhibitor, 0.6 for JAKi, and 1.1 for cytotoxic T-lymphocyte antigen 4 (CTLA4)-A. All confidence intervals were crossing 1, suggesting no significant increase in risk for cancer (excluding NMSC) and NMSC with any of the bDMARDs or tsDMARDs, in comparison to TNFi.

Preventive Treatments in Rheumatoid Arthritis: The ALTO Study

Andrew Cope, Centre for Rheumatic Diseases, King's College London, UK, reported follow-up data from the APIPPRA Long-Term Outcomes (ALTO) study, which followed participants for up to 6 years.[8] The APIPPRA trial enrolled individuals who were anti-citrullinated protein antibody (ACPA)-positive and had arthralgia but no clinical synovitis. Participants were randomised to receive either abatacept (ABA) or placebo for 12 months, followed by observation off-treatment. By Year 4, arthritis-free survival was similar in both groups, with nearly 60% of participants in each arm having developed arthritis. These findings indicate that, while ABA delayed disease progression, it did not provide durable prevention. A subgroup analysis identified a population of participants with multiple RA-associated autoantibodies in whom ABA conferred a more sustained protective effect. Individuals with a mature autoantibody profile, but no clinical synovitis, may respond more favourably to T cell co-stimulation blockade and could be an appropriate target population for preventive intervention with ABA.

Treating Pre-Clinical Synovitis in Rheumatoid Arthritis with Methotrexate

Results from the TREAT EARLIER trial was also presented.[9] The trial enrolled participants with clinically suspect arthralgia and subclinical joint inflammation identified by MRI of the hands or feet. It included both ACPA-positive and ACPA-negative individuals, who were randomised to receive a one-time intramuscular injection of corticosteroid and oral methotrexate for 1 year, or a matched placebo. Participants were then observed for the subsequent 4 years. In the 5-year subgroup analysis, outcomes were stratified by ACPA status. ACPA-negative participants treated with methotrexate demonstrated significantly improved arthritis-free survival compared to those who received placebo. In ACPA-negative individuals, 9% of those treated with methotrexate progressed to RA over 5 years, compared to 32% in the placebo arm. In contrast, ACPA-positive individuals did not experience a reduction in RA development with methotrexate treatment.

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Palindromic Rheumatism and Treatment Outcomes

Raimon Sanmartí, Hospital Clínic de Barcelona, Spain, reported on the Spanish PALABA multicentre study that compared hydroxychloroquine (HCQ) and ABA in the management of palindromic rheumatism (PR).[10] In this study, 70 patients with PR were randomised to receive either ABA or HCQ at standard doses. Patients met PR criteria and were seropositive for rheumatoid factor or ACPA. The primary outcome was the development of RA at 2 years. This was

seen in 28% of patients on HCQ and only 9% on ABA. Those on ABA had significantly less PR attacks (23%) compared to HCQ (56%). Most patients (80%) treated with hydroxychloroquine progressed to RA in the first 12 months, while in the group treated with ABA, progression to RA was observed after 18 months of follow-up. Kaplan-Meier curves for RA-free survival over 24 months also favoured ABA (log-rank test: p=0.029). ABA appears to delay the onset of chronic RA and better control PR than HCQ.

CONCLUDING REMARKS

The abstracts and presentations at EULAR 2025 delivered important insights that continue to shape the evolving management landscape in rheumatology. In PsA, evidence supports a shift toward earlier, more intensive intervention strategies and highlights the emerging role of dual-targeted therapy in selected patients. The proposed GRAPPA definitions for complex and treatment-resistant PsA offer a structured approach to managing challenging cases. In axSpA, the integration of digital health was exemplified by the Axia AI-powered digital therapeutic, which demonstrated significant improvements in disease activity and quality of life.

Advances in RA focused on prevention and early intervention, with methotrexate benefiting ACPA-negative individuals with subclinical inflammation, and ABA showing promise in delaying progression in both preclinical RA and PR. The updated EULAR guidelines on LN endorse early combination immunosuppression and reinforce the importance of comprehensive, multidisciplinary care. Across diseases, imaging and biomarkers continue to refine treatment decisions and define prognosis, while safety data remain reassuring for modern immunotherapies. These studies underscore a trend toward personalised, proactive, and data-informed treatment approaches across the spectrum of inflammatory rheumatic diseases.

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