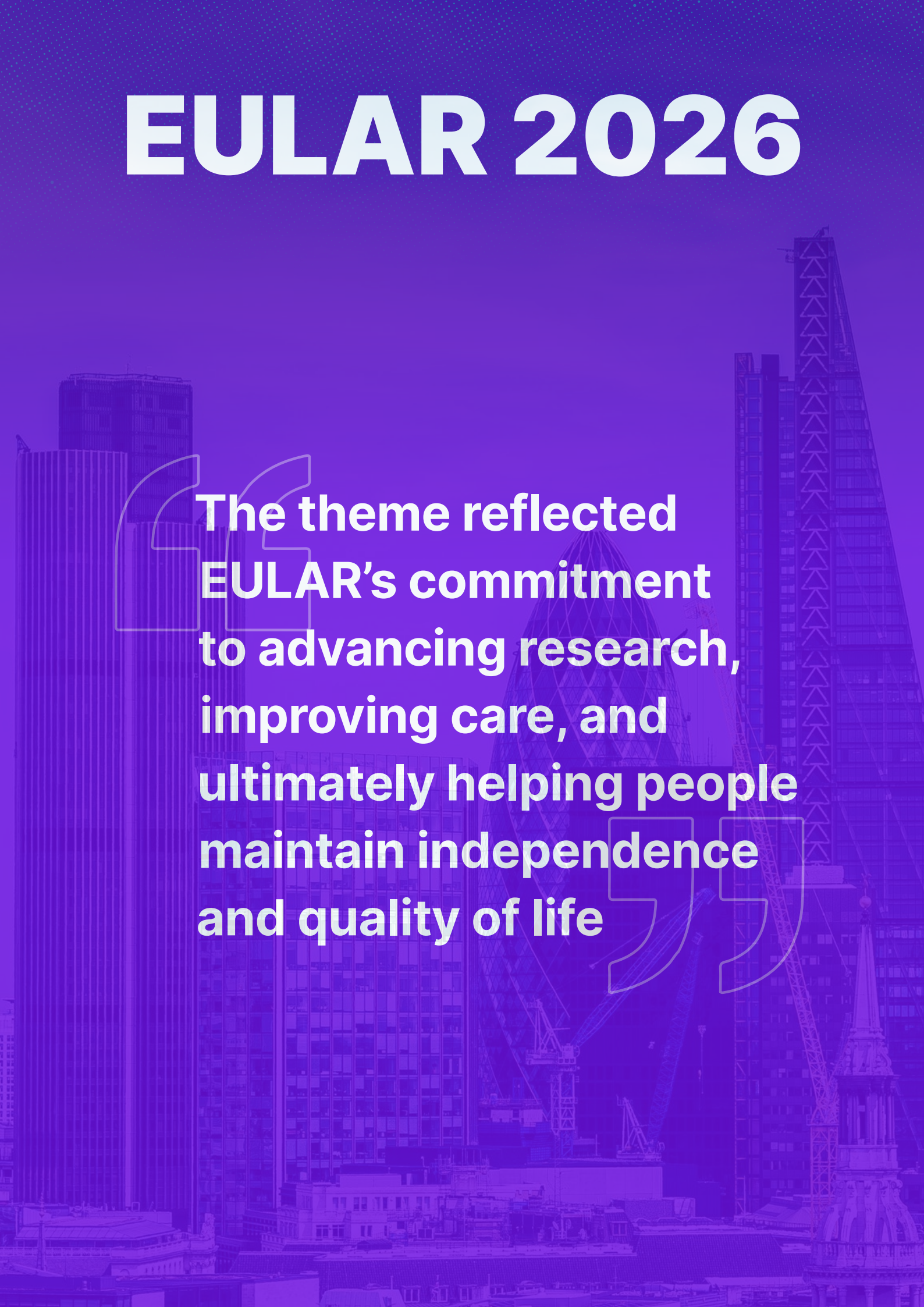
EULAR 2026



The theme reflected EULAR's commitment to advancing research, improving care, and ultimately helping people maintain independence and quality of life

Congress Review

Review of the European Alliance of Associations for Rheumatology (EULAR) 2026 Congress

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THE EUROPEAN Alliance of Associations for Rheumatology (EULAR) Congress 2026 opened in London, UK, under the theme 'United in Motion', bringing together a record-breaking 14,100 delegates from 120 countries. Featuring 190 scientific sessions and approximately 7,500 abstract submissions, the Congress once again demonstrated the scale and global reach of the rheumatology community.

The opening ceremony centred on the importance of movement for people living with rheumatic and musculoskeletal diseases (RMD). While mobility is often taken for granted, speakers emphasised that for many patients it can be significantly impacted by disease. The theme reflected EULAR's commitment to advancing research, improving care, and ultimately helping people maintain independence and quality of life.

A key focus of the ceremony was collaboration. EULAR highlighted the contributions of its diverse community, including healthcare professionals, researchers, trainees, and people living with RMDs. Speakers underscored the importance of ensuring that patient perspectives remain central to research, education, and clinical practice, with patient involvement continuing to play an increasingly important role in shaping future priorities.

Several major organisational initiatives were showcased. MyEULAR, launched in 2025, has already attracted more than 20,000 users worldwide and continues to expand as a digital platform, bringing together educational resources, research content, networking opportunities, and congress materials. Delegates were also encouraged to explore the growing EULAR Content Library, which aims to improve access to educational resources throughout the year.

Addressing inequalities in care was another major theme. The first phase of the RheumaFacts initiative, led by Laure Gossec, EULAR President-Elect, has collected data from 36 countries to provide a clearer picture of rheumatology services across Europe. Early findings have identified important disparities in access to specialist care and support services, providing evidence to inform future advocacy and policy efforts.

EULAR also announced several new initiatives designed to support education and global equity. The newly launched European Certificate of Rheumatology aims to help standardise specialist training through an online examination developed for rheumatology trainees and fellows. Meanwhile, the EULAR Equity Fund, established to improve access to rheumatology care worldwide, received 53 applications from 36 countries during its inaugural funding round, reflecting strong international engagement with the programme.

As delegates prepared for several days of scientific presentations, educational sessions, and networking opportunities, the opening ceremony reinforced EULAR's vision of a global community working together to advance rheumatology. By combining scientific excellence with education, patient partnership, and a commitment to reducing healthcare inequalities, EULAR 2026 set the stage for a congress focused not only on innovation but also on meaningful impact for people living with RMDs.

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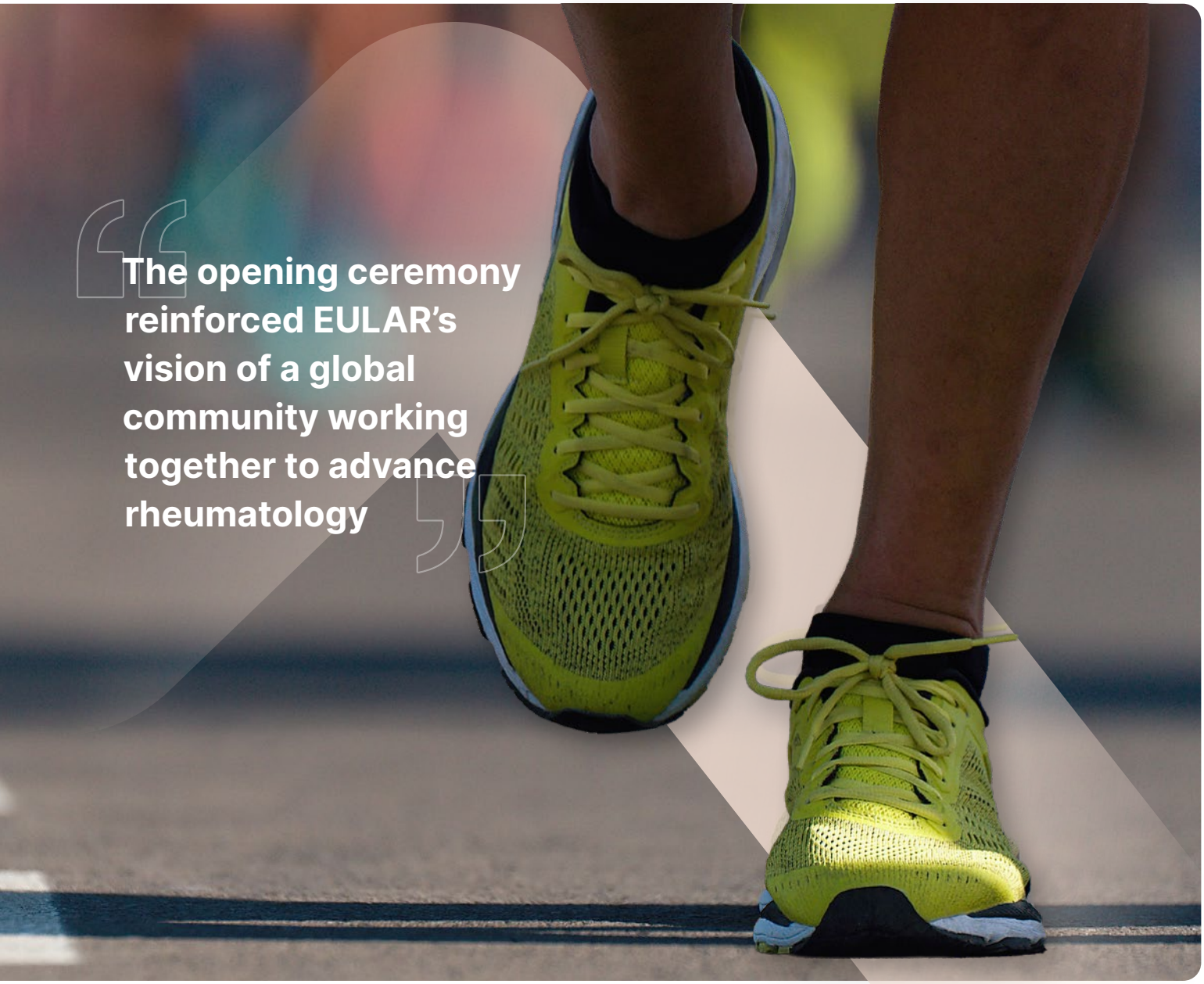


Guideline-Based AI Chatbots Show Promise for Patient Education in Rheumatology

DISEASE-SPECIFIC AI chatbots may help people with rheumatic and musculoskeletal diseases access reliable health information and reduce reliance on general internet searches, according to research presented at EULAR 2026.[1]

Health literacy plays a crucial role in disease management and outcomes for people living with rheumatic and musculoskeletal diseases. However, patients often face challenges when seeking information about their condition, treatment options, and long-term prognosis. While online searches can provide quick answers, the quality and accuracy of information vary considerably, creating a need for trustworthy and accessible educational resources.

To address this gap, the authors developed 10 disease-specific AI chatbots based on established German rheumatology clinical guidelines. The chatbots were promoted through patient organisations and rheumatologists, allowing users to ask disease-related questions and provide feedback on the responses received.

During the first 4 months of implementation, the platform recorded 5,131 chatbot interactions across 1,312 individual sessions. Direct feedback was submitted for 2,165 responses, with 92.9% receiving positive ratings and only 7.1% receiving negative ratings.

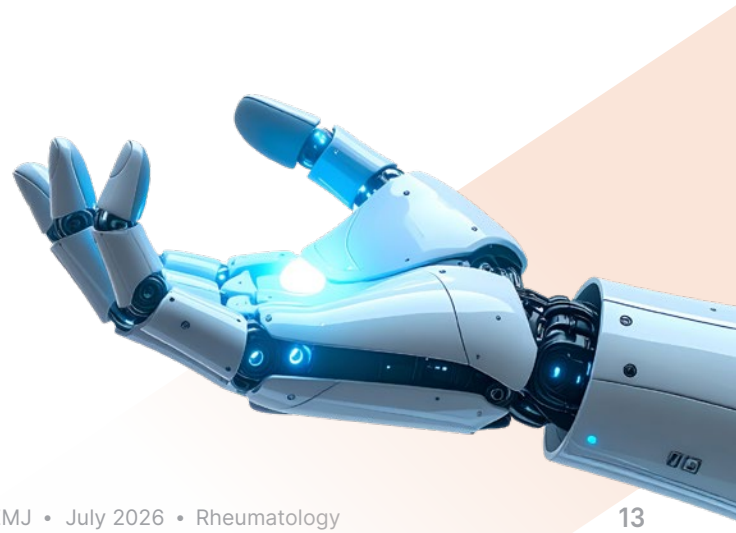
A separate evaluation questionnaire was completed by 520 users, of whom 94% reported having a diagnosed rheumatic disease. The most common conditions represented were rheumatoid arthritis, axial spondyloarthritis, and systemic lupus erythematosus. Although 41% of participants had previously used AI tools to seek health information, the new guideline-based chatbots were particularly well received.

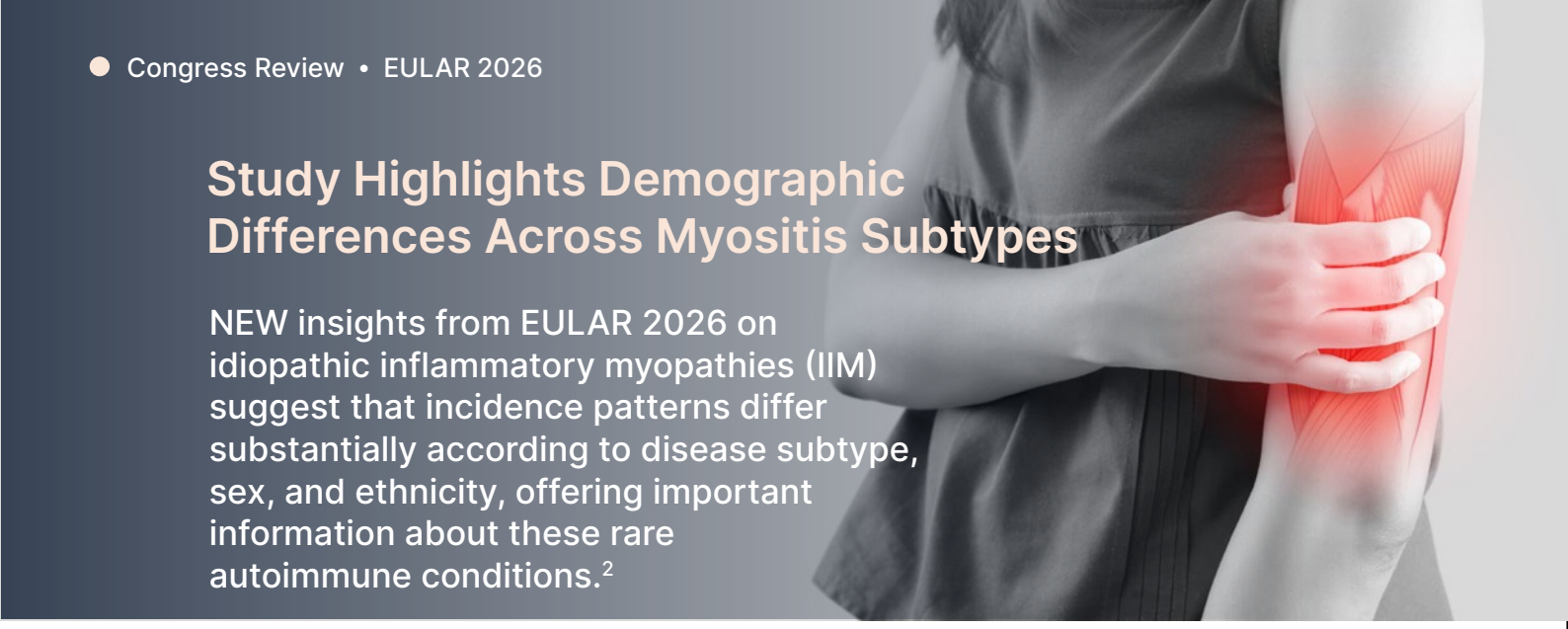
Overall, 86% of respondents strongly agreed that the chatbot was easy to use and that the information provided was easy to understand. Most users considered the tool a valuable addition to existing patient education materials, and, notably, 58% reported preferring the chatbot over general internet searches when seeking disease-related information.

The findings suggest that AI tools grounded in evidence-based clinical guidelines may offer a practical way to improve patient access to reliable information while reducing the challenges associated with interpreting complex medical resources independently.

Presenting the findings at the Congress, the investigators highlighted the strong levels of usability, trust, and perceived usefulness demonstrated by users. The positive response suggests that carefully designed AI tools could play an increasingly important role in supporting patient education and empowering individuals to make informed decisions about their care.

As interest in digital health solutions continues to grow, the study provides early evidence that guideline-based AI chatbots may complement traditional educational resources and help bridge existing gaps in patient information delivery within rheumatology.





Study Highlights Demographic Differences Across Myositis Subtypes

NEW insights from EULAR 2026 on idiopathic inflammatory myopathies (IIM) suggest that incidence patterns differ substantially according to disease subtype, sex, and ethnicity, offering important information about these rare autoimmune conditions.[2]

IIMs are a heterogeneous group of autoimmune conditions characterised by inflammation and damage to skeletal muscle, associated with substantial morbidity. Despite the introduction of EULAR and American College of Rheumatology (ACR) classification criteria in 2017, contemporary population-based data on individual IIM subtypes remain limited.

Researchers from the UK conducted a large-scale epidemiological analysis of dermatomyositis, inclusion body myositis and other IIMs. The study identified 4,105 people with one of these conditions over a 19-year period. Among those classified as having other IIMs, 54.2% had polymyositis.

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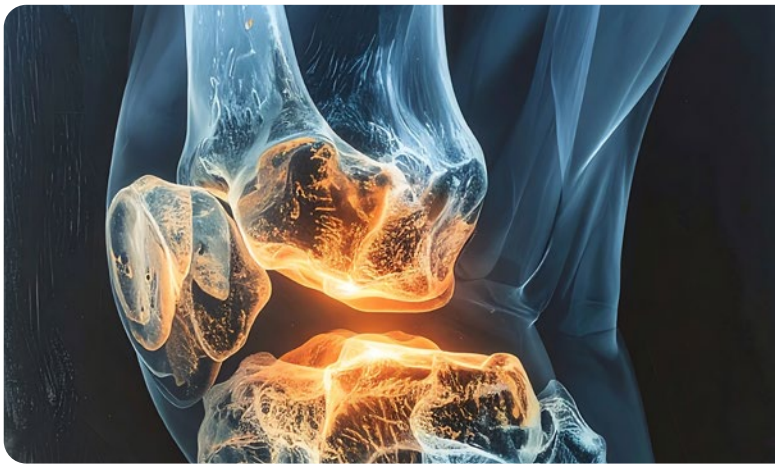
The analysis showed that the incidence of all three subtypes increased substantially during the study period. However, while crude incidence rose over time, age-standardised rates remained broadly stable, suggesting that population ageing may be driving the increase rather than a true rise in disease occurrence.

Distinct differences emerged across demographic groups. Female patients experienced a higher incidence of dermatomyositis and other IIMs, whereas inclusion body myositis was more common among males. Ethnicity was also associated with important variations in disease incidence. Compared with people of White ethnicity, those of South Asian, Black, and unknown ethnicity had a greater incidence of dermatomyositis. Similarly, the incidence of other IIMs was higher among South Asian, Black, and mixed ethnic groups.

The findings provide much-needed insight into myositis patterns across diverse populations, helping to address longstanding gaps in epidemiological evidence. The recorded incidence of inclusion body myositis was lower in the most deprived populations than in the least deprived. However, researchers noted that it remains unclear whether this reflects genuine differences in disease occurrence or disparities in diagnosis, detection, and access to care.

Researchers describe the study as the first population-based study to characterise the epidemiology of IIM subtypes across key sociodemographic groups. The research highlights the need for further investigation into potential barriers to diagnosis and management. Future studies could help determine whether observed differences reflect biological factors, healthcare inequalities, or a combination of both.

AI Imaging Tools Show Promise in Rheumatoid Arthritis Care



AI-DRIVEN imaging technologies demonstrated strong potential to improve the diagnosis, monitoring, and assessment of inflammatory arthritis, according to research presented at EULAR 2026.[3]

Accurate assessment of disease activity and structural damage remains a cornerstone of rheumatoid arthritis management. However, conventional imaging techniques often require expert interpretation and can be time-consuming, particularly when analysing large datasets. Several studies presented at the Congress explored how AI-based approaches could support clinicians by providing faster, more objective image analysis.

One study evaluated RADAR (RADAR, New York, USA), an AI algorithm developed to assess radiographic progression in rheumatoid arthritis. The model was initially trained and validated using data from the BCD cohort, comprising 7,560 hand and foot joints, before being tested in the ESPOIR cohort, a 20-year collection of X-rays. When evaluated using high-quality radiographs, the system achieved an estimated accuracy of 0.95, sensitivity of 0.93, and specificity of 0.99, demonstrating its ability to analyse large volumes of radiographic data efficiently.

Researchers also presented findings from ADMIRA, an automated deep learning-based MRI analysis system designed for patients with early inflammatory arthritis. The model was trained using visual Rheumatoid Arthritis MRI Scoring system assessments and validated in MRI scans from 180 patients. ADMIRA scores for total inflammation, synovitis, tenosynovitis, and osteitis showed good to excellent agreement with conventional visual scoring, supporting its validity as an automated assessment tool.

Ultrasound-based approaches also demonstrated encouraging results. A multivariable diagnostic model integrating musculoskeletal ultrasound findings with clinical variables achieved high diagnostic accuracy and exceptional negative predictive value across inflammatory rheumatic and musculoskeletal diseases. Investigators suggested that this targeted approach could help reduce unnecessary treatment by improving diagnostic precision in patients with suspected arthritis.

Additional research evaluated AI-assisted thermography as a non-invasive method of detecting joint inflammation. Analysis of 200 dorsal hand images from 100 patients showed that CatBoost (Yandex, Moscow, Russia) consistently outperformed other algorithms, achieving the highest levels of accuracy, sensitivity, specificity, and precision for identifying inflamed joints.

Finally, optical spectral transmission imaging was shown to correlate significantly with clinical measures of inflammatory arthritis activity. In a longitudinal analysis involving 60 patients and 1,312 wrist and finger joint assessments, optical spectral transmission scores reflected changes in disease activity over time, suggesting potential utility for long-term monitoring.

Although further validation in larger populations is required, these studies highlight the growing role of AI in rheumatology. By improving efficiency, standardisation, and diagnostic accuracy, AI-assisted imaging may help support earlier diagnosis and more effective monitoring of patients with inflammatory arthritis.

Cardiac Involvement Emerges Early in SSc

PRIMARY cardiac involvement (pCI) affects a notable minority of patients with early systemic sclerosis (SSc) and is associated with a higher-risk clinical profile, according to findings from the SOLAR registry presented at EULAR 2026.[4]

Cardiac disease is a major driver of morbidity and mortality in SSc, yet early manifestations can be difficult to detect in routine clinical practice. Researchers analysed baseline data from 372 patients enrolled in the SOLAR registry, all of whom met the 2013 American College of Rheumatology (ACR)/EULAR classification criteria and had a disease duration of 3 years or less. pCI, defined as myocardial, pericardial, coronary, or conduction system abnormalities attributable to SSc, was identified in 24 patients (6.5%) at baseline. Coronary artery disease was the most commonly reported manifestation, while heart failure and pericardial effusion were rare. Most affected patients were female, and those with pCI tended to be older than patients without cardiac involvement.

The study found several clinical features associated with an increased likelihood of pCI. Patients with diffuse cutaneous SSc were significantly more likely to have pCI than those with limited cutaneous disease, while the latter was associated with a lower risk.[4] Myositis, pulmonary arterial hypertension, overlap syndrome, and hypertension were all more prevalent among patients with cardiac involvement. In multivariable analyses, pulmonary arterial hypertension emerged as the strongest associated factor, increasing the odds of pCI more than 15-fold. Myositis, overlap syndrome, diffuse skin involvement, and older age were also independently associated with a higher risk. Although interstitial lung disease and diabetes were numerically more common in the pCI group, these differences did not reach statistical significance.

Longitudinal follow-up highlighted the dynamic nature of cardiac disease in SSc. Among 275 patients who were free from pCI at baseline and had follow-up data available, six developed incident cardiac involvement during subsequent visits, representing 2.2% of the cohort. Overall, 30 patients (8.1%) had pCI documented at least once during the first four registry visits. These findings suggest that a single baseline assessment may fail to identify evolving cardiac abnormalities, particularly in patients with multisystem disease or established risk factors.

The SOLAR data indicate that pCI is uncommon but clinically significant in early SSc. The authors suggest that structured and repeated cardiac screening may improve detection and support earlier intervention in high-risk patients.

Towards Earlier and More Precise Systemic Sclerosis Disease Monitoring

SYSTEMIC SCLEROSIS (SSc) continues to present a major challenge in clinical management and trial design due to its marked heterogeneity, variable organ trajectories, and evolving disease burden. New data presented at EULAR 2026 highlight the clinical relevance of early disease activity assessment and the need for more standardised outcome measures in SSc. Findings from two presentations explored how improved stratification and reporting frameworks could strengthen evaluation of disease progression and therapeutic outcomes.[5,6]

An oral abstract presentation from Santiago et al.[5] reported findings from a longitudinal observational analysis of the EUSTAR database, a large multicentre registry prospectively following more than 25,000 patients across more than 200 international centres. The study assessed whether baseline disease activity, measured using the modified disease activity index (mDAI), could help predict subsequent organ involvement and disease progression.

Of the 3,214 patients included, 59.1% had inactive disease at baseline (<2.5 mDAI), with patients with active disease (>2.5 mDAI) demonstrating a higher 1-year cumulative incidence of organ-specific and multi-system involvement. This included skin progression, digital ulcers/gangrene, interstitial lung disease, and cardiac involvement. Active disease was also associated with shorter time to clinical events and greater use of immunosuppressive therapies, biologics, and antifibrotic agents. Together, this study underscores the importance of early disease activity monitoring.

A presentation by Campochiaro et al.[6] examined reporting standards for digital ulcer studies, an area where inconsistent definitions and outcome assessments remain a challenge. Developed by the World Scleroderma Foundation (WSF) digital ulcer committee, the recommendations identified seven core domains for clinical trials, including ulcer classification, eligibility criteria, healing outcomes, patient-reported outcomes, background therapies, and long-term recurrence monitoring.

The framework emphasises the importance of standardising local wound care protocols, clearly defining assessment timepoints, and incorporating environmental and seasonal variables. Collectively, these considerations aim to reduce inter-study variability and improve the robustness, reproducibility, and interpretability of trial outcomes in digital ulcer research.

Taken together, the two presentations reinforce a broader shift in SSc research towards earlier and more precise disease characterisation, alongside improved methodological consistency in outcome reporting. Future research may further clarify how early disease activity indices, such as the mDAI, can be integrated into trial design and routine clinical assessment, potentially supporting more targeted treatment strategies and improved longitudinal disease monitoring in SSc.

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Studies Highlight Challenges of Long-Term Glucocorticoid Use in Vasculitis

NEW RESEARCH presented at EULAR 2026 has raised questions about the role of ongoing low-dose glucocorticoid therapy in vasculitis, with findings suggesting limited benefit in anti-neutrophil cytoplasmic antibody-associated vasculitis (AAV) and identifying a subgroup of patients with difficult-to-treat giant cell arteritis (GCA) who remain dependent on glucocorticoids despite treatment escalation.[7,8]

In an oral presentation, Chavatza et al.[7] evaluated the impact of low-dose glucocorticoids during maintenance treatment in AAV. The study included 171 patients receiving maintenance therapy at three referral centres in Greece, with a median follow-up of just over 7 years.[7]

During follow-up, 65 major flares occurred in 48 patients, corresponding to an incidence rate of 8.1 per 100 patient-years. Rituximab use was associated with a lower risk of major flares, while higher disease activity at diagnosis was linked to an increased risk. Importantly, concomitant glucocorticoid use at doses below 7.5 mg/day did not reduce the risk of major flares. However, low-dose glucocorticoid exposure was associated with increased risks of chronic damage accumulation and hospitalisation.

The investigators concluded that low-dose glucocorticoids did not reduce the risk of major flares during maintenance therapy but were associated with increased risks of chronic damage accumulation and hospitalisation, supporting earlier glucocorticoid withdrawal following remission.

A separate poster presentation by Dhrif et al.[8] proposed the first definition of difficult-to-treat GCA using data from 546 patients in the French Large Vessel Vasculitis Study Group cohort. Patients included in the analysis had at least 24 months of follow-up and comprehensive documentation of glucocorticoid dosing and relapse history.

The proposed definition incorporates three criteria: ongoing disease activity preventing withdrawal of at least one immunosuppressive therapy after 24 months, inability to taper glucocorticoid dosage below 5 mg/day because of persistent disease activity, and the occurrence of at least two relapses during follow-up.

Using this definition, difficult-to-treat disease was identified in 9.7% of patients. This subgroup was characterised by predominant large-vessel involvement, a higher proportion of female patients, and greater difficulty reducing glucocorticoid treatment beyond 6 months. At Month 24, patients with difficult-to-treat disease required a mean maintenance glucocorticoid dose of 8.8 mg/day compared with 2.68 mg/day in those without difficult-to-treat GCA. Glucocorticoid dosage at Month 6 was also found to predict progression to difficult-to-treat disease among women with large-vessel vasculitis.

The authors noted that the proposed definition captures key unmet needs in GCA, including recurrent relapses and insufficient glucocorticoid sparing, and may help identify patients who could benefit from earlier treatment optimisation. They emphasised that the predictive model requires validation in independent cohorts.

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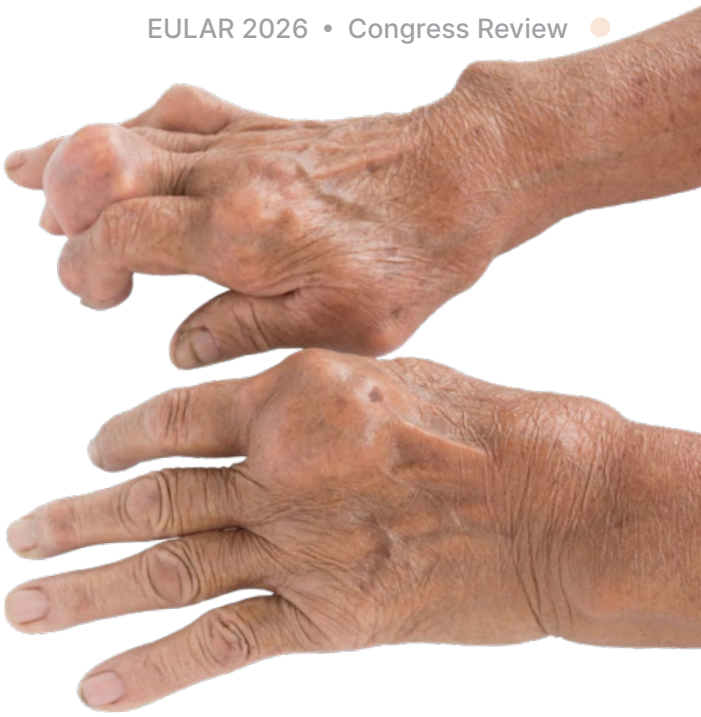
ULT Continuation Lowers Gout Flares and Cardiometabolic Risk



At EULAR 2026, new data challenged and refined contemporary thinking in gout management while also providing mechanistic insight into how body composition may influence risk across gout and rheumatoid arthritis (RA), with implications for cardiometabolic disease.[9,10]

Researchers carried out a pragmatic, open-label, randomised superiority trial from nine rheumatology centres in the Netherlands evaluating treat-to-target (T2T) urate-lowering therapy (ULT) continuation versus a structured attempt at discontinuation in patients with gout in remission.[9] Current guidelines recommend lifelong ULT with a T2T approach, but real-world adherence is variable, and discontinuation is common, reflecting uncertainty about the necessity of indefinite therapy in sustained remission.

Over 24 months, continued T2T ULT demonstrated more durable disease control. During the final 6-month follow-up period, remission criteria were met in 79.2% of patients continuing ULT compared with 62.9% in those attempting discontinuation. Across the full study period, cumulative flare incidence was substantially lower with continued therapy (12.3% versus 31.8%). In the discontinuation arm, nearly a quarter of patients required re-initiation of ULT after a median of 392 days, and more anti-inflammatory medication was needed overall. A modest renal benefit was also observed in the continuation group. Notably, while a substantial proportion of patients maintained remission off therapy, the findings support continued T2T ULT at a population level and provide a foundation for shared decision-making, particularly in balancing long-term flare prevention against potential treatment minimisation strategies.

In parallel, a large imaging-based analysis from the UK Biobank examined the relationship between adiposity distribution, muscle composition, and risk of gout and RA.[10] Using MRI data from individuals with gout (n=281), RA (n=308), and matched controls, the study demonstrated distinct patterns of body composition. Gout was characterised by increased visceral, hepatic, and intramuscular fat, while RA showed greater fat infiltration within muscle tissue. These metabolically adverse patterns were associated with increased risk of Type 2 diabetes and coronary heart disease.

Prospective analyses further showed that higher visceral and ectopic fat, alongside lower subcutaneous fat, increased the risk of incident gout, while increased intramuscular fat with reduced muscle volume was associated with future RA development. The findings support a model in which abnormal fat distribution and impaired muscle quality contribute to systemic inflammation and cardiometabolic risk in rheumatic disease.

Together, these studies reinforce the importance of sustained urate control in gout and highlight metabolic health as a shared therapeutic target across inflammatory arthritis.

79.2%

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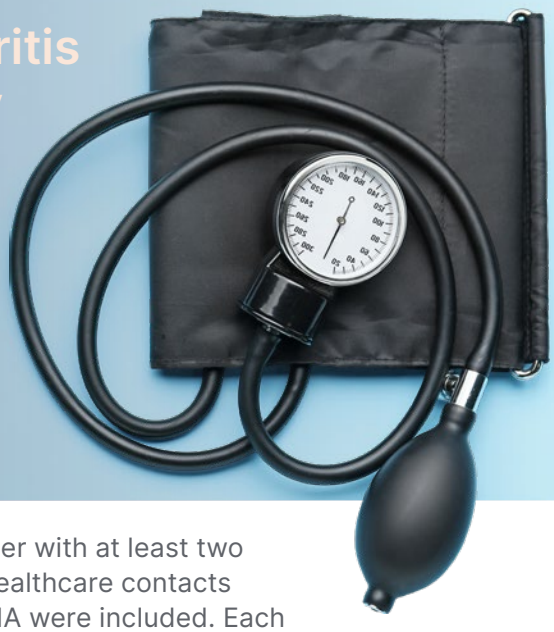
Adult Juvenile Idiopathic Arthritis Linked to Greater Comorbidity Burden in Norway

ADULTS with juvenile idiopathic arthritis (JIA) may face a higher burden of cardiovascular, kidney, and autoimmune conditions, according to a large population-based study in Norway presented at EULAR 2026.[11]



JIA is a chronic autoimmune disease that begins in childhood and causes persistent joint inflammation, with effects that can extend into adulthood.

Researchers compared 2,932 adults with JIA with 29,097 matched members of the general population to assess long-term health outcomes. The findings suggest that adults living with JIA experience a broader range of health complications than their peers, highlighting the importance of monitoring comorbidities in adults with JIA.

Compared with matched comparators, adults with JIA showed higher rates of several cardiovascular and metabolic conditions. These included hypertension (3.6% versus 1.4%; p<0.001), other ischaemic heart disease excluding myocardial infarction (1.0% versus 0.6%; p=0.01), and chronic kidney disease (0.5% versus 0.2%; p<0.001). The prevalence of autoimmune conditions was also higher, including Type 1 diabetes (1.7% versus 0.7%; p<0.001) and coeliac disease (1.4% versus 0.7%; p<0.001). These findings support the view that the effects of JIA may extend beyond the musculoskeletal system and persist throughout adulthood.

The study analysed data from the mandatory Norwegian Patient Registry between 2009–2024. Adults aged 18 years or older with at least two specialist healthcare contacts coded for JIA were included. Each participant was matched by age, sex, and county of residence to 10 individuals from the general population. Researchers assessed 5-year retrospective comorbidity prevalence and prospectively examined all-cause mortality.

Integrated care may help address long-term health risks in JIA, including cardiovascular and autoimmune conditions. The study also found higher all-cause mortality among adults with JIA, with mortality rates of 2.4 compared with 1.8 per 1,000 person-years in matched comparators.

However, the study was observational and designed to identify associations rather than establish cause and effect. In addition, recent exposure to disease-modifying anti-rheumatic drugs was not associated with differences in comorbidity prevalence or all-cause mortality within the JIA cohort.

The findings reinforce the need for lifelong monitoring after childhood disease. The authors concluded that adults with JIA may benefit from integrated care approaches that consider both inflammatory disease activity and wider health risks throughout adulthood.

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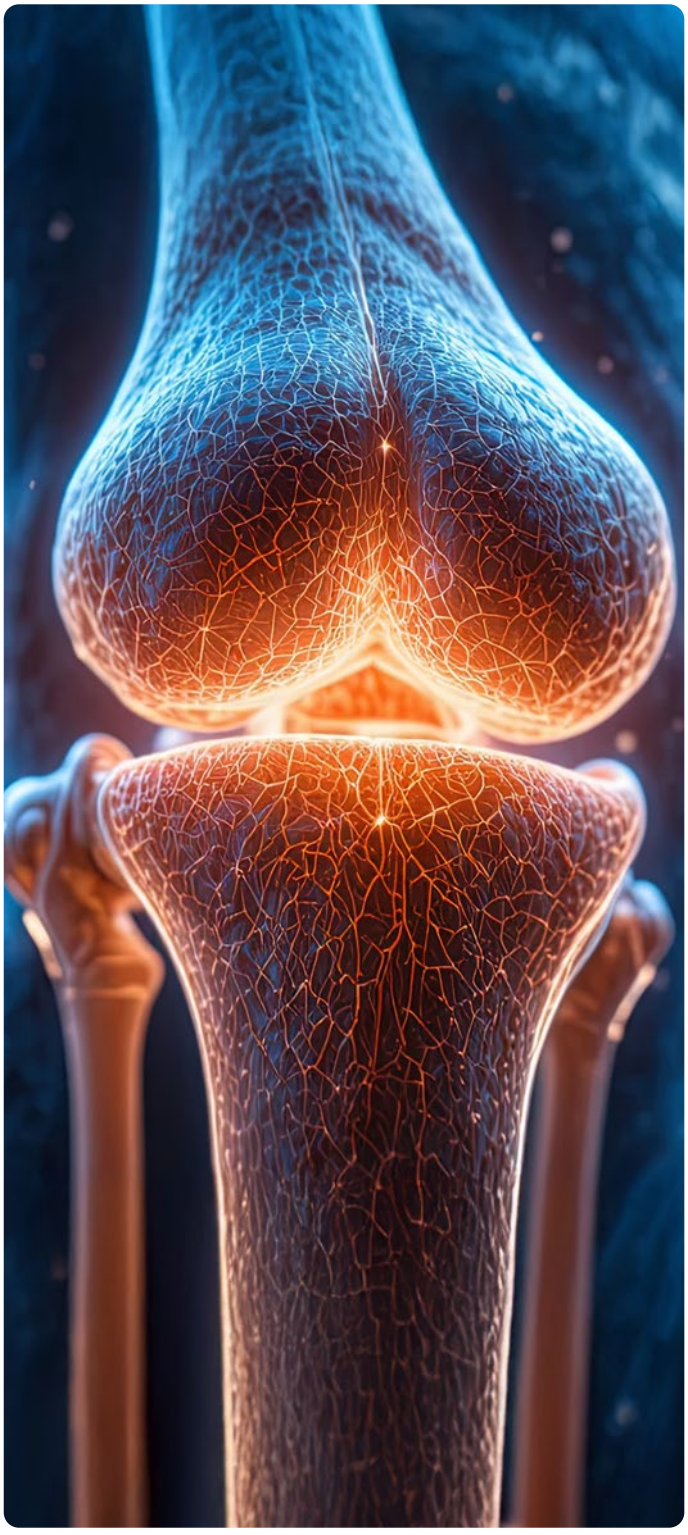
Real-World Evidence Highlights Gaps and Opportunities in Rheumatology Care

REAL-WORLD evidence is providing important insights into treatment implementation, weight management, lung disease detection, and smoking patterns among patients with rheumatic and musculoskeletal diseases, according to research presented at EULAR 2026.[12-15]



Observational data are increasingly complementing findings from RCTs and helping clinicians understand how recommendations are applied in routine practice. One study from Italy[12] evaluated adherence to a treat-to-target strategy across 1,494 outpatient visits involving patients with rheumatoid arthritis, psoriatic arthritis, and spondyloarthritis.

The analysis found that adherence was suboptimal overall and was markedly lower among patients with spondyloarthritis, where adherence reached only 40%, compared with more than 70% in rheumatoid arthritis and psoriatic arthritis. The principal barrier to implementation was the absence of documented disease activity assessments using validated indices. This accounted for approximately 90% of non-adherence cases. A smaller proportion resulted from failure to adjust treatment according to disease activity findings.

> **The analysis found that adherence was suboptimal overall and was markedly lower among patients with spondyloarthritis**

Researchers also identified factors associated with better adherence. Treatment with targeted synthetic or biologic disease-modifying antirheumatic drugs was linked to improved implementation across all disease groups, while younger age was associated with adherence in rheumatoid arthritis and spondyloarthritis.

The second study[13] examined glucagon-like peptide 1 receptor agonist use in more than 60,000 patients with rheumatic and musculoskeletal diseases. Data were analysed from individuals receiving semaglutide or tirzepatide, with a mean baseline BMI of 36.3 kg/m^2, and approximately two-thirds had diabetes.

Across all disease cohorts, weight-loss use was most common among patients with psoriatic arthritis, followed by ankylosing spondylitis and rheumatoid arthritis. At 12 months, non-diabetic users of tirzepatide lost 8% of baseline body weight compared with 6% among semaglutide users. A similar pattern was observed in individuals with diabetes, although overall weight loss was lower. Weight reduction plateaued after 12 months.

Further real-world evidence emerged from the international ANCHOR-RA study,[14] which enrolled 1,169 patients with rheumatoid arthritis who had at least two risk factors for interstitial lung disease but no known diagnosis. Investigators found that 9.1% had previously undiagnosed interstitial lung disease.

Factors associated with interstitial lung disease included older age, male sex, greater tobacco exposure, higher rheumatoid arthritis disease activity, lower oxygen saturation, abnormal lung diffusion findings, crackles on auscultation, and the *MUC5B* promoter variant.

Separately, an analysis[15] of 5,523 registry visits from Switzerland demonstrated a decline in current smoking prevalence among patients with rheumatoid arthritis between 2012–2022. However, lifetime smoking exposure increased among men with rheumatoid arthritis over the same period, contrasting with declining rates in the wider population. The findings suggest that smoking prevention efforts may have been less effective among men who later developed rheumatoid arthritis.

Together, these studies demonstrate the growing value of real-world evidence in informing clinical decision-making and identifying opportunities to improve outcomes for patients with rheumatic and musculoskeletal diseases.

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