STRASBOURG
Centre de Référence des maladies auto-immunes systémiques rares Est Sud-Ouest
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Les Hôpitaux Universitaires de STRASBOURG

IHU PACIFIC

Université de Strasbourg

"One year in review" : les (bonnes) actualités de l'année !!!

Spondyloarthrites

Winterschool 2021

Dr Renaud FELTEN, Maître de Conférence Universitaire – Praticien Hospitalier
Service de Rhumatologie / CNR RESO
CIC-P Hautepierre, INSERM 1434, UF 6990
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@DocFelten

Département Universitaire de **Pharmacologie, Addictologie, Toxicologie** et **Thérapeutique** | DUPATT de l'Université de Strasbourg

Liens d’intérêts

- Recherches cliniques : Aucun
- Advisory Boards : AbbVie, BMS, Janssen, Novartis, UCB
- Cours / formations / interventions : ABBVIE, BMS, LILLY, NORDIC, NOVARTIS, MEDAC, MSD, PFIZER, SANOFI, UCB
- Aides pour des recherches : Aucun

Introduction

- Meilleure compréhension de **la physiopathologie**
- De **+ en + de nouveaux traitements** dans les spondyloarthrites

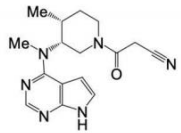
Introduction

- Meilleure compréhension de **la physiopathologie**
- De **+ en + de nouveaux traitements** dans les spondyloarthrites

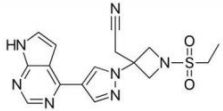
Objectifs :

1. Revoir les différents **mode d'action des nouvelles thérapies ciblées** dans les Spondyloarthrites
2. Donner des trucs et astuces pour le meilleur **choix du traitement ciblé en fonction du patient**

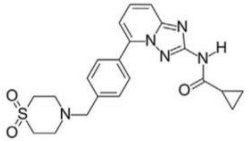
Thérapies ciblées dans les Rhumatismes Inflammatoires



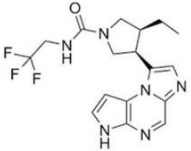
Tofacitinib



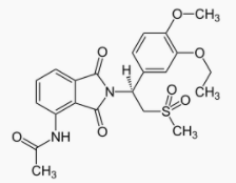
Baricitinib

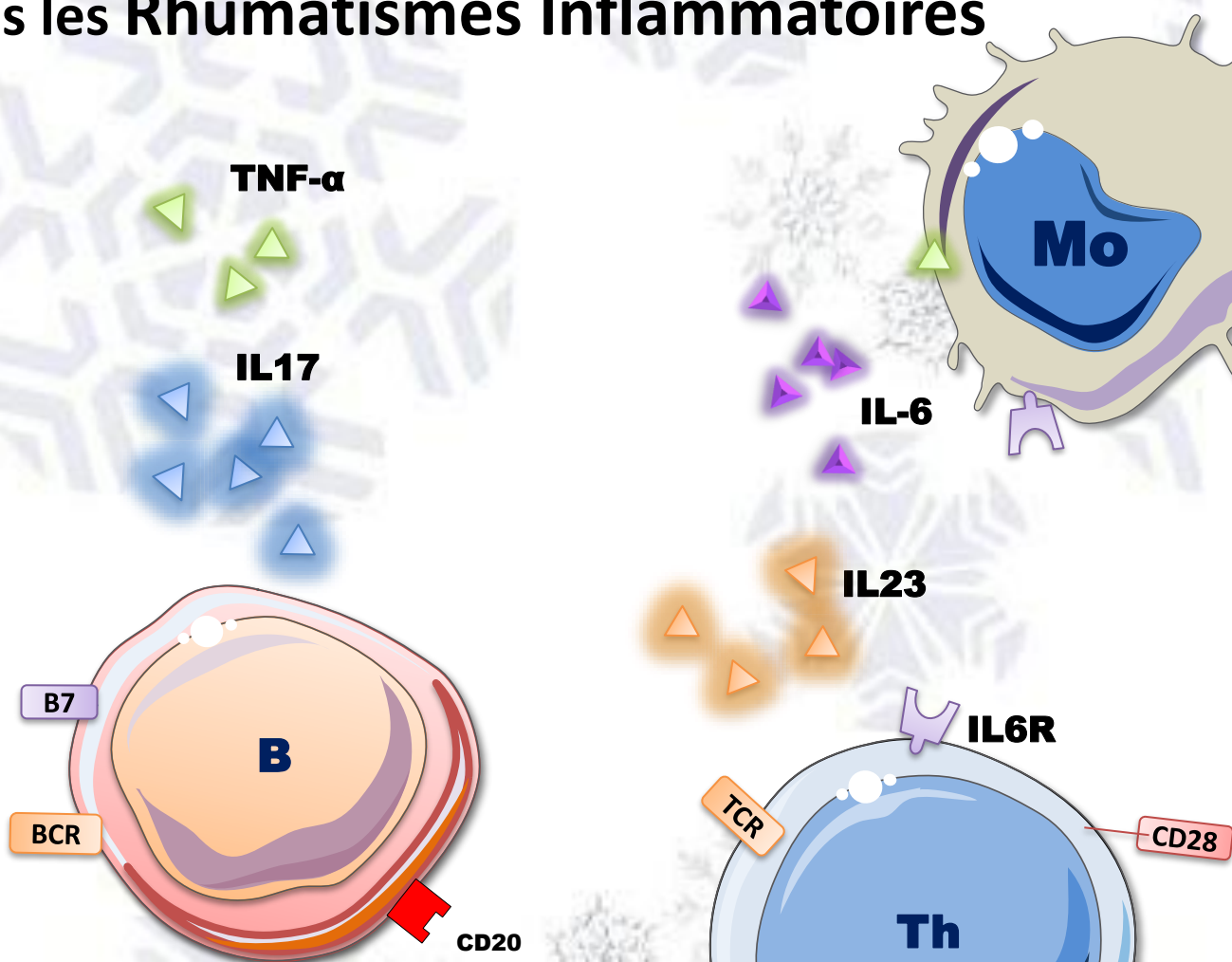


Filgotinib

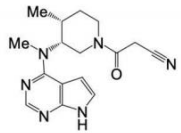


Upadacitinib





Thérapies ciblées dans les Rhumatismes Inflammatoires



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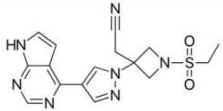
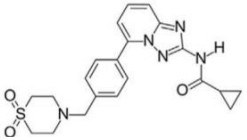
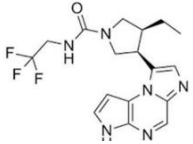


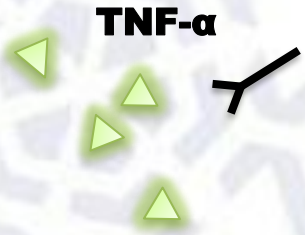
Baricitinib



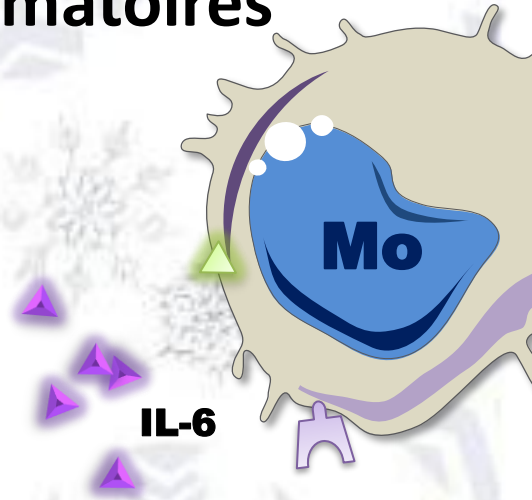
Filgotinib



Upadacitinib

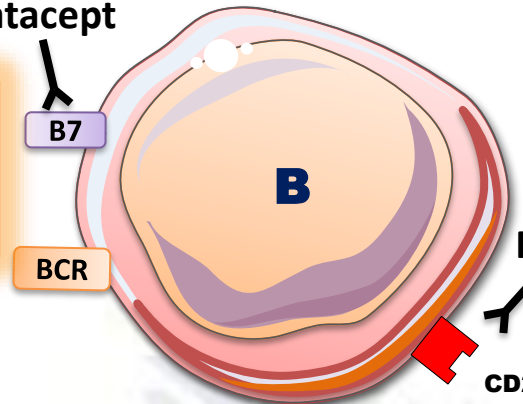


Adalimumab
Etanercept
Infliximab
Certolizumab
Golimumab



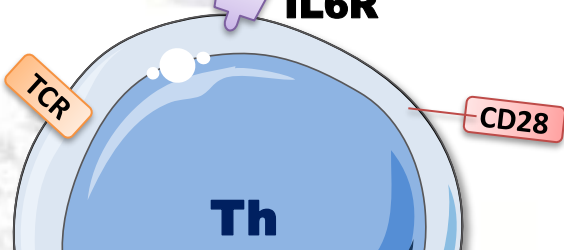
Tocilizumab
Sarilumab

PR :
13 thérapies ciblées*

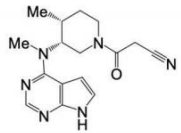


Abatacept

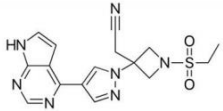
Rituximab



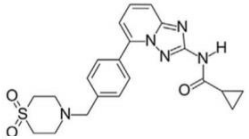
Thérapies ciblées dans les Rhumatismes Inflammatoires



Tofacitinib



~~Baricitinib~~



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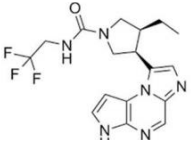
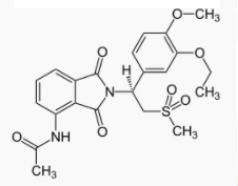


Upadacitinib



Apremilast

Spondyloarthrites : ???

TNF-α

Adalimumab
Etanercept
Infliximab
Certolizumab
Golimumab

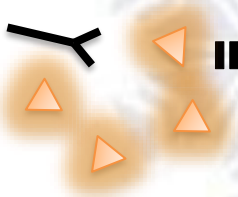
IL17

Secukinumab
Ixékizumab

Mo

IL-6

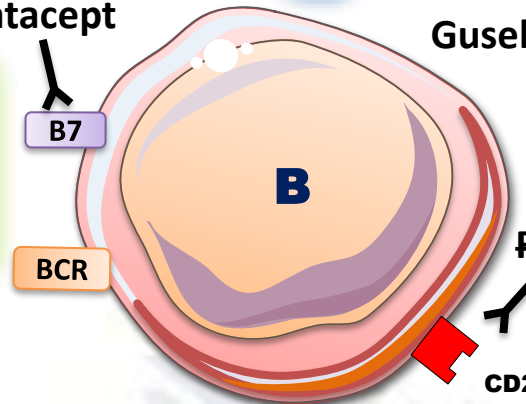
Ustékinumab
Guselkumab



IL23

~~Tocilizumab~~
~~Sarilumab~~

Abatacept



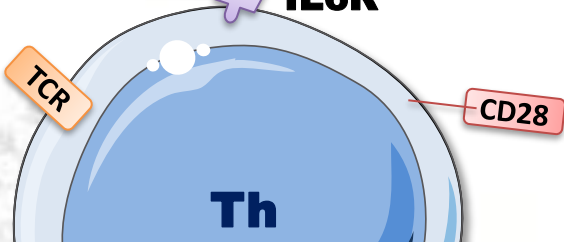
B7

B

BCR

~~Rituximab~~

CD20



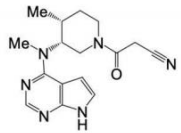
IL6R

TCR

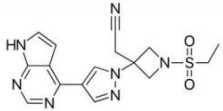
CD28

Th

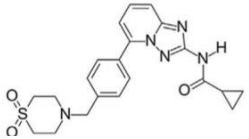
Thérapies ciblées dans les Rhumatismes Inflammatoires



Tofacitinib



~~Baricitinib~~



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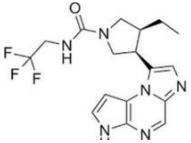
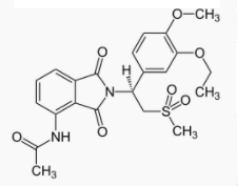


Upadacitinib

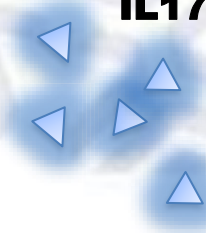


Apremilast

Spondyloarthrites : 13 thérapies ciblées

TNF-α

Adalimumab
Etanercept
Infliximab
Certolizumab
Golimumab



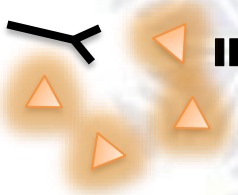
IL17

Secukinumab
Ixékizumab

Mo

IL-6

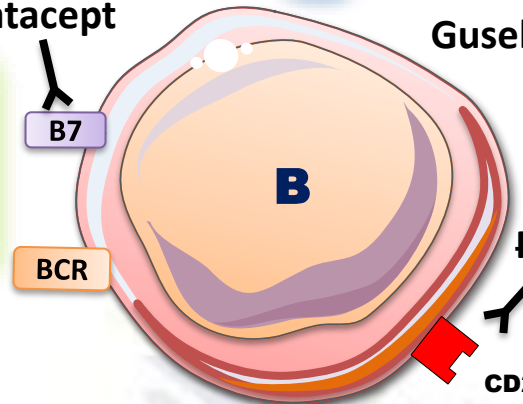
Ustékinumab
Guselkumab



IL23

~~Tocilizumab~~
~~Sarilumab~~

Abatacept



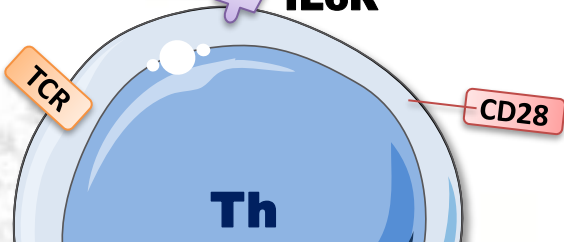
B7

B

BCR

~~Rituximab~~

CD20



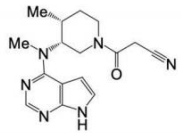
IL6R

TCR

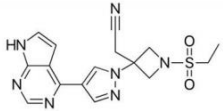
CD28

Th

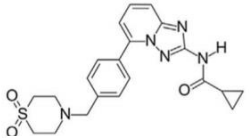
Thérapies ciblées dans les Rhumatismes Inflammatoires



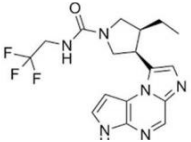
Tofacitinib



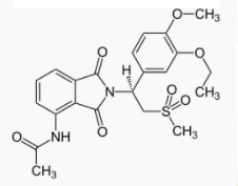
~~Baricitinib~~



~~Filgotinib~~



Upadacitinib

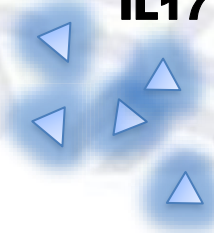


Apremilast

Spondyloarthrites : 13 thérapies ciblées

TNF-α

Adalimumab
Etanercept
Infliximab
Certolizumab
Golimumab



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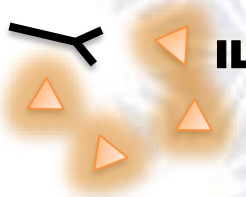
Ixékizumab

Mo

IL-6

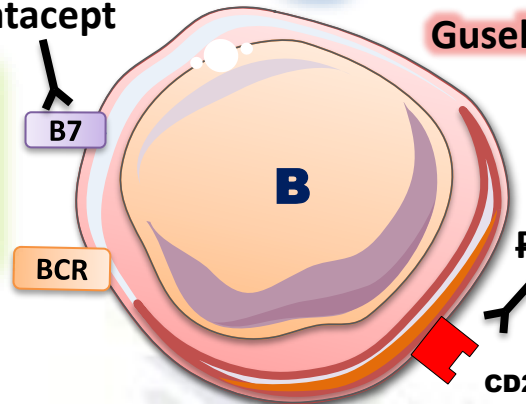
Ustékinumab
Guselkumab



IL23

~~Tocilizumab~~
~~Sarilumab~~

Abatacept



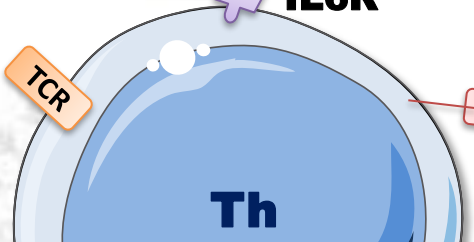
B7

B

BCR

~~Rituximab~~

CD20



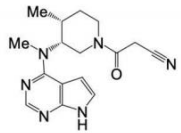
IL6R

TCR

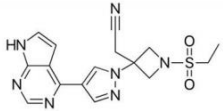
CD28

Th

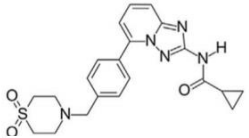
Thérapies ciblées dans les Rhumatismes Inflammatoires



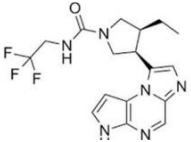
Tofacitinib



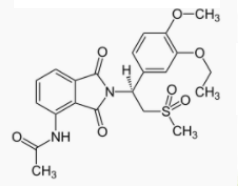
~~Baricitinib~~



~~Filgotinib~~



Upadacitinib



Apremilast

Spondyloarthrites : 13 thérapies ciblées

⇨ **Et bientôt 15 !**

TNF-α

Adalimumab
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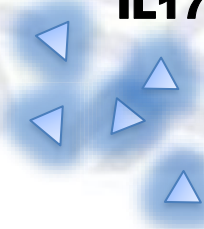
Golimumab



IL17

Secukinumab
Ixékizumab
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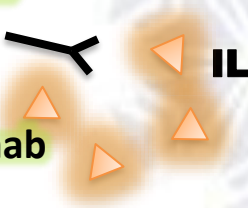
Mo

IL-6

Ustékinumab
Guselkumab
Risankizumab



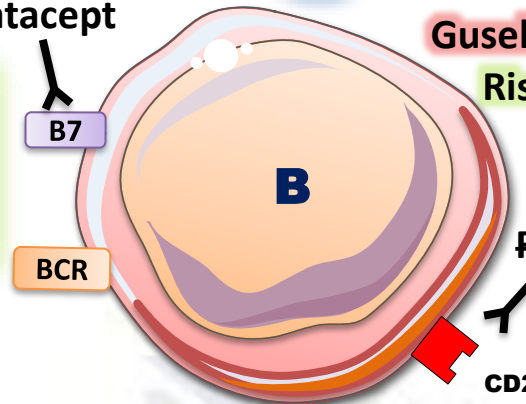
IL23

~~Tocilizumab~~
~~Sarilumab~~

IL6R

Abatacept

B7

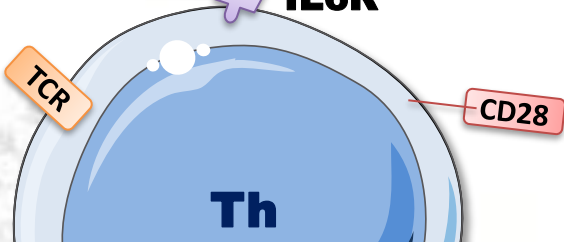


B

BCR

~~Rituximab~~

CD20



TCR

CD28

Th

Arrivée des JAKi dans l'ax-SPA

Spondyloarthritis

Tofacitinib for the treatment of ankylosing spondylitis: a phase III, randomised, double-blind, placebo-controlled study

Atul Deodhar [1], Paula Sliwinska-Stanczyk [2], Huji Xu [3], Xenofon Baraliakos [4], Lianne S Gensler [5], Dona Fleishaker [6] Lisy Wang [6], Joseph Wu [6], Sujatha Menon [6], Cunshan Wang [6], Oluwaseyi Dina [7], Lara Fallon [8], Keith S Kanik [6], Désirée van der Heijde [9]

Correspondence to Professor Atul Deodhar, Division of Arthritis and Rheumatic Diseases, Oregon Health & Science University, 3181 SW Sam Jackson Park Road, Portland, OR 97239-3098, USA; deodhara@ohsu.edu

ARTICLES | VOLUME 394, ISSUE 10214, P2108-2117, DECEMBER 07, 2019

Efficacy and safety of upadacitinib in patients with active ankylosing spondylitis (SELECT-AXIS 1): a multicentre, randomised, double-blind, placebo-controlled, phase 2/3 trial

Prof Désirée van der Heijde, MD • In-Ho Song, MD • Aileen L Pangan, MD • Prof Atul Deodhar, MD • Prof Filip van den Bosch, MD • Prof Walter P Maksymowych, MD • et al. Show all authors

Published: November 12, 2019 • DOI: https://doi.org/10.1016/S0140-6736(19)32534-6 • Check for updates

Arrivée des JAKi dans l'ax-SPA

Spondyloarthritis

Tofacitinib for the treatment of ankylosing spondylitis: a phase III, randomised, double-blind, placebo-controlled study

Atul Deodhar [1], Paula Sliwinska-Stanczyk [2], Huji Xu [3], Xenofon Baraliakos [4], Lianne S Gensler [5], Dona Fleishaker [6]
Lisy Wang
van der He
Correspond
Sam Jackson

En France AMM et remboursement

- Pour l'UPADA pour l'axSPA Rx et RPso
- Pour le TOFA uniquement dans RPso

Efficacy and safety of upadacitinib in patients with active ankylosing spondylitis (SELECT-AXIS 1): a multicentre, randomised, double-blind, placebo-controlled, phase 2/3 trial

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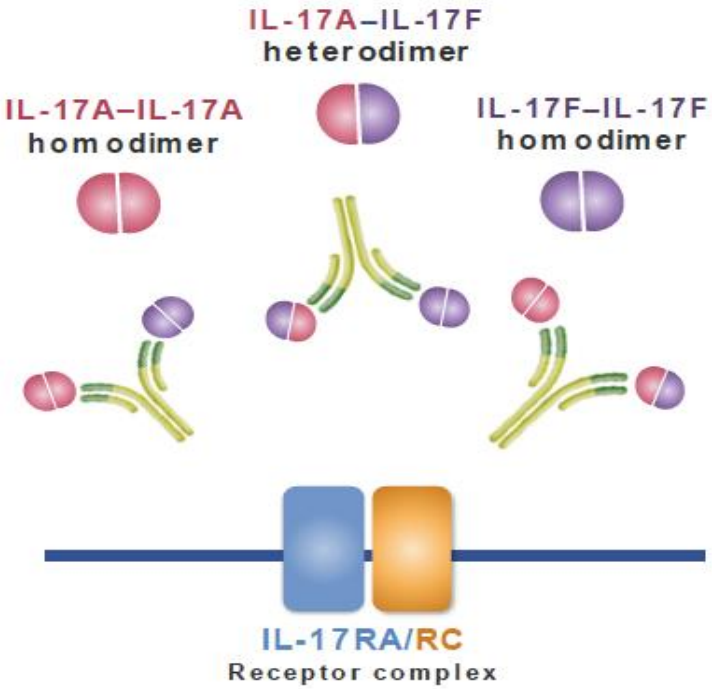
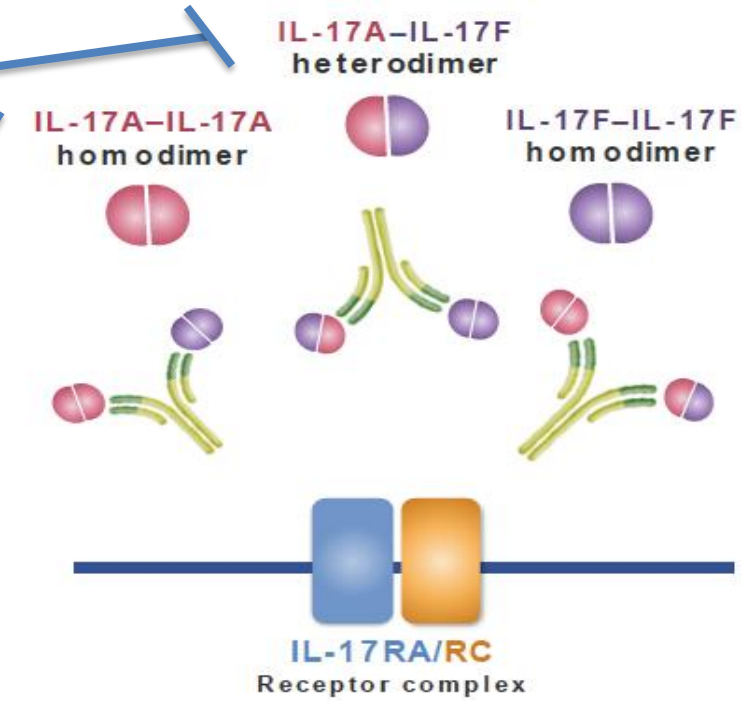
IL17i

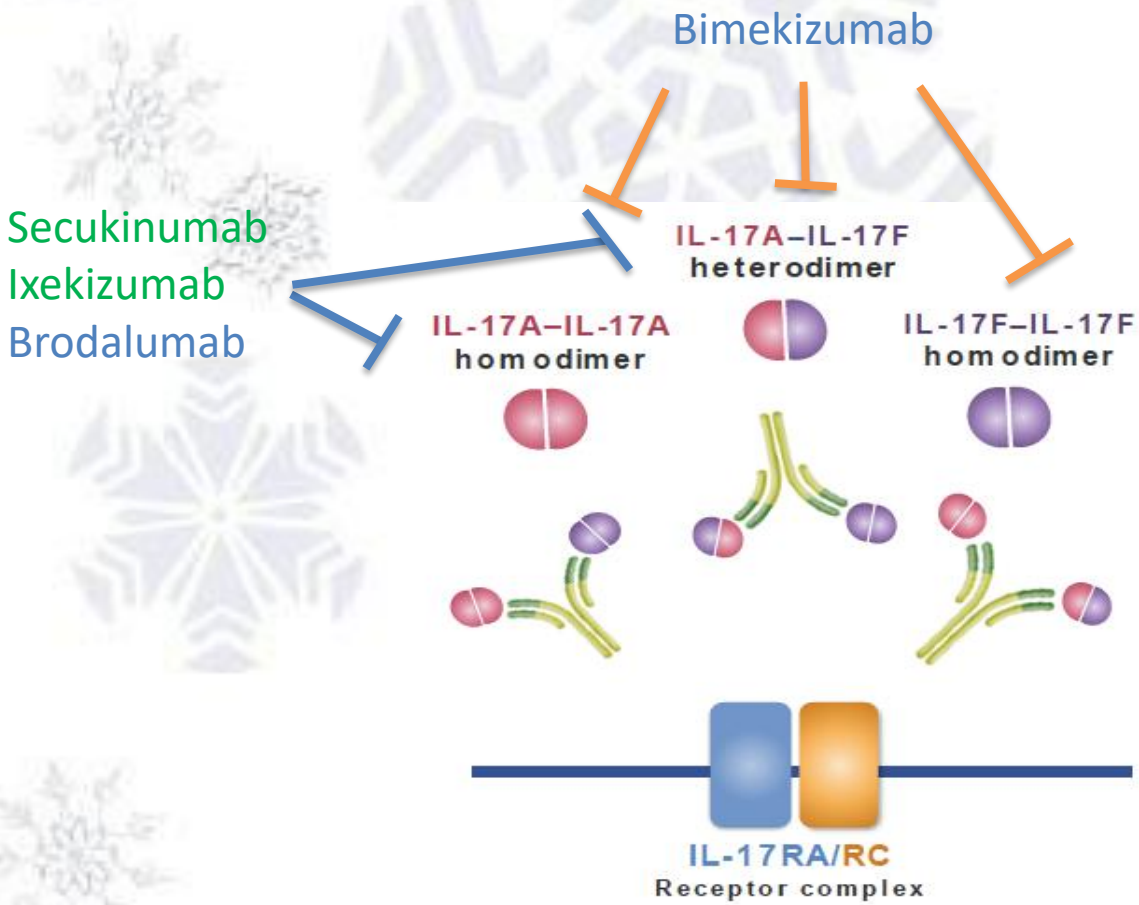

IL-17A–IL-17F
heterodimer
IL-17A–IL-17A
homodimer
IL-17F–IL-17F
homodimer
IL-17RA/RC
Receptor complex

IL17i

Secukinumab
Ixekizumab
Brodalumab



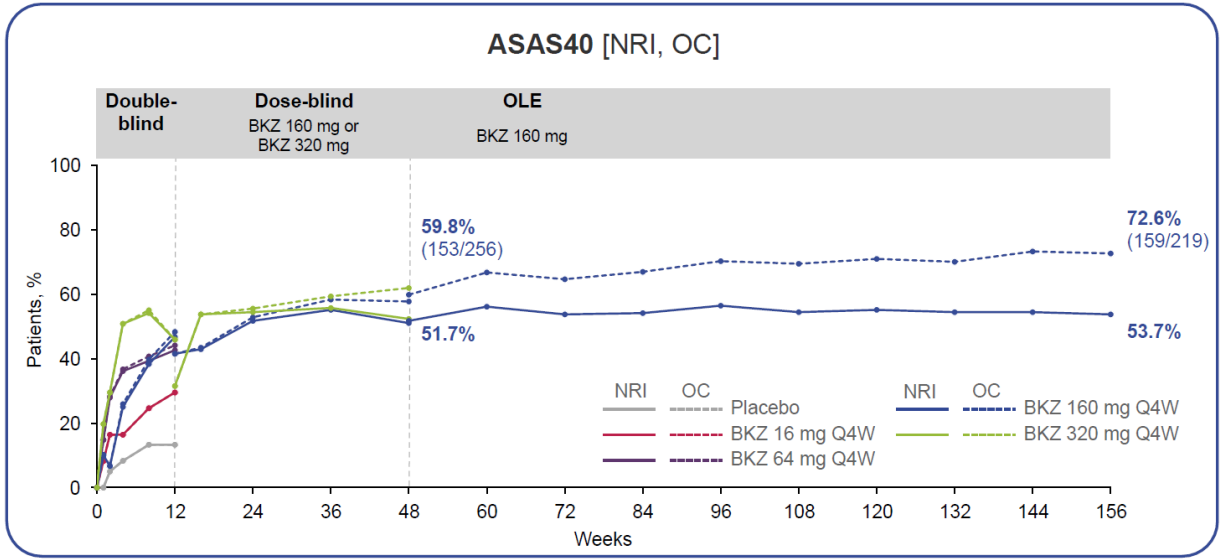
IL17i


Bimekizumab
Secukinumab
Ixekizumab
Brodalumab
IL-17A–IL-17F
heterodimer
IL-17A–IL-17A
homodimer
IL-17F–IL-17F
homodimer
IL-17RA/RC
Receptor complex

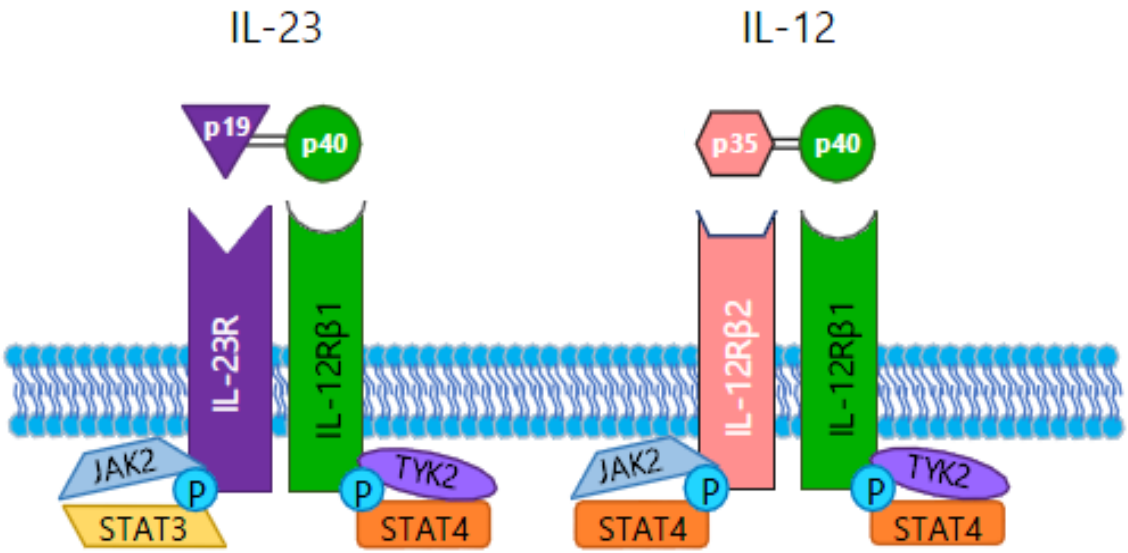
Bimekizumab Long-Term Safety and Efficacy in Patients with Ankylosing Spondylitis: Interim Results After 3 Years of Treatment in an Ongoing Phase 2b Study

L.S. Gensler,[1] A. Deodhar,[2] D. van der Heijde,[3] D. Poddubnyy,[4] A.J. Kivitz,[5] M. Dougados,[6] N. de Peyrecave,[7] M. Oortgiesen,[8] T. Vaux,[9] C. Fleurinck,[7] X. Baraliakos[10]

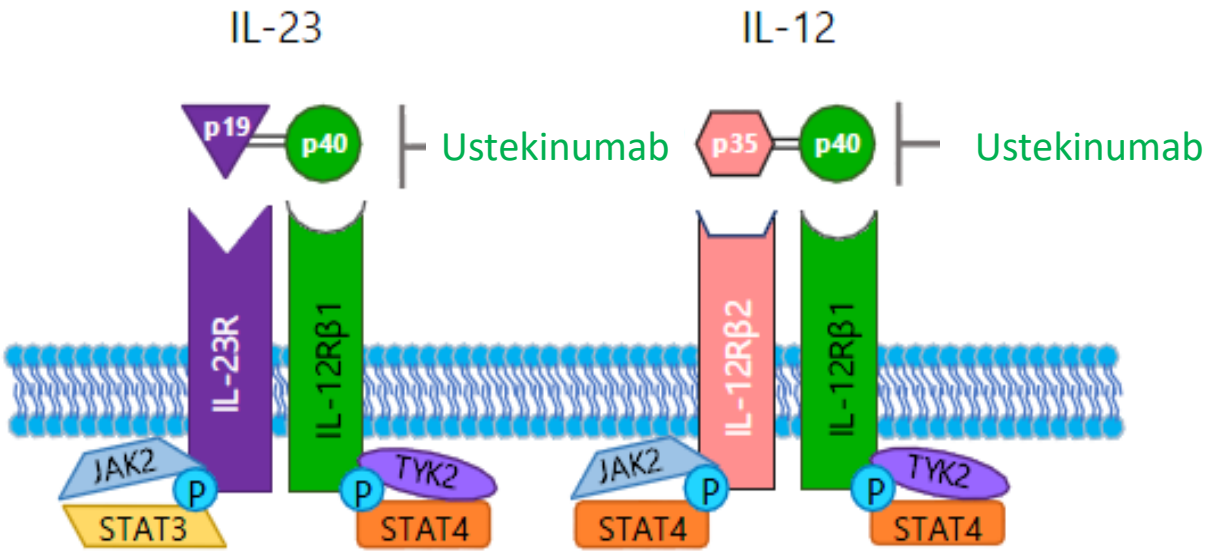
Efficacy sustained from Week 48 to Week 156: ASAS40



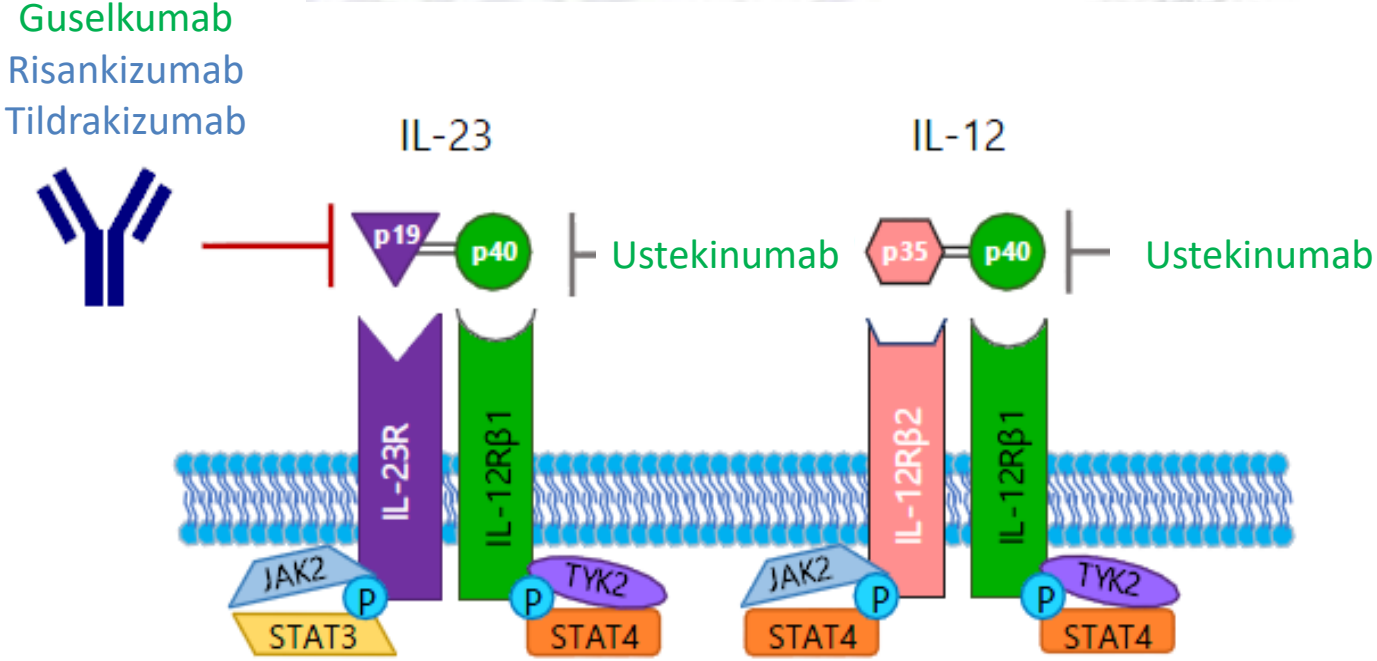
IL23i


IL-23
IL-12
p19
p40
p35
p40
IL-23R
IL-12Rβ1
IL-12Rβ2
IL-12Rβ1
JAK2
P
STAT3
TYK2
P
STAT4
JAK2
P
STAT4
TYK2
P
STAT4

IL23i

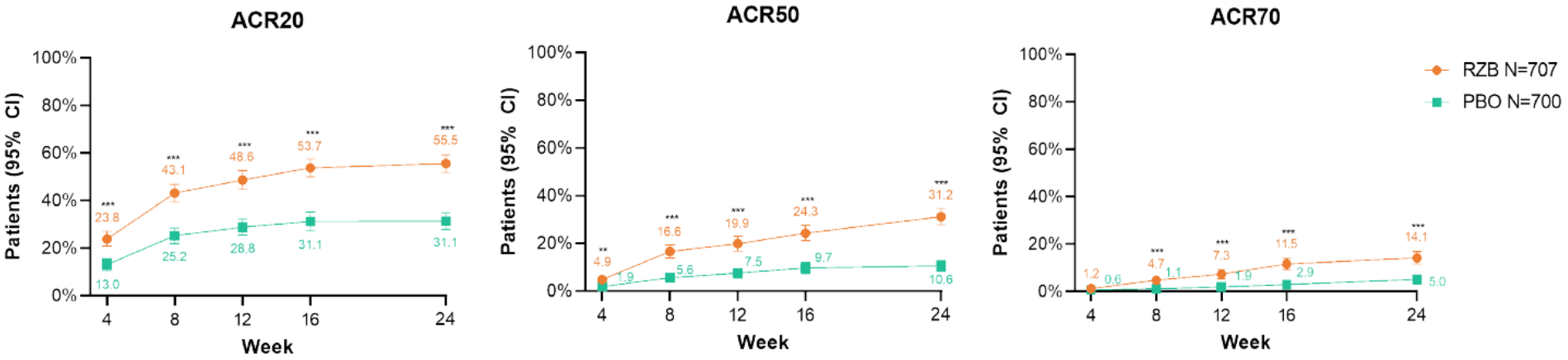

IL-23
IL-12
p19
p40
Ustekinumab
p35
p40
Ustekinumab
IL-23R
IL-12Rβ1
IL-12Rβ2
IL-12Rβ1
JAK2
P
STAT3
P
TYK2
STAT4
JAK2
P
STAT4
P
TYK2
STAT4

IL23i


Guselkumab
Risankizumab
Tildrakizumab
IL-23
IL-12
p19
p40
Ustekinumab
p35
p40
Ustekinumab
IL-23R
IL-12Rβ1
IL-12Rβ2
IL-12Rβ1
JAK2
P
STAT3
TYK2
P
STAT4
JAK2
P
STAT4
TYK2
P
STAT4

Efficacy and Safety of Risankizumab for Active Psoriatic Arthritis: 24-Week Integrated Results from the Phase 3, Randomized, Double-blind KEEPsAKE 1 and 2 Trials for csDMARD-IR and Bio-IR Patients

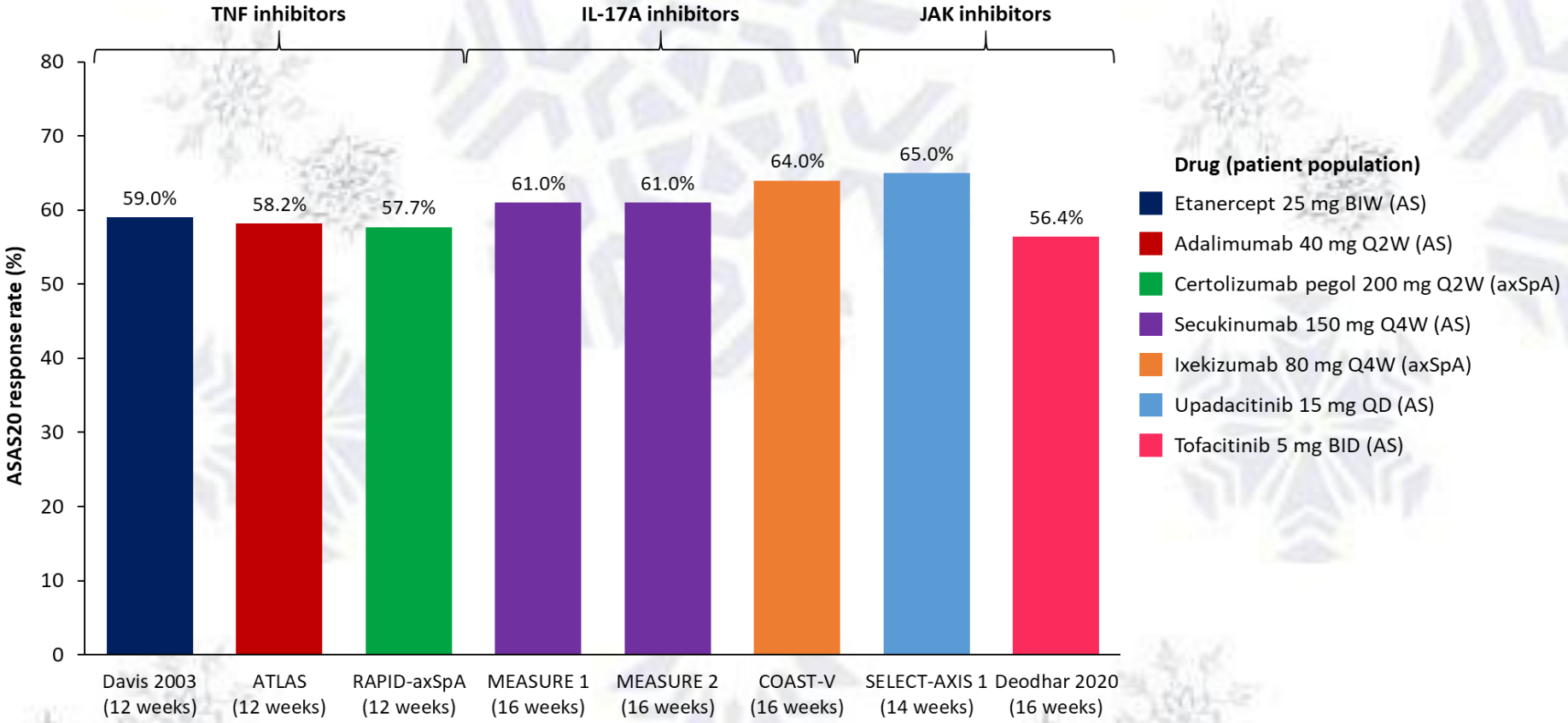
Andrew Östör[1], Kim Papp[2], Mireia Moreno[3], Cathy Spargo[4], Lisa Barcomb[5], Ahmed M. Soliman[5], Wenjing Lu[5], Ann Eldred[5], Lars Erik Kristensen[6]



ACR=American College of Rheumatology; ** P<0.01, *** P<0.001

EFFICACITÉ DU TRAITEMENT CIBLÉ

Efficacité des thérapies ciblées dans l'ax-SPA selon l'ASAS20



Felten et al. *Rheumatology and Therapy.* In press

BMJ Journals

Annals of the
Rheumatic Diseases

Psoriatic arthritis

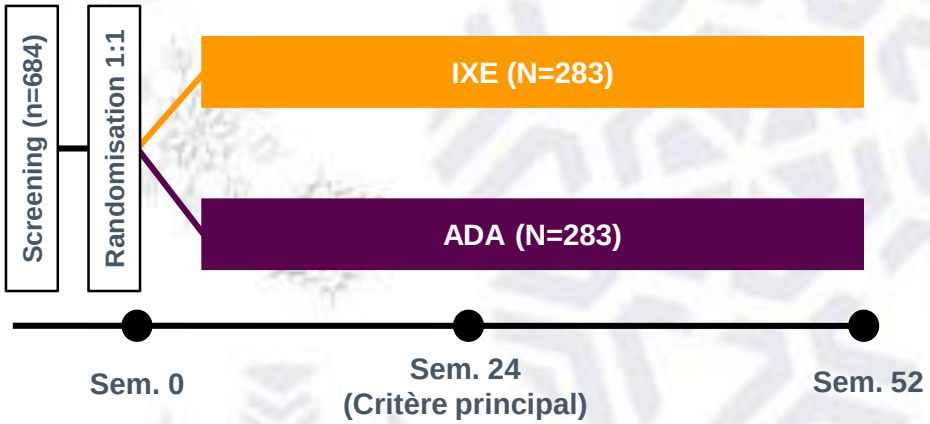
A head-to-head comparison of the efficacy and safety of ixekizumab and adalimumab in biological-naïve patients with active psoriatic arthritis: 24-week results of a randomised, open-label, blinded-assessor trial

PDF

PDF + Supplementary Material

Philip J Mease[1], Josef S Smolen[2], Frank Behrens[3], Peter Nash[4], Soyi Liu Leage[5], Lingnan Li[5], Hasan Tahir[6], Melinda Gooderham[7], Eswar Krishnan[5], Hong Liu-Seifert[5], Paul Emery[8, 9], Sreekumar G Pillai[5], Philip S Helliwell[10] The SPIRIT H2H study group

SPIRIT H2H : Design de l'étude



- Étude en ouvert avec évaluateurs en aveugle
- Patients Naïfs de traitement biologique
- Randomisation stratifiée par utilisation concomitante de csDMARD à l'inclusion, et par sévérité du psoriasis en plaque concomitant
- **Posologies des AMM en fonction de la présence d'un psoriasis en plaque modéré à sévère concomitant**

Critère principal

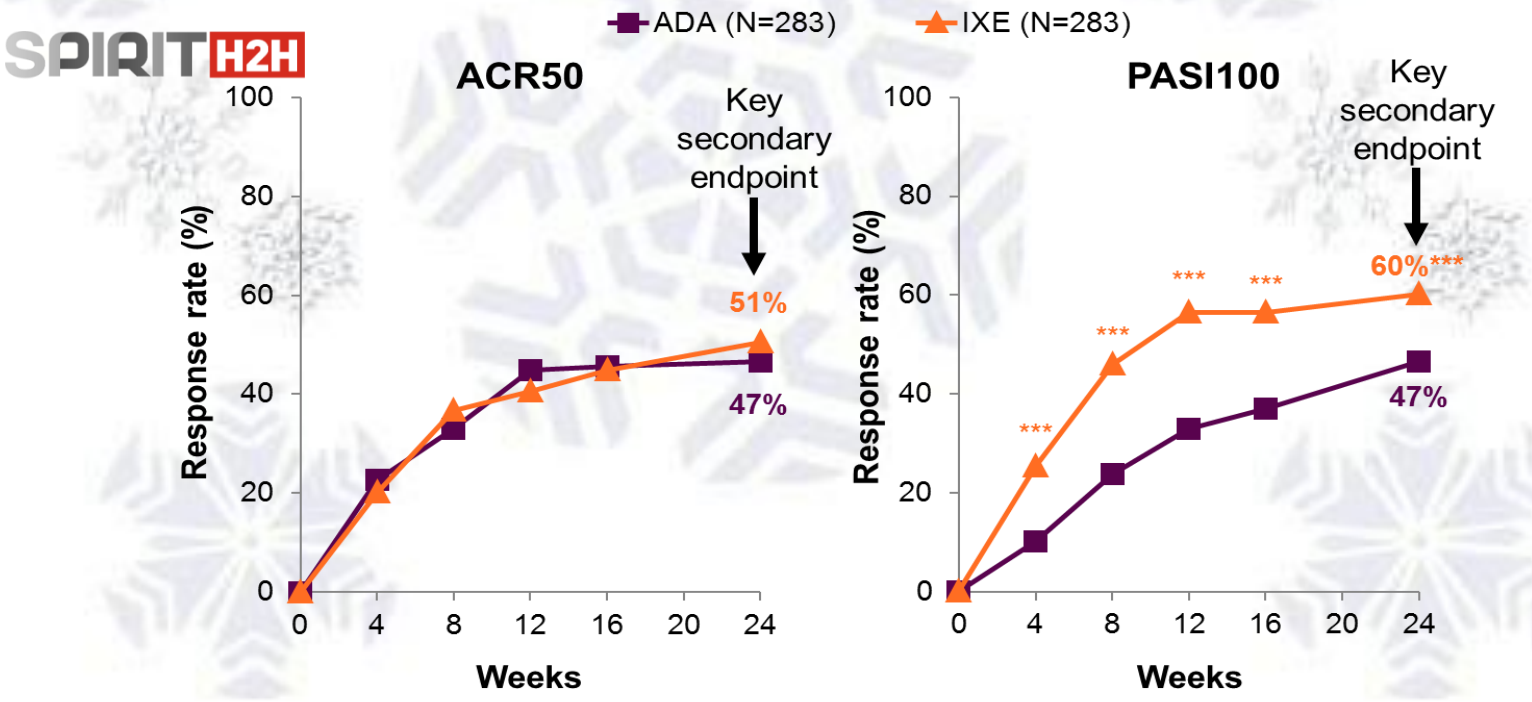
- Proportion de patients atteignant **simultanément un ACR50 et un PASI 100 à la sem. 24**
  - test de supériorité bilatéral avec α = 0.05

Critères secondaires majeurs

- Proportion de patients atteignant un ACR50 à la sem. 24 (test de non-infériorité)[a]
- Proportion de patients atteignant un PASI 100 à la sem. 24
  - test de supériorité bilatéral avec α = 0.05

[a]Marge de non-inferiorité de -12.0% pour l'ACR50 entre l'ixékizumab et l'adalimumab

ACR50 and PASI100, NRI



Patients were stratified by csDMARD use and presence of moderate-to-severe psoriasis.
ACR50, ≥50% improvement in American College of Rheumatology criteria; ADA, adalimumab; csDMARD, conventional synthetic disease-modifying anti-rheumatic drug; IXE, ixekizumab; NRI, non-responder imputation; PASI100, 100% improvement in Psoriasis Area and Severity Index score
***p≤.001 vs ADA; ACR50: p=.338 for IXE vs ADA at week 24

THE LANCET

ARTICLES | VOLUME 395, ISSUE 10235, P1496-1505, MAY 09, 2020

PDF [474 KB] Figures Save Share Reprints Request

Secukinumab versus adalimumab for treatment of active psoriatic arthritis (EXCEED): a double-blind, parallel-group, randomised, active-controlled, phase 3b trial

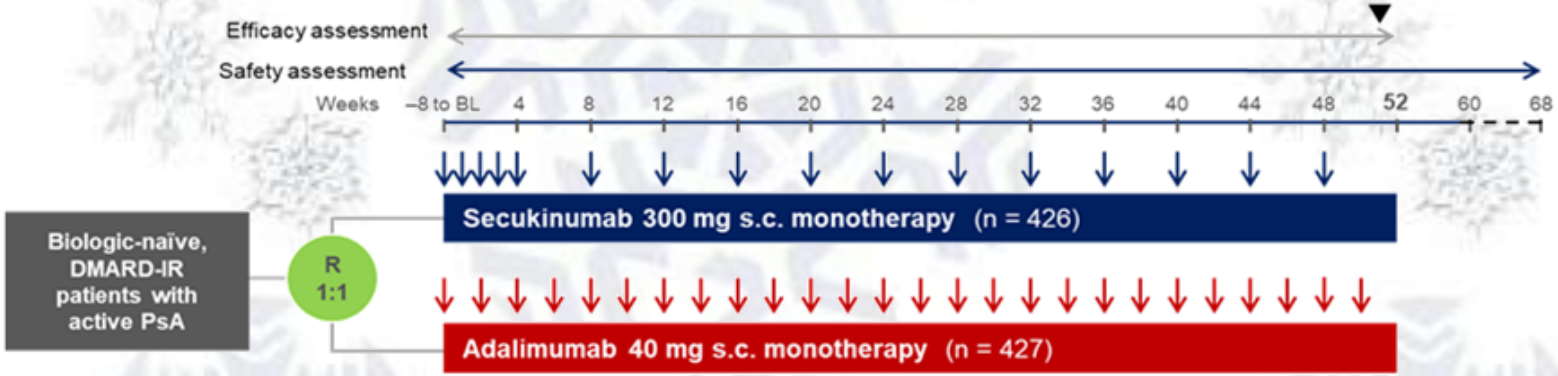
Iain B McInnes, FRCP • Frank Behrens, MD • Philip J Mease, MD • Arthur Kavanaugh, MD • Christopher Ritchlin, MD • Peter Nash, FRACP • et al. Show all authors

Published: May 09, 2020 • DOI: https://doi.org/10.1016/S0140-6736(20)30564-X •

Check for updates

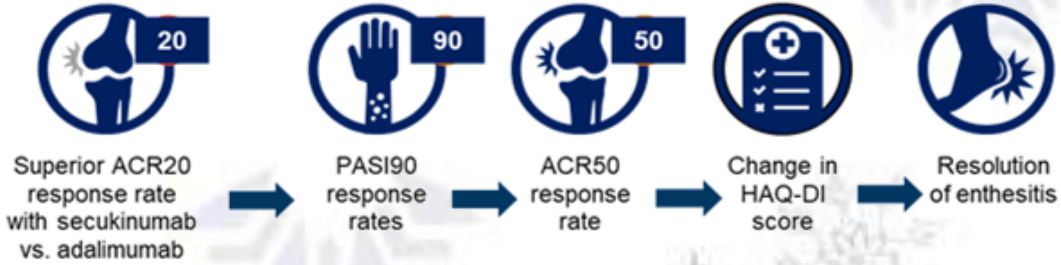
PlumX Metrics

Étude EXCEED



Primary efficacy endpoint at Week 52

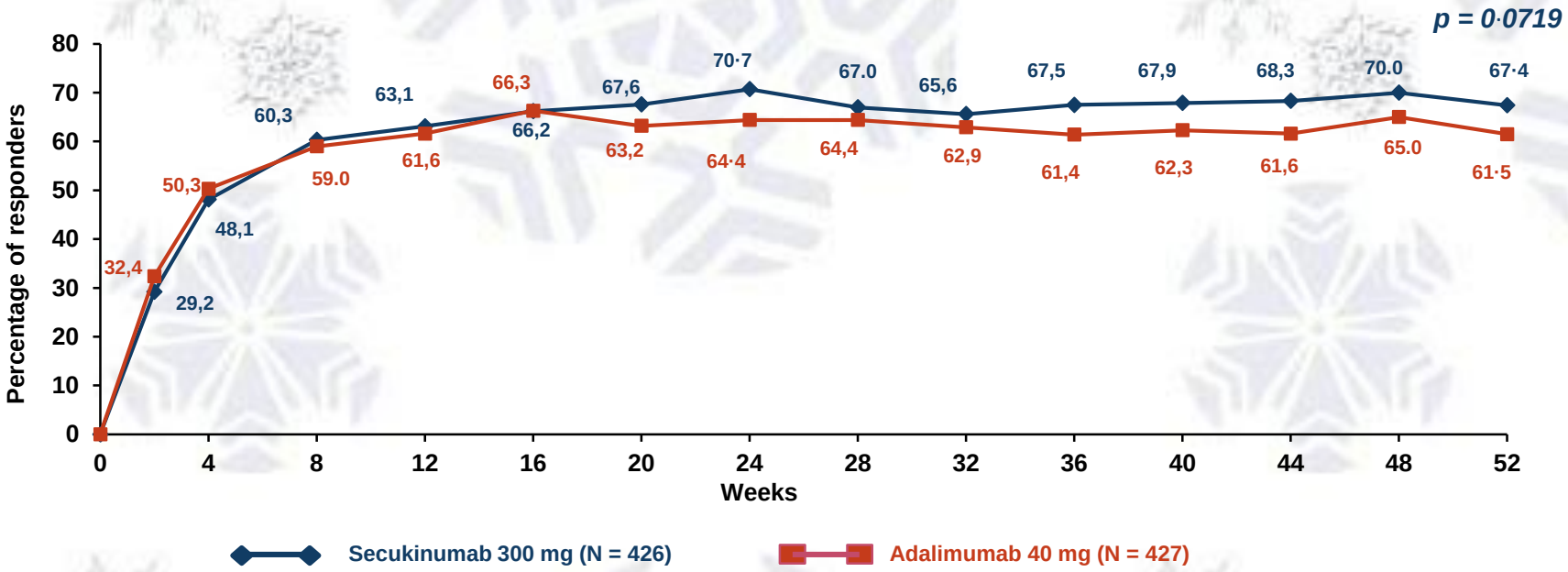
Key secondary efficacy endpoints at Week 52 on superiority



Étude EXCEED

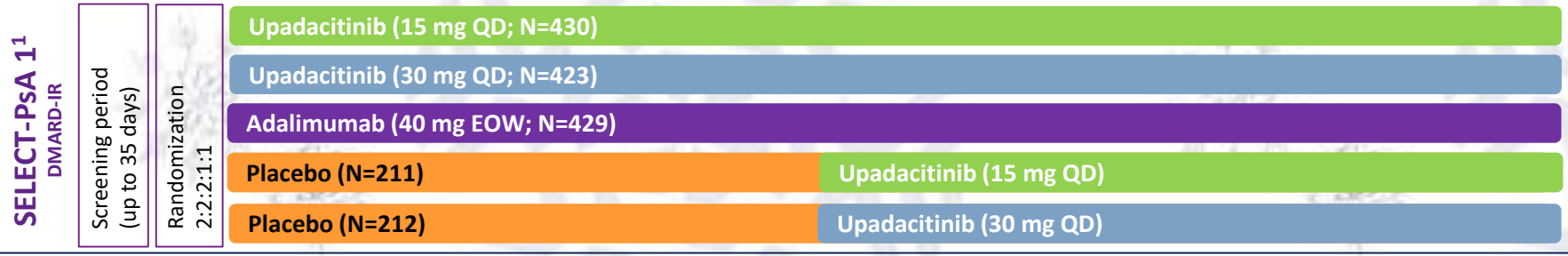
Résultats : critère principal

Réponse ACR20 à 52 semaines



McInnes et al. RWCS 2020, Maui, Hawaii, USA, 12th to 15th February, 2020 – Poster

Essai SELECT-PsA 1 : Upadacitinb



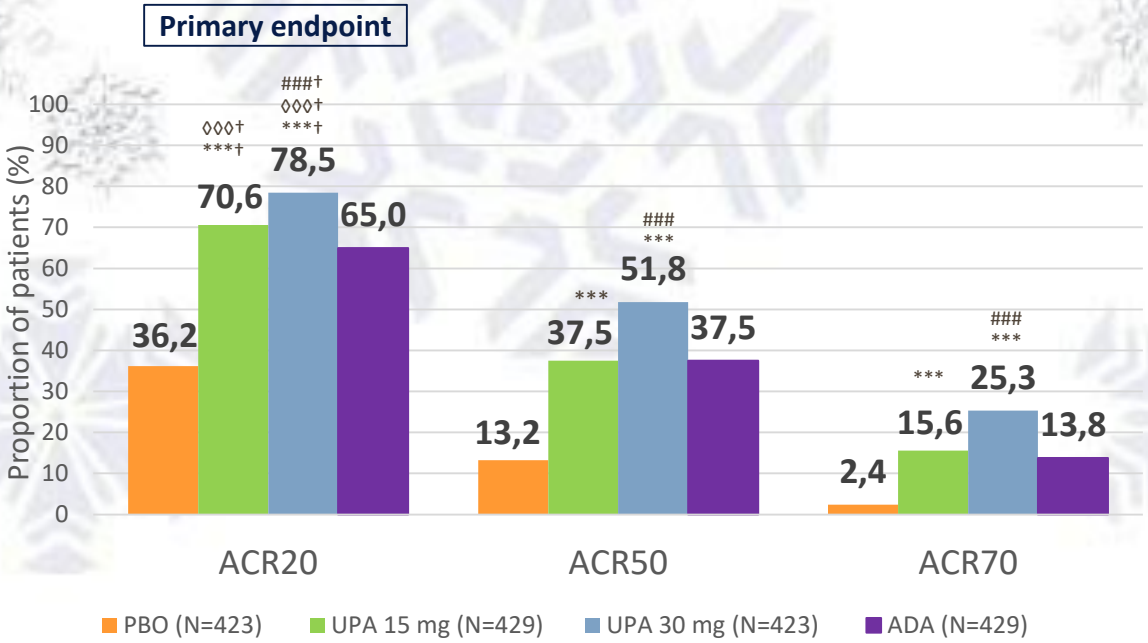
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Trial of Upadacitinib and Adalimumab for Psoriatic Arthritis

Iain B. McInnes, F.R.C.P., Jaclyn K. Anderson, D.O., Marina Magrey, M.D., Joseph F. Merola, M.D., Yi Liu, M.D., Mitsumasa Kishimoto, M.D., Slawomir Jeka, M.D., Cesar Pacheco-Tena, M.D., Ph.D., Xin Wang, Ph.D., Liang Chen, M.S., Patrick Zueger, Pharm.D., Ph.D., John Liu, M.D., et al.

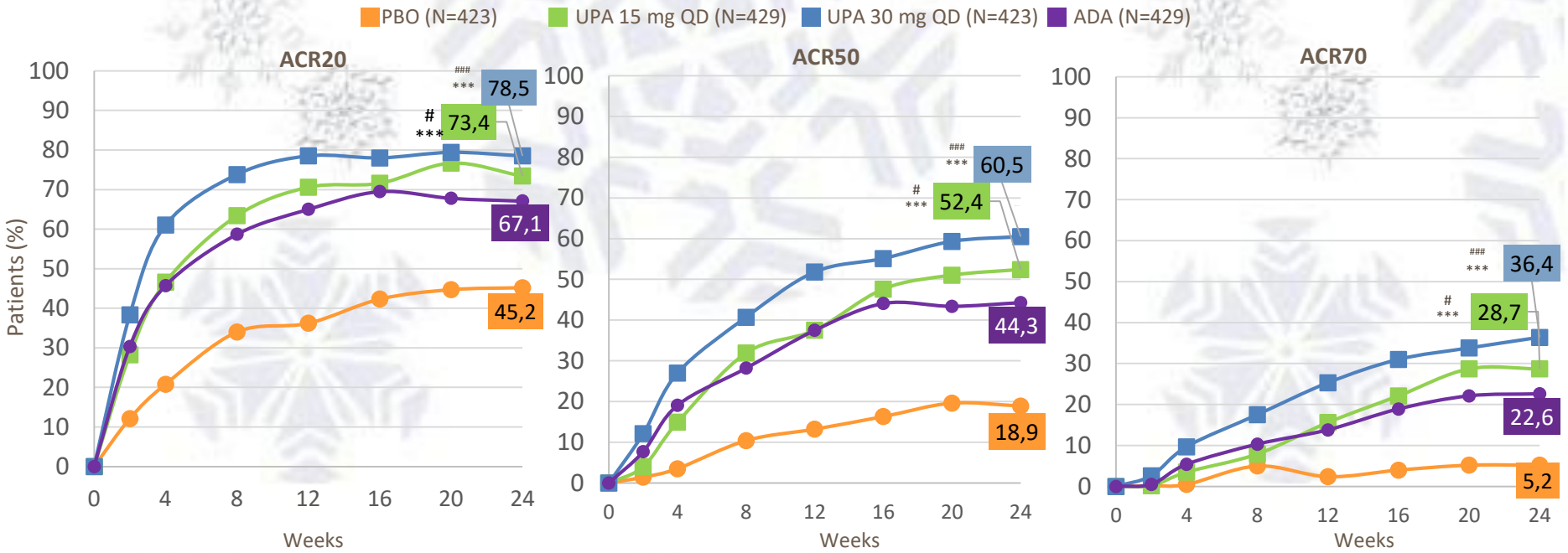
SELECT-PsA 1 : réponses ACR à S12



***p≤0.001 for UPA vs PBO; ◊◊◊p≤0.001 for noninferiority UPA vs ADA; ###p≤0.001 for UPA vs ADA.
†Statistically significant in the multiplicity-controlled analysis.
ACR20/50/70, American College of Rheumatology 20%/50%/70% improvement score; ADA, adalimumab; b, biologic; DMARD, disease-modifying anti-rheumatic drug; IR, inadequate response; PBO, placebo; PsA, psoriatic arthritis; QD, once daily; UPA, upadacitinib.

McInnes IB, et al. Trial of upadacitinib and adalimumab for psoriatic arthritis. N Eng J Med. 2020

SELECT-PsA 1 : cinétique des réponses ACR20/50/70 jusqu'à S24 (NRI)



***p≤0.001 for UPA vs PBO; #p≤0.05, ###p≤0.001 for UPA vs ADA.
ACR20/50/70, American College of Rheumatology 20%/50%/70% improvement score; ADA, adalimumab; DMARD, disease-modifying anti-rheumatic drug; IR, inadequate response; NRI, non-responder imputation; PBO, placebo; PsA, psoriatic arthritis; QD, once daily; UPA, upadacitinib.

McInnes IB, et al. Trial of upadacitinib and adalimumab for psoriatic arthritis. N Eng J Med. 2020

CHOIX EN FONCTION DU PROFIL PATIENT

LES MICI

Classe / Mode d'action / Molécules / Indications / Comorbidités	csDMARDs			bDMARDs												tsDMARDs		
				TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib
Maladie de Crohn																		
Rectocolite ulcéro-hémorragique																		

@DocFelten

Autorisé	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

Risque MICI sous IL17i

OXFORD ACADEMIC

RHEUMATOLOGY

ACCEPTED MANUSCRIPT

New-Onset Inflammatory Bowel Diseases Among IL-17 inhibitors-Treated Patients: Results From The Case-Control MISSIL Study

Jean-Guillaume Letarouilly, Thao Pham, Adeline Pierache, Émilie Acquacalda, Beatrice Banneville, Sébastien Barbarot, Pauline Baudart, Élodie Bauer, Pascal Claudepierre, Arnaud Constantin, Emmanuelle Dernis, Renaud Felten, Philippe Gaudin, Céline Girard, Bruno Gombert, Philippe Goupille, Xavier Guennoc, Isabelle Henry-Desailly, Denis Jullien, Elena Karimova, Sylvain Lanot, Loïc Le Dantec, Tristan Pascart, Laurianne Plastaras, Nathalie Sultan, Xavier Truchet, Stephane Varin, Daniel Wendling, Louise Gaboriau, Delphine Staumont-Sallé, Laurent Peyrin-Biroulet, Rene-Marc Flipo

Risque MICI sous IL17i

OXFORD ACADEMIC

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Arthritis & Rheumatology

AN OFFICIAL JOURNAL OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

AMERICAN COLLEGE of RHEUMATOLOGY
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Risk of inflammatory bowel disease in patients with psoriasis, psoriatic arthritis and ankylosing spondylitis initiating interleukin 17 inhibitors: a nationwide population-based study using the French national health data system

Laëtitia Penso, Christina Bergqvist, Antoine Meyer, Philippe Herlemont, Alain Weill, Mahmoud Zureik, Rosemary Dray-Spira, Emilie Sbidian

First published: 19 July 2021 | https://doi.org/10.1002/art.41923

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Accepted Article

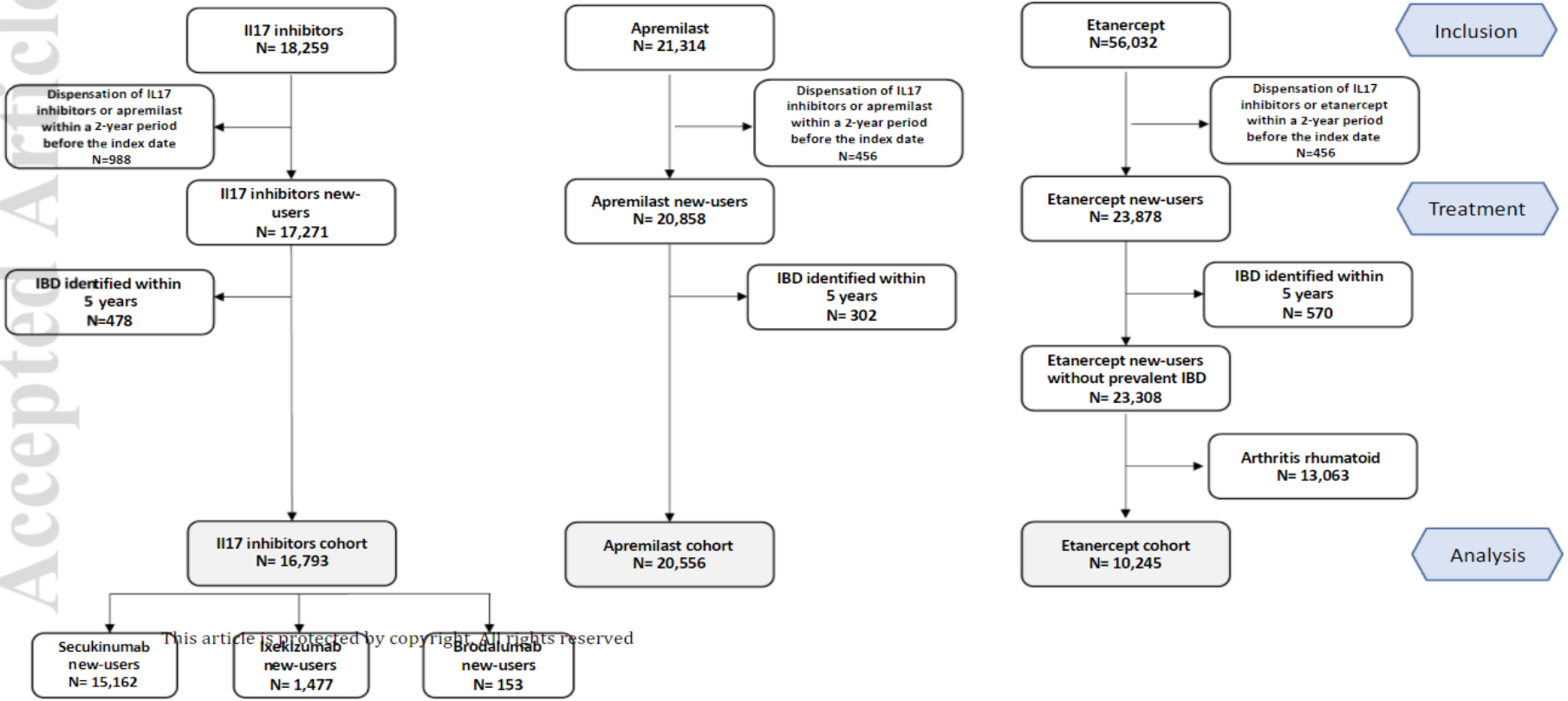

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Table 4. Associations between IL17 inhibitor/etanercept exposures and IBD according to subgroups

	Exposed to IL17 inhibitors**	Exposed to etanercept	HRw(95%CI)*
	n° of events/n° of subjects at risk	n° of events/n° of subjects at risk	
Biologic-naive patients	13/4394	37/7464	0.6 (0.3-1.1)
Patients with psoriasis exclusively	7/1658	0/466	4.1 (0.2 – 89.5)
Patients with psoriatic arthritis or ankylosing spondylitis exclusively	21/4835	31/6033	0.8 (0.5 – 1.5)
Patients with psoriasis or psoriatic arthritis	19/5884	18/3795	0.7 (0.3 – 1.3)

IBD, Inflammatory Bowel Disease; IL, interleukin; HR_w: weighted hazard ratio; 95%CI: 95% confidence interval

*Hazard ratio from the multivariable Cox proportional-hazards model with the same covariates with inverse probability weighting according to the propensity score, adjusted according to sex, comorbidity, colonoscopy, use of non-biological systemic treatment, systemic corticosteroids and biologics

**** IL17i new users with a previous 2-year exposure to etanercept were removed from this analysis

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Pas de différence significative de survenue de MICI sous IL17i vs Etanercept

IBD, Inflammatory Bowel Disease; IL, interleukin; HR_w: weighted hazard ratio; 95%CI: 95% confidence interval

*Hazard ratio from the multivariable Cox proportional-hazards model with the same covariates with inverse probability weighting according to the propensity score, adjusted according to sex, comorbidity, colonoscopy, use of non-biological systemic treatment, systemic corticosteroids and biologics

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Laëtitia Penso, Christina Bergqvist, Antoine Meyer, Philippe Herlemont, Alain Weill, Mahmoud Zureik, Rosemary Dray-Spira, Emilie Sbidian

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Table 3. Associations between IL17 inhibitor/apremilast exposures and IBD according to subgroups

	Exposed to IL17 inhibitors n° of events/n° of subjects at risk	Exposed to apremilast n° of events/n° of subjects at risk	HRw(95%CI)*
Biologic-naive patients	13/4,394	11/19,533	3.0 (1.3-7.0)
Patients with psoriasis exclusively	8/2,131	5/12,284	8.3 (2.8-25)
Patients with psoriatic arthritis or ankylosing spondylitis exclusively	38/8,668	2/1,880	1.3 (0.5-3.5)
Patients with psoriasis or psoriatic arthritis	26/5,990	4/6,393	3.5 (1.3-9.7)

IBD, Inflammatory Bowel Disease; IL, interleukin; HR_w: weighted hazard ratio; 95%CI: 95% confidence interval

*Hazard ratio from the multivariable Cox proportional-hazards model with the same covariates with inverse probability weighting according to the propensity score, adjusted according to sex, comorbidity, colonoscopy, use of non-biological systemic treatment, systemic corticosteroids and biologics

Risk of inflammatory bowel disease in patients with psoriasis, psoriatic arthritis and ankylosing spondylitis initiating interleukin 17 inhibitors: a nationwide population-based study using the French national health data system

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Table 3. Associations between IL17 inhibitor/apremilast exposures and IBD according to subgroups

	Exposed to IL17 inhibitors n° of events/n° of subjects at risk	Exposed to apremilast n° of events/n° of subjects at risk	HRw(95%CI)*
Biologic-naive patients	13/4,394	11/19,533	3.0 (1.3-7.0)
Patie[illegible]	[illegible]	[illegible]	[illegible]25)
Patie[illegible]	[illegible]	[illegible]	[illegible].5)
spondylitis exclusively			
Patients with psoriasis or psoriatic arthritis	26/5,990	4/6,393	3.5 (1.3-9.7)

Surrisque significatif de survenue de MICI sous IL17i vs Apremilast

IBD, Inflammatory Bowel Disease; IL, interleukin; HR_w: weighted hazard ratio; 95%CI: 95% confidence interval

*Hazard ratio from the multivariable Cox proportional-hazards model with the same covariates with inverse probability weighting according to the propensity score, adjusted according to sex, comorbidity, colonoscopy, use of non-biological systemic treatment, systemic corticosteroids and biologics

Classe / Mode d'action / Molécules / Indications / Comorbidités (@DocFelten)	csDMARDs			bDMARDs											tsDMARDs		
				TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib

Conclusion MICI :

- **IL-17i à ne pas utiliser en cas de MICI non contrôlée**
- Pas de sur-risque de développer une MICI en cas d'usage d'IL17i
- Possibilité de l'utiliser en cas d'antécédents de MICI en accord avec le gastro-entérologue du patient
- **Utilisation préférentielle des anti-TNF monoclonaux et anti IL12/23**

Maladi

Rectoc

Autorisé	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

LES UVEITES

Classe / Mode d'action	csDMARDs			bDMARDs												tsDMARDs		
				TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
Molécules	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib
Indications / Comorbidités																		
Uvéites									$									

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OPEN ACCESS

CLINICAL SCIENCE

Anterior uveitis in patients with spondyloarthritis treated with secukinumab or tumour necrosis factor inhibitors in routine care: does the choice of biological therapy matter?

Ulf Lindström ,[1] Karin Bengtsson ,[1] Tor Olofsson ,[2] Daniela Di Giuseppe,[3] Bente Glintborg ,[4,5] Helena Forsblad-d'Elia,[1] Lennart T H Jacobsson,[1] Johan Askling [3]

Methods

CASES - identified in the Swedish Rheumatology Quality Register
1. Ankylosing spondylitis or undifferentiated Spondyloarthritis
2. Starting Secukinumab, Adalimumab, Infliximab or Etanercept in 2015-**2018**

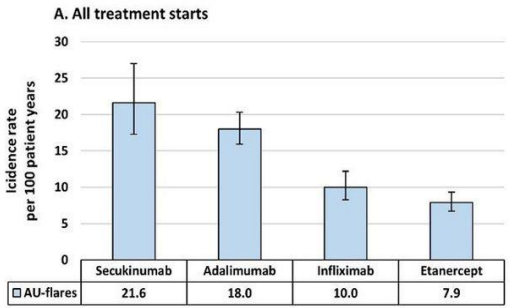
OUTCOMES - identified in the Swedish National Patient Register
Registered visits with a diagnosis of anterior uveitis in out-patient ophthalmology care

Patients N=3568
Treatment episodes N=4523

Comparaison de la survenue d'uvéites antérieures sous sécukinumab, adalimumab, infliximab et étanercept dans la spondyloarthrite axiale

Analysis	Treat-ment starts, N	Previous AU [1]	Age at treat-ment start, mean (sd)	N Previous bDMARD, median
A. All treatment starts, N=3255				
SEC	333	21%	48 (13)	2
ADA	872	34%	44 (12)	1
IFX	714	21%	43 (14)	0
ETN	1336	17%	44 (14)	0

Figure 1. Incidence rate of AU flares during bDMARD treatment, per 100 patient years



Legend

AU = anterior uveitis

AU flare = AU diagnoses separated by a ≥60 day penalty interval

Observe different scale on y-axis in panel A compared to B and C

Lindstrom U, et al. Ann Rheum Dis 2021;0:1–8.

Comparaison de la survenue d'uvéites antérieures sous sécukinumab, adalimumab, infliximab et étanercept dans la spondyloarthrite axiale

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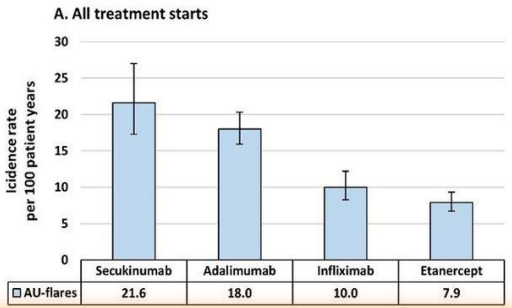
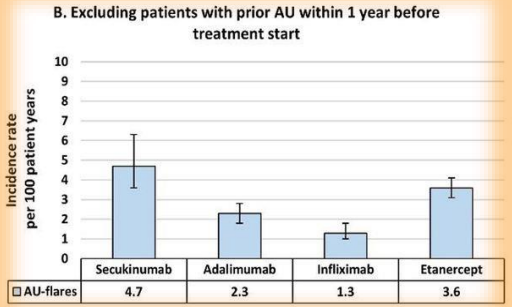
Hazard ratio, ajusté sur le sexe, l'âge et l'antécédent d'uvéite

Excluant les patients avec uvéites dans l'année précédente

Adalimumab	reference
Secukinumab	2.23 (1.13-4.43)
Etanercept	1.80 (1.12-2.89)
Infliximab	0.93 (0.47-1.85)

Figure 1. Incidence rate of AU flares during bDMARD treatment, per 100 patient years





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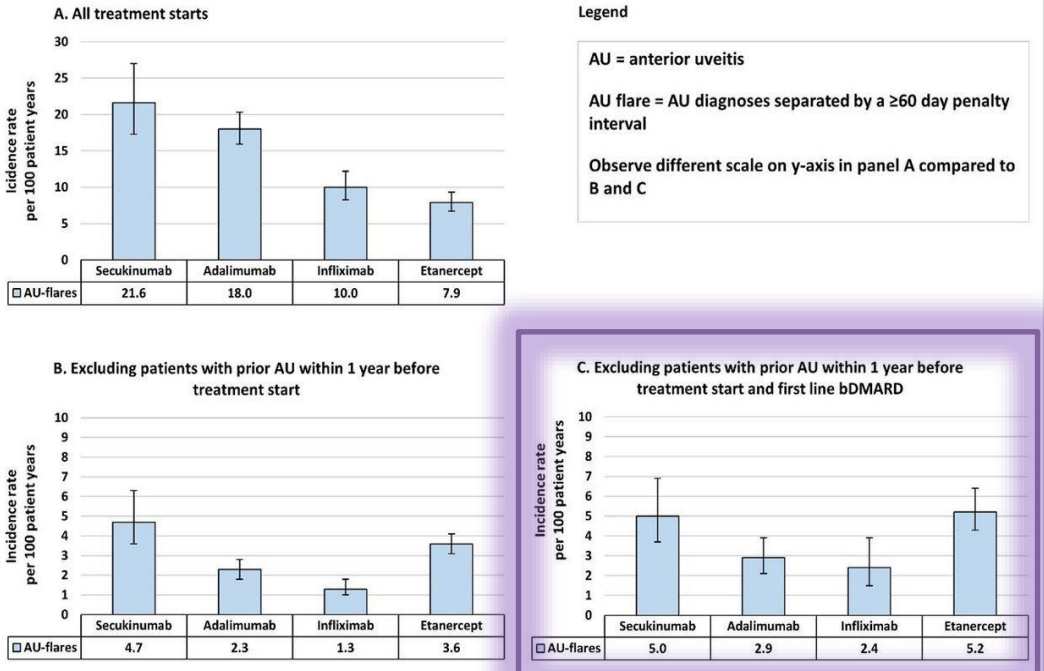
Infliximab	0.93 (0.47-1.85)

Et en plus, les 3èmes lignes de traitement et au-delà

Adalimumab	reference
Secukinumab	1.61 (0.60-4.37)
Etanercept	1.85 (1.11-3.10)
Infliximab	0.74 (0.34-1.62)

Figure 1. Incidence rate of AU flares during bDMARD treatment, per 100 patient years



Lindstrom U, et al. Ann Rheum Dis 2021;0:1–8.

Classe / Mode d'action	csDMARDs	bDMARDs											tsDMARDs	
		TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
Molécules	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib
Indications / Comorbidités																		

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Conclusion uvéites :

- Pas de sur-risque démontré de récidive d'uvéites en cas d'usage d'IL17i
- Potentiel effet bénéfique des IL17i sur la prévention des uvéites
- **Utilisation préférentielle des anti-TNF monoclonaux**

Uvéites																		
									$									

Autorisé	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

LE PSORIASIS CUTANÉ

Classe / Mode d'action / Molécules / Indications / Comorbidités	csDMARDs			bDMARDs												tsDMARDs		
				TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib
Psoriasis cutané																		

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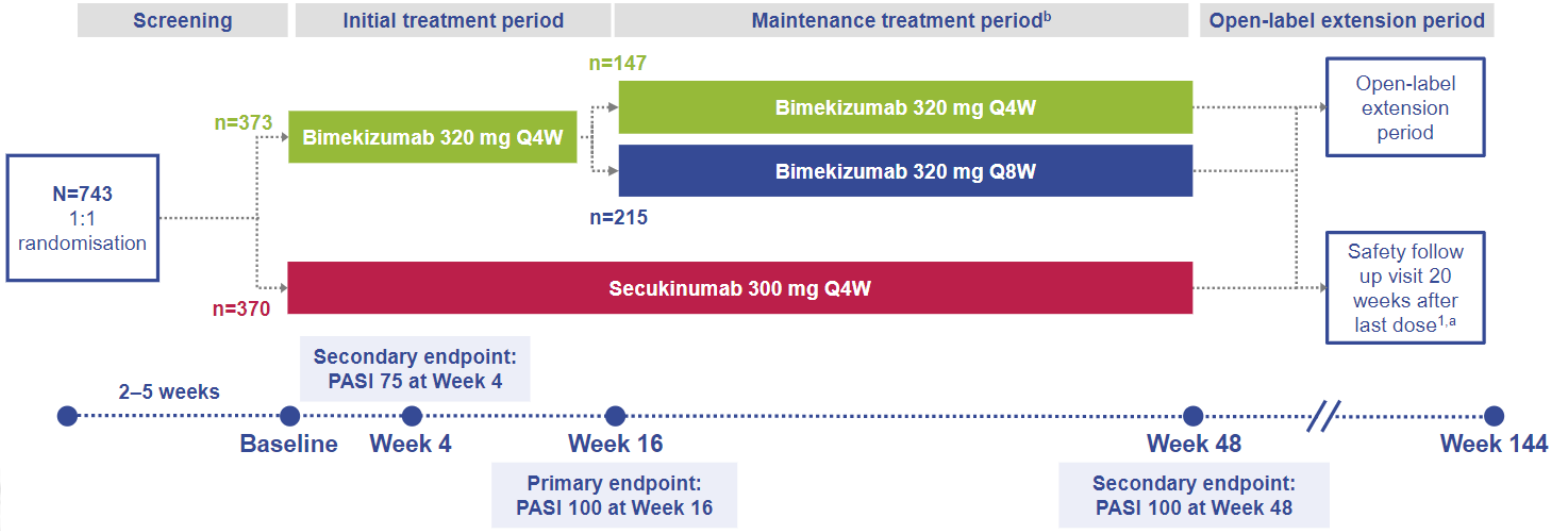
Autorisé	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Bimekizumab versus Secukinumab in Plaque Psoriasis



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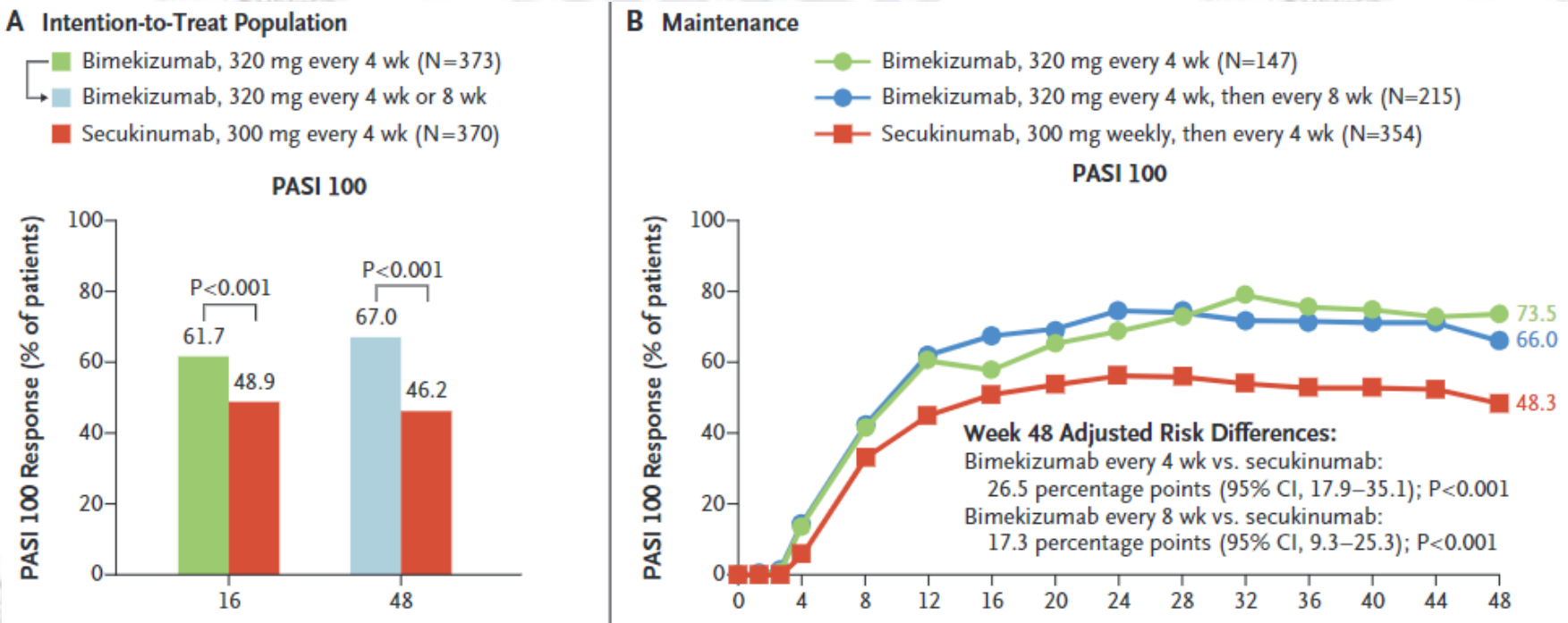

Classe / Mode d'action	csDMARDs	bDMARDs											tsDMARDs	
		TNFi					IL17i				IL12/23i	IL23i		PDE4i	JAKi	
Molécules	Leflunomide	Methotrexate	Sulfasalazine	Adalimumab	Certolizumab	Etanercept	Golimumab	Infliximab	Secukinumab	Ixekinumab	Brodalumab	Bimekizumab	Ustekinumab	Guselkumab	Risankizumab	Apremilast	Tofacitinib	Upadacitinib
Indications / Comorbidités																		

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Psorias

Conclusion psoriasis cutané :

- **Tous les traitements sont efficaces sur le psoriasis cutané**
- Mais anti-TNF < Anti-IL17A (< Anti-IL23 données du pso)

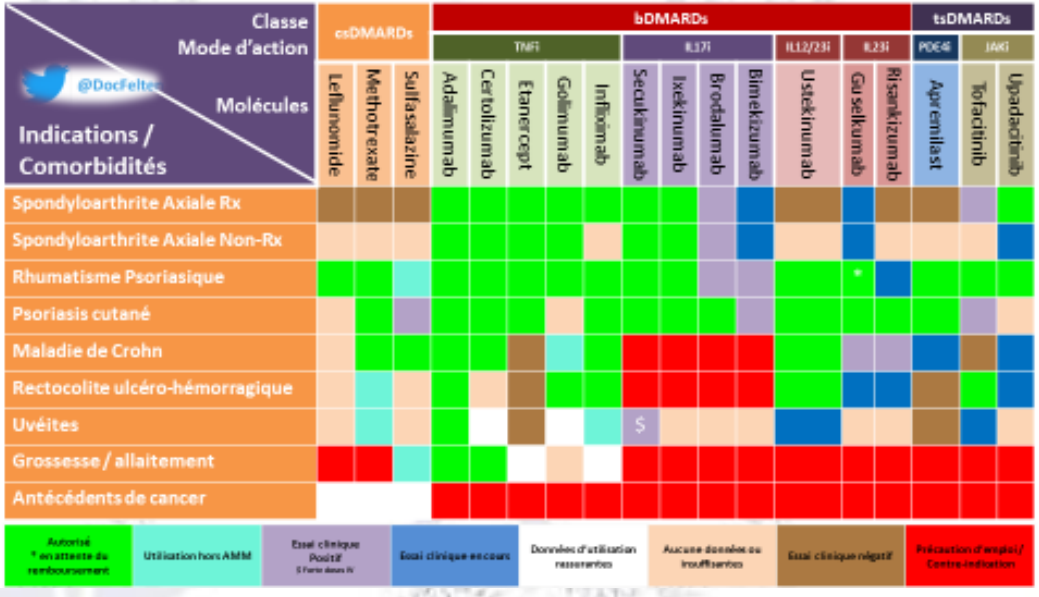
Autorisé	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

TAKE HOME MESSAGES

- De **+ en + de thérapies ciblées** aux mécanismes variés

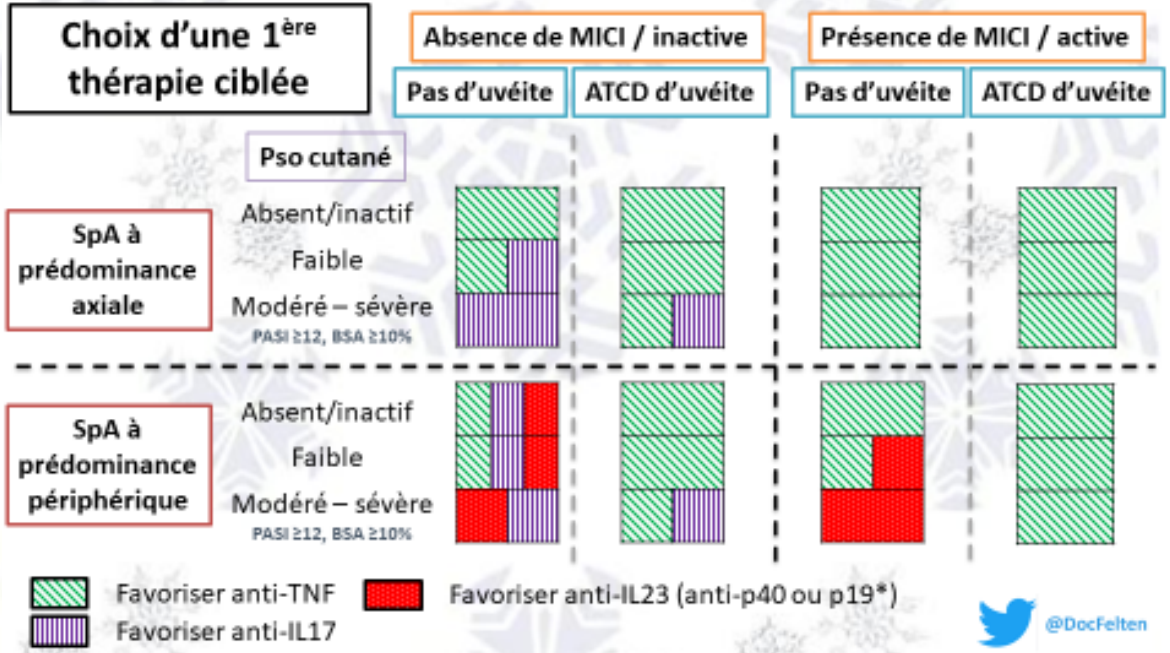
TAKE HOME MESSAGES

- De + en + de thérapies ciblées aux mécanismes variés
- Choix de la molécule en **fonction du profil patient et des comorbidités**



TAKE HOME MESSAGES

- De + en + de thérapies ciblées aux mécanismes variés
- Choix de la molécule en fonction du profil patient et des comorbidités
- **En pratique :**



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Winterschool 2021

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Indications / Comorbidités — Classe / Mode d'action	csDMARDs			bDMARDs												tsDMARDs		
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Spondyloarthrite Axiale Rx																		
Spondyloarthrite Axiale Non-Rx																		
Rhumatisme Psoriasique														*				
Psoriasis cutané																		
Maladie de Crohn																		
Rectocolite ulcéro-hémorragique																		
Uvéites									$									
Grossesse / allaitement																		
Antécédents de cancer																		

Autorisé * en attente du remboursement	Utilisation hors AMM	Essai clinique Positif $ Forte doses IV	Essai clinique en cours	Données d'utilisation rassurantes	Aucune données ou insuffisantes	Essai clinique négatif	Précaution d'emploi / Contre-indication

Choix d'une 1ère thérapie ciblée

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Choix d'une 1ère thérapie ciblée

SpA à prédominance axiale

SpA à prédominance périphérique

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Choix d'une 1ère thérapie ciblée

	Absence de MICI / inactive	Présence de MICI / active
SpA à prédominance axiale		
SpA à prédominance périphérique		

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Choix d'une 1ère thérapie ciblée

	Pso cutané	Absence de MICI / inactive	Présence de MICI / active
SpA à prédominance axiale	Absent/inactif		
	Faible		
	Modéré – sévère PASI ≥12, BSA ≥10%		
SpA à prédominance périphérique	Absent/inactif		
	Faible		
	Modéré – sévère PASI ≥12, BSA ≥10%		

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Choix d'une 1ère thérapie ciblée

		Absence de MICI / inactive		Présence de MICI / active	
		Pas d'uvéite	ATCD d'uvéite	Pas d'uvéite	ATCD d'uvéite
	Pso cutané				
SpA à prédominance axiale	Absent/inactif				
	Faible				
	Modéré – sévère PASI ≥12, BSA ≥10%				
SpA à prédominance périphérique	Absent/inactif				
	Faible				
	Modéré – sévère PASI ≥12, BSA ≥10%				

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		Absence de MICI / inactive		Présence de MICI / active	
		Pas d'uvéite	ATCD d'uvéite	Pas d'uvéite	ATCD d'uvéite
	Pso cutané				
SpA à prédominance axiale	Absent/inactif				
	Faible				
	Modéré – sévère PASI ≥12, BSA ≥10%				
SpA à prédominance périphérique	Absent/inactif				
	Faible				
	Modéré – sévère PASI ≥12, BSA ≥10%				

Favoriser anti-TNF

Favoriser anti-IL17

Favoriser anti-IL23 (anti-p40 ou p19*)

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Choix d'une 1ère thérapie ciblée

		Absence de MICI / inactive		Présence de MICI / active	
		Pas d'uvéite	ATCD d'uvéite	Pas d'uvéite	ATCD d'uvéite
	Pso cutané				
SpA à prédominance axiale	Absent/inactif				
	Faible				
	Modéré – sévère PASI ≥12, BSA ≥10%				
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		Absence de MICI / inactive		Présence de MICI / active	
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"One year in review" : les (bonnes) actualités de l'année !!!

Spondyloarthrites

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