The scientific committee (SC) of APLAR is composed of 22 expert members from each APLAR special interest group (SIG). Known as the soul of APLAR academic activities, we organise all the APLAR scientific events in cooperation with the APLAR educational committee.

For the last 2 years, the COVID-19 pandemic has placed significant burdens and challenges on all countries in the Asia-Pacific region. Therefore, APLAR has devoted its activity to establishing guidelines for optimal practice management in rheumatic diseases during COVID-19 developed by APLAR’s COVID-19 Task Force and overseen by SC. For this term, SC will continue to report on issues related to COVID-19 that alter and affect the care of rheumatic diseases. As the COVID-19 pandemic continues, active in-person communication for academic activities as well as learning opportunities are still very limited. In consideration of this situation, we are planning to hold a virtual webinar program to provide interesting topics actively driven by each SIG.

Rheumatology is one of the most rapidly developing fields in medical science due to major advances being made in immunology research. In accordance with updated knowledge, APLAR plan to open the Mid-Term 'State-of-the-Art in Rheumatology Advances' Symposium. An online short-course program between annual meetings, which will include recent updates on important rheumatic diseases in the last year. We are sure this will continue the professional development of rheumatologists in the APLAR region and improve management and outcomes in patients with rheumatic diseases suffering from pain and disabilities.

APLAR has already initiated this activity with the release of a consensus for the management of systemic lupus erythematosus (SLE) last year. We endeavour to support the development and renewal of guideline recommendations for major rheumatic diseases in collaboration with each SIG this year.

Another important mission of SC includes research collaboration among APLAR member nations and beyond APLAR, with international organisations such as the European Alliance of Associations for Rheumatology (EULAR). To accomplish this mission, we are going to develop a cohort registry involving all countries in the Asia-Pacific region, which will be the driving force to improve the scientific achievements of APLAR.

We hope the COVID-19 pandemic will come to an end soon and look forward to meeting face-to-face at the APLAR 2022 Congress in Hong Kong.
SPONDYLOARTHRITIS

The APLAR Special Interest Groups (SIGs) were established to develop sustainable scientific interactions among rheumatologists from countries within the APLAR region. Described as the ‘glue,’ they bring together like-minded rheumatologists with specific interests in each field of rheumatology. Members of SIGs are nominated by national organisations and convenors are selected by APLAR’s executive to meet the educational requirements; provide enhanced SpA patient care; and provide collaborative SpA research; and provide educational symposia for the annual APLAR congress. The APLAR SpA registry has been actively recruiting SpA patients amid the COVID-19 pandemic. The first abstract [Gulf], South Korea). Currently, we have successfully recruited over 200 patients from the COVID-19 pandemic. The first abstract on the effects of treat-to-target management in SpA has been submitted to the European Alliance of Associations for Rheumatology (EULAR) 2022 congress.

The first mission is to encourage collaborative SpA research; provide timely, unbiased, evidence-based, collaborative SpA research; provide educational symposia for the annual APLAR congress. The APLAR SpA registry has been actively recruiting SpA patients amid the COVID-19 pandemic. The first abstract [Gulf], South Korea). Currently, we have successfully recruited over 200 patients from the COVID-19 pandemic. The first abstract on the effects of treat-to-target management in SpA has been submitted to the European Alliance of Associations for Rheumatology (EULAR) 2022 congress.

The third mission is to offer continuing medical education activities for physicians and healthcare professionals looking after patients with SpA.

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TABLE 1: SLE SIG SYMPOSIUM 2021

<table>
<thead>
<tr>
<th>SESSION</th>
<th>PRESENTATION, SPEAKER</th>
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<tbody>
<tr>
<td>Recent Progress in Targeted Therapy for SLE</td>
<td>Prof Sandra Navarra</td>
</tr>
<tr>
<td>Emerging Strategy for Lupus Care and Research</td>
<td>Dr Yoshiya Tanaka</td>
</tr>
<tr>
<td>APLAR Guidelines for Management of SLE</td>
<td>A/Prof Kenji Oku</td>
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</tbody>
</table>

TABLE 2: APLAR SLE WEBINAR ON WORLD LUPUS DAY, MAY 8TH, 2021

<table>
<thead>
<tr>
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<tr>
<td>Session I, chaired by Prof Sandra Navarra</td>
<td>APLAR SLE SIG: An Introduction, Prof Yoshiya Tanaka</td>
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<td>Session II, chaired by Prof Yoshiya Tanaka</td>
<td>Updates in Lupus Nephritis Treatment, Prof Sandra Navarra</td>
</tr>
</tbody>
</table>

NEW PROJECTS OF THE VASCULITIS SIG IN 2022

In 2022, Vasculitis Special Interest Group (SIG) launches three major projects:

1. Vasculitis SIG Webinar on May 9th
2. Developing APLAR recommendations for vasculitides
3. Generating short online courses of vasculitides

In the Vasculitis SIG Webinar of this year, we are planning to leverage case-based discussion to provide interactive learning opportunities for young rheumatologists. In the webinar, interesting vasculitis case studies will be presented at the beginning with some key questions, and two discussants will share their opinions and comments. It will be a valuable opportunity to learn real-world management of vasculitides with a guide of experts in this field. Standardization treatment of vasculitides is of clinical importance. Vasculitis SIG is going to initiate developing APLAR recommendations for some of the major vasculitides such as Takayasu arteritis, giant cell arteritis, anti-neutrophil cytoplasmic antibody-associated vasculitis, and polyarteritis nodosa. Vasculitis specialists of the APLAR member nations are expected to contribute to this project and we are certain it will foster collaboration among our vasculitis community. Young rheumatologists are welcomed to join this project as a member of the systematic review team. Pathogenesis, diagnosis and management of vasculitides are rapidly evolving. Novel treatment armaments are becoming available every year with better outcomes of patients with vasculitides. As such, continuing medical education for physicians and healthcare professionals is indispensable to deliver optimal medical care. The vasculitis SIG has started generating short online courses of vasculitides to meet this demand. The vasculitis SIG will make all-out efforts to tackle these challenges and your contribution is the key element in leading to success.

In 2021, we also published two APLAR SLE management guidelines. This process involved discussions via face-to-face meetings during APLAR conferences between a steering committee (the APLAR SLE SIG members) and core group members (9 other SLE experts from the Asia-Pacific region) and lead to 35 proposed statements based on clinical practice.

APLAR Lupus Registry

APLAR Lupus Registry generates APLAR Lupus Registry. The group is currently performing to either (i) coordinate with the Asia-Pacific Lupus Collaboration (APLC), which has the largest database to date and involves several countries in the APLAR region, to construct the registry or (ii) provide support to develop and maintain country-specific APLAR databases or registries in individual countries e.g., the Chinese SLE treatment and research group (CSTAR) registry. In both cases, the registries will require logical support from their national rheumatology association or government.

PUBLISHED GUIDELINES

4. Hami-Joyo, Indonesia

APLAR Young Rheumatologists' (SLE) special interest group (SIG). Expected activities of SLE SIG are as follows and here we detail our contribution to APLAR in 2021.

APLAR Lupus Registry

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"LAUNCHING THE APLAR DIGITAL HEALTH & TELEMEDICINE"

The last two years witnessed an abrupt and unplanned move in the way rheumatology care was provided – the move to telemedicine during the pandemic. Before 2020, rheumatology did not have widespread use of telemedicine, mainly implemented due to the necessities of a limited rheumatology specialist workforce or to reach geographically remote communities. However, many of the pandemic-driven telemedicine services have been formally evaluated with a rapidly-emerging literature base providing insights into whom, how, and when telemedicine can be more (or indeed less) successful.

In addition to increased use of telemedicine, rheumatology is beginning to see more research exploiting other areas of digital health, for example, wearables, chatbots, machine-learning, patient-facing apps and online learning for professional development. While digital transformation and services are common in our day-to-day lives (such as banking, shopping, and entertainment), digital adoption in healthcare has lagged behind. Most technology adoption has been limited to digitising health records and information management. The gradual incorporation of mobile-based monitoring, digital epidemiology, AI (artificial intelligence)-aided screening and diagnosis, smart apps (electronic medical records) and precision medicine is inevitable in the near future, and therefore rheumatologists also need to be prepared for these. Our patients expect us to be prepared and continuously innovate ‘futuristic’ solutions; many patients are under the impression our clinical work is already supported by cutting-edge technology and wonder why we do not already provide apps for remote monitoring or have telemedicine embedded in our workflows. In Singapore, patients have embraced digital health initiatives such as the rollout of mobile applications to access their electronic health records, management of appointments, and teleconsultation. There are, however, growing expectations for better and more advanced applications of digital health, such as a digital health converge, robotics, AI imaging and clinical decision support. On the other hand, Singapore has also observed the real challenges of digital health, ranging from cybersecurity issues (2018 SingHealth data breach) to the digital divide between the young and old.

This digital health transformation must be done with caution to ensure improvements in the quality and safety of care patients receive while preserving the human side of medicine. The Digital Health and Telemedicine SIG faces the exciting challenge of supporting research that informs practice across a large region with differences in national digital infrastructure and health systems. Our first year’s activities will focus on building relationships of research collaborations and beneficial research areas. By supporting the development of research collaborations and education in digital health across APLAR regions, this SIG hopes to contribute to the inevitable digital health revolution in rheumatology.

APLAR DIGITAL HEALTH & TELEMEDICINE

24th Asia-Pacific League of Associations for Rheumatology Congress
Hong Kong Convention and Exhibition Centre
6 - 9 December 2022
In order to address the unmet educational need in the APLAR region, Professor Debashish Danda (President, APLAR) proposed to set up the APLAR Academy to provide timely, unbiased, evidence-based, rheumatology medical education and supplemental resources to help meet the educational requirements and provide enhanced patient care for APLAR members. Our mission is to offer continuing medical education activities for physicians and healthcare professionals looking after patients with rheumatic diseases. All participants can join the live webinars or short courses as well as access the unbiased, evidence-based, rheumatology medical education and supplemental resources to help meet the educational requirements and APLAR Academy which was endorsed by the General Assembly on August 20th, 2021.

The APLAR Academy is led by a group of senior experts committed to advancing rheumatology through programs of education and practice support relating to the care of people with arthritis and rheumatic and musculoskeletal diseases as illustrated in Figure 1.

FIGURE 1: GOVERNANCE OF APLAR ACADEMY

- **COORDINATOR**
  - Professor, Lai-Shan Tam

- **STEWARDS COMMITTEE**
  - President, Prof Debashish Danda
  - Immediate Past President, Prof Syed Atiqul Haq
  - President Elect, Prof Tatsuru Takeuchi
  - Education Committee Chairperson, Prof Catherine Hill
  - Education Committee Co-chairperson, Prof Rong Mu
  - ASPIRE Convener, Dr Priscilla Wong

- **WEBINAR COMMITTEE**
  - Prof Syed Atiqul Haq

- **SHORT-COURSE COMMITTEE**
  - Prof Catherine Hill & Prof Rong Mu

- **EDUCATION COMMITTEE MEMBERS**

- **SIG CHAIRPERSONS**

- **C&I COMMITTEE MEMBERS**

- **AVR EDUCATION COMMITTEE CHAIR**

**APLAR Grand Round**

APLAR Grand Round is a mandatory educational webinar designed for all rheumatology trainees and rheumatologists in APLAR. APLAR Grand Round, APLAR Grand Round Forum and APLAR Blackboard is a bundle of this initiative. Each APLAR Member National Organisation (MNO) is encouraged to have an AVR member and a Guest Faculties as presenters. A yearly roster with a theme and the hosting MNO is posted on the APLAR website. The presenters have full autonomy to decide the presentation and topic name around the theme.

APLAR Grand Round Forum is an online platform on the APLAR website that is open to all to write comments, share knowledge, exchange ideas and experiences. All attendees are welcome to write in this Forum around the theme of the Grand Round. APLAR Blackboard is where one multiple choice question related to the theme of the Grand Round is posted on the APLAR website. A detailed explanation with scientific evidence for the answer is provided to foster the topic learning.

**Learn more here:** [www.aplar.org/events_page/APLAR-grand-round](http://www.aplar.org/events_page/APLAR-grand-round)

**APLAR SIG Webinars**

The APLAR webinars are organised by the APLAR SIGs and take place once every month. These excellent webinars including “Gout in an Asian Population” and “A New Insight into Clinical Practice” have provided self-assessment questions to help develop clinical reasoning skills and to deepen the knowledge and insight of the topics.

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Serum Urate Targets for Gout Back in the Spotlight

T wo recent studies validate the way rheumatologists have been practicing in recent years, but poor patient adherence to treatment remains a sticking point.

Achieving an average serum urate concentration of less than 0.36 mmol/L, over a six-month period is associated with a reduction or absence of gout flares and resolution of tophi in people with gout during the second year of treatment, a study published in the Lancet Rheumatology has found. A second study, published in Arthritis & Rheumatology, has found lowering the serum urate target to less than 0.20 mmol/L, for patients with euvurate gout, does not achieve better outcomes than the recommended target of less than 0.36 mmol/L.

Associate Professor Helen Keen, a consultant rheumatologist at St. George Hospital, said the results would probably not come as a great surprise to rheumatologists.

"Both studies I think neither change our practice but indeed validate the way rheumatologists have been practicing in recent years," she said. "The ACR (American College of Rheumatologists) had previously recommended a treat-to-target strategy of 0.36 mmol/L, and 0.30 for those with tophs, which was not really based in strong clinical evidence," she said. "This somewhat justifies the ACR recommendations.

For euvurate gout, said Professor Keen, a target of 0.20 mmol/L was more difficult to achieve without clinically important improvements over a target of 0.30 mmol/L. "I think these papers, taken together, suggest that we should be aiming for a target of 0.36, but not for 0.20. It's unclear that a target of 0.30 will produce better outcomes than 0.36."

In the first study, researchers analysed patient data from two clinical trials, conducted in the US and New Zealand, on urate-lowering therapies in people with gout. Individuals who on average achieved a serum urate concentration less than 0.36 mmol/L were defined as serum urate responders (343 patients), while non-responders (245 patients) had an average serum urate of at least 0.30 mmol/L. Clinical outcomes were assessed between 12 and 24 months, with significantly fewer serum urate responders having a gout flare than non-responders (27% vs 64%). Meanwhile, research on gout flare led by Professor Nicola Dobbie, an academic rheumatologist at the University of Auckland, has found that lower may not always be better. In a two-year, double-blind, randomised controlled trial, 104 participants with euvurate gout on oral urate-lowering therapy (ULT) and serum urate >0.30 mmol/L were randomly assigned to serum urate target >0.20 mmol/L (intensive target) or <0.30 mmol/L (standard target, according to rheumatology guidelines).

Although the serum urate was significantly lowered in the intensive target group than the standard target group, fewer participants in the intensive group achieved the randomised serum urate target. The intensive target group required higher allopurinol doses and more allopurinol administration. Small increases in CT erosion scores were observed in both groups over two years, with no between-group difference. The Outcome Measures in Rheumatology (OMERACT) core outcome domains [gout flares, tophus, pain, patient global assessment, health-related quality of life and activity limitation] improved in both groups, with no between-group variation. Adverse event and serious adverse event rates were similar between groups. Dobbie-rheumatologist and head of Sydney's Clinical School of Medicine at the School of Rural Health, Professor Mark Arnold, said the treat-to-target issues for gout were overshadowed by the problem of poor patient adherence to treatment.

"Most rheumatologists have been doing treat-to-target for at least a decade," he said. He acknowledged that only a minority of gout patients ended up seeing a rheumatologist, and that this was another barrier to successful outcomes, given that the management of gout required an ongoing treatment protocol. "We should be almost delighted to see people with gout because we're almost always on a winner – provided they stick to the treatment plan," he said.

A Nail in the Coffin for PRPs in Knee OA?

P lentoid-rich plasma (PRP) injections are no better than placebos at reducing knee pain or slowing disease progression in knee osteoarthritis (OA), according to an Australian trial that sought to overcome clear weaknesses in past studies.

The largest trial of its kind to date, the RESTORE trial randomised 286 adults with mild- to-moderate radiographic knee OA and found PRP injections were no more efficacious than saline for symptom relief at 12 months. Findings were published in JAMA.

"As more high-quality trials are being conducted for PRP in OA, we find no meaningful benefit of PRP when compared with placebos," Dr Shirley Yu, a rheumatologist at Royal North Shore Hospital and co-investigator of the RESTORE trial, told Rheumatology Republic.

It follows two recent randomised controlled trials that also found PRP therapy provided no benefit for knee OA and Achilles tendinopathy over placebo or sham injections, and a Cochrane review which concluded PRP injections "probably provide little or no clinically important benefit for pain or function" of lateral elbow pain. As a result, experts said PRP injections should no longer be offered to patients in place of proven management options for OA, such as exercise and lifestyle modifications.

The RESTORE trial included 286 patients (of whom 245 were randomised to treatment and 41 to placebo) who were given either PRP or saline injections into the knee at baseline and after three and six months.

"Both studies I think increase in CT erosion scores for at least a decade," he said. "This is exacerbated by the absence of rigorous trials. Meta-analyses can amplify trial results, especially if they are positive. However, we need to be careful with the conclusions."

Meanwhile, research on PRP for pain or cartilage thickness, "high-quality evidence" that PRP treatments were not effective for treating knee OA. "The results do not carry more weight than the earlier, flawed trials of PRP for knee osteoarthritis," said Professor Abbott, who was not involved in the study. Professor Abbott noted that many past trials compared PRP with other treatments, "namely hyaluronic acid and corticosteroid injections that themselves have very shaky evidence of effectiveness", with "very, very few placebo-controlled studies" to date. However, he added the RESTORE trial may not alone provide definitive evidence denouncing PRP injections unless another, large, well-designed, well-controlled trial replicates the findings.

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The Grass is Always Greener on the Alternative Side

I remain a bit uncertain about whether cannabis really does have a place in the rheumatology armamentarium, and better trials are needed. This article is going to discuss medical cannabis for chronic pain, but cancer and headache were included in the review as well. There were if you tried to use all the published evidence is based on small trials using inhaled cannabis. The distinctive smell makes it impossible to blind thus there was a bit of a vexed issue over medicinal marijuana. This has been quite rare in my experience).

Moreover, my view is that this paper by Wang et al. (including data as evidenced in the recent Cochrane methodology. There have been some reviews looking at the evidence for cannabis, so I often recommended patients get some seeds from their grandchildren and see if this helped (preferably as butter rather than smoked). This was put to the test when the police rang me and asked if I told her to grow 57 plants! Clearly, this would be the best fit for fibromyalgia but there was no evidence she was selling it, so she got off with a caution (but she probably should have been offered a job as a gardening consultant). Generally, it seemed to help when it was used in this way. Now it is legal [but expensive], we have had a lot more experience. Results range from amazing to absolutely nothing with more of the latter. It seems to be the best fit for fibromyalgia but the published evidence is based on small trials using inhaled cannabis. The distinctive smell makes it impossible to blind thus there was a bit of a vexed issue over medicinal marijuana. This has been quite rare in my experience).

There were some studies reviewing a potpourri of conditions, with none specifically within our area. These have generally had small numbers. Thus, it was a surprise to see how many trials there were if you tried to use all the data as evidenced in the recent paper by Wang et al. (including our own Rachel (Bumble"

The overview used rigorous Cochrane methodology. There were 32 trials with more than 5,000 subjects. It was still a real mix of subjects with neuropathic pain being the most common (11 trials), but cancer and headache were also included. They only included studies lasting more than four weeks using oral, sublingual or topical formulations (not inhaled).

You can take the simple approach by looking at the forest plot below (Figure 1) and concluding that cannabinoid area modestly effective for pain with a weighted mean difference (WMD) of 0.13 (as well as 0.06 once the placebo was dropped). However, my view is that this would not be so strong. From Figure 1, you can see results are heterogeneous (as many of the confidence intervals don’t overlap). Also, the larger trials tend to have smaller or non-significant effects, suggesting bias in the smaller trials (even if the authors didn’t document this in a formal meta-regression). There are also some smaller trials with numerically worse than placebo (which is quite rare in my experience).

Overall, there was a high role of bias in these studies. The supplementary tables did suggest that it works better in non-cancer pain and specifically non-neuropathic pain. It also suggested the combination of tetrahydrocannabinol (THC) and cannabidiol (CBD) works better than CBD alone and THC has issues for drug testing. I have tended to use CBD alone for this reason but may need to rethink this. There was also some modest toxicity with transient cognitive impairment, vomiting, drowsiness, impaired attention, nausea and dizziness. Oral had more dizziness and headache, otherwise, they seemed similar.

When you combine recent experience with the studies in our area and the modest efficacy and toxicity in other areas, I remain a bit uncertain about whether cannabis really does have a place in the rheumatology armamentarium. What I would like is a well-done trial in fibromyalgia (and maybe osteoarthritis) with adequate blinding before I become more (or less) enthusiastic.

I also need some high-quality data on which of the more than 100 active components help therapeutically. I was involved in designing one of these studies a number of years ago with Australian companies and there has been no progress, so I am not optimistic.

**FIGURE 1. Pain relief on a 10 cm visual analogue scale (VAS) among people living with chronic pain who received non-inhaled medical cannabis or cannabinoids versus placebo.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Cannabis group</th>
<th>Mean±SE</th>
<th>Placebo group</th>
<th>Mean±SE</th>
<th>Mean difference</th>
<th>95% CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic non-cancer pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rigby et al 2005</td>
<td>2.85±0.90</td>
<td>33</td>
<td>1.96±0.89</td>
<td>32</td>
<td>0.89±0.89</td>
<td>-0.60 to 2.39</td>
<td>0.17</td>
</tr>
<tr>
<td>Sekaran et al 2006</td>
<td>-2.00± 1.14</td>
<td>27</td>
<td>-1.94± 1.14</td>
<td>27</td>
<td>0.06± 1.14</td>
<td>-2.24 to 2.36</td>
<td>0.93</td>
</tr>
<tr>
<td>Nx</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

**Predicting Early RA on MRI**

MRI scans can help predict rheumatoid arthritis (RA) progression and could prevent overtreatment in select groups of patients with early arthritis, a large Dutch imaging study has found. The prospective study of nearly 970 patients with undifferentiated arthritis (UA) tested the predictive value of MRI scans compared with the swollen joint counts, inflammatory markers and autoantibodies that are usually assessed. The study, which was published in Rheumatology, found that detecting tenosynovitis on MRI predicted the patients more likely to develop RA and who would benefit from early treatment before joint destruction occurs. The results of this study could be helpful in achieving precision medicine in patients with UA and in preventing overtreatment, Dr Nikolot den Hollander and colleagues at the Leiden University Medical Center in the Netherlands wrote.

Two groups of early arthritis patients, who had at least one affected joint and symptoms for less than two years, were consecutively included over 10 years. Patients either didn’t fulfill criteria for SA and had no clear alternative diagnosis, or their treating rheumatologist had indicated undifferentiated arthritis. The predictive value of MRI was similar in both groups so MRI could be helpful in clinical practice and future imaging studies, the researchers wrote. Contrast-enhanced MRI of the hands, wrist and feet taken at baseline were scored for inflammatory features, including bone inflammation, synovitis and tenosynovitis. Of these inflammatory features, MRI-detected tenosynovitis was the strongest predictor of developing RA 12 months later. Patients with inflammatory tendon sheaths on MRI were 2.3–3 times more likely to develop RA within a year, the study found. MRI was most valuable among autoantibody-negative patients with oligoarthritis, where a negative MRI largely excluded the development of RA. “The absence of MRI signs of tenosynovitis in this subset [of patients] predicts that RA is unlikely,” said Sydney-based radiologist Dr Sebastian Pung, who was not involved in the study. The result may prevent overtreatment, the researchers said.

Moreover, MRI-detected tenosynovitis, but not synovitis, was as predictive as the total inflammation score, suggesting that “in practice, only MRI-detected tenosynovitis can be assessed rather than evaluating all features,” Dr den Hollander and colleagues wrote. Professor Paul Bird, a rheumatologist at UNSW Sydney examining the use of MRI scans in inflammatory arthritis, said that based on the study results, MRI of the hands, wrists and feet could help classify patients at risk of developing RA and stratify treatment accordingly. “One of the challenges for clinicians is classifying patients with ACPA-negative oligoarthritis and this can have implications for access to therapy,” Professor Bird said. “The study provides evidence that MRI can be a predictive of progression to RA in patients with undifferentiated arthritis,” he continued. “Longer follow-up would be useful, but the results show utility of the method after 12 months.”
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