Report by Dr. Fred Doris, Recipient of 2016 ORADE Grant.

Clinical Science Session, EULAR – Thursday, June 9, 3:30pm

Presentations by Michael Weinblatt (Chair), Michael Schiff (Abstract SP0096), Robert de Jorge (Abstract SP0097) and K. Michaud (Abstract OP0142)

Can you name the medicine that we identify as the 'anchor' or 'gold standard' in the treatment of our patients with rheumatoid arthritis? Of course, Methotrexate is the drug. Rheumatologists inherited from this pharmaceutical from our dermatology colleagues in the 1980s. I was privileged to attend EULAR for the first time in many years as a result of an ORADE (ORA Development and Education) grant to fund my attendance in London in 2016. The clinical science session that I reviewed, "Optimization of MTX in RA Treatment ", presented lots of familiar information. There were a surprisingly number of educational nuggets that I had never knew or … just forgot.

- ✓ We still under dose our anchor drug. In a descriptive review from the University of Nebraska from 1998-2009, a lot of RA patients didn't get MTX (even before a biologic). Average dosing was 11.5 mg!
- ✓ Mike Schiff is about to publish an algorithm on PK/PD dosing. You are all right; MTX 25 mg po is roughly about 17.5 mg sc dosing.
- ✓ MTX dose doesn't predict patient response.
- ✓ Genomics doesn't predict patient response but it might relate to the concentration of the important downstream polyglutamates (PGs) that seem to correlate to ACR responses.
- ✓ Predicting MTX response might be predictable, but is still rather wishy washy: SNRPs, RBC folate levels, patient factors such as smoking etc.
- ✓ MTX action may not be exclusively due to anti-folate purine disruption. Adenosine receptor expression in rheumatoid synovium may be a basis for methotrexate action.

- **EULAR was well organized and informative for me. Thanks ORA for sending me!**

Dr. Fred Doris, June 2016