Report from the 4th Annual Workshop for Myositis Network (MYONET), January 30 – 31, 2014, Prague, Czech Republic

Summary

This meeting was attended by clinicians and scientists from different European centers involved in clinical care and in research on patients with idiopathic inflammatory myopathies (IIM). Altogether 50 participants met in the hotel Clarion in the center of Prague in the Czech Republic. There were participants from the Czech Republic, Sweden, Netherlands, United Kingdom, Norway, Belgium, Switzerland, Austria and Germany as well as from other countries interested in the program, such as from France, Denmark, Hungary, Poland, Italy and China. The aim was to bring interested parties together and discuss ongoing and future activities in the area of myositis research. There were several areas that were discussed in detail. New MyoNet web page for the program was presented. "Euromyositis registry" is a web based database of patients with IIM. There are over 3000 patients already entered into the database, some with longitudinal follow-up data. Details on the registry were presented together with some amendments that were recently introduced. Policy of joining the registry was outlined for the centers not yet participating in this activity. Juvenile dermatomyositis has been added to the registry. Addition of inclusion body myositis was discussed. A report from large Chinese registry of patients with myositis was given and interest was raised in collaboration between the two registries.
A change occurred recently in MyoNet regarding the autoantibodies research. PeterCharles from London has left the field and the tasks as well as the serum materials were transferred to Johan Ronnelid from Uppsala, Sweden. Results of investigations will appear directly in the registry. Other aspects of autoantibody detection were discussed together with the update on the gold standard immunoprecipitation technique. Several European collaborations are ongoing regarding the new antibodies and their clinicoserologic correlations.
Report from the ESF supported meeting on pathology aspects was given and further work to reach consensus what to include in the pathology reports on myositis samples is ongoing.
More than 3000 samples from 13 countries were analyzed using immunochip technique and results are being processed. Genes more frequently found in myositis patients will be compared with clinical and autoantibody data.
New project investigating a role of type I interferons in several autoimmune diseases was presented and MyoNet members were invited to participate.
Variable responsiveness to change in different muscles during manual muscle test was presented. New treatment approaches and current studies to treat myositis were overviewed and discussed.
Finally results of the recent project which developed new classification criteria for patients with idiopathic inflammatory myopathies were presented.
Meeting was well received and it was announced that the 1st international conference in myositis will take place in Radisson Royal Blue Park Hotel, Frösundavik, Stockholm, Sweden, in the 1st week of May 2015.

Description of the scientific content of and discussions at the event

Abbreviated minutes for the Annual workshop for Myositis Prague 30th-31st January 2014

Myositis network, report from Steering Committee (Ingrid Lundberg): EuMyoNet approved by ESF in May 2010. 9 countries. Budget 85k EUR/year. Half term report well received. End of the program May 2015.
New Myonet webpage: - new patient folder (may be translated to local languages); - everybody encouraged to submit their activity reports and results.
Euromyositis registry: - certificate to those who care (or need one); - currently over 3000 pts in database, need better f/u info; - biobank for genetic and serological studies; - facilitates clinical trials; - platform for functional cellular and molecular studies; - need for a new funding from 2015 (options: Horizon 2020, New AFM grants + other initiatives collaboration with Pharma, research foundation?).
AFM grant to develop biomarkers 230k EUR. Apr-May/ 2015 Stockholm: first international conference on IIM
Reminder: All data presented at this workshop is confidential!!

Myositis registry including IBM (Hector Chinoy): History of registry. Practical demonstration of the database. Core data versus longitudinal (visit) data. Lacking longitudinal data on many patients.
Diagnosis classification is important. Necrotizing myopathy now does not include statin induced and is entered separately. For statins have to record proper category (IMNM/rhabdo/myopathy) based on the provisional agreement. Problems with coding antisynthetase syndrome (PM versus DM versus isolated ILD). Contains all IBM classification criteria. Able to record autoAbs including method and day of detection. Need more work to finalize the biopsy section. Possible to record detailed treatment info.

Discussion: There needs to be an option to tick not done in the 0-10 sections, important for JDM, zero may mean different things (0 or not done). Is database useful in the clinic? A: quicker than the old way, but hospitals with fully electronic record need to enter twice, integration would be nice. Scoreboard may be shown to patient during visit. Challenge to design registry useful for both research and clinical use, compromises have to be made.
New validated measures and tools should be built in in the future (or dropped).

Registry - practical issues (Niels Steen Krogh)
Who is the guy behind the Internet? How to enter and review data – demonstration. Data protection, procedures to set up access. HAQ and other patient reported data should be entered by pts in the future.

UK JDM registry (Lisa McCann): In Euromyositis there are only 77 JDM, 10 JPM (adult section). JDRG database collects data about 435 JDM cases. What information is important to capture? Cooperation with CARRA, PRINTO when forming the JDM minimal dataset. JDM Euromyositis has 10 domains. Almost ready to go live - waiting for steering committee approval. Next steps: advertise and get others to enter data. One of advantages is to follow children into adult age. Need to gain international agreement on the minimal dataset. Planned for 2014-16 (includes not only expert opinion but also feedback from patients and parents).
Discussion: it is hard to agree on minimal amount of data, difficult to remove things to keep set truly minimal. Core data should be aimed at clinically important issues, another tier may include research oriented agenda
Should adult JDMs be entered as adults or as children?

Chinese myositis network (Guochun Wang): There is lack of data regarding incidence and prevalence of IIM in China Single center experience: total of 100 new cases per year, DM more common than PM, IBM is very rare. Community based epidemiological survey is underway. Overview of clinical research published. Basic research: NETosis in DM (impaired DNase activity in pts with ILD). TWEAK-Fn14 in PM/DM. STRAIM: treatment trial, planning to enroll 564 cases, randomized, open label treatment, Registry ChiCTR-TRC, based on the presence of ILD, comparing GC, GC+MTX, GC+MMF (with ILD) or LEF (without ILD).
Chinese registry established, cooperation with Beijing institute of genetics. Over 400 patients, include clinical+other data. Joined Euromyositis network. Large patient pool, looking for cooperation.
Discussion: Everybody is impressed. Data regarding leflunomide efficacy in IIM? Registry is similar to Euromyositis, it is used in clinical trials. Might be good to cooperate at the classification criteria project, phenotypes are different. Anti-MDA5 more common in China. Is it related to NETosis? Pollution levels in Beijing related to differential expression of different subtypes? Pollution related to risk of ILD? Use differential pollution levels and correlate with MDA-5. City versus country. There is no difference in incidence between China and Japan. In UK pollution is getting better but autoimmunity is getting more common. Why is there very little IBM: not recognized versus truly low prevalence. How much autoAb screening is done? In all patients, 4-5 autoAbs. Is MDA-5 routinely done (only in this department, percentage is high). There may be 2000 new IIM cases a year in China!

General discussion: How to get more IBM cases into the registry? Set up a dedicated project? Getting retrospective biopsies on registered cases, getting extra consents from patients. Need to cooperate with neurologists. There are therapeutic trials for IBM coming our way. There are important differences between individual classification criteria. Value of the Mup44 antibody? Overlap with Sjögrens syndrome- may be Ro positive and still be IBM.
Statin induced myopathy needs to be investigated. Not only the HMGCR positive ones, but others as well (mild persistent elevation of enzymes). Is it safe to restart statin? Should statin use be recorded in the registry?
Beware of archive material. Many old cases may be misdiagnosed.
Is 6 minute walk test useful? It is used in assessment of IBM as primary endpoint.

Current status of autoAb screening in MyoNet (Johan Rönnelid): What is available on the new line blot (as of Jan 2014): (MJ, anti-TIF, CADM140, SAE, Mi2a), anti-HMGCR not available yet. Ro52 no longer on the blot. How the Euroimmun line blot is read - able to get quantitative readings with scanner. How to create a new lab request, what happens in the lab? Test tubes have to be labeled with the proper sample number (EM and 5 digit code, PRINT, no scribbles), all samples in one Excel table, PI informed by Email as soon as results available. So far - 5 patients found with multiple specificities, always either Mi-2 or PM/Scl. Will send out instructions, will set deadlines for sample analysis (every three months?)
Discussion: Excel tables are the same for the lab and database to prevent errors, results are technically placed in the request. Euromyositis registration required to get results. Is re-evaluation in Bath required - board to decide, samples are available. Samples from the Kennedy Institute were sent to Karolinska after Peter Charles left MyoNet. Line blot specificities have not been validated on a larger scale yet. What is the cost? Much cheaper than hospital lab, 2EUR per strip + technician time.

IP results + new autoAbs (Neil McHugh): 2000 IPs completed, 824 PM, 668 DM, 138 IBMs. 140 bands difficult to distinguish, Ro not available. Only 15 % IBMs are negative. Looking at CAM autoab associations. 172 UK JDM pts + 42 adults from EuMyonet. NXP, TIF1, MDA all precipitate 140, can discriminate, working on a system to validate results, ELISAs available, 550 samples migrate around 140, compared with healthy controls, and myositis samples without band in this region. Sensitivity of ELISA is good, specificity?? There may be association between titer and activity HMGCR - working on ELISA, validating using immunoblot, over 1000 samples analyzed, ELISA seems to be working well. Low positive versus high positive. There seems to be tight correlation between statin use and antibody generation. Overview of ongoing projects.
Discussion: In France MDA5 like antisynthetase phenotype. Anti-HMGCR can be present without history of statin use. Mi-2 patients without DM - may be a lineblot issue (Euroimmune seems to perform better in terms of specificity). Use tests in other autoimmune diseases as well (apart from IIM). Correlate environmental exposure between children and adults with the same antibody but different phenotype (problems with screening ILD in children - radiation exposure).

New IBM antibodies - Mup44/cN-IA ad anti-Mup44 (Megan Herbert): cNA-IA antibodies published simultaneously by 2 groups. Dephosphorylating enzyme. 3 regions recognized by IBM sera. Synthetic peptide ELISA tested with good results. 36% sera highly reactive to 1 or more peptides. Compared to other autoimmune diseases (weak reactivity when healthy control cut off used, better discrimination with higher cut-off), also appear in SLE and Sjögrens syndrome. Looking for other epitopes, expressed in HEp2 cells, cN-1A localization in muscle tissue (type 2 muscle fibers), co-localization with actinin, found in some rimmed vacuoles. Myositis specific perinuclear staining reported previously, could not replicate.
Discussion: investigate clinical features of SLE and SjS pts with these antibodies. Correlate autoAb positivity with biopsy.

Anti TIF1 autoAbs (Heřman Mann): Comparing clinical features, autoantibody and HLA associations between 3 groups: , TIF1 positive CAM positive, CAM negative and TIF1 negative CAM patients. Waiting for complete data from the UK cohort.
Discussion: Is there a difference between children and adults with the antibody in terms of genetics?

Quantitative detection of anti PM/Scl (Lenka Pleštilová): 10% IIM patients are positive, ELISA to detect anti-PM1a (main epitope of the main antigen) used. BAFF levels compared with healthy controls, correlated with other features Cohort of 87 patients including some with longitudinal data. 40 controls. Antibody detected in sera and or plasma. High BAFF levels in PM/Scl positive patients compared to HC. Levels and changes of levels correlated with clinical parameters (and changes thereof). Change of BAFF correlates with anti-PM1 and CK, also with changes of measures of disease activity. Potential biomarker and therapeutic target?
Discussion: In the RIM study there was a good response to rituximab in anti-Jo1 positive patients and less so in PM/Scl patients. Is there more BAFF in anti-Jo1?

General discussion: Does previous administration of IVIG influence autoab detection? Reminder of our aim: to get good phenotype and genotype associations. AFM grant available to cover serotyping. Should we do IP in everybody or only in patients with negative pre-screening using line blots. More effort needed to validate lineblot. Need to discuss options (using ELISA, testing old sera etc?).

Pathology diagnosis of IIM- workshop report (Jan de Bleeker): Every biopsy should be analyzed in a uniform fashion, same technique and same scoring system. Correlate biopsy findings with other features. Avoid the unspecific category. Learning from the JDM world. Group evaluation of biopsies - opinion different at the microscope and at desk. Follow-up ENMC workshop will be in March (only experienced pathologists to attend). Analyze 50 biopsies, reach consensus.
Discussion: Pathologist should describe what he/she sees, not to make a diagnosis. Collect personal ideas and preferred techniques from experts, use web-page. Make it simple in order to reach consensus. Avoid complex grading. Send out biopsies around to ensure quality control/consistency. Can 3 labs prepare the same biopsy specimens?

Pathology in JDM (Janice Holton): Biopsy features in JDM. 2007 score tool developed to record and grade changes in JDM biopsies. Consensus what to include and how to define changes. 2013 validation, quadriceps/ biceps, inter and intra-rater reliability, correlate findings with clinical data. The tool is reliable, correlation with clinical features was good, some changes more prominent in biceps biopsies.

Discussion: Starting point is different - JDM - grade changes, IIM - make diagnosis. Can biopsy score be used to predict of treatment response? Currently analyzing the key features. Repeated biopsies in adults might be helpful. Need a large number of biopsies (heterogeneous population). Repeated biopsies should be part of a trial design. Tissue processing needs to be clearly specified.

Immunochip studies (Simon Rothwell): Genetic overlap across 12 autoimmune diseases. Illumina chip designed - 186 regions implicated. Makes analysis cheaper. 3284 samples from 13 countries were analyzed. Controls not available for some populations. Analysis by diagnosis and antibody. Some samples of pts with various other conditions - include or not? What genes are implicated, polymorphisms associated with risk, differences between phenotypes? Integrating HLA, associations with new/rare autoAbs.
Discussion: First major project using the registry data. What is the importance of controls?

Interferon signature in 3 systemic diseases (Lars Rönnblom): New project to start within 2 weeks. AstraZeneca funding available. SLE, SjS and IIM. Overexpression of type 1 IFN regulated genes. Why? What are the consequences? Identify additional risk genes, gene variants and their effects. Suitable therapeutic targets? Looking for 1k IIM pts, 1k SLE pts, 1k SjS and 1k controls. Using human 1900-gene immunoarray including conserved elements and their introns. Structure set up, first meeting May 16th in Uppsala. Duration planned - 5 years, may be terminated after two years by sponsor. Success criteria formulated, rules of conduct are set. Which patients should be selected? DM + anti-Jo1 positive? Facilitate collaboration between networks.
Discussion: Is myositis research a good investment for a Pharma company? Immunochip data not suitable, contains only exons, no information on function. Sequencing of 1/10 of the whole genome, 5Mbases up and down each gene Looking for myositis pts (500 DM + 500 Jo1 positive) with clinical data recorded in the Euromyositis registry.

Overview of IIM genetics (Bob Cooper): Serotypes correlate with phenotypes, HLA. Mutual exclusivity of MSAs is intriguing. Mechanisms of age related sarcopenia - ER stress involved, aging partially inflammatory process. Adam Lightfoot experimenting with myotubes, observing effect of stress, ROS induced damage. Single fibers contractile dysfunction, non-inflammatory component may be responsible for residual weakness after immunosuppressive treatment. Upcoming event: ESF Myositis genetics conference May 13-14th Manchester.

How to judge muscle strength changes during treatment (Olivier Benveniste): Retrospective single center trial. Different muscle groups. Several functional tests. Responsiveness to change was evaluated using statistical methods DM, IMNM, overlap myositis patients included. MRC grading modification (0-3 scale) published (Vanhoutte EK et al. Brain, 2011). Best responsiveness to change: Hip flexion, Shoulder abduction, Barre and Mingazzini. Hip abduction and knee extension felt to be "useless". Have to be tested prospectively against QMT.
Discussion: How to motivate patients. Issue of a ceiling effect. 1-5 scale may not be sufficient to assess mild changes

Therapeutic trials in IIM (Jiří Vencovský): Prometheus trial, prospective, open-label, randomized. GC versus GC+MTX in treatment naive pts. Completed, results calculated 2 days ago. Unable to fulfill recruitment goal (50 patients), 31 were recruited . Used IMACS outcome measures, primary outcome cumulative GC dose at 48 weeks. No difference found - will be presented at EULAR 2014. Paired biopsy results not analyzed yet.
Artemis trial. Abatacept in resistant cases, double blind, delayed administration. Endpoint number of responders per IMACS DOI. Study completed, used Euromyositis to capture data, Results not available yet.
SELAM trial. GC, MTX, cyclosporin or combination in refractory patients no difference, not published yet.
PRINTO JDM trial. Open design, parent/MD opinion. GC versus GC+CyA versus GC+MTX. Results presented, not published, only abstract. Cyclosporine better but more side effects.
IVIG trial – Orfagen. Results not availabe, probably negative.
FORCE trial. Rituximab in autoab positive MG or IIM patients. Completed, results to be announced later, semi-positive?
BYM338 trial in sIBM – Novartis. Phase II completed. Will start new trial in April, largest so far.
BAF312 – Novartis. S1P receptor modulator. PM and DM trial ongoing.
US stem cell transplant trial. Still recruiting (for a long time).
Arimoclomol trial in sIBM. Completed. Positive signal, not published yet. Follistatin gene transfer Becker MD and sIBM – ongoing. ACTH gel - approved by FDA. Proof of concept trial planned. Tocilizumab in refractory PM and DM planned in the US.
Discussion: Why was there no additional effect of immunosuppressive drugs added to GC? Low power? Poor response criteria? Wrong design? Truly no benefit? 20% per month in Prometheus trial - reflective of real clinical practice. Maybe should be more aggressive with dose reduction in the trials. Design steroid-free trials. What is the difference between those who respond extremely well and others? We lack prognostic markers.

New classification criteria (Anna Tjärlund): To distinguish IIM from other autoimmune conditions + separate subgroups. For both adult and childhood forms. Multidisciplinary. Developed based on information from 1602 individual cases. Traditional model, risk score based probability model and tree format attempted. Opted for a probability model. Scores assigned to individual features (may use with or without biopsy data). Validation - internal and external (Euromyositis, JDCB&R). Currently working on subgroup criteria.
Discussion: Role of autoantibodies? Use retrospective information? Probably will use for revision. How do you assess specificity of Bohan and Peter criteria? It states that other conditions should be excluded - therefore specificity much higher. However frequently forgotten in clinical practice. What about the tree model - dropped, did not performed well.

General discussion: Very aggressive reduction of GC should be tested. Step up versus step down approach to the treatment of IIM. Tight control should be attempted. Learn lessons from previous trials (better design etc.). Belimumab perhaps may work, given the role of BAFF in IIM. Why is there no acute phase response in myositis? High interferon response may be responsible.

Summary: Ingrid Lundberg reports from Myositis registry steering committee, held 31th of January morning.
Propose of the new steering committee: Founders: Ingrid Lundberg , Jiří Vencovský, Hector Chinoy. External Advisor: Niels Steen Krogh. Members on rotating basis for 3 years: Experts: Lucy Wedderburn (paediatric), Louise Diederichsen (other registry representative). Patients organisation: Paula Oakley. 2 new positions announced: Neurologist. International member.
Need for registration of ongoing and new projects. The application template will be provided by Lucy Wedderburn.
End of ESF supported Myonet project May 2015. Need for funds to run Euromyositis database after this date.
Possibility for exchange of students and young doctors.
The 1st international conference in myositis will take place in Radisson Royal Blue Park Hotel, Frösundavik, Stockholm, Sweden, 1st week of May 2015 (details will be announced).
Smaller meetings in combination with international symposium likely: Steering committee meeting, antibody, genetics, and more projects oriented.
JDM registry within Euromyositis will start soon. Parallel comparison of long term outcomes with adult patients.
Registry used for collection of data on natural course of IBM. Data entered by patients.
Interest from pharmaceutical industry (Novartis) for clinical outcome. Mortality for IBM.
Need for information about patients who do not have updated records for years. Field to record reason.
Autoantibodies in new patients (approx. from the last 2 years). Possibly 700 available or more. Patient first entered into Euromyositis registry, special code generated for sample. Results will appear in registry. New line blot (Euroimmune) will be used. Anti-Ro52 should be included. Negative samples will be tested by immunoprecipitation.
Validation of new Euroimmune line blot by IP will depend on funds availability.
Immunochip study almost finished. No need for new DNA samples for this particular study. Respond ASAP if queries.
Lars Rönnblom will distribute short information describing the Interferon signature study. DNA samples from DM and anti-Jo-1 positive PM. Myositis samples processing not before fall 2014.
2nd ESF sponsored Myositis Genetics conference - Manchester 13.-14.5.2014.
ESF support and contribution from ROCHE acknowledged.

Assessment of the results and impact of the event on the future direction of the field

The aim of the meeting was to bring together European parties interested in clinical care and research of patients with idiopathic inflammatory myopathies and discuss ongoing and future projects. Participants from several different medical specialties met, such as rheumatology, neurology and immunology, which significantly contributed to lively discussions on the presented subjects.
One of the main achievements is the formation of the Euromyositis registry, which now contains data on more than 3000 patients from 14 countries. This is the first international registry which deals with this disease. Its formation has already significantly contributed to collaboration between different countries and different centers. The existence of registry is greatly aiding the research in this area. Using the clinical data and materials associated with this registry is the only way how to conduct large international studies that require significant number of patients and thus reach a sufficient statistical power. At this meeting many aspects of the registry were further discussed and some suggestions for improvements were proposed. Juvenile dermatomyositis section was newly added.

Euromyositis registry is already a major source of data for numerous research activities and many new are being planned.
Autoantibody detection was now centralized in Uppsala in Sweden and results of detection connected directly to Euromyositis registry. This will greatly aid in completeness of results in the registry and enable large association studies. Several studies are ongoing which attempt to amass large number of samples to study association between clinical, genetic and autoantibody aspects. Immunoprecipitation is still the gold standard method that is available in Bath, UK, and several new autoantibodies were discovered using this approach. At the meeting we discussed next practical steps in detection of autoantibodies by immunoprecipitation and it was decided to investigate primarily those samples that are negative using the standard techniques, because these are the samples most likely to contain new antibodies.
One of the most important goals is to find out the genetic basis for IIM. Genome wide association scan has been performed using materials and data from a number of European countries in collaboration with USA and the result have been published recently. Currently more detailed immunochip technique was used to map susceptibility autoimmune genes in myositis. Further steps were discussed after the results become available in the next few months.
It was agreed that meeting was valuable for all participants and suggested that this type of meeting should continue for the future. New steering committee format for Euromyositis registry was proposed. Next meeting will be 2nd ESF sponsored Myositis Genetics conference - Manchester 13.-14.5.2014. The 1st international conference in myositis will take place in Radisson Royal Blue Park Hotel, Frösundavik, Stockholm, Sweden, in the 1st week of May 2015.

4th Annual Workshop for Myositis NETWORK (MYONET)
30th – 31th January 2014, Prague, Czech Republic
Clarion Hotel Old Town, Hradební 9, 110 00 Praha 1

PROGRAM

Thursday, 30 January 2014

Arrivals, registration.

12:00 -	**15:15**		**MyoNet Steering Committee Meeting** (with Lunch)
15:15 -	15:30	*0:15*	**Coffee break**
15:30 -	**19:10**		**MYOSITIS REGISTRY** **Chair**: Jiri Vencovsky
15:30 -	15:35	*0:05*	Welcome *(Jiri Vencovský, Czech Republic)*
15:35 -	15:45	*0:10*	Myositis Network (MYONET), report from Steering Committee *(Ingrid Lundberg, Sweden)*
15:45 -	16:00	*0:15*	MyoNet web page *(Ingrid Lundberg)*
16:00	16:15	*0:15*	Myositis registry, including IBM – update *(Hector Chinoy, UK)*

16:15 -	17:15	*1:00*	Myositis registry (improvements, access, new aspects, new tools, results of SPRINT meeting etc.) *(Niels Steen Krogh, Denmark)*
17:15 -	**17:45**	*0:30*	**Coffee break**
17:45 -	18:00	*0:15*	Juvenile dermatomyositis in registry *(Liza McCann, Niels Steen Krogh, Lucy Wedderburn, UK*)
18:00 -	18:10	*0:10*	Chinese myositis network (*Guochun Wang, China)*
18:10 -	19:10	*1:00*	Discussion *(all)*
20:00			**Dinner at the hotel**

Friday, 31 January 2014

8:30 -	**10:10**		**AUTOANTIBODIES** **Chair:** Olivier Benveniste
8:30 -	8:50	*0:20*	Current status of autoantibody screening in Myositis Network *(Johan Rönnelid, Sweden)*
8:50 -	9:05	*0:15*	Results from immunoprecipitation studies in MyoNet + new autoantibodies *(Neil McHugh, UK)*
9:05 -	9:20	*0:15*	New autoantibodies in IBM - latest findings on Mup44/cN-IA and anti-Mup44 antibodies *(Megan Herbert, Ger Pruijn, The Netherlands)*
9:20 -	9:30	*0:10*	Anti-TIF1 autoantibodies in European patients (*Heřman Mann, Czech Republic*)
9:30 -	9:40	*0:10*	Quantitative detection of anti-PM/Scl antibodies (*Lenka Pleštilová, Czech Republic)*
9:40 -	10:10	*0:30*	Discussion (*All*)
10:10 -	**10:40**	*0:30*	**Coffee break**
10:40 -	**11:40**		**PATHOLOGY AND CLINICAL** **Chair**: Lucy Wedderburn
10:40 -	10:55	*0:15*	Pathology diagnosis of inflammatory myopathies: workshop report (*Jan de Bleeker, Belgium, Patrick Gordon, UK*)
10:55 -	11:10	*0:15*	Pathology in juvenile DM *(Janice Holton, UK)*
11:10 -	11:40	*0:30*	Discussion (*All*)
11:40 -	**12:25**		**GENETICS AND MECHANISMS** **Chair:** Ingrid Lundberg
11:40 -	11:55	*0:15*	Immunochip studies *(Simon Rothwell, Janine Lamb, UK*)
11:55 -	12:10	*0:15*	Dissecting disease mechanisms in three systemic inflammatory autoimmune diseases with an interferon signature *(Lars Rönnblom, Sweden)*
12:10 -	12:25	*0:15*	Possible IIM disease mechanisms upstream of inflammatory cell infiltrations *(Adam Lightfoot, Liverpool, UK)*

12:25	12:45	*0:20*	Discussion to genetics, future strategies, practical issues, logistics *(All)*	
12:45	**13:30**	*0:45*	**Buffet lunch**	
13:30	**14:20**		**THERAPY OUTCOMES**	**Chair:** Robert Cooper
13:30	13:45	*0:15*	Outcomes reflecting the best increase in muscle strength at 6 months of immunosuppressants on 51 patients with inflammatory myopathies (*Olivier Benveniste, France*)	
13:45	13:55	*0:10*	Therapeutic trials in IIM – overview information (*Jiri Vencovsky, Czech Republic*)	
13:55	14:05	*0:10*	New classification criteria for IIMs (*Anna Tjärnlund, Ingrid Lundberg, Sweden)*	
14:05	14:20	*0:15*	Discussion (All)	
14:20	14:50	*0:30*	**Coffee break**	
14:50	**16:00**		**VARIOUS ASPECTS + GENERAL DISCUSSION**	**Chair:** Jiri Vencovsky, Ingrid Lundberg
14:50	15:20	*0:30*	Any other activities *(TBD)*	
15:20	16:00	*0:40*	General discussion and future plans *(All)*	
16:00			**Coffee and end of the meeting**	

Poster: Requirement of apoptotic stem/precursor cell clearance for the *in vivo* establishment of autoimmune myositis
Clara Sciorati, Antonella Monno, Angelo A. Manfredi, Patrizia Rovereuerini

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