Asoreuma presente en ACR/ARHP 2016

El ACR meeting 2016 reunió a más de 16.700 participantes nacionales e internacionales, incluyendo médicos, profesionales de la salud de más de 100 países.

Esta reunión de seis días fue una muestra de temas de actualidad en la ciencia básica y clínica de la atención reumatológica, así como la prevención, el diagnóstico y el tratamiento de las enfermedades reumáticas y sus condiciones comórbidas.

Los asistentes pudieron escoger entre más de 450 presentaciones educativas, que fueron presentadas utilizando diversas habilidades basadas en formatos de aprendizaje interactivos diseñados para maximizar la experiencia de aprendizaje de los asistentes. Talleres, pósteres, presentaciones orales y visitas guiadas. Fueron tan sólo algunas de las ofertas interesantes que disfrutaron todos los asistentes. Esperamos la próxima reunión de este evento que será en el año 2017 en San Diego, California.
Desarrollo del Curso ACR 2016

Dr. Carlo Vinicio Caballero, Dr. Carlos Pineda, Dr. José Salas y Dr. Pedro Iván Santos.

Panorámica del Curso ACR 2016

Dr. Carlos Enrique Toro recibiendo reconocimiento de PANLAR a Asoreuma, otorgado por los 50 años de la Asociación Colombiana de Reumatología.
Participación académica
Asoreuma en el ACR/ARHP 2016

Comparison of Body Mass Index, Anti-Citrullinated Peptides Antibodies Status and Periodontal Condition in First Degree Relatives Individuals to Rheumatoid Arthritis

Miembros de Investigación: Sonia Unriza-Puin1, Wilson Bautista-Molano1,2, Gloria Lafaurie1, Rafael Valle-Oñate2,4, Philippe Chalem3, Lorena Chila-Moreno1, Juan Manuel Bello-Gualtero2,4, Consuelo Romero-Sánchez1,2,4

Meeting: 2016 ACR/ARHP Annual Meeting
Washington, November 11-16

Introduction / Objectives: The aim of this study was to investigate the body mass index (BMI), anti-citrullinated protein antibodies (ACPAs) status and the presence of periodontitis and IgG-1/IgG-2 antibodies against Porphyromonas gingivalis (Pg) in the first-degree relatives (FDRs) of RA patients and compare these variables with a control group of healthy individuals from the general population.

Methods: In total, 100 FDR individuals and 200 healthy controls matched by age and gender were included. Rheumatologic and periodontal assessment was performed, and the presence of ACPAs and anti-P. gingivalis antibodies was evaluated. Group-wise comparisons were analysed using the McNemar and Wilcoxon tests. A conditional logistic regression analysis was performed to establish the associations between BMI, ACPAs and periodontitis in both groups.

Results: In the FDR group, 70% of the subjects were female, with a mean age of 37.3±13 years. Obesity was observed in 17% and 7% of the FDRs and controls, respectively. ACPAs were found in 7% of the FDRs vs. 2.5% of the controls. Periodontitis was diagnosed in 79% and 56% of the FDRs and controls, respectively. Among the FDRs, 15% had severe periodontitis. There were associations in the FDR group related to the presence of obesity (OR: 2.93, 95% CI 1.03-8.28), ACPAs (OR: 2.45, 95% CI 0.7-8.32) and periodontitis (OR: 3.70 95% CI 1.89-7.29). Regarding anti-P. gingivalis antibodies and smoking history, no differences were found between the groups.

Conclusion: Obesity, ACPAs and periodontitis (diagnosis and severity) can be considered as relevant conditions associated with the development of RA in FDRs.

Prevalence of comorbidities and risk factors of spondyloarthritis in Latin America: a comparative study with the general population: data from the multinational ASAS-COMOSPA study

Wilson Bautista-Molano* 1, 2, Robert Landewé3, Rubén Burgos-Vargas4, José Maldonado-Cocco5, Anna Moltó6, Rafael Valle-Oñate2, Désirée van der Heijde1

Meeting: 2016 ACR/ARHP Annual Meeting
Washington, November 11-16

Background: Increased risk of several comorbidities has been reported in spondyloarthritis (SpA). Data and knowledge regarding the prevalence of these comorbidities and risk factors in Latin America are limited.

Objective: To determine the prevalence and risk of developing comorbidities as assessed in the ASAS-COMOSPA study in patients with SpA in three Latin American countries, and to compare these prevalences with the information in the general population in order to investigate whether the prevalences and the risks of comorbidities are increased.
Methods: Data from 390 consecutive patients with SpA enrolled in the international cross-sectional ASAS-COMOSPA study from Argentina, Colombia and Mexico were analyzed. Standardized (age and gender) prevalences (95% CI) were estimated for arterial hypertension (AHT), tuberculosis (TB), and total malignancies (colon, skin, lung, lymphoma, prostate, cervix and breast). Age and gender-specific data from the general population were obtained from the CARMELA study for AHT, the Global TB report and the GLOBOCAN project for malignancies. Data analyzed for AHT was confined to Colombia and Mexico. The prevalences in SpA patients were compared with the prevalences in the general population per age- and gender-specific stratum. Standardized risk ratios (SRR) were calculated per age- and gender stratum. SPSS 22 was used to perform the statistical analyses.

Results: In total, 64% of the SpA patients in COMOSPA were male, the mean age was 45 (14.7) years and the disease duration was 7.0 (8.1) years. The most common comorbidities were AHT (25.3%), hypercholesterolemia (21.8%), osteoporosis (9.4%) and gastrointestinal ulcer (7.8%). The prevalence of AHT was 21.4% (95% CI 15.4 to 28.9) and was increased compared to the general population (12.5%, 95% CI 11.4 to 13.7). The AHT risk of patients with SpA (24 to 64 years) was 1.5 times higher compared with the general population. The overall prevalence of TB was 3.3% (95% CI 1.8 to 5.7), and was higher compared with the general population (0.32%). The total risk of TB was found to increase 10.3 times than expected to general population. There was not a significantly increased prevalence of malignancies compared with the general population.

Conclusions: In patients with SpA we have observed a higher prevalence and risk for AHT and TB than expected from the age-and gender-adjusted general population in Latin America. A systematic evaluation and screening of these comorbidities and risk factors may help to properly monitor and detect these conditions in SpA patients.

Validation and reliability of translation of the ASAS Health Index in a Spanish speaking population with spondyloarthritis

Wilson Bautista-Molano1, 2, Robert B.M. Landewé3, Uta Kiltz4, Rafael Valle-Oñate2, Désirée van der Heijde1

2016 ACR/ARHP Annual Meeting Washington, November 11-16

Objective: To validate a Spanish-language translation of the ASAS Heath-Index (ASAS-HI) testing its reliability, construct validity and responsiveness in Colombian-patients with spondyloarthritis.

Methods: Translation was done following a forward-backward procedure. Patients fulfilling the ASAS criteria for either axial or peripheral-SpA participated. Test-retest reliability was assessed by intraclass correlation coefficient (ICC) in patients without treatment changes. In patients who required a therapeutic intervention, responsiveness was assessed using the standardized response mean (SRM). Construct validity was evaluated by Spearman correlation. Internal consistency (Cronbach’s-α) and discriminative ability of the ASAS-HI were assessed.

Results: Fifty patients were included: 54% male, mean (SD) age 44.8(13.1), symptom duration 15.8(9.7) years, BASDAI 4.6(2.2), BASFI 4.7(2.5), ASDAS-CRP 2.2(1.0). AxSpA was established in 44 patients (AS=30, nr-axSpA=14) and pSpA in 6. The score of the ASAS-HI was 8.2(5.1). The test-retest reliability was good with an ICC of 0.84. SRM was 2.58 (1.75-3.37) in 10 patients with any intervention and 2.94 (2.13-4.24) for 7 patients starting TNF-blockers. Construct validity showed a good correlation between ASAS-HI and pain, BASDAI, BASFI, and ASDAS (r=0.60). A high internal consistency was found with a Cronbach’s-α of 0.91. ASAS-HI discriminated well between patients with different stages of disease activity (BASDAI and ASDAS). Those with higher disease activity had higher ASAS-HI scores.

Conclusion: The Spanish-language translation of the ASAS-HI has proven to be psychometrically valid for Colombian-patients with SpA. This version is available to evaluate the state of health and functioning in these patients and can be used in clinical practice.

Romosozumab or Teriparatide in Postmenopausal Women With Osteoporosis Transitioning from Oral Bisphosphonate Therapy: A Randomized Open-label Phase 3 Trial

B Langdahl, MD, PhD1; C Libanati, MD2; DB Crittenden, MD3; MA Bolognese, MD4; JP Brown, MD5; NS Daizadeh, PhD3; E Dokoupilova, MD6; K Engelke, PhD7; JS Finkelstein, MD8; HK Genant, MD9; S Goemaere, MD10; L Hyldstrup, MD11; E Jodar-Gimeno, MD, PhD12; TM Keaveny, PhD13; D Kendler, MD14; P Lakatos, MD, PhD15; J Maddox, DO16; J Malouf, MD16; FE Massari, MD17; JF Molina, MD18; MR Ulla, MD19; A Grauer, MD3

2016 ACR/ARHP Annual Meeting Washington, November 11-16

Background: Previous bisphosphonate treatment has been shown to attenuate the bone forming effect of teriparatide. We compared the effects of 12 months of romosozumab and teriparatide on bone mineral density (BMD) in women with postmenopausal osteoporosis transitioning from bisphos-
Methods: This randomized phase 3, open-label, active-controlled study enrolled women with postmenopausal osteoporosis who had taken an oral bisphosphonate for ≥3 years before screening and alendronate the year before screening; an areal (a) BMD T-score ≤−2.5 at the total hip (TH), femoral neck (FN), or lumbar spine (LS); and reported a history of fracture. Subjects were randomized to romosozumab (210 mg monthly) or teriparatide (20 g daily). The primary endpoint was percentage change from baseline in aBMD by DXA at the TH through month 12 (mean of month 6 and 12 changes). Secondary endpoints included percentage change from baseline at months 6 and 12 in aBMD by DXA at the TH, FN, and LS; hip integral and cortical volumetric (v) BMD by quantitative computed tomography; and estimated hip strength by finite element analysis.

Findings: 436 women were randomized to romosozumab (N=218) or teriparatide (N=218). Through 12 months, the mean (95% CI) percentage change from baseline in TH aBMD was 2.6% (2.2, 3.0) with romosozumab and −0.6% (−1.0, −0.2) with teriparatide (difference between groups, 3.2% [2.7, 3.8]; p<0.0001). Romosozumab also resulted in significantly greater gains at months 6 and 12 in aBMD at all sites evaluated; in integral and cortical vBMD; and in estimated hip strength compared with teriparatide (p<0.0001 for all comparisons). The incidence of adverse events were generally balanced between treatment groups.

Interpretation: In women with osteoporosis transitioning from bisphosphonate therapy, 12 months of romosozumab induced greater BMD gains at the hip and spine and improved estimated hip strength compared with teriparatide and was well tolerated.

Identification of Subsets of Systemic Lupus Erythematous Patients by Principal Component Analysis and Urine Biomarkers.

Miembros de Investigación: Jose A. Gómez-Puerta 1-2, Blanca I. Ortiz Reyes 1, Tomás Urrego 1, Adriana L. Vanegas 2-3, Carlos H. Muñoz 2-3, Mauricio Restrepo 2, Wilmer G. Rojas-Zuleta 2, Sofía Arteaga 2, Luis A. González 2, Mauricio Rojas 1, Gloria Vásquez 1-2.
1. rupo de Inmunología Celular e Inmunogenética, Universidad de Antioquia, Medellín, 2. Sección de Reumatología, Universidad de Antioquia, 3. Hospital Universitario de San Vicente Fundación, Medellín, Colombia

ACR/ARHP Annual Meeting

Background/Purpose: Systemic lupus erythematosus (SLE) is clinically heterogeneous disease, with a considerably variability of disease expression among patients. There have been several attempts to classify subsets or cluster of SLE patients according genes, clinical characteristics and autoantibodies. However, information about classification of SLE patients based on urinary biomarkers is scarce. We investigated whether subdivision of SLE is possible using a panel of urine biomarkers by principal component analysis (PCA).

Methods: We included in 100 consecutive SLE patients (ACR criteria 1997) from a tertiary University Hospital. We measured urinary levels of 5 different biomarkers: monocyte chemotactic protein 1 (MCP-1), neutrophil gelatinase-associated lipocalin (NGAL), TWEAK, Ceruloplasmin (CP), and Transferrin (TF) using a commercial ELISA kits (R&D system and Assaypro, USA). In addition, serum anti C1q antibodies were measured by ELISA (Inova, USA). SLE activity was measured with SLEDAI. The PCA was performed by Statgraphics Centurion XVI for Windows (Statgraphics Corp., Rockville, USA). The PCA allowed simultaneous analysis of the relationship between 5 different urine biomarkers, as well as different clinical features and anti C1q antibodies. Creatinine clearance was considered as anchor factor of the PCA.

Results: 100 SLE patients were recruited (88% female) with median age of 33.6 ± 12.4 years and median disease duration of 11.5 ± 14.8 years. Hematologic disease (89%), arthritis (83%), cutaneous involvement (82%), and renal disease (66%) were among most common manifestations. Three components achieved an eigenvalue greater than 1.0. PCA revealed that the first 3 components accounted separately for a variability of 72%. According with those components we identified 3 subsets: Group A) patients with normal renal function and moderate disease activity, group B) patients with high disease activity and high levels of anti C1q, TF and CP and group C) patients with active lupus nephritis with high levels of 24 hours proteinuria, MCP-1, NGAL and TWEAK (Figure). Patients from Group B were older, had a shorter disease duration and higher SLEDAI scores than the other 2 groups.

Conclusions: We identified 3 different subgroups of SLE patients by PCA approach using urine biomarkers and serum Anti C1q antibodies. Whether this subgroups represent a different clinical outcome or a worst prognosis requires further analysis.

Lupus neonatal: Reporte de caso y revisión de la literatura.

Autor principal: Christine Arango, Fellow reumatología pediátrica, Universidad El Bosque. Bogotá, Colombia.
Email: arango391@gmail.com

Coautores: Ricardo Gastelbondo, Nefrólogo pediatra, Fundación Car
El lupus neonatal es una entidad infrecuente en recién nacidos hijos de madres portadoras de anticuerpos antiRo, antiLa y/o antiRNP. Es una condición autolimitada excepto en el compromiso cardíaco (secundario a lesión estructural del tejido de conducción). Se presenta un reporte de caso de recién nacido con bloqueo auriculo-ventricular completo secundario.

**Objetivo**

Reporte de caso de la enfermedad para discusión académica y el conocimiento de la comunidad científica.

**Metodología**

Estudio descriptivo tipo reporte de caso.

**Resultados**

Hija de madre de 28 años con antecedente de lupus eritematoso sistémico diagnosticado en 2013. A la semana 19 de gestación se realiza diagnóstico fetal de bloqueo auriculo-ventricular de segundo grado con posterior evolución a bloqueo auriculo-ventricular completo. Por oligohidramnios, feto pequeño y derrame pericárdico se desembaraza a las 32 semanas de gestación. Se confirma la presencia de bloqueo auriculo-ventricular completo asociado a antiRo positivo, además de hiperkalemia, acidosis metabólica, bicarbonato bajo y pH urinario alcalino persistentes (posible acidosis tubular renal asociada). A los 64 días de vida presenta signos de bajo gasto cardíaco requiriendo implantación de marcapaso bicameral.

**Conclusiones**

El lupus neonatal en una enfermedad infrecuente en los hijos de madres con lupus eritematoso sistémico. El compromiso cardíaco acarrea consigo una importante morbimortalidad. En más de la mitad de los casos las madres son asintomáticas requiriéndose un alto índice de sospecha. A la fecha sin reportes de asociación con acidosis tubular renal. Se requiere un seguimiento cercano de estos niños dado el mayor riesgo de desarrollar enfermedades autoinmunes a futuro.

**Introducción**

Systemic lupus erythematous (SLE) is a multisystemic disease. Around 20% of cases occur in the pediatric population. Over the years various proposals of classification criteria have been published. In 1971 Cohen et al published the preliminary criteria, which were later on reviewed and updated in 1982 and 1997 by the American College of Rheumatology (ACR). In 1994 Ferraz et al evaluated the 1982 ACR criteria in the pediatric population with a sensitivity of 96.1% and a specificity of 100%. Recently the SLICC group published a new criteria proposal with a sensitivity of 97% (vs 83% ACR 1997) and a specificity of 84% (vs 96% ACR 1997) in the adult population. The comparison between both criteria in the pediatric population in a multicenter study found a higher sensitivity (98.7% vs 76.7% ACR 1997) with a lower specificity (85.3% vs 93.4% ACR 1997). At the moment the SLICC criteria performance in the Colombian population is not known.

**Objective**

Evaluate the sensitivity and specificity of SLICC criteria in a pediatric population with juvenile systemic lupus erythematosus (JSL) in Bogotá, Colombia.

**Methods**

Diagnostic test study. Retrospective evaluation of features present in the first month of diagnosis in patients with JSL seen in a pediatric rheumatology service at a pediatric clinic in Bogotá, Colombia between May 2007 and March 2016. Controls were included with the following diagnosis: juvenile idiopathic arthritis (n=24), dermatomyositis (n=7), autoimmune hematologic disorders (n=6), antiphospholipid syndrome (n=6), systemic vasculitis (n=5), overlapping syndromes (n=4), undifferentiated connective tissue disease (n=2) and autoimmune hepatitis (n=1).

**Results**

n=110. 55 cases and 55 controls. Mean age at onset in cases was 12.8 years (7-15 years) and in controls was 11.1 years (2-16 years). Sex distribution in cases was 83.6% girls, FM ratio 5.4:1 and in control 65.5% were girls, FM 1.8:1. The most prevalent features in cases were lymphopenia < 1500 in 54.5% (vs 10.9%, p=0.000), arthritis in 47.2% (vs 52.7%, p=0.352), proteinuria in 41.8% (vs 7.2%, p=0.000), lymphopenia < 1000 in 36.3% (vs 3.6%, p=0.000 and malar rash in 34.5% (vs 9%, p=0.001). Antinuclear antibodies were positive in 94.4% (vs 34.5%, p=0.000), anti DNA antibodies in 57.4% (vs 3.7%, p=0.000), IgM anticardiolipin in 29% (vs 12.7%, p=0.03), anti Smith in 29% (vs 0%, p=0.000), IgG anticardiolipin in 27.2% (vs 9%, p=0.012), lupus anticoagulant in 23.6% (vs 10.9%, p=0.064) and false positive syphilis test in 16.3% (vs 0%, p=0.001). There was hypocomplementemia of C3 and C4.

**Comparison between SLICC and ACR 1997 classification criteria in patients with juvenile systemic lupus erythematosus evaluated in a pediatric rheumatology service in Bogotá, Colombia.**
in 80% and 69% of cases respectively (vs 12.7% and 15.4%, p=0.000). During the first month of diagnosis 78.1% of cases completed ACR criteria and 89.1% completed SLICC criteria. The sensitivity of SLICC criteria was higher (89% vs 78%) with a lower specificity (87% vs 96%).

Conclusions
In this group of pediatric patients the sensitivity of SLICC criteria during the first month of diagnosis was higher and the specificity was lower than ACR 1997. These findings correlate with what has been reported in other pediatric groups and in adults. The severity of the disease in children is higher and the prompt diagnosis allows an early treatment. Knowledge about and implementation of these new criteria should be promoted.

JUVENILE LOCALIZED SCLERODERMA (JLS): IS IT A BENIGN DISEASE?

Arango CV1, Malagon CN1, Gomez MP2, Mosquera AC1, Yépez R2, González T3, Vargas CA4
GRIP study group. Pediatric rheumatology post graduate program, Universidad El Bosque, Bogotá1, pediatric rheumatologist, Universidad Libre, Cali2, pediatric rheumatologist, Universidad De Cartagena, Cartagena3, pediatric rheumatologist, Universidad Del Valle, Cali4, Colombia.

INTRODUCTION: JLS is a polymorphic autoimmune disease. The Pediatric Rheumatology European Society (PRes) classification criteria help to identify different clinical features. The follow up of the patients allow the recognition of morbidity and complications derived from the disease.

OBJECTIVE: Describe demographic, clinical features, morbidity and sequela derived from JLS.

METHODS: Multicentre descriptive retrospective study. Analysis of clinical records of patients with a definitive diagnosis of JLS in 10 pediatric rheumatology clinics. The patients had a minimum follow up of 6 months and a minimum of 12 months of diagnosis. Morbidity was defined as: unsightly effects (dyscromic, disfigurement lesions and/or alopecia). Sequela was defined as functional joint involvement and growth disturbances (longitudinal, circumferencial or mixed).

RESULTS: n= 88. Mean age at diagnosis 6.9 years (0-14 years) with a sex ratio F:M 2.1:1. The mean follow up time was 43 months (6-243 months). Mean time between symptoms appearance and diagnosis was 16.5 months (1-96 months). AAN were positive in 42% of patients. According to PRes criteria the distribution was: circumscribed morphea (33%), mixed (32%), linear (22%), generalized (11%) and panesclerotic (2%). The clinical phenotypes of the predominant subtypes are described in table 1. 67% developed multiple lesions. 22% had extra cutaneous involvement (neurological, ocular and articular) and 13% had another autoimmune disease. Circumscribed was the most common type, morbidity was related to unsightly effects. In mixed type the association between linear and circumscribed lesions account for 75%. This type had multiple complications (unsightly and functional effects). Linear lesions induced the three types of morbidity and showed the higher polyautoimmunity rate. The coup du sabre type had the longest duration between symptoms and diagnosis, the higher extra cutaneous involvement and a significant morbidity. Generalized scleroderma developed important unsightly and functional effects. Pansclerotic was the least common, 2 girls being affected by a severe crippling disease. The frequency of functional joint involvement, growth disturbance and multiple complications was higher in the mixed, linear and generalized types, being statistically significant.

CONCLUSIONS: JSC is a polymorphic and unpredictable disease that determines important morbidity. Late diagnosis is common and might have a negative impact on prognosis because it allows the progression of the lesions, their size, depth and number. The high number of extra cutaneous complications reflects that this is not a disease limited to the skin. Polyautoimmunity reflects an immune system dysregulation. An early diagnosis and a more dynamic immunosuppressive treatment may improve the prognosis. Patients need a regular and extended follow up.
Resume of Biologic Therapy after Tuberculosis Infection in Patients with Inflammatory Arthropathies. Daily Clinical Practice Data from an Endemic Country

Miembros de Investigación: Liliana Uribe Botero, Margarita A Saldarriaga Alvarez, Natalia Duque Zapata, Johnny Urrego, Oscar Jair Felipe Díaz, Carmen Cerón, Alejandro Uribe, Luis Alonso González and José A. Gómez-Puerta
Medicarte IPS

Congreso ACR 2016
Noviembre 2016

Resumen del Trabajo: Dentro de una cohorte de 6.508 pacientes tratados con terapia biológica, se identificaron 54 pacientes que desarrollaron una tuberculosis (TB). De estos pacientes se excluyeron aquellos pacientes con enfermedad inflamatoria intestinal, pacientes con psoriasis y pacientes. Finalmente nuestra cohorte incluyó 28 pacientes (20 AR, 6 espondiloartropatías, 1 artritis psoriásica y 1 espondiloartropatía asociada a enfermedad de Crohn. Cerca de la mitad de los pacientes presentaron una TB extra-pulmonar. 2 pacientes fallecieron como causa directa de la TB. 13 (46%) de 28 pacientes reiniciaron terapia biológica. Cinco de ellos la misma terapia biológica previa. El tiempo medio de seguimiento de la terapia biológica tras la infección por TB fue de 20 meses. No se presentó ningún caso de reactivación durante el seguimiento.

Conclusiones: En la práctica clínica diaria en un país endémico, cerca de la mitad de los pacientes que desarrollan TB pudieron reinitiar el tratamiento biológico una vez tratada la infección. En países endémicos, la infección por TB no contraindica el reinicio de terapia biológica.

Opinión: Este estudio muestra por primera vez, una casuística importante de infección por TB en nuestro medio, con especial interés en el reinicio de la terapia biológica. El estudio incluyó información de 13 centros en diferentes ciudades del país.

A Panel of Urinary Biomarkers to Assess Renal Involvement in Latin American Patients with Systemic Lupus Erythematosus

Grupo de Inmunología Celular e Inmunogenética, y Grupo de Reumatología, Universidad de Antioquia, Medellín y Hospital Universitario de San Vicente Fundación.

Resumen del Trabajo: Evaluamos una serie de biomarcadores en orina (MCP-1, NGAL, ceruloplasmina (CP), transferrina/TF), y TWEAK) y lo correlaciones con una serie de manifestaciones clínicas y serológicas. Adicionalmente se hizo un análisis por razas. Se evaluó el valor diagnóstico de los diferentes biomarcadores para la identificación de la afectación renal y la nefritis lúpica (NL) activa. Los pacientes Afro-Colombianos presentaban una enfermedad más grave, con una mayor prevalencia de NL y serositis que la población mestiza y con índices mayores de actividad (SLEDAI). Todos los biomarcadores en orina y los anticuerpos antí C1q fueron significativamente más elevados en los pacientes con NL. Adicionalmente, las concentraciones de NGAL, CP, TF y TWEAK fueron más elevadas en pacientes con NL activa vs NL inactiva. Las concentraciones de NGAL fueron significativas mayores en pacientes Afro-Colombianos.

No encontramos diferencias significativas en los diferentes biomarcadores entre las formas proliferativas y no proliferativas de NL. El análisis del área bajo la curva (AUC) mostró un buen poder discriminativo de los diferentes biomarcadores para la identificación de LN en pacientes con LES (con AUC entre 0.78 a 0.87)

Conclusiones: En nuestra cohorte de pacientes con LES, los pacientes Afro-Colombianos presentaron formas más graves con mayor actividad de la enfermedad y mayor afectación renal que los pacientes mestizos. Los diferentes biomarcadores en orina analizados mostraron un buen rendimiento para identificar NL en nuestros pacientes.

Opinión: La biopsia renal no siempre es posible y no está exenta de riesgos, por lo tanto son de suma utilidad la identificación de biomarcadores en orina. Si bien aún no están disponibles en la práctica clínica diaria, nuestros resultados son alentadores ya que no solo nos permite identificar que pacientes con LES tienen afectación renal, sino también entre los pacientes con NL cuáles tienen formas activas y cuáles formas inactivas. El valor de estos biomarcadores durante el seguimiento aún no se conoce. Estamos evaluando su utilidad al respecto.

Identification of Subsets of Systemic Lupus Erythematosus Patients By Principal Component Analysis and Urine Biomarkers

Grupo de Inmunología Celular e Inmunogenética, y Grupo de Reumatología, Universidad de Antioquia, Medellín.
Resumen del Trabajo: Analizamos 100 pacientes consecutivos con diagnóstico de lupus eritematoso sistémico (LES) de un hospital universitario. Evaluamos cinco biomarcadores en orina (MCP-1, NGAL, ceruloplasmina (CP), transferrina (TF) y TWEAK) y niveles séricos de anticuerpos anti C1q (Inova). Se realizó un análisis de componentes principales, el cual permitió identificar 3 subgrupos. Grupo A) pacientes con función renal normal y actividad de la enfermedad moderada, grupo B) pacientes con alta actividad de la enfermedad, con concentraciones elevadas de anti C1q, TF y CP y grupo C) pacientes con nefritis lúpica, con cifras elevadas de proteinuria en 24 horas y concentraciones elevadas de MCP-1, NGAL y TWEAK. Los pacientes del grupo B fueron mayores, tenían una enfermedad de menor duración y niveles de actividad (medida por SLEDAI) mayor que los otros subgrupos.

Conclusiones: Mediante un análisis de componentes principales identificamos 3 subgrupos de pacientes con LES basados en diferentes biomarcadores en suero y orina. Aún desconocemos si esos subgrupos representan un pronóstico diferente durante el seguimiento.

Opinión: La identificación de biomarcadores en orina es un área de gran interés. En este sentido, mediante un análisis de componentes principales pudimos identificar diferentes subgrupos de pacientes con LES. En una enfermedad tan heterogénea como el LES, identificar patrones de afectación renal y sistémica nos permitiría individualizar la terapia y el seguimiento de nuestros pacientes.

NÚMERO DE RESUMEN: 377

**Pain and Quality of Life Profiles in Colombian Patients with Rheumatoid Arthritis: A Mixed Cluster Analysis**

Juan Manuel Cotte1, Nicolás Molano-González2, Deisy Hernández-Parra3, Yenifer Delgado-Scarpetta3, Adriana Rojas-Villarraga2, Juan-Manuel Anaya1 and Ricardo Pineda-Tamayo3, 1Center for Autoimmune Diseases Research (CREA). School of Medicine and Health Sciences, Universidad del Rosario, Bogotá, Colombia, Bogotá, Colombia, 2Center for Autoimmune Diseases Research (CREA). School of Medicine and Health Sciences, Universidad del Rosario, Bogotá, Colombia, Bogotá D.C., Colombia, 3Art-médica IPS, Medellín, Colombia, Medellin, Colombia

Meeting: 2016 ACR/ARHP Annual Meeting

**ABSTRACT**

**Background/Purpose:** Among the symptoms of Rheumatoid Arthritis (RA), pain is often regarded as a critical factor related to quality of life (QoL) by patients, and the fact of having pain confers subjects with RA a 5 year mortality twice as high when compared with RA patients without pain (1,2). There are different causes of pain in RA patients, and the level of compromise in the QoL may vary among them too (3). The aim of this study is to identify different pain profiles in association to the QoL in Colombian RA patients.

**Methods:** This was a cross-sectional study involving 1395 patients with diagnosis of RA, all of whom had a registered EuroQoL, MDHAQ, CDAI and DAS-28 at the time of their involvement to a rheumatology specialized center, and a complete patient inclusion form which included data on disease characteristics, comorbid conditions and current treatment. A mixed-cluster analysis based on multivariate descriptive methods such as multiple factor analysis and k-means cluster analysis was done to summarize sets of related variables with strong associations and common clinical context. The variables used for the cluster analysis were the five dimensions of the EuroQol, the Visual Analog Scale of the EuroQoL, and the EuroQoL result (4).

**Results:** Four clusters were identified with varying degrees of pain and compromise on QoL (see figure 1). Due to the fact that cluster 2 was characterized by more severe pain and discomfort without severe compromise in the other dimensions, it was used as the reference group. When compared with the patients with the least compromise of their QoL as well as pain (cluster 4) this patients were identified to be older, with a higher proportion of females, and they had a lower education level. Regarding treatment, this patients used significantly less methotrexate, and significantly more glucocorticoids and biologic therapy. When evaluating comorbid conditions, Cluster 2 had significantly more Fibromyalgia, Cardiovascular Disease and Diabetes, and they also had a higher CDAI and DAS-28. Finally, regarding disability, we identified that cluster 2, in spite of its association with severe pain, was the one with the second best disability profile according to the MDHAQ. All the results mentioned above were statistically significant.

**Conclusion:** In spite of the fact that the results of a study come from a single population, they underlie the importance of identifying different pain profiles in RA patients which may benefit from specific therapies. These findings also highlight the importance of personalized medicine, which may translate into better outcomes for our patients.
Maija-Leena Eloranta8, Johan G. Brun9, Lasse G. Goransson2, Kiely Grundahl3, Jennifer A. Kelly4, R. Hal Scofield1, Simon Bowman5, Susan Lester6, Per Eriksson7, Rasmussen2, Maureen Rischmueller34, Lindsey A. Criswell35, Courtney G. Montgomery1, Wan-Fai Ng36, Gunnel Nordmark37 and Kathy L. Sivils1, 1Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 2Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, USA, Oklahoma City, OK, 3Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 4Arthritis & Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 5Department of Rheumatology, University Hospitals Birmingham NHS Foundation Trust, Birmingham, United Kingdom, 6Queen Elizabeth Hospital, University of Adelaide, Adelaide, Australia, 7University Hospital, Rheumatology clinic, Linköping, Sweden, 8Uppsala University, Department of Medical Sciences, Rheumatology and Science for Life Laboratory, Uppsala, Sweden, 9Department of Rheumatology, Haukeland University Hospital, Bergen, Norway, 10Clinical Immunology Unit, Department of Internal Medicine, Stavanger University Hospital, Stavanger, Norway, 11Karolinska Institutet, Stockholm, Sweden, 12Department of Oral Medicine, Carolinas Medical Center, Charlotte, NC, 13Ophthalmology, University of Oklahoma Health Sciences Center, Oklahoma City, OK, 14Diagnostic and Biological Sciences, Division of Oral Pathology, University of Minnesota School of Dentistry, Minneapolis, MN, 15Washington University, St Louis, MO, 16Division of Oral and Maxillofacial Surgery, Department of Developmental and Surgical Science, University of Minnesota School of Dentistry, Minneapolis, MN, 17Department of Oral and Maxillofacial Pathology, University of Oklahoma College of Dentistry, Oklahoma City, OK, 18Hard Tissue Research Laboratory, University of Minnesota School of Dentistry, Minneapolis, MN, 19Dean McGee Eye Institute, Oklahoma City, OK, 20Department of Diagnostic and Biological Sciences, University of Minnesota School of Dentistry, Minneapolis, MN, 21Division of Rheumatology, University of Minnesota Medical School, Minneapolis, MN, 22Oral Diagnosis and Radiology Department, University of Oklahoma College of Dentistry, Oklahoma City, OK, 23Arthritis & Immunology Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 24Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 25Center for Autoimmune Genomics and Etiology (CAGE), Cincinnati Childrens Hospital, Cincinnati, OH, 26Center for Autoimmune Diseases Research (CREA), School of Medicine and...
Health Sciences, Universidad del Rosario, Bogotá, Colombia, Bogotá, Colombia, 27Department of Medical and Molecular Genetics, King’s College London, London, United Kingdom, 28Division of Immunology, Infection and Inflammatory Disease, King’s College London, London, United Kingdom, 29Sjögren’s Syndrome Clinic, National Institute of Dental and Craniofacial Research, Bethesda, MD, 30Institut National de la Santé et de la Recherche Médicale, Université Paris-Sud, AP-HP, Hôpitaux Universitaires Paris-Sud, Paris, France, 31Department of Medicine, Solna, Unit of Experimental Rheumatology, Karolinska Institutet, and Karolinska University Hospital, Stockholm, Sweden, Stockholm, Sweden, 32Department of Clinical Immunology and Rheumatology, Hannover Medical School, Hannover, Germany, 33Broegelmann Research Laboratory, Department of Clinical Science, University of Bergen, Bergen, Norway, 34Rheumatology, University of Adelaide, Adelaide, Australia, 35Division of Rheumatology, UCSE, San Francisco, CA, 36Institute of Cellular Medicine, Newcastle University, Newcastle upon Tyne, United Kingdom, 37Rheumatology, Department of Medical Sciences, Uppsala University, Sweden, Uppsala, Sweden

Meeting: 2016 ACR/ARHP Annual Meeting
Date of first publication: September 28, 2016
Keywords: Gene Expression, genetics and genomics

Background/Purpose: Sjögren’s syndrome (SS) is a complex autoimmune disease with both environmental and genetic factors contributing to pathophysiology. The goal of this genome-wide association study (GWAS) was to identify SS risk loci that exceed the genome-wide significance (GWS) threshold of 5x10^{-8} in European-derived cohorts.

Methods: We studied >20,000 subjects that were genotyped on OMNIexpress, OMNI1-Quad, or OMNI2.5 Illumina arrays. Following application of strict standard quality control measures, a total of 2,809 independent SS cases and 17,102 population controls remained. Analysis was performed using logistic regression and accounted for ancestry (first 4 principal components) and gender.

Results: The weighted Z-score method was used to determine meta P-values. Results: In total, 3101 variants exceeded the GWS threshold and were supported by more than one dataset. The majority of these variants were located within previously established SS risk loci such as HLA, IRF5, STAT4, and TNIP1. In addition, 3 novel loci were identified that exceeded GWS. The first effect was located within the 5’ untranslated region of the gene NAB1 (NGFI-A binding protein 1) peaking at rs2293765 (Pmeta=3x10^{-11}; odds ratio (OR)=1.23). Bioinformatics data in this region denote epigenetic marks that are indicative of enhancer activity in T cells, B cells, monocytes, and neutrophils. Moreover, variation at rs2293765 has also been shown to alter expression in monocytes of neighboring genes including GLS (interferon (IFN) stimulation), TMEM194B (LPS stimulation), and MFSD6 (naïve). NAB1 has been shown by others to form a complex with EGR3 leading to transcriptional downregulation of the IFNGR1 locus upon IFN stimulation. The second novel effect is a missense allele, rs2304256 (V>F; Pmeta=1.22x10^{-9}; OR=0.81), located within TYK2 (tyrosine kinase 2) and predicted to be damaging in 5 transcripts resulting from this locus by SIFT. Additionally, this variant is predicted to influence the expression in monocytes of multiple genes in the region under various conditions: IFN stimulation (ICAM1, TMED1), LPS stimulation (DNMT1), and naïve (ICAM3, TYK2). TYK2 is a Janus kinase family member that is responsive to both type I and III IFN signaling. The third novel effect maps to the intergenic space between PTTG1 (pituitary tumor-transforming 1) and mir-146a, peaking at rs2431697 (Pmeta=3.38x10^{-9}; OR=0.82). Epigenetic marks in this region indicate enhancer element function in T cells, neutrophils, and monocytes as well as expression changes of PTTG1 in whole blood. To date, the role of PTTG1 in the immune system remains elusive, but this locus is a risk factor for various forms of cancer. In addition, several loci showed suggestive association with SS (Pmeta<1x10^{-5}) including XR6, PDHX-CD44, and ELM01.

Conclusion: We have established three novel genetic associations with SS involved in pathways important in the disease pathology. Further replication, imputation, fine mapping, and functional studies are needed to elicit the precise causal variants and the impact on SS etiology.

ABSTRACT NUMBER: 66

Very Rare X Chromosome Abnormalities in SLE and Sjögren’s May Localize X Gene Dose Effect

Rohan Sharma1, Valerie M Harris2, Joshua Cavett3, Biji T Kurien3, Ke Liu4, Kristi A. Koelsch5, Lida Radfar6, David M. Lewis7, Donald U. Stone8, C. Erick Kaufman9, Shibo Li10, Barbara M. Segal11, Daniel J Wallace12, Michael Weissman13, Jennifer A. Kelly14, Bernado Pons-Estel15, Roland Jons10, J. Marie Wahren-Herlenius30, Torsten Witte31, Xavier Marquet32, Christopher J. Lessard33, John B. Harley34, Kathy L. Sivils33, Astrid Rasmussen35, R. Hal Scofield33, Swamy Venturoppalli36, Xianglan Lu10, Pamela Hughes37, Andrew J.W. Huang38 and Corinne Miceli-Richard39, 1Medical Service, US Department of Veterans Affairs Medical Center, Oklahoma City, OK, 2Oklahoma Medical Research Foundation, Oklahoma City, OK, 3Arthritis and Clinical Immunology, Oklahoma Medical Research Foundation, Oklahoma City, OK, 43333 Burnet Ave., University of Cincinnati & Cincinnati Children, Cincinnati, OH, 5U.S. Department of Veterans Affairs Medical Center, Oklahoma City, OK, 6Oral Diagnosis and Radiology Department, University of Oklahoma College of Dentistry, Oklahoma City, OK, 7Department
of Oral and Maxillofacial Pathology, University of Oklahoma College of Dentistry, Oklahoma City, OK, 8King Khaled Eye Specialist Hospital, Riyadh, Saudi Arabia, 9Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, OK, 10Pediatrics, University of Oklahoma Health Sciences Center, Oklahoma City, OK, 11Division of Rheumatology, University of Minnesota Medical School, Minneapolis, MN, 12Cedars-Sinai Medical Center, West Hollywood, CA, 13Rheumatology, Cedars-Sinai Medical Center, Los Angeles, CA, 14Arthritis & Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 15Sanatorio Parque, Rosario, Argentina, 16Broegelmann Research Laboratory, Department of Clinical Science, University of Bergen, Bergen, Norway, 17Department of Rheumatology, Strasbourg University Hospital, Strasbourg, France, 18Center for Autoimmune Diseases Research (CREA), School of Medicine and Health Sciences, Universidad del Rosario, Bogotá, Colombia., Bogotá, Colombia, 19Department of Medical and Molecular Genetics, King’s College London, London, United Kingdom, 20Division of Rheumatology, Hospital for Special Surgery, New York, NY, 21Centre for Liver Research, Institute of Biomedical Research, School of Immunity and Infection, College of Medical and Dental Sciences, University of Birmingham, Birmingham, United Kingdom, 22Mount Sinai Hospital, Toronto, ON, Canada, 23Institute of Cellular Medicine, Newcastle University, Newcastle upon Tyne, United Kingdom, 24Rheumatology, Department of Medical Sciences, Uppsala University, Sweden, Uppsala, Sweden, 25University Hospital, Rheumatology clinic, Linköping, Sweden, 26Department of internal medicine, Clinical Immunology unit, Stavanger, Norway, 27Department of Diagnostic and Biological Sciences, University of Minnesota School of Dentistry, Minneapolis, MN, 28Rheumatology, Queen Elizabeth Hospital, Adelaide, Australia, 29Hard Tissue Research Laboratory, University of Minnesota School of Dentistry, Minneapolis, MN, 30Department of Medicine, Experimental Rheumatology Unit, Solna, Sweden, 31Hannover Medical School, Hanover, Germany, 32Rheumatology, Rheumatology department, Bicetre Hospital, Paris-Sud University, Le Kremlin Bicêtre, France, 33Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, Oklahoma City, OK, 34Center for Autoimmune Genomics and Etiology (CAGE), Cincinnati Children’s Hospital, Cincinnati, OH, 35Arthritis and Clinical Immunology Research Program, Oklahoma Medical Research Foundation, USA, Oklahoma City, OK, 36Rheumatology, Cedars-Syani Medical Center, Los Angeles, CA, 37Division of Oral and Maxillofacial Surgery, Department of Developmental and Surgical Science, University of Minnesota School of Dentistry, Minneapolis, MN, 38Washington University, St Louis, MO, 39Rheumatology, Université Paris-Sud, Paris, France

Background/Purpose: Sjögren’s syndrome and systemic lupus erythematosus (SLE) are chronic, autoimmune diseases that are related by clinical and serological manifestations as well as genetic risks. Both diseases are much more commonly found in women compared to men at a ratio of about 10 to 1. We have previously shown that relatively common X chromosome aneuploidies, 47XXX (Klinefelter’s syndrome, 1 in 500 live male births) and 47XXX (1 in 1000 live female births), are enriched among men and women, respectively, with Sjögren’s or SLE. We undertook this study to describe rare X chromosome aneuploidies among large cohorts of patients with these diseases.

Methods: We examined large cohorts of Sjögren’s syndrome or SLE patients with intensity plots of X chromosome single nucleotide polymorphism (SNP) alleles. In addition, we also carried out karyotype of peripheral blood mononuclear cells from Sjögren’s syndrome and SLE subjects.

Results: Among 2,426 women with SLE we found three patients with a triple mosaic consisting of 45X/46XX/47XXX, a statistically significant increase compared to controls and the known birth rate by binomial confidence intervals. Among 2,138 women with Sjögren’s syndrome, one patient had 45X/46XX/47XXX with a triplication of the distal p arm of the X chromosome in the 47XXX cells. Neither the triple mosaic nor a partial triplication were found among controls. In fact, the triple mosaic occurs in approximately 1 in 25,000 to 50,000 live female births, while a partial triplication such as the one found is even rarer. In another cohort of Sjögren’s patients, we found a mother–daughter pair in which the mother had an inversion of the proximal region of Xq and the daughter had a Xp isochromosome with partial triplication of distal Xp.

Conclusion: Very rare X chromosome abnormalities are present among patients with either Sjögren’s or SLE. These rare variants may be informative as to location of a gene or genes on the X chromosome that mediate a gene dose effect as well as critical cell types in which a gene dose effect is operative.

Superior gains in bone mineral density and estimated strength at the hip for romosozumab compared with the teriparatide in women with postmenopausal osteoporosis transitioning from bisphosphonate therapy: results of the phase 3 open-label structure study


Aarhus University Hospital, Aarhus, Denmark; UCB Pharma, Brussels, Belgium; Amgen Inc, Thousand Oaks; Bethesda Health Research Center, Bethesda, United States; Laval University and CHU de Québec (CHUL) Research Centre, Quebec City, Canada; Medical Plus, Uherske Hradiste, Czech Republic; BioClinica Inc., Hamburg, Germany; Department of Medicine,
Agéndate!

**Febrero**
24 Asamblea ordinaria

**Mayo**
3 - 5 Mayo : I Curso Regional de Costa Rica ACCAR

**Junio**
14 - 17: Congreso EULAR / Madrid

**Septiembre**
6 - 9 : II Curso de Revisión en Reumatología *Actualización en Biosimilares* / Lima - Peru

**Noviembre**
5 - 7: Congreso del American College of Rheumatology (ACR) 2017, San Diego (EE.UU.)

Asoreuma está de luto por la muerte del doctor Jose Nates fallecido el pasado mes de Noviembre, miembro de la Asociación Colombiana de Reumatología, así que con profundo pesar destacamos esta noticia y enviamos un fuerte abrazo a todos sus familiares y amigos.

Massachusetts General Hospital, Boston; Department of Radiology, University of California San Francisco, San Francisco, United States; Ghent University Hospital, Gent, Belgium; Hvidovre University Hospital, Hvidovr, Denmark; Servicio de Endocrinología, Hospital Universitario Quirón, Madrid, Spain; University of California Berkeley, Berkeley, United States; University of British Columbia, Vancouver, Canada; Department of Medicine, Semmelweis University, Budapest, Hungary; Universitat Autónoma de Barcelona, Barcelona, Spain; Instituto de Investigaciones Metabólicas, Buenos Aires, Argentina; Reumalab Centro Integral de Reumatología, Medellin, Colombia; Instituto Latinoamericano de Investigaciones Médicas, Córdoba, Argentina.
Feliz Navidad
& Feliz Año Nuevo

Apreciados colegas y amigos

Desde la Junta Directiva de la Asociación Colombiana de Reumatología queremos enviarles este sincero mensaje deseando una Feliz Navidad y un próspero Año Nuevo 2017.

Así mismo queremos agradecer su apoyo y contribución en las diferentes labores que venimos desarrollando con el objetivo de cumplir con nuestros objetivos estratégicos como Asociación: liderazgo educativo y académico, posicionamiento ante el país y fortalecimiento gremial.

En este año 2016 trabajamos en proyectos de diferente naturaleza, todos orientados al crecimiento y desarrollo de nuestra Asociación, entre los cuales se destacaron:

1. Proposición de inclusiones y exclusiones en el plan de beneficios de reumatología.
2. Modelo de atención en artritis reumatoide.
4. Creación del registro de terapias biológicas en Colombia (BIOBADACOL), en asocio con BIOBADASER.
5. Certificación de profesionales empresariales con locentes.
6. Integración con PANLAR.

Este 2016 también será recordado por emotivos y alegres momentos como en el mes de agosto cuando desarrollamos nuestro IX Curso de Actualización en Reumatología, en la ciudad de Montería, evento académico de primer nivel que contó con la participación de un gran número de miembros de Asoreuma y reconocidos conferenciantes internacionales.

Igualmente en el mes de octubre, realizamos el primer en Colombia de ProjectMAD, documental basado en el libro Mi sueño americano, que tiene como autora a la doctora María Miller, quien a su vez es la protagonista del largometraje, y que vino a Bogotá para este evento, junto con el director de cine colombiano Farin Botero.

Vale recordar que durante este mismo mes celebramos por todo lo alto nuestras Bodas de Oro en la ciudad de Bogotá, evento que contó con la presencia del Ministro de Salud, Alejandro Gaviria Uribe.

Así mismo, también nos trajo tristezas, especialmente con la partida de dos queridos miembros Asoreuma, Dr. Ignacio Calle y Dr. Jaime Nates, a quienes hoy recordamos.

Finalmente, esperamos que el final de este año 2016 sea el mejor, en compañía de sus seres queridos, rodeado de sentimientos de alegría, tranquilidad y paz, deseando de una vez lo mejor para el Nuevo Año 2017, el cual sin duda estará cargado de retos y oportunidades tanto personales como gremiales, entre los que desde ya vale destacar al XVI Congreso Colombiano de Reumatología que se desarrollará en la ciudad bonita de Colombia, Bucaramanga, desde el 1 al 6 de agosto.

Feliz Navidad y Próspero Año Nuevo 2017

Junta Directiva
Asociación Colombiana de Reumatología
Convenios Miembros Asoreuma

Promociones Miembros ASOREUMA:

Disfruta de las Promociones y Descuentos que obtienes al ser Miembro ASOREUMA

La Mesa de los Señores

Presentando tu Carné de Miembro ASOREUMA, tú y tú familia obtienen: 15% de Descuento en productos durante todo el año.

Oficinas: Calle 95 N°11A-38 Bogotá, Colombia
Tel: (57) (1) 6228766

Tienda: Calle 95 N°11A-38 Bogotá, Colombia
Tel: (57) (1) 7030564

Urbano Bar Restaurante

Presentando tu Carné de Miembro ASOREUMA tu y tu familia recibirán Especiales promocionales exclusivas todos los días.

Carrera 66 11-28
Cali, Colombia

Este documento es para uso personal e intransferible, e identifica al titular como Miembro de Número Asoreuma. El titular se obliga a darle el uso debido y a guardar el comportamiento ético y civil ajustado a la comunidad de profesionales y la sociedad en general.

Junta Directiva
Asociación Colombiana de Reumatología

Nombre Miembro ASOREUMA
Cédula

Disfruta de las Promociones y Descuentos que obtienes al ser Miembro ASOREUMA

www.asoreuma.org
asoreuma@asoreuma.com

Tu mejor decisión!
Asoreuma te desea una
Feliz Navidad
y
Prospero Año Nuevo
Únete a Nuestras Redes Asoreuma

y disfruta de los álbumes de fotografías, convenios y eventos que ofrece la Asociación.

CLIC PARA MAYOR INFORMACIÓN