RHEUMATOLOGY MASTERCLASSES

WORLD RHEUMATOLOGY FORUM SUMMIT 2026

14th-15th March 2026

Mayfair Lake Resort, Raipur, Chhattisgarh, India

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STATE OF THE ART LECTURES

Dr. Hector Chinoy
PhD, FRCP
Professor of Rheumatology & Neuromuscular Diseases.
University of Manchester, UK & Consultant Rheumatologist, Salford Royal Hospital, Salford, UK.

Topic : Therapeutic Roadmap for Idiopathic Inflammatory Myositis (IIM)
Speaker : Prof. Hector Chinoy (UK)

In this state-of-the-art lecture, Prof. Hector Chinoy discussed the rapidly evolving therapeutic landscape in idiopathic inflammatory myositis (IIM). Despite advances in disease understanding, significant unmet therapeutic needs remain, particularly in managing refractory muscle disease and reducing long-term steroid toxicity. IVIG continues to play an important role, especially in patients with resistant disease.

A key theme of the lecture was the shift toward precision immunology, where genetics and myositis-specific autoantibodies help define clinical phenotypes and guide targeted therapy. Interferon pathways appear central to disease biology, with a Type I interferon signature predominantly seen in dermatomyositis, while Type II interferon signatures are observed in dermatomyositis and antisynthetase syndrome. These pathways are increasingly becoming important therapeutic targets.

Emerging treatments include brepocitinib (TYK2/JAK1 inhibitor), which demonstrated significant improvement in Total Improvement Score (TIS) and greater steroid reduction in the VALOR trial, highlighting the promise of JAK/TYK2 pathway inhibition. Other novel approaches include FcRn inhibition with efgartigimod, which reduces pathogenic IgG autoantibodies, and interferon-targeted therapies such as anifrolumab and dazukibart.

Looking ahead, the field is also exploring advanced immune therapies such as CAR-T cell therapy, along with other innovative strategies including RNA-based CAR-T and in-vivo T-cell engineering, particularly for refractory disease.

Take-home message: The management of myositis is transitioning from broad immunosuppression toward targeted immunotherapy and cellular therapies, ushering in a new era of precision medicine in idiopathic inflammatory myositis.

Dr. William Tillett
PhD, FRCP
Senior Lecturer, University of Bath, UK
Consultant Rheumatologist, The Royal National Hospital for Rheumatic Diseases, Bath, UK

Topic : Selecting drugs to optimise outcomes in psoriatic arthritis
Speaker : Dr. William Tillett, Bath (UK)

Dr. Tillett highlighted that early tight control and treat-to-target strategies significantly improve outcomes in Psoriatic Arthritis (PsA). The TICOPA trial demonstrated superior responses with tight control compared to standard care, with higher ACR20/50/70 rates (62/51/38% vs 44/25/17%).

Combination conventional therapy also showed benefits. In COMPLETE-PsA, methotrexate plus leflunomide achieved higher PASDAS and minimal disease activity (MDA) rates than methotrexate alone, improved drug survival, and delayed the need for biologics, although gastrointestinal intolerance was more frequent. The CONTROL trial further demonstrated that adalimumab plus methotrexate produced markedly higher MDA rates at 32 weeks compared with methotrexate escalation alone, and weekly adalimumab could rescue many non-responders.

However, real-world data indicate a substantial residual disease burden. In the UNISON-PsA study (n=1,596), 65–75% of patients failed to achieve MDA at six months despite advanced therapies. A global survey of nearly 5,000 patients reported only 58–64% treatment satisfaction, mainly due to incomplete symptom control, cost, and adverse effects. Registry data from VALORE (~30,700 patients) also show frequent treatment switching, with over one-third of patients switching therapies within three years and increasing use of IL-17 and IL-23 inhibitors after TNF inhibitors.

Emerging trials support early intensive therapy. Studies such as STAMP and SPEED suggest that early biologics or combination csDMARD strategies may achieve faster and better disease control than traditional step-up approaches, while the MONITOR study confirmed that treat-to-target strategies are feasible in routine practice.

Take-home message : Despite multiple therapeutic options, many PsA patients continue to have active disease. Early intensive treatment and treat-to-target approaches, including biologics or combination therapy, appear to offer better outcomes than conventional step-up methotrexate strategies.

Highlights

Stalwarts starting the programme

First day, first session of Abstract presentation

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MASTER CLASSES

Dr. Hector Chinoy PhD, FRCP

Professor of Rheumatology & Neuromuscular Diseases
University of Manchester, UK & Consultant Rheumatologist, Salford Royal Hospital, Salford, UK.

Topic: Myositis associated interstitial lung disease

Discussion on myositis related ILD started with clinical assessment and lab evaluation along with HRCT and pulmonary function tests.
Change in FVC, DLCO with progression or decline are more associated with poor prognosis therefore assement of change is more valuable than baseline value only.
HRCT chest should be reported by an ILD radiologist to understand architectural distortion, pattern and extent of involvement.
Antibody testing should be interpreted with a pinch of salt after corroboration with the entire clinical picture. Some antibodies are higher risk for ILD like PL12, OJ, KS and MDA5; where as others are usually low or no risk. Ro52+ is an important poor prognostic indicator in these cases.
It has been found that MDA5+ disease seems to he associated with certain environment (infection, weather) and genetic predisposition that lead to exaggerated immune response. Key clinical feature is vasculitic skin lesions. Different phenotypes have been seen in MDA5+ line RP-ILD, mild to moderate ILD, cutaneous vasculopathy and arthritis. Treatment options include immunosuppression and vasodilator therapy.
Poor prognostic factors for RP-ILD include clinical, radiological, laboratory and infections. Treatment options currently available like RTX, CYC, Nintedanib with current evidence was also discussed along with the ACR 2025 guidelines for CTD-ILD. Take home message is that clinical collaboration in a multi- disciplinary setting is key for optimal management.

Dr. William Tillett PhD, FRCP

Senior Lecturer, University of Bath, UK
Consultant Rheumatologist, The Royal National Hospital for Rheumatic Diseases, Bath, UK

Topic: Comorbidities in Psoriatic Arthritis

Psoriatic arthritis (PsA) is a multisystem disease with a high burden of comorbidities, significantly affecting outcomes and quality of life. Nearly 80% of patients have multimorbidity, often with two or more associated conditions.
Common comorbidities include hypertension (34.2%), metabolic syndrome (28.8%), obesity (27.4%), dyslipidaemia (24.2%), diabetes (19.9%), ischemic heart disease (19.4%), depression (11.9%), gastrointestinal disease (9.9%), and liver disease (3.4%). These conditions strongly influence treatment selection and persistence of TNF inhibitors.
The GRAPPA recommendations provide the most comprehensive framework for managing PsA in the presence of comorbidities. Treatment decisions should carefully consider associated conditions—for instance, methotrexate should be used cautiously in patients with fatty liver disease (MASH/MAFLD), while JAK inhibitors require caution in patients with cardiovascular risk or VTE risk.
Obesity deserves special attention as it independently increases the risk of developing PsA and can mask sarcopenia. Weight reduction has been shown to improve disease activity, sometimes approaching the benefits seen with biologic therapy. Emerging evidence suggests ketogenic diets may reduce DAPSA and PASI scores, and PDE4 inhibitors may promote weight loss by reducing visceral fat. Combination strategies such as tirzepatide with ixekizumab (TOGETHER-PsA trial) may improve disease control, although potential muscle loss remains a concern.
Key message: Routine screening for comorbidities and tailoring therapy accordingly are crucial for optimal management of PsA.

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CROSS TALKS

Dr. Anita Mahadevan MD, DNB

Professor & Head, Department of Neuropathology, NIMHANS, Bengaluru.

Topic : Interpreting Histopathology in Inflammatory Myositis

Inflammatory myopathies are heterogeneous autoimmune muscle disorders that pose diagnostic challenges due to varied clinical phenotypes, atypical presentations, and seronegativity in nearly 30% of patients. Although myositis-specific antibodies have good specificity (~85%), they are not universally present, making muscle biopsy an important diagnostic tool.

Immunohistochemistry improves diagnostic sensitivity, though markers such as MHC-I upregulation are sensitive but not entirely specific. Emerging biomarkers like ISG15 and KLRG1 may further refine biopsy-based classification.

Characteristic biopsy patterns help differentiate subtypes. Polymyositis shows $CD8^+$ T-cell–mediated endomysial inflammation with MHC-I expression on non-necrotic fibers. Dermatomyositis demonstrates perivascular/perimysial inflammation, perifascicular atrophy, and complement (C5b-9) deposition on capillaries. Inclusion body myositis shows rimmed vacuoles with ubiquitin and p62 accumulation, while immune-mediated necrotizing myopathy shows prominent myofiber necrosis with minimal inflammation.

Appropriate muscle selection, biopsy timing, prior therapy, and specimen handling influence diagnostic yield. When integrated with clinical, serological, and imaging findings, muscle biopsy remains crucial—especially in seronegative cases and in distinguishing inflammatory myopathies from mimics.

Dr. Rajiv Sekhri MD

Consultant Dermatologist, Fortis Hospital,Noida

Topic : Psoriasis: What a Rheumatologist should know?

Dr Sekhri highlighted important cutaneous clues that help rheumatologists recognise psoriasis and its link to psoriatic arthritis. Plaque psoriasis, the most common form, presents as symmetric, well-demarcated erythematous plaques with silvery scales and may demonstrate the Auspitz sign on gentle scraping. Guttate psoriasis appears as widespread raindrop-like papulosquamous lesions and can show the Koebner phenomenon following trauma. Variants such as inverse psoriasis (involving axillae and groin) and annular psoriasis may mimic fungal infections, but features like symmetry, flexural involvement, and minimal scaling help differentiate them.

Dr Sekhri also demonstrated typical nail involvement seen in psoriasis. Nail changes occur in 30–50% of patients and include pitting, dystrophy, and the classic oil-drop sign; unlike dermatomyositis, psoriatic nail disease lacks prominent periungual telangiectasia. About 15% of patients with psoriasis develop psoriatic arthritis, and in a similar proportion arthritis may precede skin disease. Nail involvement is present in nearly 80% of patients with psoriatic arthritis. A strong genetic predisposition exists, with the risk of psoriasis around 8% if one parent is affected, increasing to nearly 40% when both parents have the disease.

Key take-home message : Careful examination of the skin and nails can provide crucial diagnostic clues for early recognition of psoriatic disease and help rheumatologists identify patients at risk of developing psoriatic arthritis.

Dr. Deepak Talwar MD, DM

Director & Chair, Pulmonary Sleep & Critical Care
Metro Centre for Respiratory Diseases, Noida, India

Topic : HRCT in myositis associated ILD

Dr. Deepak Talwar, introduced the topic by stressing on the implications of radiographic patterns of ILD on HRCT on the diagnosis, disease course and prognosis of myositis-ILD.

The 3 classical signs (anterior upper lobe, and exuberant honeycombing and straight edge) have low sensitivity, but high specificity for CTD-ILD. Myositis specific antibodies dictate pattern of ILD irrespective of presence or absence of Myositis.

When compared to other CTD-ILDs, myositis-ILD has an increased prevalence of OP pattern. Notably, cooccurence of NSIP and OP pattens on the same HRCT, is predictive of myositis-ILD. Features such as Sub-pleural, Sharp Margins, Migratory, Waxing & Waning help differentiate OP from infective cause of pneumonia.

Acute onset presentation of ILD is associated with AIP pattern; subacute presentation is associated with OP and NSIP patterns and chronic presentation is associated with NSIP and UIP patterns.

HRCT is also important to monitor response to treatment.

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MEET THE MASTERS

Myositis: Mimic & Malignancy : Dr Hector Chenoy Risk and Diagnostic Clues:

Anti-TIF1γ antibodies in dermatomyositis are associated with a significantly increased malignancy risk (≈6-fold). Common associated cancers include ovarian cancer in women, with regional differences such as nasopharyngeal cancer reported in Japan. According to IMACS cancer screening recommendations, patients should undergo baseline malignancy screening followed by repeat evaluation at 1, 2, and 3 years after antibody detection. FDG-PET scanning may be considered in high-risk patients, particularly those over 40 years with anti-TIF1γ positivity or additional risk factors. Antibody-based stratification can therefore provide important prognostic information.

Distinguishing Myositis from Mimics: Careful clinical assessment remains essential. Proximal symmetrical weakness with preserved reflexes and elevated CK typically suggests inflammatory myositis. In contrast, distal weakness with reduced reflexes points toward neuropathy or motor neuron disease, while asymmetrical weakness with upper motor neuron signs suggests a central nervous system cause. The temporal onset also provides clues like, acute presentations may indicate infection, toxins, vasculitis, or rhabdomyolysis, whereas subacute or chronic progression is more consistent with autoimmune myositis, muscular dystrophies, or endocrine/metabolic disorders.

Take-home message : Accurate diagnosis requires triangulating clinical features, antibody profile, CK levels, and EMG or biopsy findings, while remaining cautious when antibody results do not match the clinical phenotype and remembering that several conditions can mimic inflammatory myopathy.

Dr Phani kumar MRI in Idiopathic Inflammatory Myositis

MRI has become a key imaging tool in the evaluation of inflammatory myopathies because of its high sensitivity in detecting muscle edema (T2WFS/STIR – disease activity) and fatty infiltration on T1-weighted images (chronic damage). In routine practice, MRI of the bilateral thighs using T1 and T2WFS/STIR sequences is commonly performed to assess the distribution and severity of muscle involvement.

Certain MRI patterns can provide clues to IIM subtypes. Dermatomyositis typically shows bilateral patchy edema in the anterior thighs with fascial and subcutaneous involvement, while antisynthetase syndrome more often affects the posterior thigh and tensor fascia lata with relative sparing of the adductors. Immune-mediated necrotizing myopathy usually demonstrates diffuse symmetrical edema involving axial and posterior thigh muscles, whereas polymyositis tends to involve proximal posterior muscles with greater muscle atrophy. Inclusion body myositis is characterized by asymmetric involvement, particularly of distal muscles such as flexor digitorum profundus and medial gastrocnemius, with prominent fatty replacement.

Whole-body MRI using sequences such as T1, STIR, Dixon, and diffusion-weighted imaging can help assess the global distribution of muscle involvement, monitor disease progression, and detect associated complications such as lung disease, malignancy, or avascular necrosis. Newer quantitative MRI techniques, including Dixon fat-fraction analysis, T2 relaxation mapping, and diffusion imaging, are increasingly being explored in research settings for more precise assessment of inflammation and muscle damage.

Despite its excellent sensitivity, MRI findings are often non-specific and must be interpreted in conjunction with clinical features, serology, and muscle biopsy. Greater standardization of MRI protocols across centers remains an important unmet need, and clinicians should remain vigilant for conditions that can mimic inflammatory myopathy on imaging.

Suspecting and diagnosing axial psoriatic arthritis & smart use of imaging in psoriatic arthritis – Dr. William Tillett

Dr. Tillett highlighted important differences between axial psoriatic arthritis (axial PsA) and classical ankylosing spondylitis, emphasizing that current ASAS classification criteria for axial spondyloarthritis may not fully capture the spectrum of axial involvement seen in psoriasis.

Compared with classical axial SpA, axial PsA often presents with older age of onset, a lower prevalence of inflammatory back pain, reduced HLA-B27 positivity (14–44%), milder sacroiliitis, less symmetrical syndesmophytes, and a more balanced male–female ratio. These differences make diagnosis challenging in clinical practice.

Treatment decisions should take into account associated conditions such as psoriasis, inflammatory bowel disease, and uveitis. IL-17 inhibitors should be avoided in patients with IBD, while JAK inhibitors, particularly upadacitinib, are emerging as promising options. In contrast, tofacitinib has limited efficacy in Crohn's disease, and abatacept is generally ineffective for axial disease. Deucravacitinib was also mentioned as a potential future therapeutic option.

Dr. Tillett also emphasized the role of lifestyle interventions, noting that regular physical activity, such as 30 minutes of walking five times per week, can significantly improve disease outcomes. Diagnostic challenges remain, particularly distinguishing axial PsA from diffuse idiopathic skeletal hyperostosis (DISH), especially in patients with high BMI.

What is and what is not Psoriasis? – Dr. Rajiv Sekhri

Dr. Sekhri emphasized the importance of distinguishing psoriasis from several dermatological conditions that can closely mimic it, as misdiagnosis may lead to inappropriate treatment.

Key clinical clues help differentiate common mimickers. Sebopsoriasis often extends beyond the hairline, unlike seborrhoeic dermatitis, which remains limited to seborrhoeic areas. Pityriasis lichenoides may resemble guttate psoriasis, but the presence of brownish residual pigmentation and a different lesion evolution help distinguish it. In flexural areas, inverse psoriasis presents as well-defined erythematous plaques, whereas dermatophytosis typically shows less sharply demarcated margins with peripheral scaling. Prominent pruritus should raise suspicion for contact dermatitis.

A careful nail examination can provide additional clues. Findings such as nail pitting, onycholysis, and subungual hyperkeratosis support psoriasis and help differentiate plantar psoriasis from tinea pedis.

When the diagnosis remains uncertain, histopathology and dermatopathology consultation can aid confirmation. For localized resistant lesions, treatment options include intralesional corticosteroids, tacrolimus, and topical JAK inhibitors.

The session highlighted that systematic clinical examination and appropriate investigations are crucial to avoid diagnostic pitfalls in psoriasis and its mimics.

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INAUGURAL FUNCTION

FUN QUIZ

The Rheumatology Fun Quiz at WRF 2026 in Raipur provided a refreshing break from the day's intensive academic sessions. Designed as an audience-participation quiz, it encouraged delegates to actively respond to questions posed directly to the hall, creating a lively and engaging atmosphere. Correct answers were rewarded with chocolates, adding a playful and competitive spirit to the session.

The quiz was conducted by Dr Sushant, Dr Devender, Dr Anusha, and Dr Niladri, whose humor and energetic style kept the audience entertained throughout. The questions creatively linked rheumatology with music, movies, and historical milestones in the specialty, blending pop culture with medical knowledge.

Chaired by Dr Kiran Seth, Dr Vijaya Prasanna, and Dr Azaj Kariem, the session stood out as one of the most interactive and enjoyable moments of the conference, bringing delegates together in a spirit of learning and camaraderie.

AWARDS

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CHALLENGING CASES

Rare and scary : Dr Sandeep Yadav

A 19-year-old male presented with 1 week of proximal muscle weakness with Gottron's papules and heliotrope rash, suggestive of dermatomyositis. Investigations showed elevated muscle enzymes, negative ANA, low complement, and MRI thigh suggestive of inflammatory myositis. He received pulse methylprednisolone followed by methotrexate with initial improvement.

He was later readmitted with worsening weakness, dysphagia, cranial neuropathy, and respiratory distress, progressing to respiratory failure requiring intubation with absent reflexes. Nerve conduction studies showed a demyelinating neuropathy consistent with Guillain–Barré syndrome, and he was treated with plasmapheresis and IVIG.

This represents a rare case of neuromyositis, where inflammatory myopathy coexisted with a demyelinating neuropathy resembling GBS. Although muscle biopsy could have helped confirm the subtype of inflammatory myopathy, nerve biopsy is often difficult to demonstrate diagnostic changes in GBS because the pathology predominantly involves proximal nerve roots and radicular segments. Nailfold capillaroscopy might have provided additional supportive clues toward dermatomyositis in this patient.

Trigger, Mimic or Coincidence : Dr Shubha Bhalla

A 61-year-old female presented with rapidly progressive inflammatory myopathy with dermatomyositis rash, dysphagia, and anasarca, in the background of disseminated tuberculosis infection. Investigations showed elevated muscle enzymes, negative ANA, and normal complement levels. Myositis-specific antibody testing revealed anti-SRP positivity, while myositis-associated antibodies including anti-ribosomal P and U1-RNP were strongly positive.

Muscle biopsy was suggestive of dermatomyositis. The patient was treated with pulse intravenous methylprednisolone and IVIG along with anti-tubercular therapy (ATT).

The immune activation associated with tuberculosis may have triggered an underlying autoimmune process. The coexistence of anti-ribosomal P, U1-RNP, and anti-SRP antibodies is unusual, and anti-SRP myopathy typically presents with very high CK levels and minimal skin involvement, making this presentation atypical. Deferring aggressive immunosuppression and initiating IVIG with ATT proved to be an effective strategy.

The face tells a different story : Dr Shivraj Padiyar

A 47-year-old female presented with progressive bilateral facial and neck swelling for 1 year with painful non-healing buccal mucosal ulcers. Initial salivary gland biopsy showed acute on chronic sialadenitis, and she received antibiotics without improvement. MRI reported inflammatory changes in the parotid, submandibular, and masticatory spaces, and a right cheek biopsy showed inflammatory masticatory muscle myositis. ANA was 1+ speckled with low-titer anti–Jo-1 positivity and normal CPK, and she received low-dose steroids with partial response.

Due to clinicoserological discordance and poor steroid response, repeat imaging showed edema of multiple facial muscles with lymphadenopathy, and repeat biopsy again showed inflammatory myositis. PET-CT demonstrated uptake in masticatory muscles and salivary glands. Open biopsy from parotid, cervical lymph node and buccal mucosa revealed high-grade non-Hodgkin lymphoma. Despite CVP chemotherapy, she developed respiratory distress and succumbed to illness.

A Real-World world Challenge : Dr Saranya C

A 56-year-old male with long-standing psoriasis on methotrexate therapy presented with inflammatory polyarthritis and worsening cutaneous disease. The patient had multiple comorbidities including obesity (BMI 33.1 kg/m²), hypertension, hyperlipidemia, and grade-2 fatty liver on ultrasonography. MRI of the sacroiliac joints revealed acute-on-chronic sacroiliitis (right > left), consistent with axial involvement.

Due to intolerance to apremilast, he was initiated on adalimumab; however, treatment was complicated by paradoxical worsening of psoriasis, necessitating a switch to secukinumab. The patient initially responded to secukinumab (150 mg following loading doses and then every 4 weeks), which was later spaced to 8-weekly dosing after one year. Subsequently, methotrexate had to be discontinued due to transaminitis and the development of severe obstructive sleep apnea. The patient later developed non-specific colitis, raising concern for possible inflammatory bowel disease potentially associated with IL-17 inhibition.

This case highlights the therapeutic challenges in managing psoriatic arthritis with axial involvement in the presence of significant metabolic comorbidities and treatment-related adverse effects, emphasizing the complexity of treatment selection and long-term disease management.

Road to the Axis: Dr Sree Devi S

A 17-year-old male with a 9-month history of joint symptoms initially presented with oligoarthritis involving both hips and the right knee, along with left Achilles tendon pain and difficulty walking. He was initially treated as tubercular arthritis but did not show improvement and was later referred for further evaluation.

Over time, he developed polyarthritis involving both small and large joints, along with plaque psoriasis over the scalp, palms, and soles and inflammatory low back pain. Examination showed peripheral arthritis, restricted hip movements, Achilles tendonitis, and nail changes such as pitting and subungual hyperkeratosis. Laboratory tests revealed elevated inflammatory markers, HLA-B27 were negative. X-ray pelvis shows grade 3 sacroilitis and Rt hip arthritis. He was initially started in adalimumab and methotrexate later shifted to etanercept in view of non-responsiveness to adalimumab. Etanercept spaced to 2 weekly due to financial constrains and later shifted to tofacitinib and methotrexate.

This case highlighted the difficulty in recognizing axial involvement in psoriatic arthritis, particularly in young patients, and emphasized the importance of early diagnosis and appropriate management to prevent damage.

Ammunition running out,and a war to wage: Dr Raghavendra H

A 34-year-old woman with a 10-year history of plaque psoriasis demonstrated the challenges of long-term disease management, treatment escalation, and family planning in psoriatic disease. She was initially treated with methotrexate for two years, which was later stopped for pregnancy planning. Following the birth of her first child and a period of remission, she experienced a relapse and was started on secukinumab, which maintained disease control for nearly five years.

Recently, she developed worsening joint symptoms with enthesitis and synovitis and was switched to adalimumab. However, the treatment failed to control her symptoms and led to worsening psoriasis. She was subsequently initiated on ixekizumab along with low-dose methotrexate, resulting in improvement in both skin and joint manifestations.

This case highlighted key clinical dilemmas in psoriatic disease management, including the effectiveness of switching within the same biologic class and treatment decisions in patients planning pregnancy.

The key insights given through this case were the IL 17 inhibitors non responders might respond to a second IL 17i unlike TNFi . Inj. Certolizumab pegol can be safely used during pregnancy.

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CHALLENGING CASES

Overcoming a Herculean Task : Dr. Kasturi Hazarika

A 17-year-old HLA-B27–positive male presented with inflammatory back pain and oligoarthritis and developed psoriasis a year later, evolving into severe and difficult-to-treat psoriatic arthritis. Initial treatment with methotrexate and low-dose steroids was followed by leflunomide, secukinumab, tofacitinib, and infliximab with dose escalation, but disease activity persisted. The clinical course was further complicated by atlanto-axial instability requiring surgical fixation and an inability to taper steroids, necessitating multiple therapeutic switches including golimumab.

The discussion emphasized defining refractoriness only after an adequate therapeutic window aligned with clinical trial endpoints—approximately 12 weeks for TNF inhibitors and up to 24 weeks for IL-23 inhibitors. In refractory psoriatic arthritis, dose escalation or off-label strategies may be considered in selected cases, particularly when higher drug exposure may be justified, while carefully balancing potential benefits against safety risks such as infections.

Takes Two to Tango : Dr Nikhil Gupta

A 50-year-old male with psoriatic arthritis since 2012, with obesity and type 2 diabetes, had difficult-to-treat disease with discordant joint and skin responses. Initial therapy from 2017 included methotrexate, leflunomide and low-dose steroids with subsequent escalation due to inadequate response. Etanercept with methotrexate and leflunomide achieved good control of arthritis but persistent skin disease. In contrast, secukinumab with conventional DMARDs improved psoriasis but joint disease remained active. Golimumab-based therapy later provided temporary control of both domains before loss of response, requiring further switches including apremilast and secukinumab combinations.

Given persistent refractory disease with pathway discordance, alternating biologic therapy was attempted with golimumab and secukinumab for six months, followed by guselkumab and golimumab from April 2025, resulting in sustained remission of both joint and skin disease. Dual biologic therapy in psoriatic arthritis remains rare with limited evidence and infection concerns, but may serve as a rescue strategy in carefully selected refractory cases.

Surviving the Therapy, Not the Disease : Dr. Vishnupriya S

A 46-year-old male with chronic plaque psoriasis and psoriatic arthritis had a refractory disease course complicated by multiple comorbidities including diabetes, hypertension, and coronary artery disease. His treatment journey was marked by several therapy-related adverse effects. Prior alternative treatments were followed by methotrexate-induced transaminitis, while apremilast led to suicidal ideation and worsening diabetes and hypertension. Prolonged over-the-counter steroid use resulted in secondary adrenal insufficiency and an osteoporotic hip fracture. On examination, he had nail pitting and dystrophy, active inflammatory arthritis with enthesitis and dactylitis, and elevated inflammatory markers. RF, ACPA and HLA-B27 were negative, while evaluation revealed low cortisol, low ACTH and an ejection fraction of 40%.

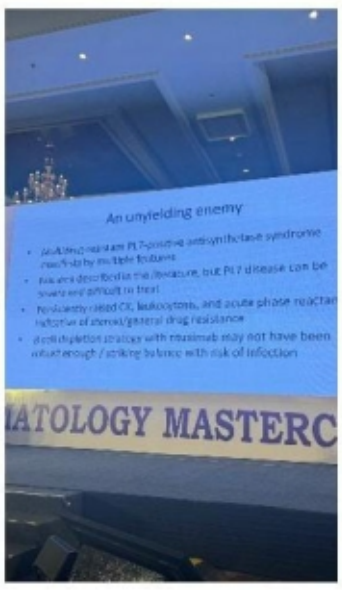
He was started on secukinumab along with teriparatide and hydrocortisone replacement, which improved cutaneous psoriasis with partial control of arthritis and dactylitis. This case highlights the challenges of managing PsA with multiple comorbidities and therapy-related complications, and underscores the risks of complementary therapies and unsupervised OTC steroid use. TNF-α inhibitors may also offer potential cardiovascular benefit by reducing systemic inflammation and therefore should not be prematurely avoided unless severe heart failure is present.

Double trouble: Dr Harikrishnan G

59 year old female with past history of TB, presented with chronic exertional dyspnea. She was found to have mechanic hands, restrictive PFT and NSIP-ILD. Anti-EJ and anti-Ro were positive. She was treated with prednisone and MMF and she responded well. 7 months later she presented with subacute onset fever, breathlessness and a non-healing ankle ulcer. CT showed multiple centrilobular nodules and GGOs and ankle MRI showed ankle Synovitis and tenosynovitis and ulcer edge biopsy showed a granuloma. She was diagnosed as disseminated TB, MMF was stopped and ATT was started. She responded to treatment and ILD remained stable at follow-up. This case highlights the importance of keeping a high index of suspicion for infections, especially in atypical clinical presentations.

Deceptive beginnings : Dr. Rahul Bisaralli

A 31 year old female patient presented with a 3-month history of dyspnea, with CT showing OP pattern. Immunological investigations showed RF+, ANA nuclear coarse speckled and Jo1 borderline positive. She was started on prednisone and MMF. However, 2 months later she presented with fever and acute worsening of breathlessness. Inflammatory markers were elevated; CT showed acute exacerbation of RP-ILD and pmeumomediastinum. Myositis profile was positive for MDA-5. She was given pulse steroid and tacrolimus. However, the patient succumbed to her illness. This case underscores the need for early detection of RP-ILD, especially in the phenotype of MDA-5 patients with no skin manifestations



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International Experts With Organizing Team

On behalf of the Organising Committee, we extend our heartfelt gratitude to all the esteemed faculty and delegates who graced the World Rheumatology Forum Summit 2026 – Rheumatology Masterclasses with their presence and participation. Your enthusiastic involvement, insightful discussions, and valuable contributions made this academic gathering truly enriching and memorable. The exchange of ideas, clinical experiences, and emerging perspectives in rheumatology during these two days greatly enhanced the scientific value of the meeting and strengthened our shared commitment to advancing patient care and research in this field.

We are deeply thankful to our distinguished faculty members for generously sharing their expertise, guiding discussions, and inspiring the audience with their knowledge and experience. Your dedication to teaching and mentorship played a vital role in making the sessions engaging, informative, and impactful. We also sincerely appreciate all the delegates whose active participation, thoughtful questions, and keen interest added vibrancy to the conference. Your presence and enthusiasm created an atmosphere of collaboration and learning that truly reflects the spirit of the rheumatology community.

Hosting this event would not have been possible without the collective support, encouragement, and goodwill of every participant. It was a privilege for us to welcome such an accomplished and passionate group of professionals to Raipur, and we are grateful for the warmth and camaraderie that marked the entire event. As we conclude this successful edition of the Rheumatology Masterclasses, we carry forward the inspiration, knowledge, and professional bonds created during the summit. We look forward to continued collaboration and to welcoming you again at the next summit of the World Rheumatology Forum at Kolkata.

- Dr. Arun Kumar Kedia

TEAM NEWSLETTER


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AWARD WINNERS

Prof. A N Chandrasekaran prize

"Best case presentation by young consultant"

Winner

Dr Sanket Shah
Rheuma Care, Ahmedabad
"Wolf in Brown Clothing"

Prof. A N Chandrasekaran prize

"Best case presentation by young consultant"

Runners-up

Dr C Saranya
Professor, Saveetha Medical College, Chennai
"A real-world challenge"

Prof. V R Joshi prize

"Best abstract - Oral presentation by Rheumatology trainee"

Winner

Dr Tejaswee Banavathu
Max Superspeciality Hospital Saket, New Delhi
Å Refractory Sweet-like neutrophilic dermatosis with chondritis, periorbital edema and inflammatory arthritis unveiling VEXAS syndrome in an elderly male

Prof. Sukumar Mukherjee prize

"Best abstract - Oral presentation by Medicine trainee"

Winner

Dr Rohan Ghosh
Kolkata Medical College
Autoimmunity Striking The Gut And The Spine: A Rare Presentation Defying Boundaries

Prof. A N Malaviya prize

"Best abstract - Poster presentation" (by Rheumatology trainee)

Winner

Dr Gopika Mohan
Amrita Institute of Medical Sciences
"From VEXAS-Mimic to Neutrophilic Leukemia: The Spectrum of Clonal Hematopoiesis in Rheumatology"

"Best abstract - Poster presentation" (by Rheumatology trainee)

Runners-up

Dr Disha Arora
Indraprastha Apollo, New Delhi
"Recurrent Hyper C Kemia in the Setting of Hypereosinophilia: A Diagnostic Enigma"

Prof. A N Malaviya prize

"Best abstract - Poster presentation" (by Medicine trainee)

Winner

Dr Ananth G
MGM Medical College, Indore
"Idiopathic Inflammatory Myositis Mimicking Guillain-Barré© Syndrome: A Diagnostic Pitfall"

"Best abstract - Poster presentation" (by Medicine trainee)

Runners-up

Dr Maheshwar Raj
ACS Medical College, Chennai
"Anemia and Renal Failure in an Elderly Woman: Not Always CKD"

"Best abstract – Poster presentation by Medicine trainee" – Original study

Winner

Dr Raveena Kumar
JSS Medical College, Mysuru.
"analysis Of Epidemiology And Diagnosis Of Isolated Non-infectious Uveitis"

"Best abstract – Poster presentation by Medicine trainee" – Original study

Winner

Dr Kavya NP
CMC, Vellore
"Case Series of SRP1 antibody associated Immune Mediated Necrotizing Myositis"

"Best abstract – Poster presentation by Consultant"

Winner

Dr Swapnil Suresh Jagtap MD, DM
Department of Clinical Immunology and Rheumatology
SGPGIMS, Lucknow, India
"Dermatomyositis: Unusual presentation of JAK 3 mutation"

RHEUMATOLOGY MASTERCLASSES

WORLD RHEUMATOLOGY FORUM SUMMIT 2026

14th-15th March 2026

Mayfair Lake Resort, Raipur, Chhattisgarh, India

www.wrfsummit.com

Legacy of Learning: A Teacher's Reflection on WRF

Prof Dr A N Malaviya

'It was a privilege to attend the recent meeting of the World Rheumatology Forum (WRF) held at Raipur on 14–15 March 2026. The meeting was organised with remarkable attention to academic quality and clinical relevance, and the level of engagement from participants was truly impressive.

What stood out most was the enthusiastic participation of young physicians - trainees, fellows, DM/DNB residents, and postgraduate students from internal medicine and paediatrics. The opportunities provided through interesting case-presentations and poster sessions created an encouraging academic platform for these early-career clinicians to present their work, exchange ideas, and interact with experienced faculty from India and abroad.

Such initiatives are extremely valuable for the future of rheumatology in our country. By exposing young physicians to the breadth and depth of this specialty early in their training, meetings like the WRF help stimulate interest in rheumatology as a career choice. In a country where the rheumatologist–to–population ratio remains far from adequate, these academic forums play an important role in inspiring the next generation to enter this field.

The institution of awards for trainee presentations, including poster awards and recognition for young investigators, adds an additional dimension of encouragement and mentorship. These recognitions not only reward scientific curiosity but also foster a culture of inquiry and academic excellence among young clinicians.

Meetings such as the WRF demonstrate how thoughtfully planned academic interactions can meaningfully strengthen rheumatology in India. They bring together international expertise, national experience, and youthful enthusiasm in a way that benefits both current practice and the specialty's future growth.

Heartiest congratulations to the organising team for conducting such a stimulating and high-quality academic meeting.

Thanks!

Prof Dr Alkendu Ghosh

Bridging Excellence: Reflections from Raipur, Vision for Kolkata

WRF 2026 Raipur : The collective exchange of crosstalks in rheumatogy is being highly appreciated in WRF 2026 ,Raipur. Marvelous venue mixed with excellent time management (always ahead of schedule) in the setting of top notch scientific deliberations has put a great milestone in the WRF 2026 meeting. Participations of the youngsters including trainees in medicine and rheumatogy along with young consultants in Rheumatogy created a big impact felt by all of us. Sincere congratulations to the team WRF 2026.

WRF 2028 , Kolkata : It is with profound joy we welcome you all to the WRF 2028 in our vibrant and culturally rich city of Kolkata. Here the science of Rheumatology will not merely be discussed but will be refined and reimagined. Welcome to Kolkata. Welcome to the possibility. Welcome to the future.

Thanks!

THANK YOU!

Prof Dr V P Pandey
Organising Chair

"My sincere thanks to all the speakers, delegates, and organizers of WRF 2026,—truly one of the finest scientific feast.

The two days of high-level deliberations, punctual sessions, and the exchange of state-of-the-art medicine have left a lasting impact on practicing rheumatologists, physicians, and post-graduate aspirants alike. The way our '*Super Experts'* navigated complex issues and provided clarity to our queries was masterfully done.

The true achievement of this forum will be the echoes of its impact, which I am certain will yield positive results in our clinical practice for years to come. With the continued participation of all forum members, I am confident we will keep building these essential platforms for our community.

Warm wishes and deep gratitude to everyone involved.

Dr Sham S
Message from Scientific Chair

I would like to thank all the delegates first for their active academic participation. I would like to thank Dr Hector Chinoy, Dr William Tillett, Dr Anita Mahadevan, Dr Rajiv Sekhri and Dr Deepak Talwar for the wonderful academic deliberations and for their tireless interaction with all the delegates.

I would like to thank all the young consultants who presented their cases, trainees, and the souvenir team. Last but not the least, the newsletter team lead by Dr Sourabh has nicely captured the WRF 2026 proceedings lucidly in this newsletter.

Dr Arun Kedia
Message as Organising Secretary

Hosting this event would not have been possible without the collective support, encouragement, and goodwill of every participant. It was a privilege for us to welcome such an accomplished and passionate group of professionals to Raipur. We tried to cater to the best so that everyone remembers this meeting forever. As we conclude this successful edition of the Rheumatology Masterclasses, we carry forward the inspiration, knowledge, and professional bonds created during the summit. We look forward to continued collaboration and to welcoming you again at the next summit of the World Rheumatology Forum at Kolkata.

WRF 14th- 15th March, Raipur Chhattisgarh 2006

Announcement of next WRF 2028 in Kolkata