Abstract Submission Form

The Women's Heart Center Program Committee is accepting abstract submission forms through **August 15, 2025**. Completed forms should be emailed to WHC@TheChristHospital.com.

Abstract submissions should be gender- and sex-specific research pertaining to one of the program topics outlined below.

The Program Committee wishes to encourage young scientific investigators and will reward up to 4 abstracts/posters submitted by presenters considered early career (definition provided below). First place will receive $1000, second place will receive $500, and two honorable mentions will each receive $250.

The presenting author will be sent an email with the status of the submission by **August 22, 2025**. If your abstract is accepted, your notification will contain complete presentation information. However, please note the following:

- All human subject research must conform to the principles of the Declaration of Helsinki of the World Medical Association.
- The presenting author should be able to provide documentation of IRB approval if requested.
- The Program Committee is unable to reimburse presenters for travel, hotel, or per diem expenses.
- Submission of an abstract constitutes a commitment by the presenting author (or designee) to present in-person at the symposium on October 3, 2025, during the following times:
    - Registration & Networking: 7:00 – 8:00 am
    - Networking Lunch: 12:00 – 1:30 pm
    - Poster Session Award Announcement: 4:50 – 5:10 pm
- All accepted abstract presenters must register for the symposium via Eventbrite and pay the applicable registration fees (trainees and invited speakers will have the registration fee waived).
- If an author wishes to withdraw an abstract, please email WHC@TheChristHospital.com.

Presenting Author Information

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Early Career (Defined as physicians, scientists, medical students, and other healthcare providers currently in residency or fellowship programs or within three years of training)? Yes ☐ No ☒

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Abstract Topic (must be gender- or sex-specific)

☒ Preventative cardiology	☐ General cardiology	☐ Interventional cardiology
☐ Heart failure	☐ Cardio-oncology	☐ Cardio-obstetrics
☐ Electrophysiology	☐ Cardiovascular Imaging	☐ Coronary Microvasculature

☐ Social Determinants of Health ☐ Mental Health ☒ Precision Medicine

Title: Include the full title as it will appear on the poster.
Rilonacept Reduces Pericarditis Recurrence Risk: Clinical Outcomes From the RESONANCE Patient Registry

Background: In an initial paragraph, provide relevant information regarding the background and purpose of the study, preferably in no more than two to three sentences.
Recurrent pericarditis (RP) is an IL-1-mediated chronic autoinflammatory disease. The phase 3 trial RHAPSODY demonstrated that rilonacept (IL-1α and IL-1β cytokine trap), the first and only FDA-approved treatment for RP, was effective in treating RP not only as a third-line agent (3L; after corticosteroids) but also as a second-line agent (2L; instead of corticosteroids) and reduced recurrence risk as monotherapy. The REgiStry Of the NAtural history of recurreNt periCarditis in pEdiatric and adult patients (RESONANCE) has been collecting long-term combined prospective and retrospective data from US-based pericardial-disease-dedicated programs since 2020.

Methods: Briefly state the methods used.
Database cut-off (DCO) was 05 February 2025. Data on RP management were collected and analyzed from pts with ≥2 years of observation in RESONANCE. Disease duration at DCO was defined as time from RP diagnosis to either disease resolution (no disease flares while off all RP treatments for ≥6 months before DCO) or last follow-up (for pts with ongoing treatment at DCO). Pericarditis recurrences (investigator-assessed) were confirmed based on RP symptom data and/or objective findings. Annualized recurrence rates were calculated per RP treatment regimen as total pericarditis recurrences divided by total patient-years (PY) while receiving that treatment. Wilcoxon signed-rank test was utilized to analyze the significance in change of annualized recurrence rates before and after rilonacept initiation.

Results: Summarize the results in sufficient detail to support the conclusions.
At DCO, 81 pts had ≥2 years of follow-up data in RESONANCE; mean (SD) age was 51.0 (16.8) years; most (66.7%) were female; 84% had idiopathic etiology; median (Q1-Q3) disease duration was 3.1 (2.6-3.7) years; and median observation was 2.93 (2.54-3.38) years. Patient-year treatment exposures per treatment were: NSAIDS ± colchicine (n=79; 187.8 PY), corticosteroids (n=30; 61.1 PY), anakinra (n=1; 1.2 PY) and rilonacept (n=35; 72.8 PY). Of the 35 pts treated with rilonacept for any duration (median observation: 3.2 years; median time on rilonacept: 2.08 years), the most common reason for rilonacept initiation was chest pain/recurrence on prior treatment (n=28). The annualized recurrence rate while receiving rilonacept was significantly lower versus all combined prior lines of treatment (4.00 vs. 0.02 events per PY; p=0.002); this outcome was consistent across line of treatment for rilonacept use (2L: 3.73 vs. 0.06 events per PY, p=0.02; 3L: 4.14 vs. 0 events per PY, p<0.001; **Table 1**).

Conclusions: Concisely state the conclusions reached.
This first report of real-world outcomes from RESONANCE shows that rilonacept-containing regimens for RP as 1st, 2nd, or 3rd line therapy reduced recurrence risk over long- term (>2 year) treatment, supporting prolonged management during RP natural history.

Tables/Figures/Graphics: Include images that are part of your submission here. Images should be high resolution and have a file type of “gif”, “jpg”, or “jpeg”.

Table 1. Recurrence Rates Before and After Rilonacept Initiation

Treatment Line for Rilonacept-Containing RP Treatment	Prior Regimen	Annualized Recurrence Rate* (events/PY)		P-value	Reasons for Rilonacept Initiation[b]
		Prior to Rilonacept[a]	While on Rilonacept		
1st line	**N/A** (n=5)	N/A	0	N/A	First line therapy upon RP diagnosis (n=5)
2nd line	**NSAID ± Colchicine** (n=10)	3.73	0.06[d]	0.02	Chest pain/Recurrence (n=8) Unknown (n=2)[c]
3rd line	**Corticosteroid-Containing Regimen** (n=19)	4.14	0	<0.001	Chest pain/Recurrence (n=19) Intolerance to prior therapy (n=3)
4th line	**NSAID + Colchicine + Steroid→Anakinra** (n=1)	4.04[e]	0	>0.05	Chest pain/Recurrence (n=1) Intolerance to prior therapy (n=1)
Total Rilonacept (n=35)		**4.00**	**0.02**	**0.002**	

*Annualized recurrence rate was calculated by dividing the total number of pericarditis recurrences (investigator-assessed; may include patient-reported chest pain and/or elevated markers of inflammation and/or EKG changes and/or pericardial friction/rub) by the total patient-years of follow-up.

[a]Including 1st recurrence episode after management of incident episode with NSAIDs and/or colchicine and/or corticosteroids.

[b]More than one reason for treatment transitions could be captured.

[c]Reason unknown.

[d]One Investigator-assessed recurrence reported in 1 patient; this event included chest pain only, as CRP (0.8 mg/dL) was not above the RHAPSODY event adjudication criterion of 1 mg/dL. This patient continued on rilonacept with no additional events reported by DCO.

[e]This patient experienced two recurrences while on NSAID + colchicine + steroid and one recurrence on anakinra.

PY, patient year.