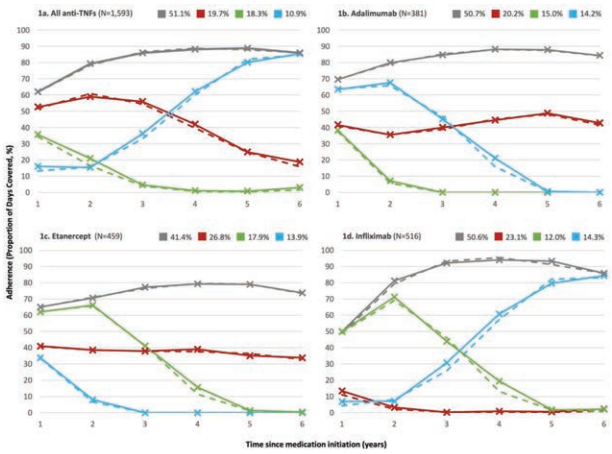

Figure 1. Longitudinal adherence trajectories of anti-TNFs

Figure 1.

REFERENCES: NIL.
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Disclosure of Interests: None Declared.
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POS0373

A SYSTEMATIC LITERATURE REVIEW OF RANDOMISED CONTROLLED TRIALS EVALUATING COLCHICINE FOR CARDIOVASCULAR PREVENTION: THERE IS AN ELEPHANT IN THE ROOM

Keywords: Systematic review, Cardiovascular disease

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Background: Colchicine (COL) is widely used in rheumatology for treatment and prophylaxis of acute gout flares, other crystal diseases, and autoinflammatory diseases. In recent years evidence on the efficacy of COL for the prevention and treatment of cardiovascular diseases (CVD) has accrued. Since patients with gout and other inflammatory RMDs have a higher CV risk, COL may be a useful resource for CV prevention in rheumatology.
Objectives: To review the randomised controlled trials (RCT) investigating the use of COL for CV prevention from a rheumatology perspective.
Methods: A systematic literature review (SLR) of 7 databases was conducted following the PICO framework. Three researchers independently screened abstracts and titles and then full texts were reviewed to determine eligibility (RCTs enrolling adult subjects with or w/o history of CVD treated with COL for CV prevention). Data from eligible articles were extracted and risk of bias (RoB) was assessed with validated tools.
Results: A total of 3867 articles were retrieved and screened, 174 articles were read in full and 20 of them were eligible for inclusion. Of 19440 enrolled patients, 9655 were randomised to receive COL at a dose varying between 0.5mg/day and 2mg/day and for a period ranging between 10 days and several months (covering in part or in full the study follow-up period). Main inclusion criteria were recent acute coronary syndrome or planned cardiac surgery. In two studies, patients with stable chronic heart failure or stable coronary disease were recruited. The primary outcome varied across studies, being for example new-onset CV events, need of hospital admission, CV death, a composite index including all of these, or serum concentrations of high-sensitivity C-reactive protein. Median follow up time was largely different across studies allowing to stratify them in short term (<1 month, 2 studies), medium term (1-3 months, 7 studies), long term (4-6 months, 4 studies), very long term (>6 months, 4 studies) studies. The remaining studies assessed in-hospital events. In 7 out of 20 RCTs previous or ongoing COL use for any indication was as exclusion criterion. However, no further details about the reason for taking COL was provided. Male gender was predominant in all studies (between 65 and 96%) whereas mean age ranged between 59 and 69 years. A thorough CV history was collected at recruitment, however there was no mention to uric acid levels or a previous diagnosis of gout. Furthermore, 3 RCTs excluded patients with known autoimmune/inflammatory disease (in 2 of them ongoing immunosuppressive or steroid therapy was an additional exclusion criterion) however the other RCTs did not mention coexisting autoimmune/inflammatory diseases. The primary endpoint was met by 0/2 (0%) short term studies, 4/7 (57%) medium term studies, 2/4 (50%) long term studies and 2/4 (50%) very long-term studies. Neither of the studies assessing in-hospital events met the primary endpoint.
Conclusion: Our SLR of RCTs showed that COL may be useful in preventing new CV events/CV death in the general population when administrated for at least on month. However, the overall lack of information about coexisting gout/other inflammatory RMDs does not allow to derive meaningful data to be applied in rheumatology practice. Future RCTs should consider this aspect when defining the eligibility criteria and describing the patient cohorts since COL may be even more effective in patients that display a higher CV risk due to an underlying inflammatory disease. This may ultimately increase the likelihood to achieve the study primary endpoints.
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Disclosure of Interests: None Declared.
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POS0374

HOW WELL DO EULAR/ASAS-EULAR AND NATIONAL TREATMENT RECOMMENDATIONS FOR PSORIATIC ARTHRITIS AND AXIAL SPONDYLOARTHRITIS ALIGN? IS IT TIME FOR AN UPDATE OF NATIONAL TREATMENT RECOMMENDATIONS?

Keywords: Psoriatic arthritis, Health Services Research, Spondyloarthritis

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Background: National treatment recommendations are often used to optimize patient care and may differ from international recommendations. Although such potential heterogeneity may affect outcomes, mapping of these differences across European countries was last performed more than a decade ago for axial spondyloarthritis (axSpA) and has never been undertaken in psoriatic arthritis (PsA).[1]
Objectives: To assess differences and similarities between the EULAR and ASAS-EULAR recommendations for the treatment of patients with PsA and axSpA, respectively, versus national PsA and axSpA treatment recommendations across Europe.
Methods: Rheumatologists from 15 European countries (Czech Republic, Denmark, Estonia, Finland, Iceland, Italy, Netherlands, Norway, Portugal, Romania, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom) compared the most recent national treatment recommendations for PsA and axSpA with the "EULAR recommendations for the management of PsA with pharmacological therapies: 2019 update"[2] and the "2016 update of the ASAS-EULAR recommendations for axSpA"[3], in an online survey conducted between October 2021 and April 2022. The study was an initiative of the European Spondyloarthritis Research Collaboration Network (EuroSpA RCN).[4]
Results: Three countries (Czech Republic, Netherlands, and Spain) followed all EULAR recommendations for treating patients with PsA and four countries (Czech Republic, Italy, Spain, and Switzerland) all ASAS-EULAR recommendations for axSpA. A total of 4/15 countries had no national treatment recommendations for PsA or axSpA, but had other rules or regulations to follow, for which the comparisons in this study were then performed. The Netherlands had national treatment recommendations for axSpA, but not yet for PsA, for which EULAR recommendations were followed. In six countries, the national treatment recommendations for PsA predated the 2019 EULAR recommendations and in one country the national treatment recommendations for axSpA predated the 2016 ASAS-EULAR recommendations. More differences were seen between the EULAR and the national treatment recommendations for PsA than between the ASAS-EULAR and the national treatment recommendations for axSpA (Figure 1). Discrepancies between international and national treatment recommendations included: Entry criteria for start of a biologic/targeted synthetic disease-modifying anti-rheumatic drug (b/tsDMARD) varied and were the most stringent in Romania, where DAPSA>28 for PsA and BASDAI>6 and ASDAS≥2.5 for axSpA were required for the start of a bDMARD. Regarding PsA, in two countries (Finland and Switzerland) a conventional synthetic DMARD should be initiated before a b/tsDMARD including in patients with predominantly enthesal or axial disease. In several countries, no preference for IL17 inhibitors was given for PsA patients with significant skin involvement. The positioning of Janus Kinase inhibitors (JAKi) differed across countries, e.g. in Estonia JAKi were indicated after failure of two tumor necrosis factor inhibitors and in Romania JAKi were positioned at the same level as bDMARDs. Phosphodiesterase-4 inhibitors were not in use or not reimbursed