filgotinib also reduced the B- and T-cell development cytokine IL-7. In contrast, IL-8 was not affected by filgotinib. Reductions in MIP1α, MIP1β and GM-CSF are in line with a down modulation of innate immune activity.
Conclusions: Treatment of RA patients with filgotinib monotherapy resulted in significant reduction in the levels of a broad range of cytokines related to T_H1, T_H2, T_H17 and potentially B cells, as well as innate immunity. This observed anti-inflammatory activity of filgotinib is consistent with its efficacy in RA patients.
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Disclosure of Interest: A. Kavanaugh Consultant for: Galapagos, Pfizer, Abbvie, Amgen, Celgene, Janssen, Novartis, Eli Lilly, UCB, A. Van der Aa Employee of: Galapagos NV, C. Jamoul Employee of: Galapagos NV, W. Li Employee of: Gilead Sciences, L. Goyal Employee of: Gilead Sciences, Y. Pan Employee of: Gilead Sciences, P. Harrison Employee of: Galapagos NV, C. Tasset Employee of: Galapagos NV, J. Tarrant Employee of: Gilead Sciences, R. Galien Employee of: Galapagos SASU
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THU0183 IMPROVED ADHERENCE TO NEWLY PRESCRIBED DMARDS WITH CO-PRESCRIPTION WITH LOW DOSE STEROIDS IN RHEUMATOID ARTHRITIS PATIENTS ATTENDING CLINIC AT A DISTRICT GENERAL HOSPITAL IN THE UK

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Background: Non-adherence to DMARDs is associated with disease flares and increased disability. Adherence rates to prescribed medicine regimes in people with Rheumatoid Arthritis vary from 30–80% in different studies. Improving adherence to therapy leads to better disease outcome and reduced costs associated with management of RA.
Objectives: This study was carried out as a pilot study to look at the effect of co-prescription of steroids on the adherence and side effects to newly prescribed DMARDS in patients with rheumatoid arthritis.
Methods: This is a prospective, observational cohort study, for the duration of three months per participant. Patients were selected sequentially from those attending outpatient clinic at Basildon Hospitals with a confirmed diagnosis of rheumatoid arthritis (ACR/EULAR criteria), and had been planned to start on a new DMARD by the treating physician. Baseline data included demographics, disease characteristics and data regarding steroid co- prescription including route, dose and duration. Patients were reviewed at three months to look at DMARD adherence defined by continuation of the DMARD. We looked at the side effect profile as possible contributing factor to non-adherence. The effect of co-prescription with steroids and other demographic data on treatment duration was investigated using Kaplan-Meier survival plots. Logistic regression analysis was used to investigate the effect of co- prescription of steroids on continuation of medication.
Results: Fifty one patients were recruited to the study. Median age at the time of enrolment was 61 years (IQR 46–71), 73% were females and 92% were caucasians. seventy percent of the patients were seropositive and DMARD naïve with a mean DAS CRP at recruitment of 4.13 (1.21). Seventeen (33%) patients were co-prescribed with steroids at the initiation of DMARDs. Out of these 59% (n=10) were DMARD naïve. Thirteen patients received a tapering dose of oral prednisolone with a mean starting dose of 13.8mg daily (range 3mg - 20 mg) for a mean duration of 10.8 weeks. Two patients received oral prednisolone 5mg daily for 12 week. The mean cumulative dose of oral prednisolone prescribed was 632.2mg. The two remaining patients received 120 mg of depomedrone IM.
The non adherence rate for our cohort was 35%, 6% for patients co-prescribed with steroids versus 50% for patients who were not co-prescribed with steroids. The odds ratio for likelihood of discontinuation for patients who were not co-prescribed with steroids versus patients who were, was 16 (1.94–134.5, p=0.011).
At the end of three months 25% of the whole cohort, 12% of the patients who were co-prescribed with steroids versus 32% of the patients who were not co-prescribed with steroids reported side effects to the DMARD initiated. the odds ratio for reporting side effects with steroid co-prescription was 0.28 (0.054–1.438, p=0.12).
Conclusions: Co-prescription of low dose steroids with initiation of DMARDs increases the chances of adherence and possibly reduces the side-effect profile
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THU0184 ADHERENCE PROFILES TO METHOTREXATE OF PATIENTS WITH RHEUMATOID ARTHRITIS (RA) ELIGIBLE FOR BIOLOGICS: TYPOLOGIES FROM FORGET, A CROSS-SECTIONAL SURVEY OF 244 PATIENTS

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Background: Adherence to Methotrexate (MTX) is not optimal in RA patients [1]. Conflicting determinants of adherence have been identified in literature. Our hypothesis was that the discordant results were related to different typologies of patients.
Objectives: Determine the Methotrexate adherence profiles of patients with RA eligible for biologics.
Methods: The FORGET survey carried out in 2016 was aimed to assess the MTX adherence rate of RA patients, insufficient responders to MTX, biologic-naive, when an initiation of biologics was being considered. Non-adherence was defined as a compliance rate <80% according to the CQR19 (Compliance Questionnaire for Rheumatology) [2]. The factors tested were socio-demographic characteristics, DAS 28, RAID, CQR responses, beliefs, voluntary or involuntary dose skipping, social and medical support.
Results: Of the 244 patients analyzed, the non-adherence rate was 34%. The rather weak correlation between adherence (CQR) and the disease impact (RAID) tended to confirm the hypothesis of different profiles. Four typologies of patients were determined. Groups G1 and G2 were non-adherent patients with high (G1) or lower (G2) impact. Groups G3 and G4 were patients with good adherence with high (G3) or lower impact (G4. Significant adherence factors were found for these 4 groups (p<0.01) (table).

	Non-adherent patients		Adherent patients	
	G1	G2	G3	G4
%	14	19	33	34
CQR 19 (%)	21	40	78	88
RAID (0–10) mean	6,7	4,6	6,3	3,7
Skipped doses (%)	66	55	15	11
Skipped does without doctor's recommendation (%)	38	41	3	3
I comorbidity or more (%)	62	68	57	45
Depression (%)	31	14	12	3
Anxiety	16	9	9	1
Good information received (%)	69	83	81	93
I find constrains to take may treatment (% yes)	59	61	21	6
I tolerate my treatment badly (% yes)	47	18	16	18
I think every day about may arthritis (% yes)	83	63	88	53
I find it hard to keep may professional obligations because of my arthritis (% yes)	79	38	65	32
I feel well informed about my arthritis (% yes)	69	83	81	93
I had support from my relatives (% yes)	55	55	82	96
My treatment is doing me more harm than good (% no agreement at all)	0	22,7	36,8	71
The most important reason to take my treatment is that I can still do what I want to do (% complete agreement)	6,3	11,4	17,2	60,5
I do not expect miracles from my treatment (% no agrement at all)	0	0	10,3	23

Conclusions: Four adherence profiles to Methotrexate have been identified. Among the non-adherent patients, 2 topologies are opposed: 1- patients in state of suffering, with low support from relatives, negative beliefs and significant professional impact. 2-patients with less disease impact, who perceived their treatment with constraints although well tolerated. Detection of patients' profiles may allow targeted strategies to improve or maintain adherence.
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THU0185 COMPARISON OF TOFACITINIB SAFETY AND EFFICACY IN RHEUMATOID ARTHRITIS PATIENTS WITH INADEQUATE RESPONSE TO CONVENTIONAL SYNTHETIC DMARDS, OR TO ONE OR MORE BIOLOGICAL DMARDS

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Background: Tofacitinib is an oral JAK inhibitor for the treatment (tx) of rheumatoid arthritis (RA). Studies have shown diminishing response to tx in RA patients (pts) when cycling through TNF inhibitors. Prior analyses assessed tofacitinib in csDMARD-inadequate response (IR) pts vs overall bDMARD-IR pts.