35 pts); MTX plus prednisolone (P) 10 mg daily (MTX-P, 34 pts); MTX-P plus methylprednisolone (MP) 1000 mg intravenously on the first day of treatment (MTX-P-MP, 35 pts); leflunomide 20 mg daily (LEF, 37 pts). Duration of treatment was one year. Control points were 3, 6 and 12 months from the initiation of therapy. Safety data was assessed at the main control points.

Results: One hundred twenty-seven pts completed the study. Side effects were registered in the same number of patients in each group (9 patients; 24,3%>26%). Therapy had to be stopped in six patients due to side effects: MTX - 1 (depigmentation of the skin), MTX-P - none, MTX-P-MP - 1 (stomatitis) and LEF - 4 (dermatitis-2; pancytopenia with platelet count 43 $\times 10^9$/L, erythrocyte $2{,}9\times 10^{12}$/L, WBC 2×10^9/L-1; angioedema, periorbital edema and dermatitis with itching-1). Other side effects were mild: MTX - 8 pts (dyspepsia-1, elevation of transaminases-6, hair loss-1), MTX-P - 9 pts (Cushing's syndrome - 1, hair loss - 1, anemia - 1, elevation of transaminases - 4, arterial hypertension - 2), MTX-P-MP - 8 pts (hair loss-1,dermatitis-1, elevation of transaminases-5, Cushing's syndrome - 1) and LEF - 5 pts (elevation of transaminases-5). At baseline all groups were comparable in their demographic, clinical and radiographic characteristics.

Conclusions: In most cases side effects were moderate or minimal. The most serious side effects, leading to the discontinuation of the therapy, were registered in LEF group. There was no withdrawal of treatment in MTX-P group. Safety profile was the same in all groups.

Disclosure of Interest: None declared

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THU0190 DERMATOLOGICAL GUIDELINES FOR MONITORING METHOTREXATE TREATMENT REDUCE DRUG-SURVIVAL COMPARED TO RHEUMATOLOGICAL GUIDELINES

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Background: Methotrexate (MTX) is widely used in the treatment of psoriasis and psoriatic arthritis (PsA). To prevent MTX-induced adverse events dermatological MTX guidelines advise a higher number and frequency of blood tests than rheumatological guidelines (1,2). These differences are not based on evidence indicating a higher risk for patients with psoriasis compared to PsA.

Objectives: Compare the effects of MTX monitoring strategies by rheumatologists and dermatologists.

Methods: Patients with psoriasis or PsA in a Dutch teaching hospital. Inclusion criteria: start methotrexate (MTX) between 2006 and 2012 and scheduled follow-up by dermatologist or rheumatologist. Exclusions: incomplete availability of lab data. Start and stop dates and dosing of MTX and folic acid, reasons for withdrawal of MTX, numbers and results of laboratory tests performed for MTX safety, occurrence of any serious adverse event (SAE) were retrieved from electronic records.

Results: PsA patients used higher initial and maximum doses of MTX and folic acid, but psoriasis patients had a higher frequency of abnormal liver function tests, resulting in a striking difference in withdrawal of MTX (Table). In PsA MTX was more often withdrawn for remission, and less frequently for ineffectiveness leading to longer drug survival in the first course of treatment. There were no differences in the occurrence of SAE or death between these groups. Hospital admissions related to infection were recorded in 6 (3.1%) PsA vs 4 (2.1%) psoriasis patients.

Table 1. MTX dose, lab results, and reasons for withdrawal

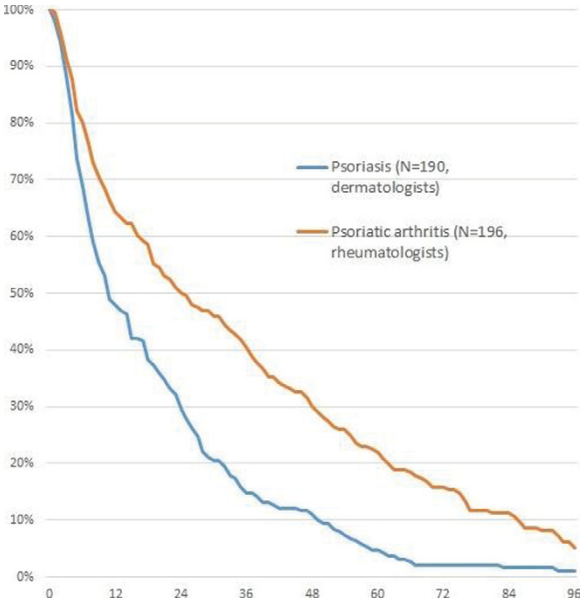
	Psoriasis (N=190)	Psoriatic arthritis (N=196)
Men, N (%)	86 (45.3)	95 (48.5)
Age (y), mean (SD)	52.3 (16.2)	51.8 (13.8)
Prior treatment with MTX	8 (4.2)	39 (19.9)**
MTX starting dose (mg/week)	12.2 (3.7)	15.2 (3.0)**
Folic acid starting dose (mg/week)	4.9 (0.7)	8.4 (5.6)**
Duration of first treatment course (months)	19.0 (19.5)	34.3 (30.5)**
Laboratory visits per treatment month	0.62 (0.81)	0.50 (0.34)*
Abnormal lab results per treatment month	0.14 (0.26)	0.03 (0.07)**
Abnormal lab results per laboratory visit	0.26 (0.39)	0.06 (0.11)**
Reasons for withdrawal of MTX		
Ineffectiveness	46 (24.1%)	31 (15.8%)*
Remission	14 (7.3%)	21 (10.7%)
Abnormal laboratory result	29 (15.2%)	8 (4.1%)**
Drug toxicity (mild, including infection)	47 (24.6%)	52 (26.5%)
Serious Adverse Event	2 (1.0%)	2 (1.0%)
Death (not related to MTX)	2 (1.0%)	4 (2.0%)
Other	22 (11.6%)	15 (7.6%)

Numbers: mean (SD), *P value ≤0.05; **P-value <0.001 (Fisher's exact test),

Conclusions: Monitoring by dermatologists resulted in more abnormal liver function tests and shorter drug survival of MTX. The monitoring strategy by rheumatologists was not associated with increased SAEs. This supports the safety of current rheumatological guidelines and suggests reconsideration of a higher number of liver function tests in dermatological guidelines.

References:

[1] Menter A, Korman NJ, Elmets C et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. J Am Acad Dermatol. http://dx.doi.org/10.1016/j.jaad.2009.03.027.



[2] Barker J, Horn EJ, Lebwohl M et al. Assessment and management of methotrexate hepatotoxicity in psoriasis patients: Report from a consensus conference to evaluate current practice and identify key questions toward optimizing methotrexate use in the clinic. J Eur Acad Dermatol Venereol 2011;25:758–64.

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THU0191 EFFECTS OF TOFACITINIB, AN ORAL JANUS KINASE INHIBITOR, ON PATIENT-REPORTED OUTCOMES IN JAPANESE PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Tofacitinib is an oral JAK inhibitor for the treatment of rheumatoid arthritis (RA). Improvements in patient-reported outcomes (PROs) have been reported in the global population of the Phase (P)2, P3 and long-term extension (LTE) tofacitinib studies.

Objectives: To explore the effect of tofacitinib on PROs in Japanese patients (pts) with RA.

Methods: In this post hoc analysis, data from Japanese pts with RA were obtained from two 12-week randomised dose-finding P2 studies in methotrexate (MTX) inadequate responder (IR) and DMARD-IR pts (NCT00603512/A3921039 and NCT00687193/A3921040), one 24-month P3 study in MTX-IR pts (ORAL Scan; NCT00847613/A3921044) and an open-label, LTE study in pts who completed a qualifying P2 or P3 study (NCT00661661/A3921041; completed April 2014). Pts received tofacitinib 5 or 10 mg twice daily (BID) or placebo (PBO) (P2 and ORAL Scan; no PBO in LTE). In ORAL Scan, non-responder PBO pts advanced to tofacitinib at Month 3; all remaining pts were advanced at Month 6. PROs included: mean change from baseline in Pt's Global Assessment of Arthritis (PtGA; visual analogue scale [VAS]), Physician's Global Assessment of Arthritis (PGA; VAS), Health Assessment Questionnaire-Disability Index (HAQ-DI), Pain (VAS), Functional Assessment of Chronic Illness Therapy - Fatigue (FACIT-F), Medical Outcomes Study (MOS) Sleep Scale and Short-Form Health Survey (SF-36) domain scores. Significance was declared for $p\leq 0.05$ for the P2 and P3 studies reported here.

Results: The analysis included 238 pts from P2 studies, 118 pts from ORAL Scan and 486 pts from the LTE study. Demographics and baseline characteristics were similar between treatment groups for all studies. In P2 studies at Week 12, tofacitinib 5 and 10 mg BID demonstrated significantly greater improvements from baseline vs PBO in PtGA, PGA, HAQ-DI, Pain, FACIT-F, MOS Sleep Scale and in 4 (Physical Function [PF], Role-Physical [RP], Bodily Pain [BP] and General Health [GH]) of the 8 SF-36 domain scores (Table). Significant improvements in PtGA, PGA, HAQ-DI, Pain and FACIT-F vs PBO were seen as early as Week 2. In ORAL Scan at Month 3, statistically significant improvements from baseline in PtGA, PGA, HAQ-DI and Pain were seen for both tofacitinib 5 and 10 mg BID vs PBO (Table) and these were maintained to Month 24. Significant improvements vs PBO as early as Month 1 were seen for PGA (tofacitinib 10 mg BID) and Pain (both doses). In the LTE study, mean changes from LTE study baseline in PtGA, PGA, HAQ-DI and Pain were -32.5, -40.8, -0.5 and -32.9, respectively, for all tofacitinib doses at Week 2, and -40.7, -50.2, -0.7 and -42.4, respectively, at Week 168. Mean changes from baseline in SF-36 domain scores at Week 12 and

Week 168, respectively, were: 7.5 and 8.6 (PF); 6.9 and 6.9 (RP); 10.4 and 11.6 (BP); 5.7 and 5.4 (GH); 7.2 and 6.1 (Vitality [VT]); 5.0 and 4.5 (Social Function [SF]); 6.3 and 5.5 (Role-Emotional [RE]); and 6.1 and 4.8 (Mental Health [MH]).

Table. PROs in Japanese patients with active RA treated with tofacitinib (full analysis set*)

	Phase 2						Phase 3		
	Study A3921039 (NCT00603512) (Week 12)			Study A3921040 (NCT00687193) (Week 12)			ORAL Scan (Month 3) (A3921044; NCT00847613)		
	Placebo (N=24)[a]	Tofacitinib 5 mg BID (N=24)[a]	Tofacitinib 10 mg BID (N=21)[a]	Placebo (N=48)[a]	Tofacitinib 5 mg BID (N=50)[a]	Tofacitinib 10 mg BID (N=49)[a]	Placebo (N=21)[b]	Tofacitinib 5 mg BID (N=44)[b]	Tofacitinib 10 mg BID (N=44)[b]
LS mean (SE) change from baseline									
PtGA (VAS)[c]	-8.8 (3.8)	-38.9 (3.8)***	-37.6 (4.0)***	-1.0 (3.1)	-34.6 (3.1)***	-43.6 (3.0)***	-5.9 (4.3)	-25.9 (3.0)**	-27.9 (3.0)***
PGA (VAS)[c]	-16.1 (3.4)	-45.9 (3.4)***	-43.7 (3.6)***	-8.4 (2.7)	-36.9 (2.7)***	-49.4 (2.7)***	-9.0 (3.6)	-34.0 (2.5)***	-37.3 (2.5)***
HAQ-DI[c]	-0.1 (0.1)	-0.5 (0.1)***	-0.5 (0.1)***	0.2 (0.1)	-0.6 (-0.1)***	-0.7 (0.1)***	-0.1 (0.1)	-0.5 (0.1)***	-0.6 (0.1)***
Pain (VAS)[c]	-6.1 (3.8)	-34.3 (3.8)***	-36.8 (4.0)***	-1.1 (3.0)	-34.4 (3.0)***	-42.9 (3.0)***	-4.5 (4.2)	-36.6 (2.9)***	-29.2 (2.9)***
FACIT-F[d]	-1.6 (1.4)[e]	6.8 (1.3)****[e]	3.8 (1.4)**[e]	-1.4 (1.0)[e]	7.5 (1.0)****[e]	8.5 (1.0)****[e]	-	-	-
MOS Sleep Scale – overall sleep problems[f]	3.6 (2.0)[e]	-6.7 (2.0)***[e]	-3.6 (2.1)**[e]	2.0 (1.9)[e]	-7.1 (1.9)***[e]	-8.0 (1.9)***[e]	-	-	-
SF-36 domain scores,[f,e] LS mean (SE) change from baseline									
Physical Function	1.3 (1.2)	6.3 (1.2)**	7.3 (1.3)**	-2.5 (1.1)	5.8 (1.1)***	9.6 (1.1)***	-	-	-
Role-Physical	1.3 (1.7)	7.3 (1.7)*	6.4 (1.8)*	-0.7 (1.2)	6.2 (1.2)***	8.9 (1.2)***	-	-	-
Bodily Pain	1.6 (1.4)	9.8 (1.4)***	10.7 (1.5)***	0.3 (1.1)	9.7 (1.1)***	12.6 (1.1)***	-	-	-
General Health	-0.2 (1.2)	6.3 (1.2)**	6.5 (1.3)**	0.2 (0.9)	5.4 (0.9)***	7.6 (0.9)***	-	-	-
Vitality	1.2 (1.7)	6.5 (1.7)*	4.8 (1.8)	3.4 (0.8)	6.6 (0.8)*	12.0 (0.8)***	-	-	-
Social Function	1.4 (1.7)	5.3 (1.7)	5.7 (1.9)	-0.7 (1.3)	4.7 (1.3)*	4.6 (1.2)*	-	-	-
Role-Emotional	0.5 (1.9)	3.6 (1.9)	4.4 (2.0)	-1.5 (1.5)	5.6 (1.4)**	8.0 (1.4)***	-	-	-
Mental Health	0.7 (1.7)	6.9 (1.7)*	2.2 (1.9)	0.6 (1.3)	8.6 (1.3)***	7.6 (1.3)**	-	-	-

Nominal *p≤0.05; **p<0.001; ***p<0.0001 vs placebo
[a]All randomised patients who received ≥1 dose of study medication; [b]PROs were not captured for all randomised and treated patients; [c]Data are FAS longitudinal model; [d]Data not available for Study A3921044; [e]Data are FAS mixed-effects model

BID twice daily; FACIT-F, Functional Assessment of Chronic Illness Therapy - Fatigue; FAS, full analysis set; HAQ-DI, Health Assessment Questionnaire-Disability Index; LS, least squares; MOS, Medical Outcomes Study; PtGA, Patient's Global Assessment of Arthritis; PGA, Physician's Global Assessment of Arthritis; PRO, patient-reported outcome; RA, rheumatoid arthritis; SE, standard error; SF-36, Short-Form Health Survey; VAS visual analogue scale

Conclusions: Tofacitinib 5 and 10 mg BID significantly improved PROs in Japanese pts with RA enrolled in the P2, P3 and LTE studies.
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THU0192 INFORMING PATIENTS ABOUT METHOTREXATE FOR THE TREATMENT OF RHEUMATOID ARTHRITIS WITH PATIENTS IN THE UNITED KINGDOM – A SURVEY OF RHEUMATOLOGISTS' STRATEGIES

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Background: Rheumatologists are the primary prescribers of methotrexate (MTX) for the treatment of rheumatoid arthritis (RA) in the United Kingdom (UK), however rheumatologists' views on their clinical practices are largely unknown. The authors conducted a qualitative study that highlighted a number of factors that contributed to their ability to discuss and commence MTX, which included how emotionally and cognitively prepared patients were to discuss treatments. The aim of this study was to further explore these themes with an online survey.
Objectives: The aims of this study were:1)To establish the views of rheumatologists about MTX for the treatment of rheumatoid arthritis (RA), 2)To examine if rheumatologists' views influenced discussing or commencing MTX during the initial consultation.
Methods: An online survey was designed and subsequently refined based on interviews with rheumatologists in the UK. The survey asked rheumatologists about their clinical setting, and their views and practices with respect to treating RA with MTX. Rheumatologists were asked how often specific pieces of MTX information were discussed during a consultation to commence MTX (5=Always to 1=never). They were also asked to identify the barriers to discussing these issues. The questionnaire included a factorial survey ie. two patient vignettes where we manipulated the following factors; male/female, emotionally prepared/unprepared and no/negative prior knowledge. Rheumatologists could select "information overload" as a barrier to communication with the patient. Random mixed effects models tested if these patient factors and information overload associated with 1) commencing and 2) discussing MTX.
Results: Ninety-six rheumatologists seeing approximately eight (IQR:5–12) new patients a week with 15±7 years of experience completed the survey. Rheumatologists reported they often/always discussed ten (IQR 8–11) pieces of information during a consultation (Fig 1A), and information overload was identified as a communication barrier (48%); 52% of rheumatologists expected the nurse to discuss MTX therapy (Fig 1B). Sixty rheumatologists completed one, and 56 rheumatologists two vignettes (n=116). The vignette conditions and information overload significantly associated with "Commencing MTX" (X^2=53.85, p <.0001, R^2=.21) and discussing MTX (X^2=30.9, p =.002, R^2=.19). Gender* emotional preparedness (β=-4.27, 95% CI:-7.33,-1.21), and information overload*emotional preparedness (β=-3.03, 95% CI:-5.24, -.82) associated with MTX commencement, whilst only gender*emotional preparedness with discussing MTX (β=-3.86, 95% CI:-6.82, -.90).

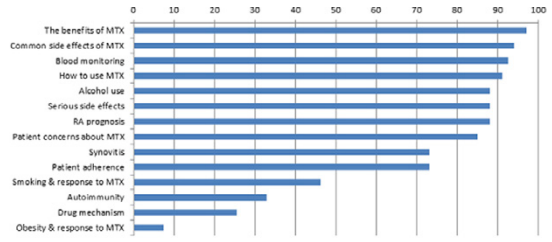

Fig.1A. The specific pieces of MTX-related information rheumatologists in the UK report they often/always discuss in clinic (%)

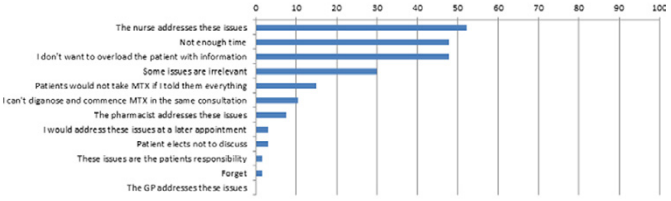

Fig.1B. The reasons rheumatologists in the UK give for not always discussing MTX-related information in clinic (%)

Conclusions: Currently UK rheumatologists convey a large amount of information to patients during early consultations. Almost half of rheumatologists identified the need to communicate large amounts of information in clinical consultations as a barrier to discussing MTX therapy. These data reflect the challenge clinicians face in trying to execute effective shared decision-making practices. Strategies to address patients' emotional responses to their diagnosis and being overloaded with MTX information are needed. Staggering presentation of information during clinical consultations may benefit some patients.
Disclosure of Interest: None declared
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THU0193 REESTABLISHMENT OF EFFICACY OF TOFACITINIB, AN ORAL JANUS KINASE INHIBITOR, IN RHEUMATOID ARTHRITIS PATIENTS AFTER TEMPORARY DISCONTINUATION

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Background: Tofacitinib is an oral Janus kinase inhibitor for the treatment of rheumatoid arthritis (RA).
Objectives: To assess the efficacy and safety of tofacitinib after temporary discontinuation and reinitiation of therapy in RA patients (pts).
Methods: Data were collected from a randomised, parallel-group (grp), controlled, open label, vaccine sub-study in RA pts participating in a long-term extension (LTE) study (NCT00413699). Pts were ≥18 years of age with active RA and had received tofacitinib 10 mg BID for ≥3 months. The sub-study included 2 treatment (tx) grps: "continuous tx" (tofacitinib 10 mg twice daily [BID] as monotherapy or with methotrexate [MTX]) and "interrupted tx" (tofacitinib withdrawn for 2