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SAT0122 WHICH MULTIMORBID CONDITIONS ARE MORE PREVALENT AROUND THE TIME OF EARLY RA DIAGNOSIS AND HAVE THE GREATEST IMPACT ON TRAJECTORIES OF DISEASE ACTIVITY IN THE FIRST YEAR? RESULTS FROM THE CANADIAN EARLY ARTHRITIS COHORT

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Background: Multimorbidity (MM) is highly prevalent in early RA (ERA), and higher counts of conditions are associated with poorer disease control[1]. It is important to understand the number of, and which specific conditions most affect disease presentation, early therapies and disease activity over time.
Objectives: To estimate the prevalence of MM conditions at the time of ERA diagnosis and associations with ERA clinical characteristics, early treatment, and trajectory of disease activity in the 1st year of follow up.
Methods: Data were from ERA patients (<1-year of symptoms) enrolled in CATCH (Canadian Early Arthritis Cohort) who met 1987 or 2010 RA criteria, and had at least two DAS28 measures in the first year. We examined baseline prevalence of: 1) cardiovascular disease (CVD), 2) diabetes, 3) cancer, 4) pulmonary disease, 5) bowel disease, 6) other rheumatic diseases, and 7) psoriasis, obtained from patient-reports of physician-diagnosed medical conditions, 8) obesity (BMI≥30), and 9) depressive symptoms (RAND-12 <42). We compared baseline demographic and clinical characteristics in ERA + each condition vs. ERA alone. We estimated adjusted effects of each condition on early use of RA therapies with logistic regression and adjusted effects of each condition on DAS28 trajectory over the first year of follow up with linear growth models.
Results: The sample included 1,595 patients, 1153 (72%) were female, with a mean (sd) age of 54 (15) years and 6 (3) months of symptoms. At baseline 1,434 (92%) were treated with conventional DMARDs (mostly methotrexate (76%)) and 33 (2%) with a biologic. More than 70% of ERA patients reported at least one MM, and over 30% reported 2+ MMs. Patients with MM were often older and had higher disease activity at baseline, with variations by condition. Patients with RA+CVD or depressive symptoms had a 60% and 90% higher adjusted odds of baseline steroid use, respectively (p<.001). In fully adjusted growth models, relative to patients with ERA only, patients with: a) diabetes, other rheumatic diseases or depressive symptoms had higher baseline DAS28 scores and less improvement over time, b) pulmonary disease, bowel disease, psoriasis or obesity had similar baseline DAS28 scores but less improvement over time; and c) CVD or cancer had higher baseline DAS28 scores but similar improvement over time (all p<0.05).
Conclusions: Multimorbidity is common in ERA patients seen in routine practice and associated with higher disease activity at baseline, less improvement over time, or both, and a greater likelihood of prescribing steroids for certain conditions. Integrating MM in to current RA care strategies may help achieve better patient outcomes.
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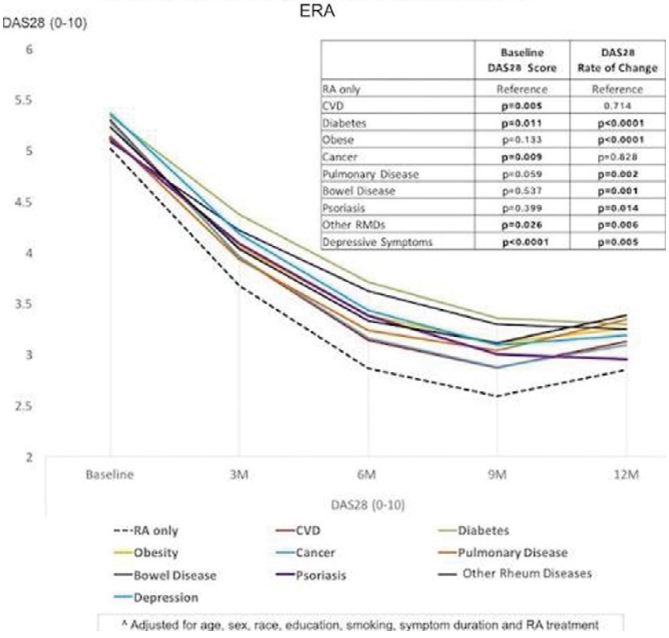
Adjusted^ effects of multimorbid conditions on trajectory of DAS28 over the first year of follow up in patients with ERA



	Baseline DAS28 Score	DAS28 Rate of Change
RA only	Reference	Reference
CVD	p=0.005	0.714
Diabetes	p=0.011	p<0.0001
Obese	p=0.133	p<0.0001
Cancer	p=0.009	p=0.828
Pulmonary Disease	p=0.059	p=0.002
Bowel Disease	p=0.537	p=0.001
Psoriasis	p=0.399	p=0.014
Other RMDs	p=0.026	p=0.006
Depressive Symptoms	p<0.0001	p=0.005

SAT0123 MULTIDIMENSIONAL EVALUATION OF PAIN IN RHEUMATOID ARTHRITIS

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Background: Although pain in rheumatoid arthritis (RA) is frequently thought to be inflammatory in nature, some studies reported clinically significant pain despite relatively low rheumatoid arthritis (RA) disease activity. Less than 50% of patients are satisfied by the management of pain.
Objectives: to report a recent multidimensional evaluation of pain in a large RA population.
Methods: Patients with RA were enrolled in 7 French Rheumatology Centers during a visit or a hospitalization in a transversal observational study. Socio-demographic data, previous and prescribed medications, disease duration, immunologic status, DAS28 score were assessed. Patients completed the multidimensional pain questionnaire from french health autority, the health assessment questionnaire (HAQ), the Beck depression scale and the anxiety scale STAI. Joint damage was evaluated by a simple erosion narrowing score.
Results: Of the 299 screened patients, 295 were included with a mean age of 58.4±11.7 years, 80.3% of female, a mean disease duration of 13.2±9.6 years, positivity of rheumatoid factors in 76.4%, anti-citrullin antibodies in 74% of cases. Concerning medications, 42.7% were treated by corticoids (mean dose=6.4 mg/d), 66% by analgesic drugs (64.1% with acetaminophen, 45.6% weak opioids, 7.1% strong opioids) and 24.4% with NSAIDs. The RA treatments were DMARDs in 69.1% and biotherapies in 82.7% of cases. The mean DAS-28 score was 3.1±1.3 with 38.7% of patients in remission and 15.4% in low disease activity. The verbal scale for satisfaction about pain management showed that a third of patients was very satisfied, the half satisfied, 16% weakly or not satisfied. The mean pain visual analogic scale (VAS) for the last 8 days was 33.6 mm ±26.5/100. 39% of patients had a pain VAS >40 mm/100. The Beck scale showed a moderate to severe depression in 34,3% of patients. Anxiety was present in 57.5%. The impacts of pain on daily behaviors were more important on work. The pain VAS for the 8 days was correlated with the score of depression et with the DAS-28 score (p<0.0001). The population with a pain VAS >40 mm had a significant more important Beck score, anxiety score, HAQ, DAS-28 score and had more impacts of pain on daily behaviors There was no association between pain and structural damage and disease duration. There was no difference between the populations with VAS>40 or <40 mm in terms of IL-6, IL-17 and IL-33 serum levels. The multidimensional evaluation of pain wasn't different between treatement groups (DMARDs, biotherapies) and between the different biotherapies. Multivariate analysis with principal component analysis