most frequent in patients treated with LEF mono or with LEF+MTX. The presence of erosions or seropositivity were not associated with any of the outcomes (table).

Conclusions: The highest impact on achieving LDA was found in disease activity at baseline and response to treatment within 3–6 month. The relevance of erosions and/or seropositivity regarding the prediction of a poorer outcome is disputable.

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SAT0675 THE ROLE OF EROSIONS TYPICAL OF RHEUMATOID ARTHRITIS IN THE 2010 ACR/EULAR RHEUMATOID CLASSIFICATION CRITERIA: RESULTS FROM A VERY EARLY ARTHRITIS COHORT

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Background: A EULAR task force has proposed that in addition to the 2010 ACR/EULAR rheumatoid arthritis (RA) classification criteria (2010 RA criteria), patients can still be classified as having RA with less than 6 criteria points on the presence of ≥3 joints with typical erosions on conventional radiographs of hands and feet (erosion criterion) (1).

Objectives: To determine how the EULAR definition of erosive disease contributes to the number of patients classified as RA according to the 2010 RA criteria in an early arthritis cohort.

Methods: Patients with arthritis of ≤16 weeks duration and a clinical diagnosis of RA or undifferentiated arthritis (UA) with available hand and feet radiographs were included from the Norwegian Very Early Arthritis Clinic (NOR-VEAC) study. Erosive disease was defined according to the EULAR definition accompanying the 2010 RA criteria, i.e. ≥3 erosive joints (1). We calculated the additional number of patients being classified as RA based on the erosion criteria at baseline and during follow-up. Other cut-offs and the distribution of erosive joints was also examined.

Results: The current study included 289 patients (mean (SD) age 48 (14.7) years, 54.3% females, median (25, 75 perc) duration of joint swelling 46 (19.5, 79.0) days). At baseline, 120 patients (41.5%) fulfilled the 2010 RA criteria. Of the remaining 169 not fulfilling the 2010 RA criteria, 55 patients had ≥1 erosive joint (40 with hand erosions, 28 with feet erosions and 13 with hand and feet erosions) and 15 (5.2%) patients fulfilled the erosion criterion (Figure 1). The distribution of erosive joints in the 169 patients not fulfilling the 2010 RA criteria at baseline is shown in the table.

	Erosive joints at baseline					
	PIP	MCP	Wrist	CMC + os trapezium	MTP	IP1 feet
≥1 erosive joint (n=55)	23	17	12	8	22	12
≥2 erosive joints (n=27)	11	13	10	8	12	8
≥3 erosive joints (n=15)	6	8	9	6	8	7

118 patients had radiographic follow-up at 2 years, of whom only 1 additional patient solely fulfilled the erosion criterion during follow-up (7 additional patients fulfilled both the 2010 criteria and the erosion criterion). Among patients with no erosions at baseline (N=74), 13 (17.6%) developed erosions during follow-up (PIP joints n=3, MCP n=4, wrist n=3, CMC joint n=1, MTP joints n=9 and IP1 joint in the foot n=3).

Conclusions: Among this cohort of patients with very early arthritis, 5.2% were classified as RA at baseline based solely on the erosion criterion. Of the 118 patients with 2-year follow-up data, only 1 additional patient was classified based on the erosion criterion alone during follow-up, thus, follow-up radiographs in patients with early UA do not seem to provide additional information in classifying patients with RA.

References:

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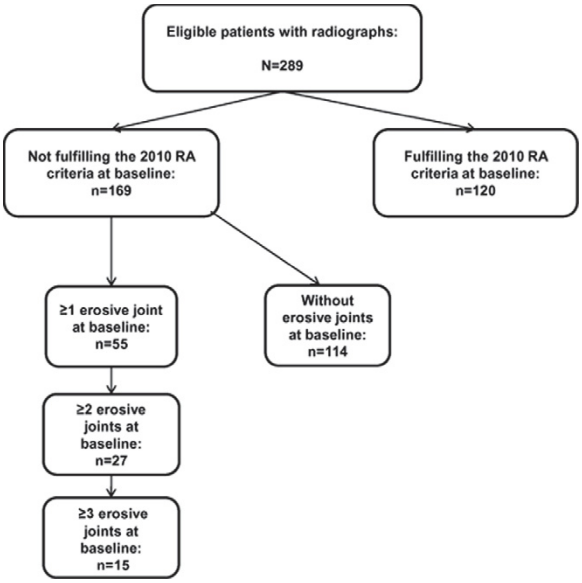

Figure 1

SAT0676 (SERONEGATIVE) MALES SHOW BETTER EULAR TREATMENT RESPONSE THAN FEMALES IN NEWLY DIAGNOSED RHEUMATOID ARTHRITIS (RA)

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Background: Gender has been reported to play a role in attainment of RA remission (1), but the data are inconsistent. The impact of gender in early RA therefore warrants further investigation.

Objectives: To assess the impact of gender on early RA outcomes.

Methods: An audit, designed as a national prospective longitudinal observational study, was conducted to assess early RA care. All NHS providers in England and Wales were required to participate. Follow up data were captured over 3 months for subjects with a diagnosis of RA. Logistic regression was used to estimate associations between gender and DAS-28 response. Smoking status, baseline disease activity, age, antibody status, symptom duration, referral times, and treatment were considered in multivariate models.

Results: 136 of 146 eligible trusts submitted data. 11,752 subjects consented, 5,622 were diagnosed with RA. DAS-28 response was available for 2234/5622 (39.7%). Male patients had a similar 3 month improvement in their DAS-28 to females, despite having a lower mean baseline score. Male gender associated with a higher rate of good EULAR response (DAS improvement >1.2, follow up DAS <3.3), with an adjusted odds ratio of 1.42 (CI 1.17–1.72). There were no differences between the genders in their treatment use or in other aspects of care including speed of referral (Table 1).

Table 1

	Male N=786	Female N=1432	P value
Age mean (SD)	61.6 (13.2)	58.1 (15.1)	0*
Smoker %	28	21	0**
Social deprivation decile mean (SD)	5.4 (2.9)	5.5 (2.9)	0.6**
Seropositive %	66	70	0.05**
symptom duration days	230	226	0.8*
Baseline DAS-28 mean (SD)	5.1 (1.4)	5.3 (1.3)	0.03*
FU DAS-28 mean (SD)	3.3 (1.5)	3.6 (1.5)	0.0001*
Change in DAS-28 mean (SD)	1.8 (1.7)	1.7 (1.6)	0.08*
EULAR good response %	43.4	36.7	0.002**
Timely referral %	16	15	0.3**
Timely rheumatology assessment %	39	39	0.7**
Steroids commenced at baseline %	87	86	0.7**
Early DMARD treatment %	28	27	0.9**
Any DMARD prescribed within 6 weeks %	70	70	0.9**
DMARD choice; Methotrexate monotherapy %	69	68	0.6**
DMARD choice; combination therapy %	44	44	0.8**

*t-test **chi-squared. Social deprivation decile from deprivation rank calculated via super output area.