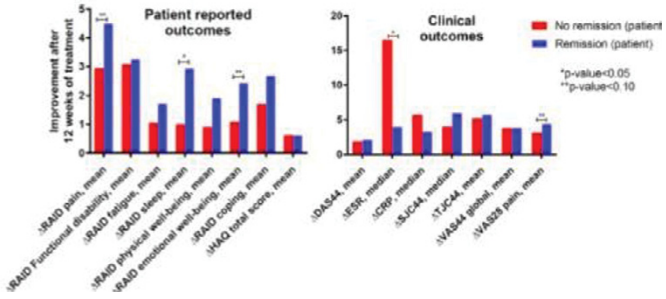
response and ACR 70 criteria were determined after 12 weeks of treatment with a fixed schedule methotrexate and prednisone. Physician perceived remission (PhR) was defined as a global assessment of ≤20 on a visual analogue scale, phrased: "*How active do you think the RA of your patient is today?*". Patient perceived remission (PatR) was phrased as: "*Would you say that, at this moment, your disease activity is as good as gone? Yes/no*". In patients in PhR, the change in components of the DAS44 and questions of the Rheumatoid Arthritis Impact of Disease (RAID) and Health Assessment Questionnaire (HAQ) were compared between patients in and not in self-perceived remission.

Results: The agreement on remission between patients and physicians was 64% and was dependent of the definition of remission. In Boolean remission, EULAR good response and ACR70 remission agreement was: 86%, 63% and 80% respectively (table). Patients in PhR, the patients in PatR had more improvement on all RAID subdomains. There were no significant differences in clinical outcomes (ESR was significantly different at baseline, but not after 12 weeks; see figure).

Figure. Comparison in improvement in patient reported and clinical outcomes after 12 weeks of treatment, in patients in physician remission, who are and are not in self-perceived remission.



Conclusions: Two-third of the patients agreed with the physician on being in remission. In all different definitions for remission, this discordance between physician and patient on perceived remission remained similar. Patients in self-perceived remission had more improvement in components of the RAID, but not in clinical outcomes. Further research is needed to identify domains of patients perceived remission.

Disclosure of Interest: None declared

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AB0278 ULTRASOUND EXAMINATION IN DIAGNOSIS OF EARLY RHEUMATOID ARTHRITIS

W. Hamdi [1], S. Miladi [1], K. Matallah [1], M. Bouaziz [2], D. Kaffel [1], I. Zouch [1], M.M. Kchir [1]. [1]*Rheumatology department;* [2]*Radiology department, Institute Kassab of Orthopedics, Manouba. Tunisia, Tunis, Tunisia*

Background: Fortunately, management of RA at the early stage has become possible thanks to both the emergence of new biotherapies and the strategy treat to target. Musculoskeletal ultrasound (US) is a potent tool for the detection of synovitis, effusion and bone erosion in RA.

Objectives: The aim of this study was to assess the contribution of US in diagnosing RA at the early stage of the disease.

Methods: A cross-sectional study was performed during 2 years. Patients with a history of inflammatory joint pain for ≥6 weeks and ≤2 years with synovitis of at least one joint were enrolled in this study. All patients underwent clinical assessement, laboratory tests and plain radiography of hands and feet.US was assessed within one week of clinical examination. Synovitis and erosion were defined according to the OMERACT.

Results: One hundred patients were included in this study with an average age of 51,8±14,6 years-old. Female outnumbered male with a sex ratio of 3,8. The mean duration of the disease was 10,9±7,4 months. When admitted to our department and after clinical examination it was found that 31% of patients presented polyarthritis, 4% had oligoarthritis and 7% suffered from monoarthritis. *US findings:* US was found to be more sensitive than clinical examination to detect synovitis. Among the 2200 joints assessed by US, a synovitis was detected in 81% patients, an intra-articular effusion in 36% patients and PD signals in 51% patients. Also, flexor tenosynovitis were present in 55% patients and extensor tenosynovitis in 59% patients. Erosions were more detected in plain radiography (70%) than in US (41%). Clinical parameters (VAS, duration of morning stiffness, number of night awakens, TJC) were not correlated with most US findings. Nevertheless, correlation was detected for US effusion (r=0,250, p=0,028) and for US Doppler (r=0,289, p=0,011) with SJC. PDUS examination correlated with CRP results (r=0,302, p=0,023) but not with ESR results. A significant, positive correlation was observed between erosions in X-rays or US assessment (r=0,342, p=0,002). The US detected synovitis in 25% of patients who had no swollen joint at the clinical examination when admitted to our department and had detected erosions in 9% of patients having negative plain X rays.

Conclusions: Ultrasound appears as a sensitive tool to detect subclinical synovitis (25%) and infra- radiological erosions (9%). It helps us to make an early diagnosis and start appropriate treatment before the onset of irreversible joint destruction.

Disclosure of Interest: None declared

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AB0279 HIGH RATE OF DISABILITY PENSION IN CHILEAN RHEUMATOID ARTHRITIS PATIENTS WITHOUT ACCESS TO BIOLOGICS. HOSPITAL PADRE HURTADO EXPERIENCE

S.E. Ibáñez Vodnizza, O. Valenzuela, F. Silva, M.J. Villar. *Rheumatology department, Clínica Alemana de Santiago/Hospital Padre Hurtado, Santiago, Chile*

Background: Until the year 2016, most of the Chilean rheumatoid arthritis patients in the public health system did not have acces to biologic treatment. Now the access is limited to those with high disease activity (DAS 28 >5.1).

Objectives: Our main objective was to evaluate the rate of patients benefited by disability pension within the group of rheumatoid arthritis patients seen in our center, before the introduction of biologic treatment for those with high disease activity. Our secondary objective was to estimate the association between having a disability pension and the characteristics of the patients.

Methods: Consecutive rheumatoid arthritis patients (according to the ACR 2010 criteria), 18 years old or older, that attended to our rheumatology consult between September and December of 2015, were included. Patients with other types of pensions (retirement) were excluded. Information about work status, gender, age, years since diagnosis, medications used, DAS 28 ESR and its variables was collected.

Results: 104 patients were included. 38.5% had a disability pension. We found significant differences between the patients with and without disability pensions for age, years since diagnosis, tramadol use, the number of tender joints, the number of swollen joints and DAS 28 ESR (Table 1). After multivariate logistic regression, age (OR 1, 95% CI 1.02–1.15), tramadol use (OR 0.3, 95% CI 0.08–0.92) and the number of swollen joints (OR 1.4, 95% CI 1–1.96) continued to be significantly associated.

Table 1. Disease characteristics

	All	Without Disability Pension	With Disability Pension	P
Number of patients (%)	104 (100)	64 (61.5)	40 (38.5)	NA
Female (%)	86 (82.7)	53 (82.8)	33 (82.5)	NS
Age (median, IQR)	55.5 (15)	52.5 (18)	58 (15)	0.002
Years since diagnosis (median, IQR)	8.8 (12.2)	5.8 (8.2)	12.3 (19.1)	<0.001
Number of DMARDs used (median, IQR)	2 (2)	1 (2)	2 (2)	NS
Prednisone users (%)	89 (85.6)	52 (81.3)	37 (92.5)	NS
NSAIDs users (%)	75 (72.1)	46 (71.9)	29 (72.9)	NS
Acetaminophen users (%)	68 (65.4)	39 (60.9)	29 (72.5)	NS
Tramadol users (%)	35 (33.7)	13 (20.3)	22 (55)	0.001
Number of tender joints (median, IQR)	4 (6)	3 (5)	6 (11)	0.018
Number of swollen joints (median, IQR)	2 (4)	1 (4)	3 (8)	0.012
ESR (median, IQR)	20.5 (21)	16.5 (18)	25 (31)	NS
VAS pain (median, IQR)	60 (40)	60 (40)	80 (40)	NS
DAS 28 ESR (mean, SD)	4.5 (1.6)	4.1 (1.4)	5 (1.8)	0.026

IQR = interquartile range, DMARDs = Disease-Modifying Antirheumatic Drugs, NSAIDs = Non-steroidal anti-inflammatory drugs, ESR = Erythrocyte Sedimentation Rate, VAS = Visual Analog Scale, DAS = Disease Activity Score, NS = Not significant.

Conclusions: Near forty percent of our rheumatoid arthritis patients, that did not have access to biologic treatment, were being paid a disability pension, and this condition was significatly associated with more years of age, tramadol use, and the number of swollen joints. The mean DAS 28 ESR in the patients with disability pension was 5. The limit of a DAS 28 >5.1 to authorize the use of biologic treatment possibly will not help to reduce the rate of patients with disability pension in our group.

Disclosure of Interest: None declared

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AB0280 INFLUENCE OF HLA CLASS II ANTIGEN (DRB1 AND DQB1) ON THE PRODUCTION OF ANTI-CYCLIC CITRULLINATED PEPTIDE ANTIBODIES IN A TUNISIAN POPULATION

S. Boussaid [1], S. Kochbati [2]. [1]*Departement of Rheumatologie, la Rabta Hospital;* [2]*Departement of Rheumatologie, Habib Thameur Hspital, tunis, Tunisia*

Background: Rheumatoid arthritis (RA) is the most common chronic inflammatory rheumatism. It's a complex autoimmune disorder. The aim of this study is to focus on the relationship between HLA-DRB1 genes and RA specific antibodies against cyclic citrullinated peptides (anti-CCP antibodies).

Methods: This prospective study was performed on a total of 81 Tunisian patients with rheumatoid arthritis. All patients fulfilled the American College of Rheumatology (ACR 1987) criteria for RA. For each patient we assessed DNA and serum samples. The DNA was extracted from lymphocytes using a commercial kit (Quiagen). The HLA class II (DQB1 and DRB1) was performed by Polymerase Chain Reaction technique Specifying-sequence primers (PCR-SSP). The specific products of PCR were analyzed by 2.5% agarose gel electrophoresis. All tests include positive and negative controls appropriate for each blood sample. The phenotypes of patients were obtained through the Software One Lambda DNA/SOFTWARE (SSP2L-generic DRB/DQB).

Results: The mean age of our population was 49.17±11.21 years (age 24–78). The disease average duration was 7.44±2.12 years (4 months - 29 years), 82.71% of RA were women and 17.29% were men. Seropositive RA were 80.24%, and 71% of RA have anti CCP positive antibody. Univariate analysis of the presence of anti-CCP antibodies in conjunction with HLA DRB1 and DQB1 was performed. Carriership of HLA DR*0301, 0401 and 1501 were significantly associated with the presence of anti-CCP antibodies ($p<0.0001$). Four DRB1 0401 carriers were homozygotes with three out of them having anti-CCP antibodies.
Carriership of HLA DQB1*0201, 0301, 0302,0501 and 0601 was associated with the presence of anti-CCP antibodies and so was HLA-DQB1*0401, but with a less significant association.
Conclusions: Although no formal conclusions on causality can be drawn from this association study, these findings suggest that anti-CCP antibodies are associated with different phenotypes; which suggest that various pathogenetic mechanisms underlie the positivity for anti-CCP in RA.
Disclosure of Interest: None declared
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AB0281 CHARACTERIZATION OF CHANGES IN LYMPHOCYTE SUBSETS IN BARICITINIB-TREATED PATIENTS WITH EARLY, DMARD NAÏVE, RHEUMATOID ARTHRITIS IN A PHASE 3 STUDY

T. Takeuchi[1], R. Fleischmann[2], M. Schiff[3], M. Issa[4], W. Macias[4], T. Rooney[4], S. Zuckerman[4], D. Schlichting[4], I. McInnes[5]. *[1]Keio Univ., Tokyo, Japan; [2]Univ. Texas SW Med Center, Dallas; [3]Univ. Colorado, Denver; [4]Eli Lilly and Company, Indianapolis, United States; [5]Univ. Glasgow, Glasgow, United Kingdom*

Background: In RA-BEGIN (NCT01711359), baricitinib (bari), an oral Janus Kinase (JAK)1/JAK2 inhibitor, improved signs and symptoms of moderately to severely active RA in patients (pts) who had received no or limited prior csDMARD and no prior bDMARD therapy.[1]
Objectives: To analyse changes in absolute lymphocyte count (ALC) and cell subsets (LCS) in RA-BEGIN.
Methods: Pts (N=588) were randomised 4:3:4 (MTX up to 20mg QW, bari 4mg QD, bari 4mg+MTX) for 52 Wks. T and B cells plus subsets and natural killer (NK) cells were quantified by flow cytometry at baseline (BL) and Wks 4, 12, and 32.
Results: At BL, low cell counts were observed in 4.3%, 8.2%, 5.3%, 18.3%, and 19.7% of pts for ALC, CD3+, CD8+, B (CD19+), and NK cells. In the MTX group, slight declines in mean counts were observed for all cell types at post-BL visits (Table). For bari and bari+MTX, cell counts increased for all cell types at Wks 4 and 12, with, except for B cells, a return towards BL, or slightly below, at Wk 32. Changes in other T and B cell subsets generally reflected these patterns (data not shown). Treatment emergent (TE) low NK cell counts occurred in 11.6%, 13.4%, and 20.5% of pts for MTX, bari, and bari+MTX; TE low CD8+ cell counts occurred in 5.2%, 3.2%, and 8.3% of pts. Overall serious infection (SI) rates were 3.8%, 3.8%, and 2.3% for all pts in MTX, bari, and bari+MTX; rates were 6.8% (4 of 59 pts), 4.8% (2 of 42), and 2.8% (2 of 72) for pts with ≥1 low post-BL NK cell count and 15.8% (3 of 19), 25.0% (2 of 8), and 5.3% (1 of 19) for pts with ≥1 low post-BL CD8+ cell count. Herpes zoster (HZ) rates were 1.0% 2.5%, and 2.3% for all pts in MTX, bari, and bari+MTX; rates were 3.4% (2 of 59 pts), 4.8% (2 of 42), and 4.2% (3 of 72) for pts with ≥1 low post-BL NK cell count and 10.5% (2 of 19), 12.5% (1 of 8), and 5.3% (1 of 19) for pts with ≥1 low post-BL CD8+ cell count.

	MTX (N=210)				Bari 4 mg (N=159)				Bari 4 mg + MTX (N=215)			
Week: 0	4	12	32	0	4	12	32	0	4	12	32	
ALC: 1890	-110*	-110*	-80	1920	310***	380***	-20	1940	410***	220***	-100*	
CD3+: 1384	-108***	-98.5**	-102.5***	1369	148***	207***	-78*	1403.5	210***	90**	-150***	
CD8+: 435	-36**	-45***	-48***	422	52***	69***	-34**	435	80.5***	27*	-63***	
CD19+: 261	-17.5	-10	-13	258	103***	113***	51***	269	119***	101***	46***	
NK: 218	-11	-25**	-23**	247	74***	49***	-24**	234	64***	14	-44***	

Data are mean (Wk 0) and LSM Δ from BL (Wks 4, 12, 32), last observation carried forward. *p<0.05, **p≤0.01, ***p≤0.001 within grp comparison, LSM Δ from BL. Reference ranges (cells/μL): ALC=800–4280; CD3+=603–2990; CD8+=125–1312; CD19+=107–698; NK=95–64.

Conclusions: Low B and NK cell counts were common at BL, and post-BL changes within normality occurred in all treatment groups. Compared to MTX, bari was not associated with an increase in the % of pts with low NK or CD8+ cell counts while bari+MTX did show an increase in the % of pts with a low NK cell count. Changes appear distinct for LCS suggesting different mechanisms may underscore the effect of JAK inhibition. Whether low NK or CD8+ cell counts predispose to increased risk for SI or HZ was difficult to assess due to few pts with low counts experiencing these events.
References:
[1] Fleischmann R, et al. A & R. 2016.
Disclosure of Interest: T. Takeuchi Consultant for: Pfizer Japan, Astra Zeneca KK, Eli Lilly Japan KK, Novartis Pharma KK, Daiichi Sankyo Ltd, Nipponkayaku Ltd, Janssen Pharma KK, Merck Serono Ltd, Takeda Pharma Ltd, Mitsubishi Tanabe Pharma, Astellas Pharma, Abbvie GK, Bristol-Myers KK, Asahi Kasei Medical KK, Speakers bureau: Celtrion, Nipponkayaku Ltd, Pfizer Japan, UCB Japan, Daiichi Sankyo Ltd, Takeda Pharma Ltd, Chugai Pharma Ltd, Abbvie GK, Bristol-Myers KK, Eisai Co Ltd, Mitsubishi Tanabe Pharma, Janssen Pharmac KK, Astellas Pharma, R. Fleischmann Grant/research support from: Abbvie, Amgen, AstraZeneca, Bristol-Myers Squibb, Celgene, Eli Lilly and Company, Genetech, GSK, Janssen, Pfizer, Merck, Regeneron, Roche, Sanofi-Aventis, UCB, Consultant for: Abbvie, Akros, Amgen, Bristol-Myers Squibb, Celgene, Eli Lilly and Company, Genentech, GSK, Janssen, Pfizer, Sanofi-Aventis, UCB, M. Schiff Consultant for: Abbvie, BMS, Eli Lilly and Company, Johnson & Johnson, Speakers bureau: Abbvie, M. Issa Employee of: Eli Lilly and Company, W. Macias Employee of: Eli Lilly and Company, T. Rooney Employee of: Eli Lilly and Company, S. Zuckerman Employee of: Eli Lilly and Company, D. Schlichting Employee of: Eli Lilly and Company, I. McInnes Grant/research support from: Eli Lilly and Company, Abbvie, Pfizer, Novartis, Roche, Janssen, Consultant for: Eli Lilly and Company, Abbvie, Pfizer, Novartis, Roche, Janssen
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AB0282 RHEUMATOID ARTHRITIS PATIENTS ACHIEVED BETTER QUALITY OF LIFE THAN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS AT SUSTAINED REMISSION: THE IMPACT OF DISEASE DIAGNOSIS ON HEALTH-RELATED QUALITY OF LIFE OUTCOMES

V. Pascual Ramos, I. Contreras-Yáñez, L. Llorente, K.R. Valencia-Quiñones, J. Romero-Díaz. *Immunology and Rheumatology, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico*

Background: Systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA) impact the health related quality of life (HRQoL) of the patients. The 36 item Medical Outcome Study Short-Form survey (SF-36) assesses HRQoL and allows comparison of outcomes among different conditions. Whether remission represents similar status in terms of QoL in RA and SLE patients is unknown. In 2004 and 1999, respectively, recent-onset RA and SLE cohorts were initiated in a referral center for rheumatic diseases in México City; the SF-36 was applied beginning from enrollment.
Objectives: To compare the SF-36v2 scores between patients from both cohorts who achieved for the first time sustained remission (SR) and to define the role of disease diagnosis as associated to SF-36v2 normative data in SR patients.
Methods: First SR was considered when RA and SLE patients achieved at least 12 months of continuous follow-up with either SLE disease activity index 2000 update =0 or Disease Activity Score (28 joints) ≤2.4, respectively. Up to December 2015, updated data from 172 RA patients and 211 SLE patients with at least one year of follow-up were reviewed. In the SLE cohort, SF-36 was incorporated to routine assessments from 2005 onwards, meanwhile in the RA cohort it was applied since the beginning of enrollment. The SF-36v2 licensee re-scored the SF-36 used in the SLE cohort. In all the cases, Spanish versions were used and scoring was adjusted by gender and age. SF-36v2 scores were available for the totality of SR assessments. Logistic regression models were used to investigate factors associated with normative SF-36v2. Written informed consent was obtained from all patients.
Results: Cohorts were integrated primarily by middle-aged females (89%), with recent-onset disease (5.3±3.2 months); at inclusion, RA patients were older and lesser educated; follow-up was longer in SLE patients (10.6±2.9 vs. 7.5±3.2 years, p≤0.001) and a higher number of them died (15% vs. 2%, p≤0.001).
A higher proportion of patients achieved SR sooner in the recent-onset RA cohort than in the SLE cohort: 58% vs. 30.6% of the patients, after 30.8±23.9 vs. 59.4±37.5 months, respectively, p≤0.001. At SR, RA patients achieved better scores in 6 out of 8 SF-36v2 domains and in the physical health component summary (PHCS) compared with SLE patients; also, a greater proportion of RA patients achieved norms in five domains and in the PHCS; SLE patients achieved more frequent roles (physical and emotional) norms and scored higher mental health component summary than their counterpart. Finally, at SR RA patients had greater improvement in the majority of SF-36v2 domains and both summary components, despite having worse SF-36v2 scores at baseline evaluation.
In SR patients from both cohorts, age (β: 1.06, 95% CI: 1.02–1.1, p=0.03) and SLE diagnosis (β: 9.64, 95% CI: 3.61–25.75, p≤0.001) were predictors of not achieving normative PHCS.
Conclusions: RA patients who achieved SR had better HRQoL than their SLE counterparts. Age and SLE diagnosis were associated with not achieving HRQoL norms in SR patients.
Disclosure of Interest: None declared
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AB0283 ONE-YEAR FOLLOW-UP OF QUALITY OF LIFE IN RHEUMATOID ARTHRITIS PATIENTS FROM BULGARIAN POPULATION TREATED WITH CSDMARDS AND BDMARDS

V.V. Boyadzhieva, N.R. Stoilov, M. Ivanova, R. Stoilov. *Rheumatology, University Hospital "St. Iv. Rilski", Medical faculty, Medical University, Sofia, Bulgaria*

Background: Rheumatoid arthritis is a chronic systemic disabling condition associated with pathology mainly of the peripheral joints. Quality of Life (QoL) encompasses the impact of the disease and its treatment on the ability of the patient to fulfill/satisfy his or her needs. Assessing QoL in RA is an attempt to ensure the concern of patients that this important aspect of their daily lives will be measured.
Objectives: To evaluate the change of QoL of Bulgarian patients with RA after 6 months to 1-year of treatment with csDMARDs and bDMARDs by using two