BL characteristics were balanced between treatment groups in each disease severity category. M3 efficacy was significantly greater with tofacitinib 5 and 10 mg BID vs placebo, regardless of BL disease severity. As expected, larger proportions of tofacitinib-treated pts with moderate vs severe BL RA achieved LDA by either DAS28 (32.3–36.7% vs 13.8–19.1%) or CDAI (49.2–55.0% vs 26.0–31.7%). Similarly, a higher proportion of pts achieved remission in the moderate vs severe BL groups by DAS28 (20.0–22.8% vs 6.2–9.0%) or CDAI (11.5–12.1% vs 5.1–6.7%). A greater proportion of pts achieved HAQ-DI <0.5 with moderate vs severe RA classified by BL DAS28 (45.0–60.6% vs 24.5–30.0%) or BL CDAI (40.8–52.4% vs 24.7–30.4%). Greater improvements from BL in disease activity and HAQ-DI were seen for pts with severe vs moderate RA classified by BL DAS28 (Table), and by BL CDAI (Tofacitinib 5/10 mg BID Δ CDAI: -21.1/-23.0 vs -8.1/-9.4; Δ HAQ DI: -0.5/-0.6 vs -0.3/-0.4).

Conclusions: Tofacitinib 5 and 10 mg BID demonstrated efficacy in treating pts with moderate and severe RA with >7 years' mean disease duration. By M3, pts with severe vs moderate BL disease activity had greater improvements in disease activity and physical functioning; higher proportions of pts with moderate vs severe BL disease activity achieved remission, LDA or normal physical functioning. Interpretation of this post hoc analysis may be limited by the smaller sample size of the moderate disease group and the combining of mono- and combination-therapy results.

Acknowledgements: This study was sponsored by Pfizer Inc. Editorial support was provided by A Pedder of CMC and funded by Pfizer Inc.

Disclosure of Interest: S. Schwartzman Consultant for: Pfizer Inc, P. Sunkureddi Grant/research support from: Pfizer Inc, Consultant for: Pfizer Inc, Speakers bureau: Pfizer Inc, L. Takiya Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, M. Snyder Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, H. Fan Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, T. Lukic Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, J. Roberts Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, W. F. Rigby Grant/research support from: Amgen, Pfizer Inc, Roche, Consultant for: Bristol-Myers Squibb, Eli Lilly, Pfizer Inc, Roche

DOI: 10.1136/annrheumdis-2017-eular.1846

AB0437 EFFICACY AND SAFETY OF LONG-TERM ANALGESIC THERAPY WITH ETORICOXIB FOR PATIENTS WITH RHEUMATIC DISEASES

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Background: There are some data in literature on decompensation of arterial hypertension and other chronic diseases during the treatment with coxibs which in practice unfortunately limits their administration for patients with comorbidities.

Objectives: To evaluate the efficacy of analgesic effect of etoricoxib and frequency of comorbidities exacerbation on such treatment.

Methods: 58 patients with rheumatoid arthritis (34.4%), osteoarthritis (29.2%), ankylosing spondylitis (19%), gout (14%), psoriatic arthritis (3.4%) at the age of 25 to 75 years (the average age, 52.9 $\pm$ 13.03 years) were included. 79.3% patients had comorbidities (diseases of digestive system – 37.9%, arterial hypertension – 53.4% (including 3.2% with decompensated hypertension), bronchial asthma – 1.7%). All the patients before the appointment had taken NSAIDs (diclofenac, nimesulid, ketoprofen, meloxicam, aceclofenac, ibuprofen) with lack of effect (84.4%) or minimal effect (15.6%). Etoricoxib was administered in 100% cases. Pain severity according to visual analogue scale (VAS), comorbidities exacerbation and blood pressure were assessed at the beginning and during the first month of treatment.

Results: The average time period between 2 appointments was 20.72 $\pm$ 9.3 days. By the second appointment 98.2% patients were taking etoricoxib regularly, and good tolerability of the medication was noted (63.8% excellent, 36.2% good). The average VAS score at the first appointment was 7.27 $\pm$ 1.04, at the second appointment – 2.75 $\pm$ 1.12, in the meantime VAS score improvement was noted mostly in the group of patients with long disease duration (more than 3 years). At the time of second examination total relief of back pain was revealed in 16.7%, in knee joint – 35.5%, in hip joint – 68.1%, in the neck – 61.9%, in small joints – 30.8%, of shoulder blade pain – 82.4%. No comorbidities exacerbation was noted. There were also no cases of sudden blood pressure increase on the administered therapy, including patients with arterial hypertension.

Conclusions: Etoricoxib administration leads to significant decrease of pain syndrome and its relief without increasing blood pressure and exacerbations of chronic comorbidities.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3972

AB0438 RHEUMATOID ARTHRITIS DRUG THERAPY IN THE PERIOPERATIVE PERIOD OF LARGE JOINTS ARTHROPLASTY, ITS IMPACT ON THE LONG-TERM RESULTS OF SURGERY

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Objectives: To analyze the results of large joints arthroplasty depending on the received rheumatoid arthritis (RA) drug therapy

Methods: Knee and hip joints arthroplasty was performed for 54 RA patients (48

women, 6 men), mean age 51.4 $\pm$ 12.8 years. At the time of the operation disease duration was 11.8 $\pm$ 3.8 years, high activity (DAS28) - in 26%, moderate - in 55.5%, the low - at 18.5% patients. At the time of surgery 39 (72.2%) pts continued to take basic anti-rheumatic drugs (DMARDs) (methotrexate at a dose of 10–20 mg per week - 32, leflunomide (20 mg daily) - 5). Corticosteroids (prednisone at a dose of 5–15 mg, an average of 7.1 mg per day) - 25 (46.2%) patients, of which in combination with DMARDs - 10 (18.6%). Before the operation, and after the 6 months joint pain (VAS), disease activity - DAS28, functional ability HAQ index were evaluated. In 32 patients, these same indexes were estimated after 12 months.

Results: The reduction of pain intensity VAS was observed in the first month after a joint arthroplasty, after 6 months VAS fell almost to 31.8 mm (p<0.05). Activity of the disease decreased (high - 11.2%, moderate - 44.4%, low - 44.4%), HAQ - from 1.61 $\pm$ 0.41 to 1.09 $\pm$ 0.26 (p<0.05). After 12 months HAQ - 1.01 $\pm$ 0.28.

The analysis showed that in patients not receiving corticosteroids (n=29) arthroplasty was conducted in 13.6 $\pm$ 3.2 years after RA onset, and receiving long-term steroids (n=25) significantly earlier (p<0.05) - through 9.9 $\pm$ 3.5 years. The functional capacity of patients in the group receiving DMARDs without corticosteroids (n=29) (the HAQ 6 months - 0.9 $\pm$ 0.24, 12 months - 0.81 $\pm$ 0.16) was significantly (p<0.05) higher compared with patients receiving corticosteroids (n=25) without the basic treatment (HAQ 6 months -1.13 $\pm$ 0.21, over 12 months -1.24 $\pm$ 0.19)

Conclusions: Large joints arthroplasty is an effective method to improve the functional capacity of patients with RA. For patients receiving corticosteroids need of arthroplasty arises a few years earlier. The function of the joints after surgery and in the remote period is better when patients continuously receive DMARDs compared to steroid therapy, the dose should be reduced to a reasonable minimum for the time of surgical treatment.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3955

AB0439 EFFICACY AT THREE YEARS OF DAILY CLINICAL USE OF IGURATIMOD IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Igruratimod (IGU) is a small-molecule antirheumatic drug that was developed in Japan and is currently only approved for treatment of rheumatoid arthritis (RA) in Japan and China. IGU suppresses tumor necrosis factor- α -induced production of interleukin (IL)-6, IL-8 and monocyte chemoattractant protein 1 via the inhibition of nuclear factor- κ B activation in cultured human synovial cells and human acute monocytic leukemia cells. There are some reports about the efficacy and safety of IGU in patients with RA. However, the assessment about efficacy of the clinical use of IGU has mainly been restricted to short-term (within one year) outcome.

Objectives: The purpose of this study was to assess the efficacy of IGU in 3 years

Methods: Sixty-nine RA patients (14 males and 55 females, mean age of 63.9 years, mean disease duration of 14.9 years) were enrolled in this study. The clinical course of RA was evaluated during 3 years. The patients who discontinued the IGU therapy were analyzed by the last observation carried forward method.

Results: The survival rate at 3 years was 49.3%, and 8 patients discontinued the IGU therapies due to insufficient response, 12 patients due to adverse events such as exanthema, pneumonitis or hepatic disorder, and other patients based on their requests. The DAS28-CRP, DAS28-ESR, SDAI and CDAI significantly decreased at 6 months, 1, 2, 3 years compared with baseline. The low DAS28-CRP at 3 months and younger age were associated to the continuation of IGU. Furthermore, 27 patients (39.1%) were in remission at 3 years. In the remission achievement group, the DAS28-CRP and the usage rate of prednisolone at baseline were significantly lower and patients' age was younger. A logistic regression analysis revealed the low DAS28-CRP and low usage rate of prednisolone at baseline were significant factors contributing to the achievement of a clinical remission at 3 years.

Conclusions: We assessed middle-term outcome of the clinical use of igruratimod therapy in RA patients. The low DAS28-CRP and low usage rate of prednisolone at the initiation of IGU were significant factors of clinical remission achievement at 3 years.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.6040

AB0440 IMPACT OF VITAMIN D DEFICIENCY UPON DISEASE ACTIVITY AND IMMUNE DISORDER IN RHEUMATOID ARTHRITIS PATIENTS

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Background: Emerging evidence suggests that vitamin D plays an important role in immune regulation.

Objectives: The objective of this work was to determine if patients with rheumatoid arthritis (RA) are at risk for vitamin D deficiency and whether vitamin D levels correlate with disease activity or immune disorders.

Methods: This study was a retrospective research. RA patients who had vitamin D levels and immune function indexes of each other were included. Patients receiving or have received vitamin D, corticosteroids, disease-modifying anti-rheumatic drugs or a tumor necrosis factor antagonist and those who had hepatic or renal insufficiency were excluded. Multivariate analysis was performed to examine correlations and control for confounding factors.

Results: As suggested threshold (≤ 25 ng/ml), the overall prevalence of vitamin D insufficiency was 265 of 280 (94.8%). Mean serum vitamin D insufficiency levels of 11.15 ± 4.74 ng/ml for RA patients were significantly lower compared to controls (31.62 ± 6.46) ($p=0.001$). Among all the subjects, 208 (72.7%) were females. Vitamin D levels in high disease activity group were lower compared to vitamin D level in patients with low and moderate disease activity (DAS-28 score > 5.1 , $3.2-5.1$, < 3.2 , respectively, $p < 0.001$) and vitamin D levels had an inverse correlation with DAS28 score (β -coefficient -0.164, $p=0.018$, per 1 ng/ml). In patients with RA, the levels of vitamin D were moderately and inversely associated with Th 17 (β -coefficient -0.158, $p=0.019$, per 1 ng/ml). However, no significant relationship was found between vitamin D and these variables (T cell, B cell, NK cell, Treg, Th1, Th2, Th17/Treg) in patients.

Conclusions: Lower levels of vitamin D are associated with worse DAS28

Table 1. Disease activity, immune function indexes with RA as mean $\pm$ standard deviation or number (%) for total group and based on vitamin D status

Variables	All patients N=280	Patients with Vitamin D insufficiency N=265	Patients without Vitamin D insufficiency N=15	P (Insufficiency vs no insufficiency)
Women	208 (72.7)	201 (74.2)	7 (33.3)	0.012
Age (yr)	56.421 $\pm$ 12.325	56.109 $\pm$ 12.225	61.933 $\pm$ 13.215	0.075
Disease duration (yr)	9.004 $\pm$ 9.336	9.017 $\pm$ 9.374	8.782 $\pm$ 8.938	0.925
ESR	59.064 $\pm$ 36.483	59.325 $\pm$ 36.731	54.467 $\pm$ 32.544	0.617
DAS 28	4.754 $\pm$ 1.429	4.768 $\pm$ 1.426	4.508 $\pm$ 1.526	0.494
T cell	1242.473 $\pm$ 585.533	1249.317 $\pm$ 586.751	1122.933 $\pm$ 569.670	0.417
B cell	204.397 $\pm$ 182.279	208.206 $\pm$ 185.967	137.867 $\pm$ 72.572	0.146
NK cell	237.419 $\pm$ 187.449	233.782 $\pm$ 188.784	300.933 $\pm$ 153.989	0.178
Th1	88.290 $\pm$ 116.113	87.583 $\pm$ 116.660	103.377 $\pm$ 108.907	0.691
Th2	12.729 $\pm$ 10.819	12.852 $\pm$ 10.992	10.121 $\pm$ 5.788	0.461
Th17	9.271 $\pm$ 9.023	9.330 $\pm$ 9.145	8.010 $\pm$ 6.059	0.669
Treg	33.710 $\pm$ 28.519	34.060 $\pm$ 29.025	26.257 $\pm$ 12.426	0.424
Th17/Treg	0.421 $\pm$ 0.639	0.421 $\pm$ 0.647	0.411 $\pm$ 0.445	0.964

Table 2. Multivariate associations of serum 1,25(OH)₂D₃ concentrations with RA (n=280)

Variables	β -coefficient	95% CI	p
Gender	-0.241	-5.337 to -1.562	0.001
Age	0.182	0.024 to 0.168	0.009
DAS 28	-0.164	-1.243 to -1.116	0.018
Th 17	-0.158	-0.199 to -0.018	0.019

Figure 3: The correlations between of serum 1,25(OH)₂D₃ levels and Th 17 levels.

and higher levels of Th17 with RA, especially in female patients. The levels of 1,25-dihydroxycholecalciferol (1,25(OH)₂D₃) could be a marker to monitor the disease activity in RA patients and vitamin D may be an alternative supplementary treatment for RA.

Acknowledgements: This work was supported by research grants from the National Natural Science Foundation of China (no. 81301532/H0603) and the Shanxi Science and Technology research projects of China (no. 201603D321074).

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3202

AB0441 USING OF SUBCUTANEOUS METHOTREXATE IN AGED PATIENTS WITH SEROPOSITIVE RA

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Background: Increasing life expectancy is a global process involving multiple nations, thus deeper insights into methotrexate (MTX) therapeutic potential in aged people is of paramount importance, as MTX still remains an anchor DMARD in RA management.

Objectives: To assess the results of 12-months therapy with subcutaneous MTX (SC MTX) injections in RA patients aged more than 60 years.

Methods: The 12 months open study included pts with active RA (DAS28 > 3.2), meeting ACR/EULAR (or ACR 1987) criteria, with RA lasting up to 3 years, and naïve to SC MTX. All pts were RF and/or ACPA-positive, 68% had increased BMI, 31% - obesity, 8% were smokers, 25% were taking oral GCS (≤ 10 mg/day equivalent to prednisolone). All pts were administered SC MTX monotherapy once a week as a DMARD, starting at 10–15 mg/week, with subsequent 5 mg up-titration each 1–2 weeks (to max 30 mg/week) up to achieving the target (remission or minimum disease activity) or up to emergence of an adverse drug reaction (ADR). Folic acid (min 5 mg/week) was administered at any day(s) except for the day of SC MTX injection for ADR prophylaxis. Disease activity was scored using DAS28. GEBA were administered in pts with insufficient SC MTX clinical effect. Pts were monitored within universal institutional REMARKA program, envisaging physical examination, blood analysis and biochemistry panel (including liver enzymes and creatinine). STATISTICA 10 software was used for data processing.

Results: 32 RA pts (28 females, 4 males) were included (mean disease duration 12 ± 10 months, mean age - 65.7 ± 4.7 years, mean DAS28 score -5.6 ± 0.9). Cumulative SCMT dose by the end of the study reached 264 ± 180 mg). The therapeutic target (remission or minimum disease activity) based on DAS28 score) was achieved in 20 pts receiving SCMT monotherapy, 12 pts required administration of GEBA. Adverse drug reactions (ADRs) were documented in 10 pts, including cases of more than one ADR at a time: breast abscess (1), alopecia (2), diarrhea (2), skin rash (1), a metallic aftertaste (1), local post-injection reactions (1), nausea (2), elevation of liver enzymes (3), leucopenia (1), pneumonia (1). There were 5 cases of SC MTX monotherapy discontinuation (2 - temporary, and 3 - permanent). The majority of pts (88%) could manage self-injection without additional training or assistance from medical staff.

Conclusions: 62.5% of aged RA pts participating in the study managed to achieve the therapeutic target after 12 months of SC MT monotherapy, although 31% ADRs rate required temporary (2)/permanent (3) SCMT discontinuation.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.2418

SLE, Sjögren's and APS - treatment

AB0442 REAL-LIFE EXPERIENCE WITH BELIMUMAB IN SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): CONTROL OF DISEASE ACTIVITY AND FLARES IN A MULTICENTER COHORT

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Background: Data on the efficacy of belimumab in SLE mainly originate from large randomized clinical trials, whereas reports from real-life clinical practice are lacking.

Objectives: To describe the clinical experience from the use of belimumab in Greece since the approval of the drug.

Methods: Multicentre observational study of patients receiving belimumab, with documentation of disease activity (SLEDAI-2K index), achievement of low disease