targeted-synthetic DMARDs. The use of any conventional synthetic DMARD was associated with lower HAQ-DI indices (p=0.0243), while the use of any biologic DMARD or targeted-synthetic DMARD was related to greater functional impairment (p=0.0018). By evaluating separately, abatacept (p=0.0046), rituximab (p=0.0001) and tocilizumab (p=0.0441) were associated with higher levels of HAQ-DI. The results are summarised in table 1.

Abstract AB0200 – Table 1. Health assessment questionnaire-disability index score position and dispersion measurements and result of comparison between groups

Conclusions: In our prospective cohort, patients with high levels of RF, bone erosion, in use of any biologic DMARD or targeted-synthetic DMARD, abatacept, rituximab or tocilizumab had worse functional capacity indexes. When compared to non-use, the use of any conventional DMARD was associated with better rates of HAQ-DI.

REFERENCES:


Disclosure of Interest: None declared


AB0201

ASSOCIATION BETWEEN BASELINE CALPROTECTIN SERUM LEVELS AND RESPONSE TO BIOLOGICAL THERAPY IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Calprotectin (CLP) is an important proinflammatory factor of innate immunity released from activated granulocytes and macrophages during inflammation, which has also been identified in synovial fluid. It is a potential pro-inflammatory biomarker reflecting joint damage. CLP levels in synovial fluid are well correlated with levels in plasma, which allows measuring it easily in patients with rheumatoid arthritis (RA). However, the additional value of CLP over other biomarkers is unclear.

Objectives: To study the association of baseline CLP serum levels with the clinical response and serum drug levels in patients under biological therapy at 6 and 12 months after starting treatment.

Methods: Prospective observational study including 109 patients with RA who started biological treatment (Infliximab/IX;Adalimumab/Ada;Etanercept/Etn; Certolizumab(Cz);Golimumab(Glm); Tocilizumab(Tcz) and Rituximab(Rtx) in a tertiary hospital since 1999 to 2016. Serum CLP levels were measured by ELISA with the commercial kit CALPROLAB (Lyssaker, Norway). Levels of biological drug and ADA were measured by capture and bridge ELISA respectively. C-reactive protein (CRP) and DAS28 were measured by local laboratories. Disease activity was assessed by the DAS28.

Conclusions: In our cohort ERA patients initially treated with GCs had higher disease activity scores at onset compared to subjects without GCs. The lesser chance of achieving remission defined according to DAS28.2 points and 6 remission (DAS28.2) was observed in ERA patients compared to patients with RA treated without GCs. A higher rate of remission defined according to DAS28 values. ERA patients that didn’t manage to stop GCs at the sixth month (38.8%) had a higher BMI (p=0.04) and a lesser chance of achieving remission defined according to DAS28.2 values. ERA patients treated with bDMARDs and no differences were observed regarding radiographic progression.

AB0202

GLUCOCORTICOIDS IN THE INITIAL TREAT-TO-TARGET STRATEGY OF EARLY RHEUMATOID ARTHRITIS


Background: As stated in the 2013 update of RA recommendations, glucocorticoids (GCs) should be used as bridging therapy for up to 6 months, ideally tapering them at earlier time points.1 Objectives: To evaluate whether initial combination therapy with GCs and disease modifying anti-therapeutic drugs (DMARDs) influences clinical and radiological outcomes in the real-life practice of a cohort of early rheumatoid arthritis (ERA) patients.

Methods: A total of 367 ERA patients with less than 12 months of disease duration were enrolled in the study. ERA patients fulfilled the 2010 ACR criteria for RA and were followed according to the treat-to-target strategy. The mean follow-up (FU) was 38.2±32.8 months. At baseline, and every three months, the ACR/EULAR data set variables were recorded. At baseline and every year, hand and foot radiographs were examined according to modified Total Sharp score (mTSS). At each visit, clinical improvement and remission were evaluated according to EULAR criteria. The achievement of CDC (28-joint Disease Activity Score using C reactive protein <2.6, Health Assessment Questionnaire<0.5 and change from baseline in mTSS ≤0.5) was assessed every year of follow-up.

Results: At baseline 291 (71.9%) ERA patients started GCs at a dosage of 0.2 mg/Kg, gradually tapered and withdrawn as rapidly as clinically feasible. As expected, these patients presented higher values of acute phase reactants (p=0.001), and higher levels of disease activity scores (p=0.001) and disability index (p=0.001), compared to the 76 subjects (18.8%) who had not been pre-scribed GCs. Patients not treated with GCs were in higher percentages anti-citrullinated peptide antibody (ACPA) (75.0%) and IgM-heumatoid factor (RF) (64.5%) positive, compared to subjects taking GCs (62.9%, p=0.05; 49.8%, p=0.02, respectively). There were no differences regarding age, disease duration, BMI, smoking habit and presence of erosions at onset. The mean duration of GC treatment was 7.5±7.9 months and the mean dosage during FU was <5 mg prednisone per day. During the FU, in the two groups a similar percentage of patients started a combination therapy with biological (b)DMARDs and no differences were observed regarding radiographic progression. A higher rate of remission defined according to DAS28 values.1 ACR/EULAR criteria, and CDC criteria, was registered in patients not treated with GCs compared to subjects who required corticosteroid therapy. ERA patients that didn’t manage to stop GCs at the sixth month (38.8%) had a higher BMI (p=0.04) and a lesser chance of achieving remission defined according to DAS28 values.1 ACR/EULAR criteria, and CDC criteria during follow-up. Moreover, a higher percentage of them required a combination therapy with bDMARDs during FU (p=0.0001).

Conclusions: In our cohort ERA patients initially treated with GCs had higher disease activity scores at onset compared to subjects without GCs. The lesser chance of achieving remission and the higher rate of bDMARD therapy in ERA
patients not able to stop GCS, reflect a more aggressive disease, refractory to con-
ventional drugs.

REFERENCE:

Disclosure of Interest: None declared

AB0203
CLINICAL PHENOTYPE AND ULTRASOUND CHARACTERISTICS OF RHEUMATOID ARTHRITIS FLARE AFTER DISCONTINUATION OF CONVENTIONAL SYNTHETIC DMARDs
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Background: Current protocols based on early and intensive treatment with csDMARDs in rheumatoid arthritis (RA) have allowed the achievement of remission in a considerable proportion of the patients and opened the perspec-
tive, in selected cases, of a drug-free monitoring scheme. Treatment discontin-
uation can lead, however, to possible recurrence of joint inflammation and clinical flare. Understanding the dynamics acting upstream these events remains a fundamental research task with direct clinical and patho-biologic implications...

Objectives: To delineate the clinical, serological and ultrasonographic changes associated to a drug-free flare in patients discontinuing csDMARD after achieve-
ment of stable remission. Co-primary objective was to compare, through a retro-
spective analysis in the same patients, these changes with early features of the pathology at onset, before treatment introduction.

Methods: 92 RA patients in stable DAS28 remission following a DAS-steered treatment strategy with MTX were recruited in our Centre and introduced to a drug-free monitoring scheme according to the following inclusion criteria: a) treat-
ment introduced within 12 months from symptoms’ onset, b) at least 24 months of con-tinuative treatment, c) DAS28 <2.6 for at least 6 months in the absence of glu-
corticoids. After discontinuation, all patients were follow-up at three months intervals across 24 months through complete clinical, ultrasonographic (power Doppler ultrasound –PDUs- in hands and feet) and serological analyses. Treatment was re-introduced upon occurrence of moderate disease activity (DAS28 ≥3.2) in a single occasion.

Results: A total drug-free follow-up of 1398 person-months was analysed with a median (IQR) of 15(6–29) months. Thirty-eight patients (27/38 in ACR/EULAR Bood-
lean remission, 16/38 with PD score=0 at withdrawal visit) required treatment re-
introduction after a median (IQR) time from discontinuation of 6(3–9) months (range 3–18). DAS28 variations at re-treatment showed a mean (SD) increase of 2.26 (1.03), reflecting significant differences in all DAS components (p<0.001 for ESR, tender joint count, swollen joint count and GH). Clinical activity in flaring subjects was paralleled by average changes in synovial US, with increased PD scores in hands joints (median [IQR]: 3.5 [0.5–7] vs 1 [0–2], p<0.001), feet (1 [0–4] vs 0 [0–
0.5], p=0.002) and tendons (0 [0–2] vs 0 [0–0], p=0.02), determining ex-novo PD positive in 85.7% of PD negative patients (p=0.001). Despite stringent remission achieved at the time of discontinuation, no significant differences were observed between disease onset and drug-free flare in DAS28 (p=0.026), patient global assessment of disease activity (p=0.53) and synovial US scores (p=0.61 for grey scale, p=0.31 for PD) with recurrence of similar patterns of joint involvement.

Conclusions: Drug-free clinical flare can occur over a wide temporal window, in the absence of detectable signs of inflammation at the time of treatment discontin-
uation. It can associate with ex-novo recurrence of US pathologic changes at joint and tendon level, reproducing some of the quantitative/qualitative features of dis-
ease onset.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2018-eular.3408

AB0205
COMPARISON OF THORACIC HRCT AND SELF-
REPORTED QUESTIONNAIRES IN THE ASSESSMENT OF PULMONARY INVOLVEMENT IN RHEUMATOID ARTHRITIS PATIENTS: PRELIMINARY RESULTS
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Background: Pulmonary involvement in rheumatoid arthritis (RA) is one of the articular manifestations affecting morbidity and mortality during the course of the disease. Pulmonary function tests (PFTs) and thoracic high-resolution com-
puterised tomography (HRCT) are the standard of care in the assessment of pul-
monary involvement in RA. In this study, we aimed to compare the findings between self-reported questionnaires and HRCT to detect pulmonary abnormal-
ities in RA patients.

Methods: Forty-two RA patients fulfilling ACR/EULAR classification criteria (2010) who had thoracic HRCT within 6 months of any symptom and/or any path-
ology on radiography of chest were included in the study. The patients were also assessed by modified Borg Scale, SF-36 Quality of Life Scale and Leicester Cough Questionnaire for the evaluation of respiratory symptoms.

Results: Demographics and clinical characteristics were summarised in table 1. Warrick score, assessing the severity and extent of alveolitis and fibrosis on thor-
coric HRCT, was evaluated in 15 patients with ILD (score range:4–28). DLCO values were lower in patients with Warrick score ≥1 (73±22% vs. 88±12%, p=0.019) while FVC were not found to be different. The findings of HRCT and self-reported questionnaires were summarized in table 2. An association between self-
reported questionnaires and Warrick scores was not detected. Presence of any parenchymal lesions was found to be associated with SF-36 total score (p=0.048). DLCO levels were found to be negatively correlated with SF-36 total scores (r=−0.470, p=0.006).

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