Abstract AB0294 – Table 1. Most frequent^a reasons for choosing or not choosing each treatment mode as 1st choice

Reasons for choosing OR, n (%) (N=57)		Reasons for not choosing OR, n (%) (N=43)	
Speed of administration	30 (52.6)	Difficultly remembering	15 (34.9)
Ease of administration	30 (52.6)	Possible drug-drug interactions	11 (25.6)
Portability	23 (40.4)		
Reasons for choosing SI, n (%) (N=29)		Reasons for not choosing SI, n (%) (N=71)	
Speed of administration	16 (55.2)	Avoidance of pain due to needles	33 (46.5)
Frequency of dosing	12 (41.4)	Avoidance of needles	30 (42.3)
Having a feeling of control	11 (37.9)	Difficulties when traveling	19 (26.8)
		Need to refrigerate	18 (25.4)
Reasons for choosing CI, ^b n (%) (N=10)		Reasons for not choosing CI, ^c n (%) (N=100)	
Feels comfortable with experts administering	4 (40.0)	Need to go to the clinic	38 (38.0)
Prefers someone else to administer	3 (30.0)	Inconvenience	36 (36.0)
Reasons for choosing INF, n (%) (N=16)		Reasons for not choosing INF, n (%) (N=84)	
Frequency of dosing	13 (81.3)	Time-consuming	51 (60.7)
Feelings of safety and care	5 (31.3)	Hassle and inconvenience	28 (33.3)
		Need to go to the clinic	26 (31.0)

^aReported by ≥25% of patients. ^bN includes 2 patients who chose CI as clear 1st choice and 8 patients who chose CI as clear 2nd choice. ^cBased on total sample

CI, clinic-injection; INF, infusion; OR, oral; SI, self-injection

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AB0295

RISK FACTORS FOR PROGRESSION AND PROGNOSIS OF RHEUMATOID ARTHRITIS-ASSOCIATED INTERSTITIAL LUNG DISEASE: SINGLE CENTRE STUDY WITH A LARGE SAMPLE OF CHINESE POPULATION

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Background: Poor prognosis has been shown in rheumatoid arthritis-associated interstitial lung disease (RA-ILD) patients, and the mortality rate was significantly higher than RA patients without ILD. Studies showed that one-third of RA-ILD patients had progressed within two years. However, factors associated with ILD progression and survival in RA-ILD have not been previously described in a large centre China cohort.

Objectives: To investigate the risk factors for ILD progression and explore the prognostic factors for survival in RA-ILD patients.

Methods: 791 consecutive RA patients who completed lung HRCT were considered as potential participants. 266 RA-ILD patients were finally included in this retrospective cohort study. To identify independent risk factors for ILD progression, multivariate logistic regression analyses were used. Cox hazards analysis was used to determine significant variables associated with survival.

Results: 1, The mean age at diagnosis of RA-ILD was 64.80±10.71 years old. 162 (60.90%) were females and 104 (39.09%) were males. 2, UIP and NSIP pattern were the commonly types of RA-ILD, accounting for 37.22% and 25.94% respectively. Extent of lung involvement analysis showed that limited was predominant (130/266, 48.87%), with smaller numbers of moderate (67/266, 25.19%) and extensive (69/266, 25.94%) lung involvement. 3, The 3 year survival rate of RA-ILD patients was 81.24%, and the 5 year survival rate was 69.71%. A total of 82 deaths occurred during follow-up, of which 56 died of respiratory failure due to ILD progression and/or pneumonia, while 14 with malignancies (8 with lung cancer). 4, Logistic regression analysis showed that an increased anti-CCP antibody titer (OR: 4.03, 95% CI: 1.04–15.69, p<0.05) and DLCO%<45% (OR: 8.31, 95% CI: 2.17–31.75, p<0.01) were independent risk factors for the ILD

progression. 5, Cox hazards analysis revealed that advanced age(>60 years old) of RA-ILD diagnosis (HR: 2.32, 95% CI: 1.27–4.25, p<0.05) and extensive lung involvement on HRCT (HR: 2.19, 95% CI: 1.24–3.87, p<0.05) were associated with worse survival. Treatment with cyclophosphamide (HR: 0.43, 95% CI: 0.26–0.69, p<0.01) was associated with better survival.

Abstract AB0295 – Figure 1. Study flow diagram

Conclusions: In RA-ILD patients, DLCO%<45% is the strongest predictor for ILD progression. Advanced age and extensive lung involvement on HRCT, rather than the baseline UIP pattern, independently predict mortality after controlling for potentially influential variables. Furthermore, cyclophosphamide treatment helps to improve the prognosis in real-world experience.

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AB0296

14–3–3ETA POSITIVITY IS ASSOCIATED WITH HIGHER RHEUMATOID ARTHRITIS DISEASE ACTIVITY MEASURED BY MULTI-BIOMARKER DISEASE ACTIVITY ASSAY

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Background: Early diagnosis of rheumatoid arthritis (RA) is crucial but recognition of its disease activity and prognosis can help tailor treatment for patients in order to avoid debilitating consequences. 14–3–3eta has been described to have diagnostic utility as a biomarker of RA; however its use as prognostic factor is still under investigation.¹ The η (eta) isoform is one of seven from the 14–3–3 family of regulatory proteins and is expressed extracellularly in much higher concentrations in the synovial fluid and serum of patients with RA. A multiple-biomarker disease activity (MBDA) score was recently introduced; 396 candidate cytokines and biomarkers were narrowed to twelve, correlating with disease activity.

Objectives: The purpose of our study was to investigate if 14–3–3η can be used as a prognostic factor and if it was associated with higher disease activity in RA patients. We compared the positivity of 14–3–3η in those with low, moderate, and high disease activity based on MBDA scores. In addition, as MBDA scores provide individual biomarker levels, we wanted to determine if there was a correlation between 14–3–3η and specific biomarker patterns.

Methods: A retrospective chart review was conducted on 70 RA patients (satisfied the 2010 ACR diagnostic criteria) at an outpatient rheumatology clinic in an inner-city population. Serum 14–3–3η protein was measured by ELISA with a positive threshold range (Quest Diagnostic) of 0.2 ng/mL. The MBDA scoring scale was 1–29 for low disease activity, 30–44 for moderate and 45–100 for high. The t-test was used to analyse for a significant difference in MBDA scores as well as individual biomarker levels in 14–3–3η positive patients.

Results: Of the 70 RA patients, 37 were 14–3–3η positive and 33 were negative. Thirty (81%) of 14–3–3η positive patients were on at least one DMARD compared to 16 (48.5%) of negative patients. The mean and median MBDA scores of 14–3–