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

<table>
<thead>
<tr>
<th>Reason for choosing OR, n (%)</th>
<th>Reason for not choosing OR, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speed of administration</td>
<td>30 (23.6)</td>
</tr>
<tr>
<td>Ease of administration</td>
<td>30 (23.6)</td>
</tr>
<tr>
<td>Portability</td>
<td>21 (15.9)</td>
</tr>
<tr>
<td>Reasons for choosing ILD, n (%)</td>
<td>Reasons for not choosing ILD, n (%)</td>
</tr>
<tr>
<td>Speed of administration</td>
<td>18 (14.1)</td>
</tr>
<tr>
<td>Frequency of doing</td>
<td>12 (14.1)</td>
</tr>
<tr>
<td>Having a feeling of control</td>
<td>11 (13.7)</td>
</tr>
<tr>
<td>Reasons for choosing INF, n (%)</td>
<td>Reasons for not choosing INF, n (%)</td>
</tr>
<tr>
<td>Feelings of safety and care</td>
<td>10 (12.1)</td>
</tr>
</tbody>
</table>

*Most frequent responses are listed.

Conclusions: There is a need for additional treatment options for RA-ILD, particularly for patients with high disease activity.

Disclosure of Interest: None declared


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.

REFERENCES:

Disclosure of Interest: None declared


Abstract AB0296

14–3–JETA 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–Jetas has been described to have diagnostic utility as a biomarker of RA; however its use as prognostic factor is still under investigation. The n (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-biomerker 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 14–3–3ζ was used to determine significant variables associated with survival.

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 were the commonly types of RA-ILD, accounting for 37.22% and 25.94% respectively.

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.

REFERENCES:

Disclosure of Interest: None declared

3n positive patients were 49.4 and 47, while negative patients’ scores were 36.9 and 38, respectively (p=0.002). Thus, 14–3n positive patients had high disease activity while 14–3n negative patients had moderate disease activity. Mean levels of matrix metalloproteinase 3 (MMP-3), serum amyloid A (SAA), and CRP in 14–3n positive versus negative were 52.3 ng/mL and 28.4 ng/mL (p=0.01), 24.3 mg/mL and 6.96 mg/mL (p=0.02), and 21.5 mg/L and 9.82 mg/L (p=0.02), respectively.

Conclusions: 14–3n positive RA patients have higher disease activity based on the ESR score compared with higher levels of MMP-3, SAA, and CRP. MMP-3 is associated with joint destruction through degradation of the components of extracellular matrix in the synovial joint. SAA and CRP are acute phase reactants but SAA has been linked with increased cardiovascular and renal disease in RA patients. 14–3n positive patients should be treated aggressively to decrease disease activity and limit extra-articular manifestations.

REFERENCE:
[1] Maksymowych W, Naides S, Bykerk V, Siminovich K, et al. Serum levels of matrix metalloproteinase 3 (MMP-3), serum amyloid A (SAA), and CRP in 14–3n positive versus negative were 52.3 ng/mL and 28.4 ng/mL (p=0.01), 24.3 mg/mL and 6.96 mg/mL (p=0.02), and 21.5 mg/L and 9.82 mg/L (p=0.02), respectively.

Disclosure of Interest: None declared

AB0297 PREDICTORS OF AN INADEQUATE RESPONSE TO TREATMENT IN LATIN AMERICAN PATIENTS WITH EARLY RHEUMATOID ARTHRITIS

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Background: Inadequate response to treatment in early rheumatoid arthritis (RA) is associated with adverse outcomes. We have previously shown high baseline levels of disease activity in Latin American RA patients.1

Objectives: To identify the baseline predictive factors of inadequate response to treatment in patients with early RA from a GLADAR cohort, at one year from cohort entry.

Methods: GLADAR cohort includes 1093 consecutive RA patients with disease onset <1 year from 46 centres in 14 Latin American countries. For these analyses, patients with complete clinical and laboratory assessments with DAS28-ESR>3.2 at the baseline, and one-year follow up visits were included. Inadequate treatment response was ascertained with the EULAR definition which is based on DAS28-ESR obtained at one-year of follow up [a variation ≥0.6 in any category of activity (mild, moderate or severe) and a variation >0.6 but ≤1.2 in the high activity category]. Gender, age at diagnosis, diagnosis delay, socioeconomic status (by the Gough scale), ethnicity, medical coverage, rural origin, rheumatoid factor (RF) positivity, disability (HAQ-DI), DMARDs use, corticosteroid use, and DMARD treatment delays were examined as potential predictive factors of this outcome. Univariable and multivariable binary logistic regression models, using a stepdown technique were examined in order to determine the predictors of response at 1 year.

Results: Four hundred and forty-eight patients were included. Three hundred and eighty-five (85.9%) were female; the mean (SD) age at diagnosis was 46.1 (13.6) years; 78.3% had medical coverage and 347 patients (77.5%) were RF positive. The mean baseline DAS28-ESR was 6.3 (1.4). EULAR response was met by 347 (77.5%) patients at 1 year. Three hundred patients (67%) have received glucocorticoids, 78.8% at least one DMARD and only 1.1% had received at least one biologic compound. The baseline HAQ-DI was 1.5 (0.0–3.0). Predictors of non-EULAR response at 1 year were: female gender (OR=2.4; CI:1.0–5.6; p=0.039), a higher baseline HAQ-DI (OR=1.7; CI:1.2–2.4; p<0.003) whereas protective factors were higher DAS28-ESR (OR=0.6; CI:0.4–0.7; p<0.001) and having medical coverage (OR=0.5; CI:0.3–0.9; p=0.025).

Conclusions: We have identified baseline predictors of adverse response to treatment in LA patients with early RA. Absence of medical coverage seems to be an additional adverse factor associated with poor results. Other factors such as early response/remission or adherence to treatment should be taken into account.

REFERENCE:

Disclosure of Interest: None declared

AB0298 A LOWER WAIST CIRCUMFERENCE IS ASSOCIATED WITH CLINICAL REMISSION IN PATIENTS WITH ESTABLISHED RHEUMATOID ARTHRITIS

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Background: Abdominal Obesity is highly prevalent in patients with RA and this condition is associated with adverse metabolic outcomes, but information about the impact of this condition in clinical activity disease is scarce, specially in our region

Objectives: To assess the association between central obesity with baseline clinical activity in a cohort of patients with established rheumatoid arthritis (RA).

Methods: Cross-sectional baseline analysis of a single centre RA cohort. This cohort began in 2011 and includes patients with a diagnosis of RA ACR EULAR 2010 criteria), followed by semiannual visits. In this analysis, clinical disease activity was measured by SDAI, clinical remission and low disease activity (LDA) was defined according SDAI categories (a value <3.3, and ≤1, respectively), also definition of remission by the ACR-EULAR 2011 was applied (tender and swollen joint counts<3, CRP <1 mg/dL, and PGA<1 with patient-reported outcomes on a scale of 0–10, or SDAI<3.3). Patients with chronic pain disease (fibromyalgia, neuropathic pain and neurologic disorders such as neuropathies) and diagnosis of depression were excluded. Waist circumference (WC) was measured as a continuous variable (cm). Potential basal confounders associated with activity disease were analysed: socio demographics variables (age at diagnosis, gender, disease duration, delay of DMARDs treatment, education), anticitrullinated antibody peptide (anti-CCP) and cytokines disease activity (CRP, ESR, and SAA).

Results: Four hundred and twenty-five from 596 subjects of the cohort were included. The mean (SD) age was 58.5 (11.8) years. Disease duration was 15.2 (14.0) years; 90.4% were women and 75.8% were anti CCP positive. Two hundred and eighty-five (59.1%) have received glucocorticoids, 50.1% at least one DMARD and only 1.1% had received at least one biologic compound. The mean WC was 98.2 (11.3) cm and central obesity prevalence was 87.8% in men and 96.7% in woman. The baseline SDAI was 29.9 (24.1). Remission was met by 174 patients (42.7%) and 96.7% in women and 75.8% were anti CCP positive. Two hundred and fifty-one patients (59.1%) have received high disease activity based on the ESR score compared with higher levels of MMP-3, SAA, and CRP. MMP-3 is associated with joint destruction through degradation of the components of extracellular matrix in the synovial joint. SAA and CRP are acute phase reactants but SAA has been linked with increased cardiovascular and renal disease in RA patients. 14–3n positive patients should be treated aggressively to decrease disease activity and limit extra-articular manifestations.

Disclosure of Interest: None declared

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