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AB0350 TEMPORO-MANDIBULAR JOINT INVOLVEMENT IN RHEUMATOID ARTHRITIS

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Background: Temporomandibular joint (TMJ) disorder in rheumatoid arthritis (RA) may be associated with significant osteoarticular destruction and may be responsible of significant functional impairment.

Objectives: We aimed in this study to determine the prevalence of TMJ involvement and its correlations with RA parameters.

Methods: We report a descriptive monocentric cross-sectional study of 90 consecutive RA, followed at the Rheumatology department of Monastir Teaching Hospital in Tunisia, during 06 months (November 2016 to April 2017) and 46 matched volunteers. Clinical assessment and stomatological examination were performed in all cases.

Results: Sixty-three RA patients out of 90 (70%) had TMJ involvement. TMJ painful mobilisation, mastication difficulties, swollen TMJ, dental malocclusion and limitation of mouth opening were noted in 55 (81%), 49 (74%), 20 (30.3%), 19 (29%) and 8 (12%) of cases, respectively. Compared with the control group, painful palpation of TMJ ($p<0.000$) was significantly associated with RA.

In RA, TMJ disorder is more common in adults between 40 and 60 years of age, patients with HAQ>0.5 and a high total Vander Heijde Sharp radiographic score (SS). TMJ painful mobilisation is significantly associated with increased body mass index (BMI). Swollen TMJ is significantly associated with age (more frequent in elderly subjects), increased BMI, high RA disease activity (high DAS 28 ESR and/or DAS 28 CRP) and HAQ>0.5. Limitation of mouth opening is significantly associated with age (more common in elderly subjects), overweight, high methotrexate dose (20 mg/day), leflunomide and biotherapy use. Dental malocclusion was significantly associated with high doses corticosteroids (more than 5 mg/day). Mastication difficulties are significantly associated with more than 10 year RA duration, HAQ>0.5 and radiological impairment.

Conclusions: Temporomandibular disorder is frequent in RA (70%). TMJ disorder is observed especially in active (high DAS 28), serious (radiological impairment, HAQ>0.5) and advanced (more than 10 year duration) RA. Physicians must be careful to assess systematically TMJ in RA patients.

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AB0351 DIFFERENTIAL PERCEPTION ABOUT THE CSDMARDS ON DRUG-INDUCED INTERSTITIAL LUNG DISEASE BETWEEN RHEUMATOLOGISTS AND NON-RHEUMATOLOGISTS

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Background: As disease modified anti-rheumatic-drugs (DMARDs) were the mainstay in the treatment of rheumatoid arthritis (RA), the opportunity for general physicians to also prescribe DMARDs has recently increased in Japan. After DMARDs were initiated by specialists, subsequent drug prescription by general physicians during remission should be expected¹. However, general physicians

are more likely than rheumatologists to feel it difficult to accept patients taking even conventional synthetics (cs) DMARDs but not biologics and such discomforts may be potential barriers to cooperative management between specialists and general physicians². One of the reasons is because some csDMARDs such as methotrexate and leflunomide may induce pneumonitis or worsen RA-related pre-existing interstitial lung disease (ILD) as a rare but severe adverse event³. To minimise the risk, rheumatologists may choose low-risk csDMARDs smartly when the patients are concomitant with risk factors on ILD.

Objectives: To measure the physicians' perspective toward the risk of each csDMARDs on drug-induced ILD and their attitude in prescribing the csDMARDs to a pre-existing ILD case.

Methods: A questionnaire was given in an internet survey to registered physicians who take care of more than ten patients with RA in Japan. Topics covered were i) how is the risk of each csDMARD for drug-induced lung injury compared to methotrexate, ii) which csDMARDs should be applied to a case with mild pneumonitis on the chest CT. Cross tabulation analysis and χ^2 test as a statistical analysis was performed.

Results: A total 184 physicians consisting of 66 rheumatologists (36%) and 118 non-rheumatologists (64%) responded. The physicians' mean age was 45 years old. The rheumatologists tended to belong to rheumatology and take care of more than 200 RA patients per month in university hospitals. On the other hand, the non-rheumatologists tended to belong to general medicine and manage less than 50 patients per month in their clinics. The csDMARDs except for methotrexate were more significantly prescribed by the rheumatologists. All rheumatologists but 24% of non-rheumatologists had managed RA patients with exacerbated ILD. On physicians' perspective toward the risk of each csDMARD, the rheumatologists considered that LEF was equal to or higher than MTX and that cyclosporine A (CyA), tacrolimus (TAC), salazosulfapyridine (SASP) was relatively safer (Figure A.). In cases with pre-existing ILD, more rheumatologists agreed to use the csDMARDs except for methotrexate and leflunomide. (Figure B.)

Abstract AB0351 – Figure 1. A) Physician's opinion about how is the risk of the following csDMARDs for drug-induced ILD compared to methotrexate. B) Physician's opinion about if the following csDMARDs should be applied to a case with mild ILD on the chest CT.

R: rheumatologists, non-R: non-rheumatologists, MTX: methotrexate, LEF: leflunomide, CyA: cyclosporine A, TAC: tacrolimus, SASP: salazosulfapyridine, BUC: bucillamine, IGU: iguratimod

Conclusions: We can find the gap of risk perception about each csDMARDs between rheumatologists and non-rheumatologist and the difference of attitude in prescribing to patients concomitant with risk factors. Considerable consensus and additional enlightenment to general physicians should be necessary.

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