AB0873

US RHEUMATOLOGISTS HAVE MIXED PERCEPTIONS ABOUT MANAGING PATIENTS WITH NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS AND ANKYLOSING SPONDYLITIS

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Background: Non-radiographic axial spondyloarthritis (nrAxSpA) is a relatively new term used to describe patients who clinically appear to have ankylosing spondylitis (AS) but do not exhibit radiographic sacroiliitis. Though several biologics are currently FDA approved for the treatment of AS, there are no agents approved for patients in which there is not radiographic evidence of sacroiliitis. With several agents under investigation with the hopes of gaining a line-extension label for nr-axSpA, it is important to understand how the current treating rheumatologists view these two diseases and their current and future plans for spondyloarthritis management.

Objectives: The study sought to (a) evaluate the differences between AS and nr-axSpA diagnosis and treatment patterns (b) highlight the challenges clinicians face in managing patients with nr-AxSpa and (c) understand rheumatologists' willingness to use biologic agents to treat nr-AxSpa.

Methods: An independent market analytics firm collaborated with US rheumatologists (n=98) to learn about current and anticipated changes to the management of Ankylosing Spondylitis and Non-radiographic Axial Spondylitis. Participants were administered an online survey, lasting approximately 30 min in length and respondents were compensated for their professional time. Following the fieldwork, data were analysed in SPSS, a statistical software, to determine significant differences.

Results: 87% of the surveyed rheumatologists agree that AS and nr-AxSpA are part of a spectrum, and 37% report that they often find it challenging to differentiate between the two conditions. The majority of the respondents report that they treat these conditions in a very similar manner. In fact, 40% agree that distinguishing between the two has no relevance to their treatment decisions. Use of biologics is significantly more pronounced in AS (56% vs. 39%, respectively), largely because there is currently no FDA indicated biologic for nr-AxSpA and because many rheumatologists view nr-AxSpA simply as a less severe precursor to AS, where aggressive treatment with a biologic is not warranted. In order to gain reimbursement for a biologic in patients with nr-AxSpA, rheumatologists frequently classify patients as having AS (as opposed to nr-AxSpA). Although adalimumab is the most frequently prescribed biologic in both conditions, rapid adoption of an IL-17 inhibitor (secukinumab) is occurring in the US market.

Conclusions: There is a need to educate both primary care physicians and rheumatologists about the differences between AS and nr-AxSpA. The official FDA approval of biologic agents in nr-AxSpA is anticipated to lead to more aggressive treatment of these patients earlier in the spectrum.

REFERENCE:

- [1] RealTime Dynamix™. Ankylosing Spondylitis and Non-radiographic Axial Spondylitis

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MENTAL HEALTH DISORDERS IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS: INCREASING OUR UNDERSTANDING OF THE DISEASE. RESULTS FROM THE ATLAS-2017

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Background: Depression and other mental disorders are among the most prevalent comorbidities in patients with axial spondyloarthritis (axSpA).

Objectives: To assess the association between sociodemographic characteristics, disease progression, and mental health comorbidity with risk of mental disorders (RMD).

Methods: In 2016 a sample of 680 axSpA patients was interviewed as part of the Spanish Atlas. To quantify the RMD, GHQ-12 scale was employed. Possible RMD predictors taken into account in the analysis were: sociodemographic characteristics (age, gender, being part of a couple, patient association membership, job status); disease characteristics (BASDAI, spinal stiffness, functional limitation in 18 daily activities; and mental health comorbidities. All clinical variables showed a Cronbach's alpha coefficient guaranteeing the reliability of the scales used. First, a descriptive analysis was employed to describe the sample and study

variables. Second, univariate correlation and homogeneity analyses between each predictor (independent variable) and RMD (GHQ-12) were performed.

Results: All variables except educational level and thoracic stiffness showed significant univariate correlation with RMD. BASDAI, functional limitation and age showed higher coefficient ($r=0.543$, $p<0.001$; $r=0.378$, $p<0.001$; $r=-0.174$, $p<0.001$, respectively).

Multiple hierarchical regression analysis showed as sociodemographic variables explained in great detail the RMD ($R^2=83.2\%$). By contrast, having established sociodemographic as a control variable, the inclusion of depression and anxiety to the model increased the R^2 value to just 0.6% ($p<0.001$), while the inclusion of variables related to the disease characteristics add 5.5% ($p<0.001$) to the GHQ-12 punctuation variability. The only variables presenting a significant coefficient different from 0 were BASDAI (0.52, $p<0.001$) and functional limitation (0.14, $p<0.01$). This suggests that once the sociodemographic and mental comorbidity variables are established, a change in BASDAI levels or functional limitation impacts the GHQ-12 score.

In the stepwise regression analysis, four variables (BASDAI, functional limitation, association membership, cervical stiffness) showed a significant relation to GHQ-12 and explained the majority of RMD variability. BASDAI displayed the highest explanatory degree ($R^2=0.875$, $p<0.001$).

Abstract AB0874 – Table 1. Sample characteristics (n=474, unless other specified)

Variables	Values (means $\pm$ SD or percentage)
Age, mean $\pm$ SD	45.43 $\pm$ 10.78
Sex, No. of men	233 (49.2%)
Having a couple, No. of participants (N=444)	386 (86.9%)
Education level, No. of university studies	185 (39.3%)
Job status, No. of unemployed	68 (14.4%)
Association Membership	227 (47.9%)
BASDAI, (0-10) mean $\pm$ SD (N=442)	5.49 $\pm$ 2.17
Cervical stiffness, No. (N=447)	201 (45.0%)
Thoracic stiffness No. (N=435)	186 (42.8%)
Lumbar stiffness No. (N=458)	288 (62.9%)
Functional Limitation, (0-54) mean $\pm$ SD (N=473)	27.54 $\pm$ 12.78
Depression, No. (%) (N=474)	99 (20.9)
Anxiety, No. (%) (N=474)	134 (28.3)
GHQ-12, (0-36) mean $\pm$ SD	18.30 $\pm$ 8.01

Conclusions: In axSpA, patients at certain sociodemographic levels are more prone to present a higher BASDAI. Taking these conditions for granted, the degree of disease progression measured by BASDAI is a good indicator of RMD. Therefore, in those patients with higher disease activity, psychiatric evaluation and intervention should be considered within the medical treatment.

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AB0875

QUALITY OF LIFE IMPROVEMENT IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS TREATED WITH NSAIDS AND BIOLOGICAL THERAPY FROM THE PATIENT'S PERSPECTIVE: RESULTS FROM THE ATLAS-2017

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Background: In patients with axial spondyloarthritis (axSpA), the main long-term outcome is quality of life. Clinical trials and observational studies have shown the efficacy of biological therapy (BT) on improving the signs and symptoms of the disease. However, data assessing the impact of BT on quality of life is scarce and mainly comes from clinical trials.