Results: Comparison of least squares mean difference in clinical scores showed more consistent improvement in pts treated with BARI combo vs MTX irrespective of baseline autoantibody subclass and titre. In general, pts with low-titre anti-CarbV, AcctV and MCV subclass antibodies showed numerically less improvement in most of the analyses under BARI mono vs MTX compared to BARI combo vs MTX although for anti-CarbV subclass seronegative pts, no significant differences were found in the clinical response between BARI mono vs MTX. Furthermore, anti-MCV IgA and IgM as well as anti-CarbV IgA negative status was also associated with significant reduction of radiographic progression in pts treated with BARI combo vs MTX. For seropositive pts, response to treatment with BARI mono or combination therapy was higher in pts with highest titres of anti-MCV and anti-CarbV. However, a significant difference with respect to radiographic progression was detectable only for BARI combo vs MTX. By stratifying pts according to their antibody profile, these observed radiographic differences were achieved in the anti-MCV and anti-CarbV IgG high-positive as well as anti-CarbV IgM low-positive pts.

Conclusions: In these exploratory analyses, seropositive pts with high titres of anti-MCV and anti-CarbV at baseline showed better responses to BARI mono or combo vs MTX for composite scores, and to BARI combo in structural progression outcomes.

REFERENCE:

[1] Fleischmann R, et al. *Arthritis Rheumatol* 2017;69(3):506–517.

Disclosure of Interest: L. Martinez Gamboa Grant/research support from: Eli Lilly and Company, H. Bang: None declared, M. Issa Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, S. Zuckerman Employee of: Former employee of Eli Lilly and Company, A. Cardoso Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, T. Holzkaemper Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, F. De Leonardis Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, I. de la Torre Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, Y. Tanaka Grant/research support from: Mitsubishi-Tanabe, Takeda, Bristol-Myers, Chugai, Astellas, Abbvie, MSD, Daiichi-Sankyo, Pfizer, Kyowa- Kirin, Eisai, Ono, Speakers bureau: Daiichi-Sankyo, Astellas, Pfizer, Mitsubishi-Tanabe, Bristol-Myers, Chugai, YL Biologics, Eli Lilly and Company, Sanofi, Janssen, UCB, E. Feist Grant/research support from: Eli Lilly and Company, Novartis, Roche, BMS, Consultant for: Eli Lilly and Company, Novartis, Roche, Pfizer, Abbvie, BMS, MSD, Sanofi, Speakers bureau: Eli Lilly and Company, Novartis, Roche, Pfizer, Abbvie, BMS, MSD, Sanofi

DOI: 10.1136/annrheumdis-2018-eular.1927

THU0110

EARLY TREATMENT AND LOW DOSE CORTICOSTEROIDS MIGHT DECREASE MORTALITY IN EARLY ARTHRITIS: RESULTS FROM THE RECORD LINKAGE OF CLINICAL AND ADMINISTRATIVE DATABASES

G. Sakellariou¹, C.A. Scirè^{2,3}, F. Rumi³, G. Carrara³, C. Cerra⁴, S. Migliazza⁴, R. Caporali¹, C. Montecucco¹. ¹Chair And Division Of Rheumatology, IRCCS Policlinico San Matteo Foundation, Pavia; ²Rheumatology Unit, Department of Medical Sciences, University of Ferrara, Ferrara; ³Epidemiology Unit, Italian Society of Rheumatology, Milano; ⁴Department of information and control management, ATS Pavia, Pavia, Italy

Background: In patients with rheumatoid arthritis (RA) increased mortality, especially for cardiovascular (CV) events, is still described, despite the advances in RA management.

Objectives: To evaluate the impact of early diagnosis and treatment with disease modifying anti-rheumatic drugs (DMARDs) on mortality in patients with early RA and undifferentiated arthritis (UA) through record linkage between clinical and administrative databases.

Methods: Consecutive patients with RA or UA from an early arthritis clinic (2005–2016), treated with tight control to achieve DAS28 <3.2, were included. Health assessment Questionnaire (HAQ) and date of symptom onset were recorded at baseline. Data on mortality, cause of death and drug prescription derived from administrative healthcare databases, linked to the clinical database. Cox regression models were used to evaluate the impact of the interval from symptom onset to diagnosis (categorised <3 months, 3–6 months, >6 months), from diagnosis to treatment (<3 months, >3 months, never) and from onset to treatment (<3 months, 3–6 months, >6 months, never) on overall mortality. Analyses were adjusted for age, gender, ACPA positivity, Charlson comorbidity index, HAQ and median daily prednisone dose. Results were presented as hazard ratios (HR) with 95% CI. Secondary analyses categorising prednisone in low dose (≤5 mg/day) or medium-high dose (>5 mg/day) were performed, as well as analyses evaluating CV mortality as outcome. Moreover, analyses excluding patients not receiving DMARDs and patients dying in the first year of observation were conducted.

Results: A total of 857 patients (62% RA, 73% female, median (IQR) age 59, ^{47–71} mean (sd) baseline DAS28 3.08 (0.97)) were included. After a median (IQR) follow-up of 80^{51–109} months, 77 patients died (2 in the first year); of the 41 patients with known cause of death, 9 were for CV causes. An interval >3 months between diagnosis and introduction of DMARDs or never introducing DMARDs related to higher mortality (table 1). The mean daily prednisone dose was not a significant predictor of mortality, while in all secondary analyses patients receiving low-dose prednisone, compared to those never receiving corticosteroids, had a lower mortality (eg. HR (95% CI) 0.45 (0.26,0.78) in the model including time between symptom onset and diagnosis). Patients not starting DMARDs, compared to these starting within 3 months from diagnosis, had a higher CV mortality, while the intervals between onset and diagnosis and onset and treatment were not significant predictors. Analyses limited to patients receiving DMARDs and with the exclusion of patients dying in the first year yielded to similar results.

Conclusions: In patients with early RA and UA treatment delay significantly increases mortality, while low-dose corticosteroids seem to decrease mortality. These results support strategies aiming at early access to treatment and the use of low dose corticosteroids in the initial treatment strategy.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6260

THU0111

FREQUENCY AND PREDICTORS OF SUSTAINED REMISSION IN PATIENTS WITH EARLY RHEUMATOID ARTHRITIS TREATED WITH CONVENTIONAL SYNTHETIC DISEASE MODIFYING DRUGS

G. Zanframundo, S. Bugatti, A. Manzo, F. Benaglio, G. Sakellariou, C. Montecucco, R. Caporali. *Early Arthritis Clinic, Division of Rheumatology, University of Pavia, IRCCS Policlinico San Matteo Foundation, Pavia, Italy*

Background: The management of patients with early rheumatoid arthritis (RA) should be aimed at reaching the target of disease remission as soon as possible. In order to prevent joint damage and disability, and eventually allow treatment withdrawal, the state of disease remission should be also maintained. Whilst point remission is frequently achieved in early RA, the sustainability of remission in clinical practice remains poorly investigated.

Objectives: To investigate the prevalence and predictors of sustained remission in patients with early RA treated with conventional synthetic disease anti-rheumatic drugs (csDMARDs).

Methods: We evaluated 533 RA patients from the Pavia early arthritis inception cohort not in remission at baseline with at least 24 months of follow-up. Patients had arthritis of short duration (<12 months of symptoms) and were treatment-naïve at presentation. After diagnosis, patients were initiated a treat-to-target regimen with methotrexate aiming at low disease activity according to the 28-joint disease activity score (DAS28 ≤3.2), and were seen at regular intervals (2 months in the first 6 months, then trimestraly). Point remission was defined as the achievement of DAS28 remission (<2.6) or SDAI (simplified disease activity index) remission (≤3.3) at any time point within the first 12 months. Sustained remission was defined as mean DAS28 <2.6 and mean SDAI ≤3.3 in the 3 visits following first remission. The frequency and predictors of point remission and sustained remission were analysed by Cox and binary regression respectively.

Results: 287/533 (53.9%) patients achieved point DAS28 remission and 234/533 (43.9%) point SDAI remission. Independent predictors of point DAS28 remission were male gender (HR [95% CI] 1.84 [1.36–2.50]), shorter symptoms' duration (HR [95% CI] 0.99 [0.98–0.99]), a lower tender joint count at baseline (HR [95% CI] 0.97 [0.94–0.99]), better functional status (HR [95% CI]