— detect those patients with the highest risk of flare.⁷ US is a valuable part of future decision making in rheumatology.

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SP0117 ULTRASOUND SCANNING OF RA PATIENTS IN REMISSION

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The optimisation of the current therapeutic strategies for RA, with the establishment of early intensive treatment and with the availability of new drugs, has led to a dramatic change in the management of RA, and remission is the target of modern treatment in patients with RA.^{1,2}

Remission is ideally characterised by the absence of clinically detectable disease activity, the absence of radiographic progression and the improvement of physical function.³ However, in clinical practice it is frequently difficult to use a comprehensive definition of this condition and apply objective systems for assessing it. Then, subclinical disease activity may be present, even in patients who are in clinical remission, leading to joint damage progression⁴ and disease flare.⁵

EULAR recommendations for the use of imaging in RA patients include ultrasound (US) as an assessment tool for inflammatory activity and remission, as it is able to detect joint inflammation and predict subsequent joint damage.⁶ Recent studies have shown that US provides diagnostic and prognostic data in terms of risk of flare, disability and damage progression in RA.⁸ Furthermore, in addition to joints, US allows the assessment also of periarticular structures, such as tendons, that have been demonstrated to be the site of inflammatory changes also in patients in clinical remission.⁷

Recently, 427 RA patients in clinical remission have been evaluated in a multicentre study which included the US assessment of wrist and hand tenosynovitis and synovitis by grey scale (GS) and power Doppler (PD).² Results of this study showed a high prevalence of tenosynovitis (52.5%–95% CI 0.48, 0.57 for GS and 22.7%–95% CI 0.19, 0.27 for PD) and synovitis (71.6%–95% CI 0.67, 0.76 for GS and 42%–95% CI 0.37, 0.47 for PD). Among clinical correlates, PD tenosynovitis associated with lower remission duration and morning stiffness while PD synovitis did not. Only PD tenosynovitis showed a significant association with the flare

questionnaire [OR 1.95 (95% CI 1.17, 3.26)]. No cross-sectional associations were found with the HAQ. The presence of radiographic erosions associated with GS and PD synovitis but not with tenosynovitis. This study demonstrated that US-detected tenosynovitis is a frequent finding in RA in clinical remission. Compared with intra-articular synovitis, active tenosynovitis was more associated with RA patients reporting unstable remission. Based on those results, US demonstrated to be a useful imaging modality for assessing tenosynovitis which may help in sub-setting RA patients in clinical remission.²

More recently, a multicentre longitudinal study in 361 consecutive patients with RA in clinical remission demonstrated that the conjunct presence of PD positive tenosynovitis and synovitis predicts flare in patients with RA in clinical remission.⁷ US scanning of RA patients in remission has a crucial role in order to demonstrate active joint and tendon inflammation that are able to predict flare.

During this practical skills session at EULAR Congress 2018 the role of US in detecting subclinical inflammation at joint and tendon level will be discussed and practical demonstration on how to scan patients in remission will be performed.

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FRIDAY, 15 JUNE 2018

WIN and HOT session

SP0118 RECENT ADVANCES IN THE TREATMENT OF RHEUMATOID ARTHRITIS

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Modern management of rheumatoid arthritis (RA) is underpinned by the principle of establishing a clear treatment goal through the efficient strategic use of DMARDs in order to minimise adverse outcomes. With evolving ambitions and new targeted therapies, ongoing advances in the management of RA continue to be made: this HOT session will summarise our progress in the understanding and management across the RA disease continuum; including the state of at risk of RA status to early and later RA disease. In particular, the session will focus on studies that inform on (i) the ability to potentially abrogate progression from autoimmunity to development of RA disease (ii) currently identified strategies that offer the optimal opportunity for remission induction in ERA (iii) ability to drug taper and (iv) use of recently introduced synthetic and biologic targeted therapies. Finally, with co-morbidity outcomes including cardiovascular disease, another key focus in the contemporary management of RA, developments in improving this area of health concern will also be presented.

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