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ILLNESS PERCEPTION AND ITS CORRELATES IN PATIENTS WITH IN ANCA-ASSOCIATED VASCULITIS – PRELIMINARY REPORT

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Background: Illness perception (IP) is one of the most important factors related to health related quality of life, psychological and physical functioning and medical adherence.^{1,2}

Objectives: To explore illness perception and its relationship with chosen clinical, socio-demographic and psychological variables in patients with granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA).

Methods: 38 patients (57.9% women; median age 57 years; range 18–85; median disease duration: 11.5, range: 1–248 months) with GPA (28 patients) and MPA (10 patients). Inpatients recruited in 3 clinical centres were asked to complete Brief Illness Perception Questionnaire (B-IPQ),³ Hospital Anxiety and Depression Scale-Modified (HADS-M) and Multidimensional Fatigue Inventory-20 (MFI-20). Socio-demographic variables included age, sex, education and marital status. Medical files were reviewed to gather data on disease duration and its activity (assessed using Birmingham Vasculitis Activity Score version 3, BVASv3). $p \leq 0.05$ was considered significant.

Results: 63% of patients had active disease as defined by BVASv3. Median total score of B-IPQ was 48.5 points (range 24–64). There were no significant differences in illness perception (B-IPQ total score) between groups according to sex, education and marital status. No significant relationships between IP and age, disease duration and its activity were noted. Significant positive correlations were observed between B-IPQ total score and MFI-20 total score, general, physical and mental fatigue as well as depression, anxiety and irritability (table 1).

Abstract THU0437 – Table 1. Correlation coefficients between studied variables and B-IPQ results.

Variable	Spearman's r correlations
Age	0.06
Disease duration	-0.02
BVASv3	0.00
MFI-20 total	0.48*
General fatigue	0.48*
Physical fatigue	0.38*
Reduced activity	0.26
Reduced motivation	0.25
Mental fatigue	0.34*
Depression	0.54*
Anxiety	0.53*
Irritability	0.35*

* statistically significant $p \leq 0.05$

Conclusions: In the studied group illness perception was not related to clinical and socio-demographic factors. More negative illness perception was related to higher levels of fatigue, depression, anxiety and irritability. The results suggest that psychotherapeutic interventions seem vital for improving illness perception in this population.

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COMPARATIVE STUDY OF INFlixIMAB VERSUS ADALIMUMAB IN REFRACTORY UVEITIS ASSOCIATED TO CYSTOID MACULAR OEDEMA DUE TO BEHÇET'S DISEASE. MULTICENTER STUDY OF 40 CASES

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Objectives: To compare the efficacy of infliximab (IFX) versus adalimumab (ADA) as first biologic drug in refractory uveitis with cystoid macular oedema (CME) associated to BD.

Methods: Multicenter study of 40 patients with BD-associated uveitis with CME refractory or intolerant to standard treatment (corticosteroids and at least one conventional immunosuppressive agent). CME was considered if macular thickness was greater than 300 μ m. Comparative outcome measures were macular thickness, improvement of visual acuity (VA), activity of anterior chamber inflammation and vitritis. Results were expressed as mean $\pm$ SD for variables with a normal distribution, or as median [25th–75th interquartile range- IQR] when not normally distributed. The comparison of continuous variables among time-periods was performed with the Wilcoxon signed rank test.

Results: We selected patients with CME from a cohort of 177 patients with refractory BD-related uveitis (n=40). IFX was used in 15 cases and ADA in 25. No significant differences at baseline were observed between IFX vs ADA groups in sex (χ^2 8/7 vs 13/12, $p=0.93$), mean age (38 ± 9 vs 41 ± 10 years, $p=0.53$), HLA-B51 + (10 vs 19, $p=0.87$), uveitis pattern (panuveitis 67% vs 80%, posterior uveitis 33% vs 20%, $p=0.34$), previous conventional treatment (intravenous pulses of methylprednisolone 60% vs 52%, $p=0.62$, oral corticosteroids 93% vs 72%, $p=0.1$, methotrexate 53% vs 52%, $p=0.93$, cyclosporin A 73% vs 88%, $p=0.23$, azathioprine 53% vs 56%, $p=0.86$, other drugs 47% vs 68%, $p=0.18$), and combined treatment (67% vs 64%, $p=0.86$). After 1 year of therapy, ocular remission was achieved in 60% of cases with IFX and in 76% of cases with ADA ($p=0.28$). Regarding CME, 65% of patients with IFX reached a macular thickness <250 μ m vs 87% of patients with ADA, with no statistically significant differences ($p=0.07$). Evolution of ocular parameters is shown in the table 1. Only 2 adverse effects were observed, both in ADA group (local rash and bacteremia).

TABLE. Rapid and maintained improvement following the onset of anti-TNF agents. Data are expressed as mean $\pm$ SD or median [IQR].

	IFX	ADA	P
Basal			
VA	0.32 $\pm$ 0.24	0.40 $\pm$ 0.20	0.27
Anterior chamber cells	1 [0-1]	2 [1-3]	0.17
Vitritis	1 [0-2]	3 [0-3]	0.06
OCT	484.28 $\pm$ 130.87	461.52 $\pm$ 129.50	0.93
1 week			
VA	0.37 $\pm$ 0.23	0.43 $\pm$ 0.24	0.99
Anterior chamber cells	1 [0-1]	2 [0.5-2]	0.29
Vitritis	1 [0-2]	2 [1-3]	0.71
OCT	455.30 $\pm$ 121.39	470.77 $\pm$ 125.77	0.89
2 weeks			
VA	0.45 $\pm$ 0.25	0.48 $\pm$ 0.23	0.82
Anterior chamber cells	1 [0-1]	1 [0-2]	0.35
Vitritis	1 [0-1]	1 [0.5-2]	0.58
OCT	430.50 $\pm$ 115.76	420.02 $\pm$ 99.15	0.43
1 month			
VA	0.53 $\pm$ 0.28	0.51 $\pm$ 0.24	0.37
Anterior chamber cells	0 [0-0]	0.5 [0-1]	<0.05
Vitritis	0 [0-0]	1 [0.25-1.5]	0.70
OCT	365.30 $\pm$ 117.99	384.02 $\pm$ 95.57	0.11
3 months			
VA	0.62 $\pm$ 0.39	0.57 $\pm$ 0.29	0.55
Anterior chamber cells	0 [0-0]	0 [0-1]	1.00
Vitritis	0 [0-0]	0.25 [0-1]	<0.05
OCT	339.22 $\pm$ 118.89	319.87 $\pm$ 90.56	<0.05
6 months			
VA	0.59 $\pm$ 0.39	0.60 $\pm$ 0.29	0.08
Anterior chamber cells	0 [0-0]	0 [0-0]	1.00
Vitritis	0 [0-0]	0 [0-1]	1.00
OCT	284.50 $\pm$ 102.30	276.25 $\pm$ 97.31	<0.05
1 year			
VA	0.58 $\pm$ 0.39	0.73 $\pm$ 0.28	0.12
Anterior chamber cells	0 [0-0]	0 [0-0]	1.00
Vitritis	0 [0-0]	0 [0-0]	1.00
OCT	292.73 $\pm$ 94.40	246.20 $\pm$ 60.64	<0.05

Abbreviations: ADA, adalimumab; IFX, infliximab; OCT, optical coherence tomography; VA, visual acuity.

Conclusions: IFX and ADA show a similar efficacy in the treatment of CME in BD-related refractory uveitis.