Abstract THU0688 – Figure 1 Hazard. Ratios for Incidence of T2D in Pts With RA on Different DMARDs.

(HR > 1 favours abatacept, HR < 1 favours other therapies)

Conclusions: Pts with RA treated with abatacept had greater risk factors for T2D at baseline. However, the adjusted risk of new-onset T2D was lower among abatacept pts versus other bDMARDs.

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- [2] Ozen G, et al. *Ann Rheum Dis* 2017;76:848–54.

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THU0689

VARIABILITY OF PAIN LEVELS IS EXPLAINED BY SELF-REPORTED DISEASE ACTIVITY IN RHEUMATOID ARTHRITIS AND AXIAL SPONDYLOARTHRITIS: A 3-MONTHS PROSPECTIVE STUDY OF 165 PATIENTS

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Background: Pain is a central characteristic of rheumatoid arthritis (RA) and axial spondyloarthritis (axSpA), but it is multifactorial. Some patients describe high fluctuation of pain intensity, but fluctuation of pain and its association with disease activity has been little investigated.

Objectives: To compare the variability of pain and of self-reported disease activity in patients with RA or axSpA through repeated assessments, and to describe clinical characteristics of patients with high variability of pain.

Methods: Data were extracted from a prospective cohort study (ActConnect) including patients with clinician-confirmed RA or axSpA owning a smartphone.¹ Baseline characteristics were collected. Over 3 months, weekly self-assessments of pain and patient global assessment of disease activity on 0–10 points numerical rating scales (NRS) were obtained. For each patient, the mean of the inter-assessment differences of NRS (average of absolute change – AAC) of pain and disease activity were calculated. RA and AxSpA patients were compared by t-test. High variability was defined as the upper tercile of AAC. Pearson's correlation was used to evaluate the correlation between variability of pain and of self-reported disease activity. Univariate and multivariate logistic regression compared patients with high vs low variability of pain, without imputation of missing data, on R, including weekly self-reported flare over follow-up.

Results: Eighty-six patients with RA and 79 with axSpA were included, mean age was respectively 48.7 (SD 12.7) and 41.7 (SD 10.2) years, mean disease duration was 8 (SD 8.8 and 8.6 respectively) years, 81% and 44% respectively were female. Mean DAS28 and BASDAI were respectively 2.27 (SD 1.18) and 3.21 (SD 2.06) at baseline; 44% and 62% respectively of patients were receiving a biologic.

Mean levels of pain and patient global assessment of disease activity were non-significantly higher in AxSpA than RA patients (table 1) and variability of pain and disease activity were also higher in AxSpA (table 1). Correlation between AAC of pain and activity was 72% in RA, and 84% in AxSpA. In multivariate analyses, self-reported flares were the only determinant of pain AAC (Odds ratio 2.25 [1.27–4.38] p=0.01 and 3.26 [1.67–6.35] p<0.001 respectively for RA and axSpA).

Abstract THU0689 – Table 1

	RA	AxSpA	p value
Baseline pain	2.90 (SD 2.36)	3.40 (SD 2.30)	0.16
AAC of pain	1.02 (SD 0.74)	1.20 (SD 0.70)	0.10
Baseline PGA of disease activity	3.09 (SD 2.27)	3.73 (SD 2.48)	0.08
AAC of PGA of disease activity	0.98 (SD 0.67)	1.22 (SD 0.70)	0.02

Conclusions: In this population of overall well-controlled patients, close repeated assessments of pain showed relatively low fluctuations of pain in RA and axSpA (around 1 point on a 0–10 scale). Patients with axSpA reported slightly more pain, self-reported disease activity and fluctuations of these outcomes, than patients with RA. Fluctuations in pain were highly correlated to fluctuations in patient global assessment of disease activity, indicating significant overall between these 2 patient-reported outcomes. Self-reported flares were the main element explaining fluctuations in pain, confirming the validity of self-reported flares.

REFERENCE:

- [1] Jacquemin C, Molto A, Servy H, et al. Flares assessed weekly in patients with rheumatoid arthritis or axial spondyloarthritis and relationship with physical activity measured using a connected activity tracker: A 3-month study. *RMD Open* 2017;3:1–8.

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THU0690

RETROSPECTIVE ANALYSIS OF TEMPORAL ARTERY BIOPSY AND ITS IMPACT IN THE MANAGEMENT OF GIANT CELL ARTERITIS

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Background: Prevalence of Giant cell arteritis (GCA) as per primary care data is 17/10000 for patients >55 years of age¹. British society of rheumatology (BSR) guidelines recommend that suspected cases of GCA should be started on treatment with high dose corticosteroids immediately and then referred for temporal artery biopsy². Temporal artery biopsy has diagnostic yield around 13%³. We have done a retrospective analysis of patients who had temporal artery biopsy in order to assess the compliance with BSR guidelines and assess the diagnostic yield.

Objectives: To assess the yield of temporal artery biopsy and its impact in the management of Giant cell arteritis

Methods: The medical records of patients who had temporal artery biopsy from September 2015 to August 2017 were retrospectively reviewed. We documented demographics, management pre and post biopsy, and timeframes between referral, treatment and biopsy. Data was searched through the clinic letters, referral letters and pathology results.

Results: Total number of patients identified was 45. Among them 23 (51%) patients had typical clinical features of GCA and 21 (49%) had atypical features as per the referral letter. Age distribution found was as following: 50 years and below-3; 51 to 60 years- 7; 61 to 70 years- 15; 71 to 80 years-12; 81 to 90 years- 7 and above 90 years-1. Timeframe between biopsy referral and biopsy was as following: within 1 week-27; between 1–2 weeks- 10; between 2–3 weeks- 6 and more than 3 weeks –1. Ophthalmologists performed biopsy for 37 patient and vascular surgeons for 8 patients. Referral was made by primary care for 7 patients, acute medicine for 12 patients, neurology for 3 patients and by rheumatologist for 23 patients. Treatment was initiated in 37 (82%) patients prior to biopsy. Biopsy was positive in 11 (25%) patients, negative in 30 (66%) patients and 4 (8%) showed healed inflammatory changes (HIC). Age distribution of biopsy positive patients was as following - age 61 to 70 years - 4; age 71 to 80 years - 4; age 81 to 90 years - 3. Out of the 11 biopsy positive patients 7 were started on treatment prior to the biopsy and remaining 4 were initiated on treatment after the results. The distribution of duration of treatment before biopsy was as following - within 1 week - 2; between 1 to 2 weeks - 3; between 2 to 3 weeks - 2.

Conclusions: - Majority of the patients (80%) had temporal artery biopsy done within 2 weeks of referral

- Diagnostic yield of temporal artery biopsy was found nearly twice the existing data