PATIENT-ACCEPTABLE SYMPTOM STATUS IN RHEUMATOID ARTHRITIS: WEALTH AND AGE MATTER BEYOND DISEASE ACTIVITY AND IMPACT. AN ANALYSIS OF 548 PATIENTS

Cátia Duarte1, Eduardo Santos1, Tore K. Kvien2, Maarten de Wit3, Maxime Dougados4, Laure Gossec4, P. José António, Da Silva1, RAID Study Group, Centro Hospitalar Universitário de Coimbra, Rheumatology, Coimbra, Portugal, 2Diakonhjemmet Hospital, Rheumatology, Oslo, Norway; 3Amsterdam University, Amsterdam, Netherlands; 4Hôpital Cochin, Paris, France; 5Sorbonne Université, Hôpital Pitié-Salpêtrière, Paris, France

Background: Patient Acceptable Symptom State (PASS) represents the maximum level of symptom intensity that patients consider acceptable. Control of disease activity is associated to attainment of PASS. Recognizing the factors associated with PASS status beyond disease activity, can be helpful in identifying the need for interventions beyond disease-modifying drugs, aimed at improving the satisfaction and well-being of patients with rheumatoid arthritis (RA).

Objectives: To explore the clinical and socio-demographic factors associated with PASS status in RA.

Methods: Data of patients with definite diagnosis of RA from 11 countries (post-hoc analyses of RAID Study4, with additional data from Portugal) were used. PASS was assessed using the anchored method based on patients’ perspective, through the question: “Think about all the ways your RA has affected you during the last week. If you were to remain for the next few months as you were during the last week, would this be a) Acceptable b) Unacceptable”. Variables analysed for differences across PASS status were (a) disease activity based on DAS28-3v-values (joint counts and ESR) categories, (b) impact by the seven patient-reported domains included in the RA Impact of Disease (RAID) score, (c) demographics: age (above or below 50) and gender, and (d) Country gross domestic product (GDP) classified as High GDP (>35.000 USD per capita) and Low GDP. Differences between patients in PASS or not were assessed through t-test for independent samples or Chi-square test, as adequate. Variables with p<0.05, gender and GDP category were included in multivariate logistic regression (Forward Conditional) analysis. A subgroup analysis was performed for patients in DAS28-ESR remission.

Results: In all, 548 patients (80.5% female, mean (SD) age 55.8 (12.8) years, mean (SD) disease duration 13.6 (10.6) years, mean (SD) DAS28-3v 3.6 (1.5), 44.2% in LDA or remission) from 11 European countries (5 (n=230) with high GDP and 6 (n=318) with low-GDP) were analysed. The majority of patients (65.7%) considered themselves to be in PASS; among them 40% were in remission and 16.7% in LDA. In multivariate analyses, factors associated to being in PASS were lower disease activity (OR 1.28; [1.13-1.45]), older age (OR 1.67; [1.04-2.67]), lower pain (OR 1.45; [1.27-1.64]) and better emotional well-being (OR 1.28; [1.08-1.52]), but not GDP country category. When analysing PASS for patients in DAS28 remission independent predictors were lower pain (OR 2.5; [1.79-3.45]), older age (OR 3.30 [1.03-10.82]) and living in a low GDP category country (OR: 5.0; [1.35-20.0]).

Conclusion: PASS in RA is associated with lower inflammation, less symptoms and higher age, as expected. However, when analysing patients in DAS28 remission, thus taking inflammation as a predictor, we found older age and living in a country with lower GDP were drivers of being in PASS. Thus, beyond disease activity and patient-reported impact, this observation underlines the potential effect of economical/cultural and personal aspects upon PASS, especially in the context of remission, suggesting the need for a holistic and personalized approach in the management of patients with RA.

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Acknowledgement: Carmona L, Dijkmans BA, Engbrecht M, Gogus F, Heiberg T, Cerinic MM, Otsa K, Sokka T, Balanescu A

Disclosure of Interests: Cátia Duarte: None declared, Eduardo Santos: None declared, Tore K. Kvien Grant/research support from: AbbVie, BMS, MSD, Pfizer, Roche and UCB., Consultant for: AbbVie, Biogen, BMS, Boehringer Ingelheim, Celgene, Celltrion, Eli Lilly, Hospira, Merck-Serono, MSD, Novartis, Oktal, Orion Pharma, Pfizer, Roche, Sandoz, Sanofi, Mylan and UCB, Speakers bureau: AbbVie, Biogen, BMS, Boehringer Ingelheim, Celgene, Celltrion, Eli Lilly, Hospira, Merck-Serono, MSD, Novartis, Oktal, Orion Pharma, Pfizer, Roche, Sandoz, Sanofi, UCB.

SHOULD PATIENTS WITH RHEUMATOID ARTHRITIS (RA) ASKS FOR A BETTER DEAL THAN MERELY AN ACCEPTABLE SYMPTOM STATE? AN ANALYSIS OF 1931 RA PATIENTS

Cátia Duarte1, José Antonio P. Da Silva1, Eduardo Santos1, Eirik Kristianslund2, Maarten de Wit3, Maxime Dougados4, Laure Gossec4, Turid Helberg5, RAID Study Group NOR-DMARD, 1Centro Hospitalar Universitário de Coimbra, Rheumatology, Coimbra, Portugal; 2Diakonhjemmet Hospital, Rheumatology, Oslo, Norway; 3Amsterdam University, Amsterdam, Netherlands; 4Hôpital Cochin, Rheumatology, Paris, France; 5Sorbonne Université, Paris, France; 2Oslo University Hospital, Oslo, Norway

Background: Patients satisfaction with their symptoms state may be considered an acceptable outcome in RA. However, many patients who report being in an Acceptable Symptom State (PASS) have still moderate disease activity.1

Objectives: To explore whether it is possible to identify more stringent symptom states in patients’ perspective.

Methods: A cross-sectional analysis of unselected adult patients with the diagnosis of RA from the RA Impact of Disease (RAID) validation study2 (n=570, from 12 European countries), and from the Norwegian DMARD (NOR-DMARD)3 registry (n=1372), was performed. Symptom state was calculated using the anchored method based on the patients’ perspective, taking, as gold standard, the question: “Think about all the ways your rheumatoid arthritis has affected you during the last week. If you were to remain for the next few months as you were during the last week, how would you consider this state?”, with five levels: Very bad/Bad/Acceptable/Good/Very good. Disease activity was assessed based on the DAS28-3v (joint counts and ESR). Impact was evaluated through the seven patient-reported domains included in the RAID score. The threshold levels of DAS28-3v, Individual RAID items and RAID score for Acceptable/Good/Very Good States were calculated using the receiver-operating characteristic (ROC) curve and the optimal cut-off was determined through Youden Index.

Results: Data from 1931 patients [74.5% female, mean (SD) age 54.4 (14.1) years, mean disease duration 13.8 (10.4) years, mean DAS 28-3v-ESR 3.0 (1.4)] were analysed. In all, 14.5% considered themselves as being in a “very good”, 21% as “good” and 33.1% in a “acceptable” status. Disease activity, RAID global score and all individual seven domains of RAID were significantly different between patients across these 3 symptom states (p<0.001). Patients reporting a “Very Good” symptom status had disease activity in the range of remission (mean DAS28-3v-ESR 1.99±0.91), while patients in “acceptable” status were in range of low disease activity (DAS28-3v-ESR 2.98±1.20) and in moderate disease activity in patients with “Bad” (DAS28-3v-ESR: 3.83±1.44) and “Very Bad” status (DAS28-3v-ESR: 4.10±1.59). Remission according the Boolean ACR/EULAR criteria was observed in 70.9% of patients in “Very Good” symptom status (versus 28% in “Good”, 5% in “Acceptable” and inferior to 1% in “Bad” and “Very Bad” symptom status). The cut-off value for “Very Good” status was 0 for most individual RAID items, except for pain and fatigue ≤1 (Figure1).

Conclusion: Being in a “very good” symptom status showed a good correspondence to being in remission and having very low disease impact. This shows promising in identifying a status that patients would actually desire, more than accept for, while corresponding to a level of disease activity consistent with the long-term preservation of structure and function.
The Spectrum of Myositis Antibodies: Clinical Correlation and Prevalence of Anti-DFS70

Objective: To evaluate and compare the rates of remission/LDA by comparing Disease Activity in Psoriatic Arthritis (DAPSA) score with Very Low Disease Activity (VLDA)/Minimal Disease Activity (MDA) criteria in a real-life multicentre cohort of PsA patients.

Methods: We performed a cross-sectional analysis including the first consecutive 500 PsA patients evaluated in 8 Italian rheumatology centres since September 2017. The rates of patients achieving DAPSA remission/LDA and VLDA/MDA was computed for: peripheral arthritis (PsA) should be managed by a treat-to-target approach, but the identification of the best tool for defining the target of remission/low disease activity (LDA) is still controversial.

Background: Myositis can be a clinical feature of several rheumatic diseases. In inflammatory idiopathic myopathies (IM), such as Dermatomyositis (DM), Polymyositis (PM), Antisynthetase syndrome (ASS), muscular dystrophies, Scleroderma, Sjögren syndrome (SS), and various IIM, autoantibodies are characterized by high prevalence of MAA, more frequently PM-Scl100/75, RNP, Ku, Jo-1, Scl-70, centromere II, and topoisomerase III, Th/To, Fibrillarin) were performed using immunoblotting assay. Clinical, serological and instrumental data were recorded.

Results: 15 patients had a diagnosis of DM, 8 of PM, 3 of ASS, 5 of overlap syndrome (3 with Systemic Sclerosis (SSc), 1 with Sjögren Syndrome (SS)), 1 with cryoglobulinemia, 6 of myositis related to other rheumatic disease (1 SSc, 1 Rheumatoid Arthritis, 2 Undifferentiated Connective Tissue Disease, 2 Systemic Lupus Erythematosus). In IM, overall frequency of MAA were 46.1% (12/26) and 38.4% (10/26), respectively, with concomitant expression in 5/26 cases. The 30.7% (8/26) of patients was negative for any type of antibodies. Mi-2 (4/15-26.6%), NXP-2 (3/15-20%) and SRP (2/15-15.3%) were detected in DM subset and were associated with typical skin lesions, muscle weakness, dysphagia and microvascular damage on capillaroscopy, while no interstitial lung disease, cardiac and articular involvement were recorded. Jo-1 was positive in 5/26 patients (2 PM, 2 ASS, 1 DM=19.2%) characterized by interstitial lung disease, arthritis, skin involvement and muscle weakness and by pulmonary hypertension when associated with TIF-1γ (1 DM=6.6%). Autoantibodies profile in overlap syndrome and myositis related to other rheumatic diseases was characterized by prevalence of MAA, more frequently PM-Scl100/75, RNP, Ku, SsA/SSa52/60. Only in 1 patient with an overlap syndrome SSc/PM HMGCOR reactivity was detected. As far as cancer association, a positive history was found in 8.1% (3/37), related more frequently to Jo-1 and SsA/SSa52. Anti-DFS70ab were positive in 2/26 patients with IM (7.6%; 1 DM and 1 PM) and in 1 with SsA/SSa60. No cases of anti-DFS70ab positivity was found in other subsets.

Conclusion: Prevalence of MSA and MAA and their clinical correlations in our population are comparable to data reported in literature. Mi-2, NXP-2 and SRP can be considered markers of DM, while Jo-1 a predictor of lung involvement. Jo-1/SsA/SSa52 positivity is reported in association with lung cancer, but to our knowledge no data are present about melanoma. Our preliminary data confirm that, not only in DM but also in PM, anti-DFS70ab were observed with a low frequency; however more studies are needed to establish the pathogenic role of these antibodies.

Disclosure of Interests: Cattia Duarte: None declared, José Antonio P. da Silva: None declared, Ederio Kristiansen: None declared, Maarten de Wit: None declared, maxime dougados Grant/Research support from: Eli Lilly and Company, Pfizer, AbbVie, and UCB, Consultant for: L Gosling, Lilly, MSD, Novartis-Sandoz, Pfizer, Sanofi, and UCB, Consultant for: Eli Lilly and Company, Pfizer, AbbVie, and UCB Pharma, Consultant for: Eli Lilly and Company, Pfizer, AbbVie, and UCB Pharma, Tore K. Kvien Grant/research support from: AbbVie, BMS, MSD, Pfizer, Roche and UCB, Consultant for: AbbVie, Biogen, BMS, Boehring-nger Ingelheim, Celneg, Celtiron, Eli Lilly, Hospira, Merck-Serono, MSD, Novartis, Oktal, Orion Pharma, Pfizer, Roche, Sandoz, Sanofi, Mylan and UCB, Speakers bureau: AbbVie, Biogen, BMS, Boehringer Ingelheim, Celneg, Celtiron, Eli Lilly, Hospira, Merck-Serono, MSD, Novartis, Oktal, Orion Pharma, Pfizer, Roche, Sandoz, Sanofi and UCB, Consultant for: L Goss-sec has received honoraria from Celgene as investigator for this study, Turid Heiberg: None declared.