SAT0653

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

Cátia Duarte¹, Eduardo Santos², Tore K. Kvien³, Maarten de Wit³, Maxime Dougados⁴, Laura Gossec⁵, P José Antonio, 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, Hopital 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. In all, 14.5% considered themselves as in PASS status. Disease activity, RAID global score and all individual seven domains (p<0.001). Patients reporting a 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 70.8% 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: PASS in RA is associated with lower inflammation, less symptoms and higher age, as expected. However, when analysing patients in DAS28 remission, thus taking out 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 economic/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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SAT0654

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

Cátia Duarte¹, José Antonio P. Da Silva¹, Eduardo Santos², Eirik Kristianslund³, Maarten de Wit⁴, Maxime Dougados⁵, Tore K. Kvien⁴, Laure Gossec⁵, Turid Helberg⁵, RAID Study Group NOR-DMARD, ¹Centro Hospitalar Universitário de Coimbra, Rheumatology, Coimbra; ²Diakonhjemmet Hospital, Rheumatology, Oslo, Norway; ³Amsterdam University, Amsterdam, Netherlands; ⁴Hôpital Cochin, Rheumatology, Paris, France; ⁵Sorbonne Université, Paris, France; ⁶Oslo 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.

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 study (n=570, from 12 European countries), and from the Norwegian DMARD (NOR-DMARD) 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, 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 self-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” state 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 70.8% 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 that 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

carmela esposito1, Teresa Carbone2, Antonio Carriero, Valentina Picerno2, Maria Carmela Padula3, Angela Padula3, Vita Patun4, Salvatore D’angelo2,
1Rheumatology Division-Internal Medicine Department, Pisa University Hospital, Pisa, Italy; 2University of Pisa, Department of Immunology, Pisa, Italy; 3University of Siena, Department of Internal Medicine, Siena, Italy; 4University of Siena, Department of Internal Medicine, Siena, Italy.

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 disease (MD) and Scleroderma (SSc), 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 TIF1-γ (1 DM=6.6%). Autoantibodies profile in overlap syndrome and myositis related to other rheumatic diseases was characterized by prevalence of MAAs, more frequently PM-Scl100/75, RNP, Ku, SSA/SSB, MDA-5, TIF1-γ, Z2/52. Anti-DFS70ab were positive in 2/26 patients with IIM (7.6%; 1 DM and 1 PM) and in 1 with SSA/Ro60. No cases of anti-DFS70ab positivity was found in other subsets.

Conclusion: Prevalence of MAAs and MAAs and their clinical correlations in our population are comparable to data reported in literature. In our population are comparable to data reported in literature. 26/26 cases (100%) of patients were positive 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 TIF1-γ (1 DM=6.6%). Autoantibodies profile in overlap syndrome and myositis related to other rheumatic diseases was characterized by prevalence of MAAs, more frequently PM-Scl100/75, RNP, Ku, SSA/Ro60. Only in 1 patient with an overlap syndrome SSc/PM HMGR 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/SSB. Anti-DFS70ab positivity was found 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 pathogenetic role of these antibodies.

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