Background: Systemic signs of inflammation such as raised CRP or ESR are a classical feature of PMR, but some patients present with normal acute phase reactants (APR). It is not known whether these patients represent milder forms of PMR, whether their disease is not yet fully expressed, or whether they represent another pathophysiological subset of PMR or another disease. Data on demographic and clinical differences between PMR patients with normal versus elevated APR might provide some answers.

Objectives: To explore baseline differences in demographics and clinical characteristics in PMR patients with and without elevated APR.

Methods: We conducted a retrospective cohort study of clinical characteristics of newly diagnosed PMR patients (clinical diagnosis) who visited our outpatient clinic during April 2012 and September 2017. Patient with concomitant inflammatory rheumatic disease were excluded. Data on patient-, disease-, and treatment characteristics were extracted from the electronic health record. Descriptive statistics were used (using mean (SD), median (p25-p75) or n (%) as appropriate), and differences between patients with high APR (CRP>10 mg/L and/or ESR >30 mm/hour) were tested using Fischer’s exact test for categorical data, t-test for normally and Wilcoxon test for non-normally distributed data.

Results: 454 patients were included (table 1). Sixty-two patients had normal, and 392 had elevated APR. In the group with normal APR, fewer patients had peripheral arthritis (2 versus 9%; p=0.044) and fewer had anemia at diagnosis (17 versus 43%; p=0.001). Furthermore, patients had a longer median duration of symptoms before diagnosis (13 versus 10 weeks; p=0.0196) and were more likely to have a history of PMR (16 versus 8%; p=0.057). No significant differences were found in other clinical characteristics.

Conclusion: The results of this cohort indeed suggest that patients with normal APR are a different subset of PMR patients. Fewer cases have peripheral arthritis and anemia at diagnosis, suggesting a milder form of PMR. Secondly, our results do not support the hypothesis that PMR of those with normal APR is not yet fully expressed, as they have a longer symptom duration prior to diagnosis.

REFERENCES:

Disclosure of Interests: None declared.


Table 1: Baseline characteristics of patients with normal versus elevated APR

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normal APR</th>
<th>Elevated APR</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>74 (65-82)</td>
<td>75 (66-83)</td>
<td>0.26</td>
</tr>
<tr>
<td>Sex (M:F)</td>
<td>105:267</td>
<td>110:233</td>
<td>0.47</td>
</tr>
<tr>
<td>Disease duration (years)</td>
<td>3 (1-9)</td>
<td>6 (2-15)</td>
<td>0.018</td>
</tr>
<tr>
<td>CRP (mg/L)</td>
<td>0 (0-7.1)</td>
<td>70 (55-95)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>ESR (mm/hour)</td>
<td>6 (4-12)</td>
<td>40 (30-50)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Figure 1. Kaplan-Meier survival curve showing cumulative survival over time in years

OP0145
NORMAL VERSUS ELEVATED ACUTE PHASE REACTANTS IN PATIENTS WITH POLYMYALGIA RHEUMATICA: ARE THESE DIFFERENT SUBSETS?

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Objectives: To assess the efficacy of apremilast (APR) in patients with active oral ulcers (OU) associated with active Behçet’s syndrome (BS) over 64 weeks.

Methods: A randomized, double-blind, placebo-controlled, phase III study was conducted to evaluate the efficacy and safety of aprimilast in patients with active BS associated with active OU. 

Results: 207 patients were randomized and received treatment for 64 weeks. Mean reductions in the number of OU were similar in the aprimilast and placebo groups at week 12 (2.3 vs 2.0) and week 64 (5.5 vs 5.4), respectively. The primary endpoint of AUCWk0-12 was achieved; effects were maintained through week 64 (53.3% and 76.0%, respectively). Pts initially randomized to APR were considered to have complete or partial response of OU at Wk 12 (<0.0001) and QoL (BDQoL: P=0.0015). Significant efficacy and safety differences were maintained through Wk 64 for APR vs PBO (P=0.001). Significant efficacy was observed in pts receiving APR vs PBO from Wk 1 through 12; APR efficacy was sustained up to 64 wks (Figure). Significantly greater improvements with APR were observed in complete and partial response of OU at Wk 12 (P=0.0001); effects were maintained through Wk 64 (53.3% and 76.0%, respectively). Pts initially randomized to APR and switched to APR at Wk 12 showed comparable benefits through Wk 64 (Figure). Improvements in disease activity (BDCAI: P=0.0335; BAS: P=0.0001) and QoL (BDQoL: P=0.0003) were significant in pts receiving APR vs PBO at Wk 12 and maintained at Wk 64. Compatible effects in pts who switched from PBO to APR were observed at Wk 64. After APR was discontinued before or at Wk 64, the improvements in OU assessments decreased within 4 wks. Disease activity measures and BDQoL similarly indicated recurrence of symptoms at the 4-wk follow-up. Incidence of any adverse event (AE) was comparable for pts initially randomized to APR vs PBO during the PBO-controlled period (78.8% vs 71.8%) and through Wk 64 for pts who continued APR vs pts who switched from PBO to APR (84.3% vs 86.5%). The most common AEs with APR were diarrhea, nausea, headache and upper respiratory tract infection; most AEs were mild/moderate in severity, and no new safety concerns were identified.

REFERENCES:

Disclosure of Interests: None declared.