REFERENCE:

- [1] Bagnato G, De Andres I, Sorbara S, Verduci E, Corallo G, Ferrera A, et al. Pain threshold and intensity in rheumatic patients: correlations with the Hamilton Depression Rating scale. *Clinical rheumatology*. 2015;34(3):555-61.

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AB0232

TIGHT CONTROL MANAGEMENT OF EARLY RA ACHIEVES MORE PATIENTS IN REMISSION AT 6 MONTHS AND IMPROVES PAIN, FUNCTION AND FATIGUE AT 24 MONTHS COMPARED TO A CONTROL GROUP

Maria Aronsson^{1,2}, Annika Teleman¹, Stefan Bergman^{2,3}, Kristina Forslind⁴, Maria Andersson^{2,5}. **Background:** Even with modern antirheumatic treatment, many patients experience chronic pain and loss of function despite less disease activity. The understanding of how this chronic pain development can be prevented is sparse. There is furthermore little knowledge if a tight control management without specific treatment schemes and instructions for the physicians to follow could increase the remission frequency.

Objectives: To determine whether solely a tight control management of patients, without further intervention in the physician's work, can increase the remission frequency and improve patient reported outcome in early RA.

Methods: In all, 96 patients with early RA were consecutively included in a tight control study group (TCS). Inclusion criteria were early RA patients (<13 month duration) with no previous history of rheumatic disease. A control group, with so far 27 patients receiving standard care, has been analyzed. The tight control management included monthly visits to the physician the first 6 months, followed by visits at 9, 12 and 24 months. If not in remission at 6 months the patients' monthly visits could continue to 12 months. The study did not include any treatment guidelines for the physicians. Pain, Fatigue and the Patient's Global Assessment of the General Health (PtGA) were reported on a Visual Analogue Scale (VAS). The 28 tender and swollen joint score, DAS28, C-Reactive protein, Erythrocyte sedimentation rate and Health Assessment Questionnaire (HAQ) were assessed.

Results: There was no significant difference between the groups at baseline in gender, age, smoking, disease duration, disease activity, pain, HAQ, fatigue, RF and ACPA. There was a significant difference between groups in outcome, with 70% of TCS and 37% of control patients in remission (DAS28 <2.6), $p=0.010$, at 6 months, figure 1A. At 12 and 24 months there was no significant difference in the remission frequency, figure 1A. The TCS group improved more than the control group in Pain, Fatigue and HAQ during follow up, figure 1B-D. The median VAS pain at 24 months was 11 (IQR 2-22) in the TCS group and 22 (IQR 6-42) in the control group, $p=0.036$. The median VAS fatigue was 13 (IQR 2-38) in the TCS group and 33 (IQR 8-70) in the control group $p=0.028$ at 24 months. The difference in HAQ reached significant numbers solely at 6 months where the median was 0.13 (IQR 0-0.50) in the TCS group and 0.57 in the control group (IQR 0.16-0.94).

Figure 1. Disease activity (DAS28), functional disability (HAQ), pain and fatigue during 24 months follow-up. The TCS group is included in a tight control study with follow-ups every month during the first half year. The control group has received standard care. A. Median DAS28 in the separate groups over time. B. Median HAQ in the separate groups over time. C. Median VAS pain in the separate groups over time. D. Median VAS fatigue in the separate groups over time. * significant difference $p < 0.05$

Figure 1

Conclusion: Patients in tight control reached remission faster than patients receiving standard care. They also reported less pain and fatigue, despite the fact that there was no difference in remission frequency at 24 months. The results indicate that a tight control scheme could influence pain development in patients with early RA, but further studies are required.

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AB0233

ASSESSMENT OF THE RESPONSE TO THERAPY WITH CSDMARDS AND BDMARDS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: The significant economic burden of rheumatoid arthritis (RA) and new treatment options, consuming much of the healthcare resources, pay attention on appropriate management strategies. These strategies are due to the need for an adequate assessment of the response to treatment and changes if it is necessary. Currently used American College of Rheumatology (ACR) response criteria and disease activity score (DAS28-CRP) allows on time evaluation of the results and facilitate decision process when is the right time to switch patient's therapy.

Objectives: The aim of the study is to evaluate the effectiveness and response to the treatment with csDMARDS and/or corticosteroid and bDMARDS in patients with RA after one year follow up period using ACR 20/50/70/90 response criteria and DAS28-CRP.

Methods: A total of 220 patients with a mean age 55.05 ± 10.63 SD meeting the 1987 ACR classification criteria for RA were included in the study. The mean disease duration was 9.97 ± 5.78 SD. Patients were stratified according to treatment regimens into age-matched treatment groups: 96 on csDMARDS and/or corticosteroid (Sulfasalazine ? 15, Methylprednisolone ? 15, Chloroquine - 16, Methotrexate - 20, Methotrexate and Methylprednisolone -30) and 124 on bDMARD (Tocilizumab ? 30, Certolizumab pegol ? 16, Golimumab - 22, Etanercept - 20, Adalimumab - 20, Rituximab - 16). All participants were evaluated for ACR 20/50/70/90 response to therapy on 6th and 12th month of the follow up period, DAS28-CRP was calculated via licensed calculator. Comparison was performed by analysis variance ANOVA

Results: The majority of patients (71%) on bDMARDS achieved ACR 50 response criteria and 16% achieved ACR 70, indicating a significantly better therapeutic effect compared to the group on csDMARDS (ACR 50 - 11% ACR 70-1%) at 6th month follow up ($p < 0.001$, $p = 0.002$). Only 3% of bDMARDS patients achieved ACR 90 response on the 6th month. Most of the patients on csDMARDS (64%) reach ACR 20 response criteria after the same period of therapy. At 6th month of follow-up, best response was achieved by the patients on combined MTX and corticosteroid (CS) therapy (50%) achieved ACR 20, 27% - ACR 50 and 3% - ACR 70. At the 12th month, a significant proportion of patients on bDMARDS reached the ACR 50 (36%) and ACR 70 (52%) response criteria compared to the csDMARDS group (ACR 50 - 20%, ACR 70 - 10%) ($p = 0.0102$; $p < 0.001$). We evaluated the response to therapy according to the DAS28-CRP categories. On baseline patients on bDMARDS had higher disease activity in comparison to patients on csDMARDS ($p=0.0004$). In the follow-up to the 6th month, we observed a significant reduction in the proportion of patients (on bDMARDS) with severe disease activity - 2.4%, compared to csDMARDS group - 13.5% ($p = 0.0019$). In 26.6% of patients on bDMARDS, we found minimal disease activity, which was significantly more than 13.5% for the csDMARDS group ($p = 0.0186$). A remission was found in 5.6% of patients on bDMARDS which is significantly less than 14.6% for the group on csDMARDS. In contrast to the results obtained at the 6th month of follow-up, at 12th month we observed significantly higher percentage of patients on bDMARDS who had reached the remission category - 29.8%, in comparison with csDMARDS group - 12.5%, ($p = 0.0025$).

Conclusion: Patient treated with bDMARDS showed better response to treatment and lower disease activity than those on therapy with csDMARDS within a period of 12 months of treatment. Current management strategies should focus on switching on another medication earlier in the treatment plan when patients inadequately respond to therapy after 6 months of follow up.

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