AB0236

WHAT FACTORS ARE ASSOCIATED WITH THE EVOLUTION TOWARDS RHEUMATOID ARTHRITIS, USE OF BIOLOGICAL THERAPY AND DEVELOPMENT OF CARDIOVASCULAR EVENTS IN A COHORT OF PATIENTS WITH UNDIFFERENTIATED ARTHRITIS?

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Objectives: To describe the clinical-demographic characteristics and behaviour over time (12, 24 and 60 months) of a cohort of Undifferentiated Arthritis (UA), as well as to analyze which factors are associated with the evolution towards Rheumatoid Arthritis (RA), use of Biological Therapy (BT) and the development of Cardiovascular Disease (CVD).

Methods: Ambispective cohort study of patients with UA evaluated longitudinally from January 2009 to 2019. We analyzed baseline clinical and laboratory variables and a Multivariate Logistic Regression was performed to determine the factors associated with RA development after 5 years of follow-up. To analyze what factors were associated with the use of BT and the presence of CVD chi-square or Fisher's test were used for binary variables, and U-Mann Whitney for continuous variables.

Results: 180 patients were included, 55% were women, with an average age of 49.3 (SD 16.1) years. The average duration of symptoms before the first visit was 6.9 (SD 9.9) months. 47.2% were FR+, 41% ACPA+, 20.6% HLA-DRB1 shared epitope.

At the end of follow-up: 33.3% evolved to RA, 17.2% remained as palindromic rheumatism, 25% were diagnosed other chronic rheumatic diseases, 21.1% remitted spontaneously and 3.3% remained as UA. Of the 60 AR, 37 were diagnosed in the first year, 13 at second and 10 at 5 years of follow-up. During follow-up, 13 patients with RA started BT, and 12 patients presented CVD (7 of them died).

Table 1.: Factors associated with RA after 5 years of follow-up.

Baseline data	Total patients N=180	RA N = 60	No RA N =120	OR (95%CI)	p-value
Sex (women)	99 (45.7%)	34 (56.7%)	65 (54.2%)	1.11 (0.69-2.07)	0.751
Duration of symptoms (months)	7.7 (8.8)	7.5 (6.5)	7.8 (9.8)	0.99 (0.96-1.03)	0.864
Age at diagnosis	49.3 (16.1)	49.4 (14.5)	49.3 (16.9)	1.00 (0.98-1.02)	0.961
-Oligoarthritis	84 (46.7%)	20 (33.3%)	64 (53.3%)	2.34 (0.49-11.14)	0.284
-Polyarthritis	79 (43.9%)	38 (63.3%)	41 (34.2%)	6.95 (1.49-32.42)	0.014
Morning stiffness>1h	43 (23.9%)	22 (36.7%)	21 (17.5%)	2.73 (1.35-5.52)	0.005
RF+	85 (47.2%)	47 (78.3%)	38 (31.7%)	7.8 (3.78-16.1)	<0.001
ACPA+	73 (41.0%)	50 (83.3%)	23 (19.5%)	20.6 (9.1-46.7)	<0.001
High ESR	104 (57.8%)	40 (66.7%)	64 (53.3%)	1.75 (0.92-3.34)	0.089
Hight CRP	100 (55.6%)	40 (66.7%)	60 (50%)	2.0 (1.05-3.81)	0.035
HLADRB1 Shared epitope	37 (20.6%)	32 (53.3%)	5 (4.2%)	26.3 (9.39-73.55)	<0.001
Smoker	72 (40%)	25 (41.7%)	47 (39.2%)	1.11 (0.59-2.08)	0.747
Family history RA	39 (21.7%)	17 (28.3%)	22 (18.3%)	1.76 (0.85-3.64)	0.127
Tto glucocort (5mg/d)	88 (48.9%)	40 (66.7%)	48 (40%)	3.0 (1.57-5.74)	0.001
Tto dolquine (200mg/d)	50 (27.8%)	25 (41.7%)	25 (20.8%)	2.71 (1.38-5.34)	0.004
Tto mtx (15mg/w)	16 (8.9%)	14 (23.3%)	2 (1.7%)	17.9 (3.93-82.12)	<0.001

Table 1 identifies the factors associated with the development of RA. The MLR identified **ACPA +**, **OR (95% CI) = 10.69 (4.43 - 25.78)**, and the **HLA-DRB1 shared epitope OR (95% CI) = 9.18 (2.96 - 28.48) p <0.001** as factors associated to the development of AR. We failed to identify factors associated with the use of BT, possibly due to the sample size. The factors associated with the development of CVD, where only the use of glucocorticoids as a factor associated with the presence of CVD shows statistical significance.

Conclusion: 1) Useful clinical and laboratory characteristics have been identified to predict which patients are at risk of developing persistent arthritis. 2) HLADRB1 shared Epitope and ACPA are predictive factors of evolution to RA. 3) Possibly the continued use of glucocorticoids, even at low doses, may be related to the development of long-term CVD

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AB0237

WHAT DO SPANISH RHEUMATOLOGISTS THINK ABOUT THE EFFICACY OF THE DRUGS USED IN THE MANAGEMENT OF PATIENT WITH RHEUMATOID ARTHRITIS AND POOR PROGNOSIS FACTORS? PROGRESAR-2 PROJECT

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Background: Currently, patients with rheumatoid arthritis (RA) have a wide range of treatments available to achieve a good control of the disease and avoid progression. However, some patients, especially those with poor prognostic factors, need to switch drugs to achieve remission or low disease activity. If we can predict the response to a drug, given specific prognostic profiles, we may be able to choose the best drug for individual patients.

Objectives: To assess the degree of confidence of rheumatologists regarding the efficacy of biologic therapies and specific targeted synthetic molecules in patients with RA harbouring poor prognostic factors.

Methods: A Delphi survey was sent to a group of rheumatologists with the aim to capture the perceived efficacy of a group of drugs (antiTNF, T-cell co-stimulants, B-cells depletors, anti IL6, and JAK inhibitors) given different poor prognostic factors are present at the onset of the disease. These factors were: interstitial lung disease, elevated HAQ, positive rheumatoid factor (RF), presence of anti-citrullinated protein antibody (ACPA), elevated acute phase reactants (APR), and bone erosions observed by simple x-ray/ultrasound. The survey was circulated in two rounds, with feed-back from the first round. The degree of confidence in the efficacy of the therapies for each specific prognostic profile was collected on a Likert scale from 1 to 9. The mean (m) and standard deviation (SD) were calculated; agreement was considered if SD ≤1 and 80% of the scores were in one of the three levels (correspondingly it would be agreement on "ineffectiveness", "neutrality" and "effectiveness").

Table 1.:

Prognostic factor	Agreement on the efficacy of therapy m (SD)				
	AntiTNF	T-cell co-stimulants	Depletion of B cells	Anti IL-6	Jak inhibitors
Interstitial Lung Disease	2.5 (1.5)	8.6 (0.7)	7.0 (1.4)	6.2 (1.4)	5.1 (1.6)
High HAQ	8.1 (0.7)	7.4 (1.0)	7.0 (1.0)	8.1 (0.7)	7.9 (0.9)
RF positive	7.7 (0.8)	8.1 (0.6)	8.3 (0.5)	7.8 (0.8)	7.6 (0.8)
ACPA positive	7.8 (0.8)	8.6 (0.5)	8.2 (0.7)	7.5 (0.8)	7.4 (0.7)
Elevated APR	7.9 (0.7)	7.2 (0.7)	7.0 (0.9)	8.7 (0.5)	7.9 (0.9)
Bone erosions by Rx	8.1 (0.8)	7.9 (0.6)	7.3 (0.8)	8.2 (0.5)	7.8 (0.8)
Bone erosions by US	8.2 (0.9)	7.9 (0.7)	7.3 (1.0)	7.9 (0.8)	7.8 (0.8)

Conclusion: There is agreement among rheumatologists regarding the behaviour of particular drugs on particular prognostic profiles, except in the case of interstitial pulmonary involvement, HAQ, ACPA+ and acute