Methods: A total of 384 ERA patients with less than 12 months of disease duration (mean age 54.6 ± 14.6 years, 75% female, 73.3% seropositive) were enrolled in the study. ERA patients fulfilled the 2010 ACR criteria for RA and were followed according to the T2T strategy. At baseline, and every three months, the ACR/EULAR core data set variables were recorded. At baseline and every year, hand and foot radiographs were examined according to modified Total Sharp score (mTSS). At each visit, clinical improvement and remission were evaluated according to EULAR criteria. The achievement of Comprehensive Disease Control (CDC) (28-joint Disease Activity Score using C reactive protein <2.6 , Health Assessment Questionnaire <0.5 and change from baseline in mTSS ≤ 0.5) was assessed every year of follow-up (FU). The mean FU duration was 45.5 ± 40.6 months. In patients not reaching the target with methotrexate (MTX) after the 3rd-6th month of FU, the addition of another csDMARD (chloroquine, leflunomide or sulfasalazine) or a bDMARD was considered in order to attain at least a good EULAR response.

Results: At the twelfth month of FU, out of the 174 ERA patients (45.3%) not reaching the target with MTX, 97 (25.3%) were in combination therapy with csDMARDs and 77 (20.1%) were treated with csDMARDs in association with bDMARDs.

Similar percentages of good EULAR response, DAS remission and CDC were registered in the two groups of patients, both at 12th month of FU and at the last FU.

Although not statistically significant, fewer bDMARD treated patients showed 5-year radiographic progression (RP) (21.7%) compared to subjects in csDMARD combination (36.8%, $p=0.13$).

A higher BMI was observed in ERA patients who started bDMARDs (26.0 ± 4.1) compared to subjects in combination therapy with csDMARDs (24.8 ± 4.2 , $p=0.02$).

No differences were founded regarding age and disease duration. Autoantibody positivity was comparable between the two groups.

Conclusion: Our results support data suggesting that the treatment strategy is more important than the therapy used to achieve remission.

In fact, when a strict protocol of tight control is applied, similar clinical and radiological outcome is achieved both in patients treated with csDMARD combination, and in subjects in bDMARD association, regardless of RA prognostic factors.

A higher BMI is associated with a major frequency of bDMARD therapy, underlying a possible more csDMARD refractory disease.

REFERENCES:

- [1] Smolen JS et al, Ann Rheum Dis 2017; 76:960-977

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AB0245

PREDICTORS OF BIOLOGIC THERAPY DISCONTINUATION IN RHEUMATOID ARTHRITIS PATIENTS AFTER REMISSION ACHIEVEMENT: A MONOCENTRIC OBSERVATIONAL STUDY FROM BIOLOGIC APULIAN REGISTRY (BIOPURE)

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Background: Thanks to biologic therapies, disease remission in Rheumatoid Arthritis (RA) patients is not a wishful thinking but an achievable goal. Nevertheless, some patients experienced treatment discontinuation after obtaining disease remission. EULAR recommendations suggest to suspend steroids as soon as possible¹, but in real life-setting this point is not always hold in esteem.

Objectives: The objective of our study was to assess the impact of steroids on the long-term drug survival and the possible predictors of drug discontinuation in RA patients who achieved Simplified Disease Activity Index (SDAI) remission at 1-year upon treatment with a first biologic disease modifying anti-rheumatic drug (bDMARD).

Methods: Data of RA patients naïve to bDMARDs, registered in Biologic Apulian Registry (BIOPURE) between 1st January 2008 to 31st December

2017, were retrospectively analysed. Demographic and clinical data of all RA patients were acquired at the initiation of first bDMARDs ("screening-time") and after 1-year follow-up ("baseline-time"). The inclusion criterion in this study was the achievement of SDAI remission ($SDAI \leq 3.3$) at 1 year of treatment with a first bDMARD. At "baseline-time", RA patients on SDAI remission were divided, according to steroid administration, into concomitant "steroid-no" and "steroid-yes" groups. Drug retention rate and mean survival time (MST) were estimated using Kaplan-Meier (K-M) life-table method. Estimated hazard ratios (HRs) of discontinuing bDMARD were assessed by performing a multivariate Cox-regression analysis with stepwise backward methods.

Results: 216 RA patients started their first bDMARDs between 1st January 2008 to 31st December 2017. Among these, 86 (39.8%) patients achieved SDAI remission at 1-year of whom 54 (62.8%) were steroid free while 32 (37.2%) were still taking low-dose steroids (mean 3.8 mg/die; SD ± 1.4). Considering patients who achieved SDAI remission at "baseline-time", global drug retention was 81.4% [MST=88.5 (95% CI: 80-97) months], higher for "steroid-no" patients [90.7%, MST=98.2 (95% CI: 89-107) months] than "steroid-yes" ones [68.8%, MST=68.9 (95% CI: 57-81) months] (long rank 7.086, $p=0.008$) (Figure 1). This difference was also seen when drug discontinuation by ineffectiveness was calculated [96.1%, MST=103 (95%CI: 96-110) months vs 72.4%, MST= 70.6 (95%CI 57-84) months, long rank 10.101, $p=0.001$], but not by adverse events. Moreover, no steroid administration (HR = 0.31, 95% CI:0.10-0.93) and concomitant Methotrexate therapy (HR = 0.34, 95% CI:0.12-0.98) were independently associated with low risk of bDMARDs interruption after the achievement of SDAI remission.

Conclusion: This study provided evidence that, among RA patients who achieved SDAI remission, those who stopped steroids and continued combination therapy with MTX had a very long drug survival with just the first bDMARD in a real-life setting. These results can help rheumatologists to precociously select RA patients who might start a tapering or spacing strategy of biologic drug.

REFERENCE:

- [1] Smolen JS, Landewé R, Bijlsma J, Burmester G. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. Ann Rheum Dis. 2017 Jun;76(6):960-977.

Figure 1. Retention rate on first bDMARD of Rheumatoid Arthritis (RA) patients in remission assessed by Simplified disease activity index (SDAI) after 1 year of follow-up: global population (a), concomitant steroid (b) and concomitant MTX (c).

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AB0246

PREDICTORS OF FATIGUE IN RHEUMATOID ARTHRITIS PATIENTS WHO RECEIVE BIOLOGICAL AND TARGETED SYNTHETIC DISEASE-MODIFYING ANTIRHEUMATIC DRUGS

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Background: Fatigue is one of the most frequent symptoms in patients with rheumatoid arthritis (RA), affecting more than 80% of them. Despite

being a very disabling symptom, the variables that predict it are still unknown.

Objectives: To identify potential factors associated with fatigue.

Methods: Cross-sectional study. 60 patients were included, patients were being followed up in the rheumatology outpatient clinic of Hospital Clínico San Carlos, Madrid, Spain. Data were collected between July 2018 and January 2019. All patients met the ACR/EULAR 2010 criteria and they were in treatment with Biological agents or Targeted Synthetic DMARDs.

Main variable: Fatigue was assessed by the Bristol Rheumatoid Arthritis Fatigue Multidimensional Questionnaire (BRAFMQ) and the Bristol Rheumatoid Arthritis Fatigue Numerical Rating Scale (BRAFNRS).

Covariates: Sociodemographic, clinical, Disease-related variables and treatment. **Statistical analysis.** A descriptive analysis was carried out for the different variables. To identify factors independently associated to BRAFMQ a multivariable linear regression was applied. Results were expressed as β with their corresponding 95% CI. A value of $p < 0.05$ was accepted as statistically significant.

Results: A total of 60 patients, comprising of 53 females (88%) and 7 males (12%) with a mean age of 56.45 ± 11.89 years and mean disease duration of 14.11 ± 7.79 years were evaluated. RF was positive in 60% of patients. 65% of the patients were in active on work and 23% were retired. Regarding comorbidities, 43% had dyslipidemia, 42% hypertension, 17% hypothyroidism and 15% depression. The DAS28-ESR and SDAI scores of the patients were 2.68 ± 0.86 , 8.56 ± 5.96 respectively. The rest of the clinical, treatment characteristics, and the scores of the fatigue instruments used in the study are shown in Table 1. Physical dimension was the most affected according to patients, who perceive an average severity and affectation, and insufficient coping. The factors affecting the total BRAFMQ was evaluated in multivariate analyze Table 2. We found that patients with Disability ($p < 0.0001$) and those in treatment with Non anti-TNF ($p 0.048$), experienced more fatigue while a positive RF ($p 0.022$) decreases overall fatigue.

Conclusion: Fatigue is a substantial symptom in RA patients and should be evaluated on the daily clinical practice. The results of our study indicated that disability and type of treatment were the dominant factors in the experience and degree of fatigue. Disease activity (DAS28 and SDAI) was not associated to fatigue. The evaluation and management of fatigue should be one of the objectives in the treatment of patients with RA

Table 1. Characteristics of the sample

Variable	Descriptive statistics
Glucocorticoids mg/day, mean $\pm$ SD	4.86 $\pm$ 1.65
Treatment, n (%)	47 (78.33)
Conventional DMARDs	40 (66.67)
Anti TNF	16 (26.67)
Non-Anti TNF	4 (6.67)
Synthetic target DMARD (Jakinibs).	
HAQ (0-3) mean $\pm$ SD	0.86 $\pm$ 7.7
VAS pain mean $\pm$ SD	39.3 $\pm$ 24.27
Sleep quality self-report, n (%)	23 (39.66)
Good	35 (60.34)
Poor	
BRAFMQ (0-70), mean $\pm$ SD	21.95 $\pm$ 15.01
Physical (0-22)	10.6 $\pm$ 5.49
Living (0-21)	5.08 $\pm$ 5.04
Cognitive (0-15)	3.3 $\pm$ 3.38
Emotional (0-12)	2.96 $\pm$ 2.75
BRAFNRS, mean $\pm$ SD	
Fatigue severity (0-10)	4.75 $\pm$ 2.33
Effect of fatigue (0-10)	4.8 $\pm$ 2.43
Coping with fatigue (0-10)	3.73 $\pm$ 2.29

Table 2. Multivariate analyses of Total-BRAFMQ

Total BRAF	Coef.	Std. Err.	t	p	IC 95%
Age	-0.041	0.141	-0.29	0.769	-0.325 0.242
Sex	-6.933	4.985	-1.39	0.170	-16.938 3.071
FR positive	-9.589	3.467	-2.77	0.008	-16.546 -2.631
Non Anti-TNF	7.348	3.621	2.03	0.048	0.082 14.614
HAQ >1.1	15.863	3.290	4.82	0.000	9.259 22.467

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AB0247

INSIGHTS INTO ADHERENCE AND PATIENT-INITIATED MONOTHERAPY FOR RHEUMATOID ARTHRITIS VIA A GLOBAL SURVEY OF PATIENTS, CAREGIVERS AND PHYSICIANS

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Background: Treatment satisfaction and adherence remain issues affecting outcomes for patients (pts) with rheumatoid arthritis (RA). A better understanding of the reasons for non-adherence, and differences between pt, caregiver and healthcare professional (HCP) views on adherence, may improve decision-making and outcomes.

Objectives: To survey pts, caregivers and HCPs, in order to investigate pt behaviours and attitudes, and communications between pts, caregivers and HCPs regarding adherence to RA therapy.

Methods: Surveys were conducted online by Harris Poll between Oct and Nov 2018, among pts/caregivers and HCPs from Australia, Brazil, Canada, Germany, Japan, Spain, Taiwan, UK and US. The pt survey included pts aged ≥ 18 years with a diagnosis of RA who had taken conventional synthetic disease-modifying antirheumatic drugs (csDMARDs) with biological (b)DMARDs in the past 3 years. The caregiver survey included adults aged ≥ 18 years who lived with/provided care to a spouse/family member with RA and were involved in ≥ 2 care activities for a pt with RA who had taken csDMARDs with bDMARDs in the past 3 years. The HCP survey included responses from licensed rheumatologists (orthopaedists in Japan) who saw ≥ 10 pts with moderate/severe RA per month, $\geq 10\%$ of whom had been prescribed a bDMARD. A post-weight was applied to raw data to adjust for the relative adult population size of each country vs the total for all 9 countries surveyed.

Figure. Responses to the patient/caregiver and HCP surveys: A. Percentage of patients with RA taking non-adherent actions while on csDMARDs in combination with advanced therapies, as reported by patients, caregivers and HCPs; B. Reasons given by patients and caregivers for not taking RA medications as directed

*Patients, caregivers and HCPs responded to the following questions: patients, "During the time you have taken a csDMARD (eg, methotrexate or leflunomide), have you ever done any of the following? Please select all that apply"; caregivers, "Next, we would like to ask you some questions about the experience of the person living with RA you live with or provide support or care to with csDMARDs (eg, methotrexate or leflunomide). To the best of your knowledge, has this person ever done any of the following? Please select all that apply"; and HCPs, "As far as you know, what proportion of your patients have done each of the following due to RA?" Patient and caregiver responses to the following question: "You indicated that you may not always take your RA prescription medication(s) exactly as directed by your HCP. For which of the following reasons, if any, would you/they not take your RA prescription medication(s) as directed by your HCP? Please select all that apply." Responses are for patients, and caregivers with patients, currently on csDMARDs; patients N=603 and caregivers, N=431. Responses are for patients, and caregivers with patients, who do not take medication as prescribed or have never been non-compliant csDMARD, conventional synthetic disease-modifying antirheumatic drug; HCP, healthcare professional; NA, not applicable; RA, rheumatoid arthritis.

Figure 1

Results: In total, 900 pts, 714 caregivers and 840 HCPs responded to the surveys. Overall, 50% of both pts and caregivers reported that pts always took their current RA prescription medications exactly as directed. However, 67% of pts reported that they had not always adhered to dosing regimens (most common deviations: skipping doses [45%]; extending time between doses [44%]; taking other medications without HCP direction [38%]; taking less than the prescribed dose [34%]; dose splitting [31%]; and stopping medications altogether [28%]). Among HCP