Table 2. The four comorbidity indexes discrimination for 1- and 5-year survival in patients with RA.

Models	1-year mortality		5-year mortality	
	Harrell's c-statistics	AIC	Harrell's c-statistics	AIC
Base model	0.744	1868	0.777	10281
Base model+ CCI	0.796	1783	0.802	9879
Base model+ ECI	0.772	1829	0.793	10024
Base model+ MMI	0.779	1821	0.792	10038
Base model+ RDCI	0.773	1817	0.791	10048

Base model included age, gender, income quartiles, urbanization and occupation groups. The Harrell's c-statistic indicates model prediction as the followings: 0.5 (as well as chance), 0.7–0.8 (acceptable), 0.8–0.9 (excellent), and 0.9–1 (outstanding prediction). The AIC statistic was calculated, and a small AIC indicates better prediction of the model.

Disclosure of Interests: None declared

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AB0260 TREATMENT WITH BIOTECHNOLOGICAL DRUGS ACCORDING TO PRE-DEFINED SELECTION CRITERIA IN PATIENTS WITH RHEUMATOID ARTHRITIS: PRELIMINARY RESULTS OF A SINGLE COHORT

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Background: Current recommendations on the treatment of Rheumatoid Arthritis (RA) are based on a treat to target approach, nevertheless which biologic drug should be used in an unresponsive patient is not clarified (1). Such a strategy is essentially justified by the fact that no biotechnological drug has proved to be superior to any other (2).

Recent studies have reported some disease or patient features that are associated with a greater or lesser likelihood of response (3). Nevertheless, an adapted therapy to the single patient and based on physiopathological mechanisms has not been acquired yet.

Objectives: Aim of this study was to evaluate if the choice of a tailored therapy, based on patient and disease features, would be an effective strategy.

Methods: From April 1st 2017, at our Department of Rheumatology of the University of Campania, each patient with RA has been characterized, at enrolment, for demographic and disease features, and started a biological Disease-modifying antirheumatic drug based on an established algorithm (**Figure 1**). Attainment of the targeted end point i.e. remission (R) as assessed by Simplified Disease Activity Index (SDAI) <3.3 or at least low disease activity (LDA), SDAI<11, has been evaluated at 3, 6 and 12 months.

Figure 1: Biologic algorithm
 TNF, Tumor necrosis factor; BMI, Body Mass Index;
 RF, Rheumatoid Factor; ACPA, Anti-Citrullinated Cyclic Peptides Antibodies

Figure 1

Results: Forty-nine patients were admitted to our centre from April 1st2017 to December 31st2018. Out of them, 36 patients have been followed up at least for 3 months and were included in the study (algorithm+ patients). Out of them, 26 (72.2%) reached 6 months of treatment, while 16 (44.4%) 12 months of treatment. Among the 26 patients evaluated at 6 months, 23(88.5%) achieved the targeted end point. At 12 months, 16/16 patients (100%) preserved a status of remission or at least low disease activity. We compared our results to those registered, from January 2015 to September 2016, in a RA cohort of 79 patients (RA general cohort). We found a significant difference in regard to attainment of the target at 6 months (23/26 patients, 88.5% algorithm+ vs 45/67 patients, 67.2% RA general cohort; p=0.04) and at 12 months (16/16

patients, 100% algorithm+ vs 40/57 patients, 70.2% RA general cohort; p=0.01) (**Table 1**). Notably, 32 out of the 79 patients had undergone a biological drug which didn't follow the predefined algorithm. These patients (algorithm- patients) presented a further lower incidence of response with regard to those enrolled according to the algorithm: 22/32 patients (68.7%) at 3 months; p=0.4; 17/29 (58.6%) at 6 months; p=0.001; 17/24 (70.8%) at 12 months; p=0.03).

Conclusion: The choice of a personalized approach toward treatment of RA might be an effective strategy to achieve the targeted end point of remission or at least low disease activity in every patient.

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Table 1. Comparison of percentage of response between Algorithm + patients (n.36) and RA general cohort (n.79)

	Algorithm+ patients	RA general cohort	p
LDA/R 3 months	28/36 (77.7%)	51/76 (67.1%)	0.25
LDA/R 6 months	23/26 (88.5%)	45/67 (67.2%)	0.04
LDA/R 12 months	16/16 (100%)	40/57 (70.2%)	0.01

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AB0261 TARGET SETTING OF FUNCTIONAL REMISSION FOR HAND AND WRIST SURGERIES USING GRIP POWER AND PATIENT-REPORTED OUTCOME MEASURES IN PATIENTS WITH RHEUMATOID ARTHRITIS: A PROSPECTIVE COHORT STUDY

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Background: The treatment aim of rheumatoid arthritis (RA) is achieving and maintaining functional remission via tight medical control. However, if adequate medication is not administered in the very early stage of the disease, surgical reconstruction for the structurally damaged hand and wrist is sometimes required.

Objectives: To evaluate the effect of surgical treatment of the hand and wrist⁽¹⁾ and to set the target of functional remission using grip power and patient-reported outcome measures (PROs) at baseline.

Methods: A prospective observational cohort study was performed in RA patients who were scheduled to have primary hand and/or wrist surgeries. Assessments were performed at baseline and 12 months after surgery using grip power (GP), pain visual analogue scale (pain VAS), general health (GH), disease activity score 28- C-reactive protein(4) (DAS28-CRP (4)), disabilities of the arm, shoulder and hand (DASH), European quality of life scale with five dimensions (EQ-5D), Beck depression inventory -II (BDI-II) and health assessment questionnaire- disability index (HAQ-DI) for all registered patients. Baseline data for each item in the group with HAQ remission (HAQ-DI≤0.5) at 12 months (REM) were compared with those in the group without remission at 12 months (non-REM).

Results: There were 137 sites (63 hands, 74 wrists) in 119 patients whose average age was 62 (19-88) years and average disease duration was 14 (1-45) years. Overall, the physical function (GP, pain VAS, DASH, HAQ-DI), quality of life (HAQ-DI, GH, EQ-5D), depression (BDI-II) and disease activity (DAS28-CRP(4)) had significantly improved at 12 months (p<0.01) (**Table 1**). In the REM group (n=47), the GP and EQ-5D were significantly higher (p<0.01) and the HAQ-DI, DASH and BDI-II significantly lower (p<0.01) than in the non-REM group (**Table 2**). The cut-off value at baseline for achieving HAQ remission at 12 months after surgery was 119 mmHg (sensitivity: 0.70, specificity: 0.64) in GP, 0.81 (0.81, 0.77) in HAQ-DI, 36.9 (0.74, 0.73) in DASH, 0.69 (0.87, 0.74) in EQ-5D and 9.5 (0.72, 0.60) in BDI-II.