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AB0383

LATENT TUBERCULOSIS INFECTION SHOULD BE MONITORED IN BOTH TUMOR NECROSIS FACTOR INHIBITORS AND NON-TUMOR NECROSIS FACTOR INHIBITORS IN BIOLOGIC-NAÏVE PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: The risk of latent tuberculosis infection (LTBI) increased during the treatment of biologic agents for patients with rheumatoid arthritis. Taiwan rheumatology association recommend performing at least annual interferon-gamma release assays (IGARs) testing during biologic treatment course because of the moderate prevalence of tuberculosis in Taiwan.[1] Although increased tuberculosis reactivation rate in patients with TNF inhibitor is reported, the risk of LTBI in patients with RA treated by non-TNF inhibitors is limited.

Objectives: The aim is to use serial interferon-gamma release assays (IGARs) as a diagnostic tool for LTBI in biologic-naïve patients with rheumatoid arthritis treated with TNF and non-TNF inhibitors in Taiwan.

Methods: We retrospectively collected 313 biologic-naïve patients with rheumatoid arthritis receiving biologic agents between 2013 to 2017 in Chang Gung Memorial hospital in Taiwan. All RA patients underwent semi-annual IGRA test during biologic agent treatment. Cox proportional hazard model was used for analysis to compared RA patients with TNF and non-TNF inhibitors.

Figure 1

Results: The age of patients and disease duration are 55.9 ± 13.1 year-old and 5.2 ± 2.0 years (Table 1). The LTBI rate in patients with rheumatoid arthritis after biologic treatment is 6.7%. Out of the 21 patients with LTBI, 12(6%) patients were treated with TNF inhibitors, 9(8%) patients were treated with non-TNF inhibitors (Figure 1). 42.9%(9/21) received chemoprophylactic therapy by isoniazid but no patient suffered from active TB till the end of study period. Patients with TNF inhibitors was associated with a hazard ratio (HR) of 4.43 (95% CI, 0.80-24.39) after adjusted age, sex, diabetes history, prednisolone use and disease duration. This

Cox regression analysis of RA patients found that the risk of LTBI was not different in TNF or non-TNF inhibitors.

Conclusion: Our study revealed biologic-naïve patients with rheumatoid arthritis have the same risk of LTBI. All RA patients who need either TNF or non-TNF inhibitors should be monitored LTBI in moderate prevalence TB area.

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Table 1. Baseline characteristics in patients with RA treated with TNF or non-TNF inhibitors

	Total (n=313)	TNF inhibitors (n=200)	Non-TNF inhibitors (n=113)	p- value
Gender, female	259 (82.7%)	169(84.5%)	90(79.6%)	0.109
Age (Mean± standard deviation)	55.9	55.0	57.6	0.102
Disease duration (Mean± standard deviation)	13.1 5.2	12.3 5.5	14.4 4.7	0.001*
Diabetes mellitus	2 (0.6%)	1.8 (0.9%)	2.2 (1.9%)	0.019*
Liver cirrhosis	2(0.6%)	2(1.0%)	0(0.0%)	0.280
Prednisolone mean dose (mg/day)	223 (71.2%) 8.0	145(72.5%) 8.2	78 (69.0%) 7.6	0.479 0.623
	7.7	9.1	3.8	

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AB0384

PROMISPAIN INTERFERENCE 6B AND FATIGUE 7A SHORT FORMS AND PROFILE-29 IN RHEUMATOID ARTHRITIS PATIENTS TREATED WITH TNF INHIBITORS

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Background: PROMIS (Patient Reported Outcomes Measurement Information System) has been used in rheumatoid arthritis (RA) patients (Pts) to assess disease activity across multiple domains (i.e. physical function, fatigue, pain interference). AWARE (Comparative and Pragmatic Study of Golimumab IV Versus Infliximab in Rheumatoid Arthritis) is an ongoing Phase 4 study designed to provide a real-world assessment of intravenous Tumor Necrosis Factor inhibitor (TNFi) medications in RA pts. The study utilizes PROMIS and Clinical Disease Activity Index (CDAI) to assess effectiveness.

Objectives: This analysis examined select PROMIS measures to assess (1) relationship between baseline (BL) CDAI and PROMIS-scores, (2) responsiveness of PROMIS after initiation of TNFi and (3) relationship between PROMIS T-scores of the 4 item Profile29v2 Fatigue and Pain Interference domains and respective PROMIS Short Forms (SF).

Methods: AWARE is a prospective, noninterventional, 3-year study at 100 US sites. RA pts were enrolled when initiating TNFi treatment. Treatment decisions are at the discretion of the treating rheumatologist. We report on data from Pts' BL PROMIS Pain Interference 6b (PI), Fatigue7a (F), Profile29v2 and CDAI. PROMIS T-scores were compared across CDAI disease category (high, moderate etc) using ANOVA. We dichotomized pts based on whether their BL T-score was within 0.5SD of the population mean (i.e. 'normal') or not to evaluate for effect modification in the subsequent change in PROMIS T-scores. Data shown are mean ± std dev.

Results: Pts (N=1220) were 59.5± 13.2 yrs, disease duration 8.2 ± 9.9 yrs, 83.4% female, body weight 85.1± 24.2 kg, BMI 31.4 ± 8.51, BL CDAI 32.4 ± 15.6. A significant relationship between PROMIS T-scores (PI, F) and BL CDAI disease activity category was confirmed. There was minimal change in T-score of pts with BL PI and F T-scores ≤55 and PF>=45 over 5 infusions (approx. 5-7 months). Depending on domain,