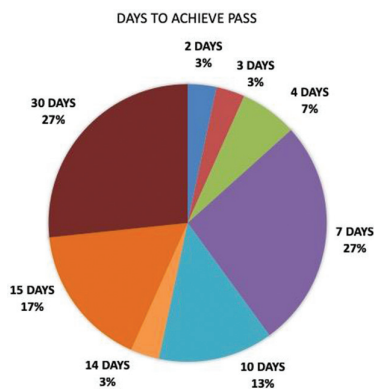


achieve PASS were estimated at T1; activity indices were calculated after 1 month of therapy and correlated with PASS.

Results: Thirty-four RA patients were enrolled (age median-IQR 58-16 years; disease duration median-IQR 144-138 months; DAS-28 median-IQR 5.09-1.92). After 1 month of therapy, 30 of 34 patients achieved PASS, of which 73% in the first 2 weeks of treatment (days to achieve PASS median-IQR 12-22) (figure). At T1, patients achieving PASS, compared to those who did not, reported less pain (median VAS 30/100 vs 72/100, $p=0.025$), a better global assessment of disease (median 40/100 vs 72/100, $p=0.023$), lower GDAI (median 12 vs 31, $p=0.048$), SDAI (median 12.8 vs 33.95, $p=0.011$) and DAS-28 (median 3.67 vs 5.54, $p=0.082$). 10 out of 30 PASS positive patients (33%) achieved a DAS-28 low-disease activity or remission at T1 vs 0% of the PASS negative cohort ($p=0.169$). Age, disease duration and number of previous bDMARDs did not significantly differ between the two subgroups.

Conclusion: Baricitinib was able to induce an acceptable state of health in about 90% of patients after the first month of therapy. The prompt effect of baricitinib on pain and fatigue could partially explain the rapid achievement of PASS, as shown by the decrease of VAS and improvement of the global assessment of disease.



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AB0423 CHANGES IN DISEASE ACTIVITY, PAIN, GLOBAL HEALTH AND PHYSICAL FUNCTION AFTER SWITCHING FROM ORAL TO SUBCUTANEOUS METHOTREXATE: RESULTS OF THE SIX-MONTH OBSERVATIONAL PROSPECTIVE STUDY IN CROATIA

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Background: In rheumatoid arthritis (RA) and psoriatic arthritis (PsA) methotrexate (MTX) is usually the first choice in the treatment strategy.

Bioavailability of oral MTX reaches plateau in doses ≥ 15 mg weekly, and this is the reason of its lower clinical efficacy.

Objectives: The objective of this observational longitudinal study was to evaluate the changes in disease activity, intensity of pain, global health, and physical function when switching from oral (P.O.) to subcutaneous (S.C.) MTX in patients with RA and peripheral form of PsA.

Methods: Forty-eight consecutive patients (79.2% women) with established diagnosis of RA (77.1%) and peripheral PsA were enrolled from the out-patient clinics in six centres in Croatia. Median age was 61 (39-79) years, and the median of disease duration was 120 (3-528) months. Data were collected at baseline (T0) including retrospective data collection from the previous 3 months (on P.O. MTX), at day 90 (± 10 days) (T1) and at day 180 (± 10 days) (T2) for the previous periods, both of them during S.C. MTX treatment. Dose of MTX remained stable during the study. Domains of interest were Disease Activity Score on 28 joints measured using ESR (DAS28-ESR), level of pain, Patient's Global Health Assessment (PtGHA) and Physician's Global Health Assessment (PhGHA) were measured on horizontal 100 mm VAS, while physical function was measured by Health Assessment Questionnaire – Disability Index (HAQ-DI).

Results: Out of 48 patients 41 patients were switched to S.C. MTX monotherapy and 7 to S.C. MTX in combination with another csDMARD. At T1 40 patients were on S.C. MTX monotherapy and 8 on S.C. MTX in combination with another DMARD, and at T2 39 patients were on S.C. MTX monotherapy, 4 on S.C. MTX in combination with another DMARD, 1 on another DMARD and 4 were lost to follow-up. DAS28 showed trend of decrease from 4.9 at baseline to 4.6 at T1 and 4.2 at T2. Analysis of transition of patients according to DAS28 EULAR criteria has shown that percentage of patients with low disease activity has raised from 4.3% at T0, to 21.7% at T1, and 24.3% at T2, while percentage of patients with high disease activity has declined from 38.3% at T0 to 21.7% at T1 and 13.5% at T2. Recommendation for prednisone therapy > 7.5 mg/QD had 12.5% patients at T0 and T1, and only 6.8% patients at T2. There was a significant decrease in adjusted mean values for level of pain (-1.46; 95%CI -1.55, -0.35), PtGHA (-1.12; 95%CI -1.50, -0.73) and PhGHA (-1.15; 95%CI -1.50, -0.80). HAQ-DI showed significant improvement during the 6-month follow-up (-0.25; 95%CI -0.32, -0.17).

Conclusion: Patients who switched from P.O. to S.C. MTX showed improvement in all observed parameters: decrease of disease activity, reduction of pain, better global health, and physical function. Results of our study are in line with previously published literature data.

Disclosure of Interests: None declared

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AB0424 A RETROSPECTIVE STUDY OF ARTHROSCOPIC SYNOVECTOMY FOR REFRACTORY KNEE ARTHRITIS COMPLICATED WITH POPLITEAL CYST

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Background: Baker's cyst or popliteal cyst is the most common mass surrounding the knee joint that results from inflammatory knee arthritis. With increasing number of arthroscopic synovectomy performed for refractory knee arthritis annually, we aim to explore its value in baker's cyst treatment.^[1]

Objectives: To investigate the efficacy of arthroscopic synovectomy on refractory knee arthritis complicated with popliteal cyst.

Methods: A retrospective analysis of 153 patients (RA= 95, SpA= 58) with refractory knee arthritis, underwent knee arthroscopic synovectomy in our hospital from 2010 to 2017, was performed. Among them, 20 patients (RA= 16, SpA= 4) complicated with popliteal cyst. We compared the changes in inflammation makers, disease activity score, imaging manifestations, symptoms, the rate and the grading of popliteal cyst^[2] before and after the operation to evaluate the efficacy of knee arthroscopic synovectomy.^[3]

Results: Inflammation markers [ESR(49.42 \pm 32.54 vs 24.46 \pm 24.17, $P<0.001$), CRP(8.55 \pm 16.43 vs 5.60 \pm 22.45, $P<0.001$), Rheumatoid Factor(191.29 \pm 373.72 vs 74.90 \pm 158.31, $P<0.001$), DAS28 score(4.67 \pm 1.25 vs 2.81 \pm 1.23, $P<0.001$), knee joint discomfort score(5.2 \pm 1.7 vs 1.9 \pm 1.5, $P<0.001$) and the amount of knee joint effusion by ultrasound scanning ($P<0.05$) in 95 RA patients were significantly decreased compared to those before the operation; Inflammation markers [ESR(36.76 \pm 28.71 vs 21.19 \pm 9.79, $P<0.001$), CRP(21.19 \pm 9.79 vs 3.36 \pm 6.44, $P<0.001$), knee discomfort score (4.48 \pm 1.06 vs 2.51 \pm 1.54, $P<0.05$), back pain VAS score(2.74 \pm 2.88 vs 1.56 \pm 1.70, $P<0.001$), and the amount of knee joint effusion by ultrasound