Strategy; NCT02187055) studies. Pts were stratified by concomitant use of 'any pain therapy' (opioids, plain analgesics [eg acetaminophen], NSAIDs or glucocorticoids [GC; ≤ 10 mg of prednisone or equivalent per day]), 'pure analgesics' (opioids or plain analgesics) and 'adjuvant analgesics' (NSAIDs or GC). Pts receiving pain medication at baseline (BL) maintained a stable dose during the studies; opioid and/or acetaminophen dose could be increased as rescue therapy. Efficacy outcomes were assessed at Month (M)3 and M6: change from BL (Δ) in Pt Assessment of Pain (Pain; visual analogue scale [VAS]) and Δ Pain stratified by DAS28-4(ESR)-defined low disease activity (LDA; ≤ 3.2) status at M3 and M6.

Results: Of 676 pts who received tofacitinib 5 mg BID monotherapy, 604 (89%) received 'any pain therapy', 141 (21%) received 'pure analgesics' and 589 (87%) received 'adjuvant analgesics'. Demographics and BL disease characteristics, including disease activity and Pain VAS, were generally similar when stratified by use/type of pain medication. Reductions in pain (Δ Pain VAS) at M3 and M6 were generally similar for pts who received tofacitinib with 'any pain therapy' vs those who did not receive 'any pain therapy' (Figure 1a). There was a trend for a numerically greater reduction in pain at M3 and M6 in pts who received tofacitinib with 'any pain therapy' and who achieved LDA at M3 and M6 vs those who received tofacitinib with 'any pain therapy' and did not achieve LDA (95% CI overlapped; Figure 1b). By contrast, pain reductions were similar for pts who received tofacitinib without 'any pain therapy', irrespective of LDA status. Similar trends were seen when pts were stratified by use of 'pure analgesics' and 'adjuvant analgesics' (data not shown).

Conclusion: In this pooled post hoc analysis, pain reduction was similar in pts with RA receiving tofacitinib, regardless of pain medication use. Pain reduction was similar in pts receiving tofacitinib without 'any pain therapy', irrespective of LDA status. These results should be interpreted with caution, as pain medication could be used as rescue therapy, few pts received tofacitinib without 'any pain therapy', and confounding by indication cannot be excluded. Further analyses are required to explore the impact of tofacitinib on the relationship between reductions in pain and disease activity.

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FIGURE 1: Change from baseline in Patient Assessment of Pain (VAS) at Month 3 and Month 6, in patients treated with tofacitinib 5 mg BID monotherapy stratified by: a) concomitant use of pain therapies; and b) DAS28-4(ESR) LDA status at Month 3 and Month 6

Figure 1

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METHOTREXATE ADHERENCE IN MOROCCAN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Adherence to conventional DMARDs (disease-modifying anti-rheumatic drugs) is highly variable in rheumatoid arthritis (RA), ranging from 22 to 107%. Many studies have evaluated these drugs adherence, but only one single systematic review evaluated specifically methotrexate adherence in patients with RA.

Objectives: The aim of this study is to evaluate the adherence to methotrexate (MTX) in Moroccan patients with rheumatoid arthritis (RA) and to investigate factors that may influence it.

Methods: A cross-sectional study enrolled subjects suffering from rheumatoid arthritis according to ACR/EULAR 2010 criteria, with a history of methotrexate treatment for more than 6 months, either as monotherapy or in combination with other conventional or biological DMARDs. The evaluation of therapeutic compliance with methotrexate was realized using two validated self-questionnaires; the Morisky-Green (MG) questionnaire consisting of 6 questions, and the CQR (Compliance Questionnaire on Rheumatology) consisting of 19 questions.

Adherence levels were defined according to the validated thresholds of the questionnaires.

The factors likely to influence the adherence were researched by a standardized questionnaire.

Results: A total of 61 subjects were studied. The mean age was 53.4 ± 12.5 years, with a weekly methotrexate average dose of 18.2 ± 4.5 mg. In combination methotrexate 77% of patients were receiving corticosteroids, 21% biological DMARDs, 19.7% other conventional DMARDs, and 42% folic acid.

The methotrexate adherence levels are presented in figure 1.

Figure 1. methotrexate adherence levels

Lack of resources and adverse effects were the main factors behind methotrexate's low level adherence. The patients with these levels had a longer duration of disease progression and higher parameters of disease activity.

Conclusion: This study shows that the methotrexate adherence level in Moroccan patients with RA is low. The patient's education should be improved in the Moroccan population for a better control of the disease.

Disclosure of Interests: None declared

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