(Table2). The highest OR is shown when $PD \geq 2$ is found in at least one wrist. Similarly, there is a significant but smaller prediction of progression between 3 to 12 months after US (Table2).

When a new joint develops PD, the likelihood of progression to IA within the next 3 months increases (Table2). This is especially predictive with wrists involvement (OR 3.10). Prediction of progression between 3 to 12 months before CS is significantly different between groups, with a higher OR for the wrists.

Conclusion: The presence of PD in one joint and every new joint with PD are both predictive of progression to IA within the next 3months. These results should lead to a logical programme for therapy and follow-up.

Abstract THU0072– Figure 1

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Table 1. demographics

	Progressors	Non-progressors	p-value
N	96	211	
Age*	53.4 (13)	49.8 (13.2)	0.494
CCP titre: High/Low(%)	92.7/7.3	50.2/48.8	0.000
Gender F/M(%)	74/26	74.9/25.1	0.863
Weeks follow-up*	76.44 (93.5)	189.9 (126.5)	0.000
Smoker: Ever/Never (%)	72.9/27.1	48.3/51.7	0.000

*Mean(SD)

Table 2. Probability of progression

if PD ≥ 1 in ≥ 1 joint									
	<3M			3-12M			>12M		
	OR (CI)	P-value	n	OR	P-value	n	OR	P-value	n
All joints	7.52 (2.9,18.9)	0.000	161	3.17	0.006	174	0.177		125
Hands	5.01 (2.1,11.9)	0.000	187	3.39	0.004	219	0.174		148
Wrists	4.47 (1.9,10.5)	0.001	188	5.21	0.000	219	0.999		148
for every new joint with PD ≥ 1									
	<3M			3-12M			>12M		
	OR (CI)	P-value	n	OR	P-value	n	OR	P-value	n
All joints	1.71 (1.3,2.3)	0.000	161	1.38	0.020	174	0.678		125
Hands	1.83 (1.2,2.7)	0.003	187	1.72	0.013	219	0.301		148
Wrists	3.10 (1.6,5.8)	0.000	188	3.05	0.000	219	0.998		148
if PD ≥ 2 in ≥ 1 joint									
	<3M			3-12M			>12M		
	OR (CI)	P-value	n	OR	P-value	n	OR	P-value	n
All joints	2.63 (1.5,4.5)	0.001	161	2.29	0.012	174	0.128		125
Hands	2.89 (1.4,5.9)	0.004	187		0.137	219	0.078		148
Wrists	12.11 (3.2,46.5)	0.000	188	5.78	0.015	219	0.999		148

Disclosure of Interests: Laurence Duquenne: None declared, Kulveer Mankia Grant/research support from: Research support from BMS and Lilly, Speakers bureau: Honoraria from Abbvie, UCB, Jacqueline Nam: None declared, Peta Pentony: None declared, Leticia Garcia-Montoya:

None declared, Andrea DiMatteo: None declared, Laura Hunt: None declared, Paul Emery Grant/research support from: Pfizer, MSD, AbbVie, Bristol-Myers Squibb, Roche, Consultant for: Pfizer, MSD, AbbVie, Bristol-Myers Squibb, UCB, Roche, Novartis, Gilead, Samsung, Sandoz and Lilly
DOI: 10.1136/annrheumdis-2019-eular.7860

THU0073

HAVE THE CLINICAL CHARACTERISTICS OF RHEUMATOID ARTHRITIS AT PRESENTATION BECOME Milder OVER TIME? RESULTS FROM A NATIONWIDE STUDY OVER THREE DECADES IN SWEDEN

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Background: The course of rheumatoid arthritis (RA) has become milder during the last decades, which could at least partly be attributed to major advances in the pharmacological treatment of the disease and the implementation of "treat to target"-strategies (1,2). It has also been suggested that RA is already milder at presentation (3)

Objectives: To investigate whether the clinical status, markers of inflammation, functional status, and patient and evaluator reported disease activity measures in patients with newly diagnosed RA, have improved over the recent decades.

Methods: Baseline data on all DMARD-naïve patients with early RA (<6 months duration) included in the nationwide Swedish Rheumatology Quality registry (SRQ) between 1991 and 2014 were retrieved. The RA diagnosis relied on the clinical judgement of the treating physician and the information comprised swollen and tender joints count (SJC; TJC), markers of inflammation (CRP; ESR), functional status (HAQ; 0-3), patient's and evaluator's assessment of global disease activity (PtGA; EGA) and patient's assessment of pain (on a visual analog scale, VAS; 0-100 mm). Baseline demographic and disease characteristics were compared between patients with disease onset 1991-2000 vs. those with onset 2011-2014, using Mann-Whitney U test and Pearson's chi-squared test.

Results: A total of 6559 early RA patients were included. Over the study period of 23 years the majority of the patients were women (68%), and the mean age at inclusion increased from 57.4 to 59.1 years. Results are summarised in Table 1. Mean CRP, ESR, TJC and SJC all decreased significantly between the two time periods compared, which was also the case for HAQ. In contrast, mean pain, PtGA and EGA increased significantly between the time periods. Furthermore, time from symptom onset to inclusion was shorter 2011-2014.

TABLE 1 (Mean (SD))	1990s	2000s	2011-2014	p-value*
Number of patients	1227	4344	988	-
Age at inclusion (years)	57.4 (15.4)	58.4 (15.0)	59.1 (14.7)	0.006
Female gender	67.3%	67.6%	70.4%	0.12
Time from symptom onset (months)	3.8 (1.5)	3.6 (1.5)	3.3 (1.5)	<0.001
CRP (mg/L)	33.1 (36.3)	29.3 (36.7)	22.6 (29.9)	<0.001
ESR (mm)	36.4 (25.8)	35.4 (24.8)	32.4 (23.7)	<0.001
TJC (0-28)	8.0 (6.6)	8.0 (6.1)	7.1 (6.0)	0.005
SJC (0-28)	9.5 (5.9)	9.0 (5.8)	7.6 (5.5)	<0.001
HAQ (0-3)	1.1 (0.6)	1.1 (0.6)	1.0 (0.6)	0.028
EGA (VAS 0-100)	50.3 (19.5)	54.4 (19.4)	54.8 (20.1)	<0.001
Pain (VAS 0-100)	49.5 (26.1)	52.3 (25.5)	53.4 (26.4)	<0.001
PtGA (VAS 0-100)	48.6 (26.7)	52.4 (25.5)	51.8 (26.7)	0.006

*1990S vs 2011-2014

Conclusion: In Swedish patients with early RA, baseline joint counts and inflammatory markers improved over the last three decades. This could partly be explained by shorter symptom duration at diagnosis but also suggests that, at onset, RA might be an inherently milder disease today. However, pain and patient's global assessment and evaluator's global assessment of disease activity increased over the same period of time, possibly indicating changes in both patients' and evaluators' expectations for management of early RA today

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Figure 1. Mean baseline values with 95% confidence interval.

Disclosure of Interests: Jon Einarsson: None declared, Tor Olofsson: None declared, Olafur Palsson: None declared, Johan K Wallman Consultant for: Consultant for AbbVie, Celgene, Eli Lilly, Novartis, and UCB Pharma., Meliha C Kapetanovic: None declared
DOI: 10.1136/annrheumdis-2019-eular.2167

THU0074

EVALUATION OF MEDICATION PERSISTENCE IN PATIENTS WITH RHEUMATOID ARTHRITIS AND SJÖGREN'S SYNDROME/INTERSTITIAL LUNG DISEASE TREATED WITH NON-TNFI DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS

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Background: RA is a systemic disease driven by pathogenic autoantibodies and inflammatory cytokines that can involve tissues and organs as well as synovial joints. Sjögren's syndrome (SS) and interstitial lung disease (ILD) are frequently reported extra-articular manifestations of RA. However, there are currently limited data on the persistency of non-TNFi inhibitor (TNFi) biologic (b)DMARDs and targeted synthetic DMARDs, such as tofacitinib (TOF), in patients (pts) with SS and ILD secondary to RA (RA-SS and RA-ILD).

Objectives: To compare medication persistence between non-TNFi DMARDs including abatacept (ABA), TOF and tocilizumab (TOC) in RA-SS and RA-ILD.

Methods: Pts (≥ 18 years) from the Truven MarketScan™ administrative claims database with RA (≥ 2 prescription claims for RA identified with International Classification of Diseases [ICD]-9 or ICD-10) being treated with a non-TNFi DMARD from Jan 2006 to Sep 2017 were included. The date of the first claim for a drug of interest on or after diagnosis of RA was considered the index date. Pts were required to have at least 6 months of continuous enrolment prior to the index date (baseline). Pts with claims for other bDMARDs on the index date were excluded from the study. Pts with a diagnosis of SS or ILD any time in the baseline or follow-up periods were included in the RA-SS or RA-ILD cohorts, respectively. Persistence was defined as the number of days from index date to first switch or discontinuation of the index date DMARD, or end of the study period, or end of enrolment, whichever came first. Pts in both cohorts were stratified by prior TNFi use (TNFi-naïve or TNFi-experienced) and by prior corticosteroid (CS) use. Pairwise comparison of persistence between the non-TNFi DMARDs was performed with ABA as the reference, using the Kruskal-Wallis test for both cohorts separately. A p value of <0.05 was considered statistically significant.

Results: A total of 2503 and 3856 pts satisfied the inclusion and exclusion criteria for the RA-SS and RA-ILD cohorts, respectively. In the RA-SS cohort, 1767, 378 and 358 pts were taking ABA, TOF and TOC, respectively; in the RA-ILD cohort, these numbers were 2937, 343 and 576. The majority (90% in RA-SS and 75% in RA-ILD) of the study population was female. In the RA-ILD cohort, the proportion of pts with prior CS use was significantly lower in pts taking ABA (vs TOF). In the RA-SS cohort, the comorbidity index between treatment cohorts was similar; however, ABA pts had significantly lower pulmonary nodules vs TOF pts (Table 1). In the RA-ILD cohort, the comorbidity index was significantly lower for ABA (vs TOF and TOC), with differences in types of comorbidities at baseline (Table 1). In the RA-SS cohort, the mean time on therapy for pts in the ABA cohort was longer compared with pts in the TOF cohort. Persistency of ABA was higher compared with TOF in the TNFi-experienced pts and in CS-experienced pts (Table 2). In the RA-ILD cohort, overall mean time on therapy for pts taking ABA was longer

compared with TOC. Persistency of ABA was higher compared with TOC in the TNFi-naïve cohort.

Conclusion: Based on the analysis of a large US claims database, pts with RA-SS prescribed ABA (vs TOF) had higher persistency, and pts with RA-ILD prescribed ABA (vs TOC) had higher persistency. Further analysis of medication persistence, adjusting for pt characteristics, is warranted.

Abstract THU0074—Table 1. demographics

Table 1. Baseline characteristics by cohort

	RA-SS cohort			RA-ILD cohort		
	ABA (n=1767)	TOF (n=378)	TOC (n=358)	ABA (n=2937)	TOF (n=343)	TOC (n=576)
Mean (SD) age, years	55.1 (11.4)	54.6 (10.5)	55.6 (12.1)	61.4 (12.0)	62.4 (11.3)	60.6 (12.8)
Female, n (%)	1635 (92.5)	349 (92.3)	325 (90.8)	2247 (76.5)	262 (76.4)	449 (78.0)
TNFi-experienced, n (%)	829 (46.9)	175 (46.3)	213 (59.5)*	1338 (45.6)	132 (38.5)*	297 (51.6)*
CS use, n (%)	1114 (63.0)	257 (68.0)	221 (61.7)	1885 (64.2)	261 (76.1)*	375 (65.1)
CCI score, mean (SD)	1.4 (0.9)	1.4 (0.9)	1.5 (0.9)	1.8 (1.2)	2.0 (1.3)*	1.9 (1.4)*
Select comorbidities, n (%)						
COPD/asthma	19 (1.1)	7 (1.9)	6 (1.7)	118 (4.0)	39 (11.4)*	40 (6.9)*
Pneumonia	60 (3.4)	19 (5.0)	16 (4.5)	309 (10.5)	53 (15.5)*	68 (11.8)
Pulmonary nodule	47 (2.7)	22 (5.8)*	12 (3.4)	216 (7.4)	81 (23.6)*	89 (15.5)*
Heart failure	42 (2.4)	3 (0.8)	5 (1.4)	219 (7.5)	31 (9.0)	45 (7.8)
Dyslipidaemia	269 (15.2)	66 (17.5)	67 (18.7)	526 (17.9)	104 (30.3)*	138 (24.0)*
Ischemic heart disease	100 (5.7)	19 (5.0)	22 (6.1)	418 (14.2)	70 (20.4)*	68 (11.8)
Osteoarthritis	524 (29.7)	126 (33.3)	118 (33.0)	935 (31.8)	127 (37)	209 (36.3)*
Lupus	171 (9.7)	26 (6.9)	37 (10.3)	132 (4.5)	9 (2.6)	28 (4.9)
Infections	953 (53.9)	198 (52.4)	187 (52.2)	1613 (54.9)	192 (56.0)	330 (57.3)

*p<0.05 vs ABA

ABA=abatacept; CCI=Charlson Comorbidity Index; COPD=chronic obstructive pulmonary disease; CS=corticosteroid; RA-ILD=patients with interstitial lung disease secondary to RA; RA-SS=patients with Sjögren's syndrome secondary to RA; TNFi=TNF inhibitor; TOC=tocilizumab; TOF=tofacitinib

Abstract THU0074—Table 2. demographics

Table 2. Persistence by cohort: overall and stratified by prior TNFi and CS use

	RA-SS cohort			RA-ILD cohort		
	ABA (n=1767)	TOF (n=378)	TOC (n=358)	ABA (n=2937)	TOF (n=343)	TOC (n=576)
Overall	n=1767 367.9 (440.5) 204	n=378 281.2 (310.3)* 167	n=358 316.1 (343.6) 175	n=2937 367.4 (439.9) 211	n=343 315.3 (317.9) 186	n=576 316.0 (366.9)* 179
TNFi-naïve	n=938 357.9 (447.8) 193	n=203 269.6 (281.9) 178	n=145 297.5 (374.6) 147	n=1599 358.5 (426.5) 201	n=211 307.3 (317.3) 165	n=279 269.7 (316.6)* 156
TNFi-experienced	n=829 379.1 (432) 225	n=175 294.7 (340.5)* 163	n=213 328.7 (321.1) 190	n=1338 378 (455.3) 223	n=132 328.3 (319.5) 211.5	n=297 359.6 (408) 208
CS-naïve	n=663 368.4 (441.7) 197	n=121 327.2 (313.6) 235	n=137 311.2 (351.5) 175	n=1052 360.7 (443.7) 208	n=82 363.1 (322.8) 281	n=201 303.9 (357.4) 175
CS-experienced	n=1114 367.6 (440) 205	n=257 259.6 (306.9)* 138	n=221 319.1 (339.4) 190	n=1885 371.1 (437.8) 213	n=261 300.3 (315.4)* 164	n=375 322.6 (372.2)* 181

Values expressed as mean (SD) median, in days reported

*p<0.05 vs ABA

ABA=abatacept; CS=corticosteroid; RA-ILD=patients with interstitial lung disease secondary to RA; RA-SS=patients with Sjögren's syndrome secondary to RA; TNFi=TNF inhibitor; TOC=tocilizumab; TOF=tofacitinib

Disclosure of Interests: Leticia Ferri Shareholder of: Bristol-Myers Squibb, Employee of: Bristol-Myers Squibb, Evo Alemão Shareholder of: Bristol-Myers Squibb, Employee of: Bristol-Myers Squibb, Aarti Rao Consultant for: Bristol-Myers Squibb

DOI: 10.1136/annrheumdis-2019-eular.1480

THU0075

EARLY VERSUS DELAYED START OF BARICITINIB IN PATIENTS WITH RHEUMATOID ARTHRITIS IN A PHASE 3 TRIAL OF PATIENTS NAÏVE TO METHOTREXATE TREATMENT

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Background: Baricitinib (bari) is an oral Janus kinase (JAK)1/JAK2 inhibitor approved to treat moderately to severely active rheumatoid arthritis (RA) in adults in over 50 countries including European countries, the US and Japan. In the 52-week (wk) Phase 3 RA-BEGIN study, bari 4-mg alone or in combination with methotrexate (MTX) showed clinical improvements compared to MTX monotherapy for MTX-naïve patients (pts) with early active RA.¹

Objectives: To assess if pts who receive bari monotherapy early attain enhanced clinical, functional and radiographic outcomes compared to pts who initiated MTX and switched to bari at wk 52.