obtained if only subjects with seropositive RA were included in the analysis. Adjustment for confounding factors did not affect the results (HR for bariatric surgery after adjustment for confounding factors 0.92, 95% CI 0.58-1.45, P=0.72).

Conclusion: In a large cohort of obese subjects followed up for up to 29 years, bariatric surgery did not affect the incidence of RA years.

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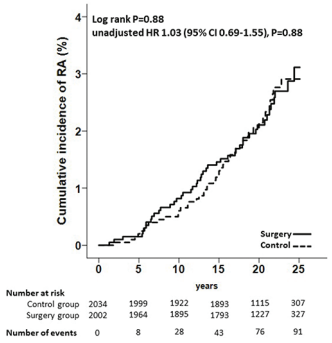

Abstract THU00107 – Figure 1

Abbreviations: HR, hazard ratio; C.I., confidence interval.

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THU0108

11. RHEUMATOID ARTHRITIS – PROGNOSIS, PREDICTORS AND OUTCOME CONCORDANCE BETWEEN PHYSICIAN AND PATIENT ASSESSMENT OF DISEASE ACTIVITY IN RHEUMATOID ARTHRITIS USING DISEASE ACTIVITY SCORE

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Background: Involving patients with rheumatoid arthritis (RA) in the assessment of their disease may increase adherence to treatment, improve disease outcomes and reduce consultation time.

Objectives: To evaluate the concordance between physician and patient assessment of disease activity in RA using Disease Activity Score (DAS-28).

Methods: During the routine consultation, patients were briefed about DAS-28 by their rheumatologist. Using a standard DAS-28 mannequin, physicians, patients and nurses reported the number of tender and swollen joint, inflammatory markers and global health on a 0-10 Likert scale. DAS-28, Clinical Disease Activity Index (CDAI) and Simple Disease Activity Index (SDAI) were calculated blindly by each participant. Agreement between physician- and patient-DAS categories was calculated using weighted kappa (WK) for category comparison. Concordance between physician- and patient-DAS was estimated using the Bland-Altman method. Predictive factors of positive concordance between physician and patient-DAS were identified using logistic regression.

Results: Four hundred and twenty patients from 7 Middle-Eastern countries were included, with a mean age of 49 years (SD 12), 84% of females, disease duration of 11 years (SD 8). Mean physician-DAS-28 was 4.03 (SD 1.51). 65% had positive rheumatoid factor, 56% had positive ACPA, 30% had erosive disease and 34% were on biotherapy. Agreement between physician- and patient-DAS categories was 89%, WK was 0.84. WK were 0.80 for DAS physician-nurse, 0.79 for DAS patient-nurse, 0.83 for CDAI physician-patient and 0.88 for SDAI physician-patient agreements respectively. All activity measures were higher in patients compared to physicians, except for the swollen joints count. The mean difference between physician- and patient-DAS was -0.09 [95% CI -0.14; -0.04] and was smaller in patients in remission (Figure 1: Bland Altman plot). Concordance was statistically associated with CRP and patient SDAI.

Conclusion: Concordance between patient and physician assessment of disease activity in RA was excellent and was higher using SDAI followed closely by DAS-28 and CDAI. Self-assessment of disease activity should be decided according to the physician's clinical judgment.

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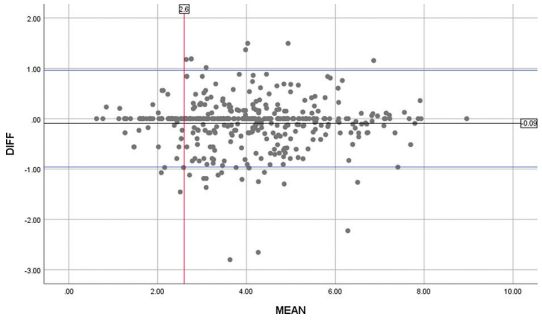

Abstract THU0108 – Figure 1. Concordance between physician- and patient-DAS-28 using the Bland and Altman method.

The physician-patient DAS-mean is plotted on the X-axis. The physician-patient DAS-difference is plotted on the Y-Axis. The horizontal black line corresponds to the mean DAS difference (-0.09 [95% CI -0.14; -0.04]). The horizontal blue lines correspond to +/-1.96 SD. The vertical red line corresponds to the DAS-28 cut-off for remission (2.6).

Disclosure of Interests: None declared

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Rheumatoid arthritis – comorbidity and clinical aspects

THU0109 INCREASED MODIFIED HEALTH ASSESSMENT QUESTIONNAIRE (MHAQ) SCORE IS INDEPENDENTLY ASSOCIATED WITH HIGH RISK OF SEVERE INFECTION IN RHEUMATOID ARTHRITIS (RA) PATIENTS

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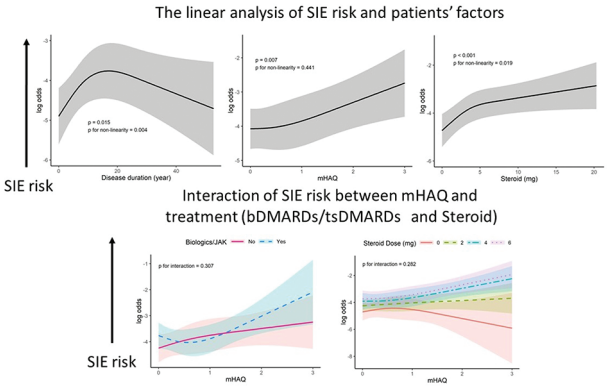
Background: Severe infections that complicate rheumatoid arthritis may cause significant morbidity and mortality. The Modified Health Assessment Questionnaire (MHAQ) is one of the scores most used for measuring the functional status of rheumatoid arthritis (RA) patients. However, the relationship between the MHAQ score and severe infection risk has not been well studied [1].

Objectives: To examine the relationship between disease-associated functional status (MHAQ) and severe infection events (SIE) in rheumatoid arthritis patients.

Methods: We used data from the "MiRAi" cohort in Japan. In total, 2174 RA outpatients were examined at the Osaka Minami Medical Center between January 2012 and October 2017. The risk factors were identified and evaluated by multivariate logistic regression, linearity analysis. Interactions of SIE risk between MHAQ and treatment were also observed.

Results: The cohort contributed to 8206 patient-years of follow-up. Overall, 251 SIEs were observed and the incidence of SIE was 3.0 infections per 100 patient-years. The mean age at first observation was 61.7 years and the mean disease duration was 10.3 years. The use of glucocorticoids (GCs), methotrexate (MTX), and biologic and targeted synthetic disease-modifying antirheumatic drugs (bDMARDs/tsDMARDs) was 59.2%, 63.8%, and 40.3%, respectively. The mean Clinical Disease Activity Index (CDAI), Simplified Disease Activity Index (SDAI), Disease Activity Scores of 28 joints (DAS28), and MHAQ at first observation were 9.76±6.39, 10.1±6.87, 2.67±0.96, and 0.43 ±0.58, respectively. Disease duration, the MHAQ score, and prednisolone dose (p=0.015, 0.007, and <0.001, respectively) were significantly associated with SIE risk (Figure). Age, sex, stage, bDMARDs/tsDMARDs use, DAS28-CRP, and MTX dose (mg/week) did not predict a significant increase in SIE. The risk of SIE increased linearly with the MHAQ. The SIE risk increased rapidly from 0 to 5 mg of prednisolone, and then increased gradually over 5 mg. The SIE risk peaked at around 20 years disease duration. No significant interaction between MHAQ and bDMARDs/tsDMARDs or glucocorticoid use were observed (p=0.307, 0.282, respectively).

Conclusion: An increased MHAQ score was lineally associated with SIE, and did not show significant interactions with bDMARD/tsDMARD use or the oral glucocorticoid dose. Therefore, the MHAQ score is considered to be a strong, independent risk factor for infection in RA patients.



Abstract THU0109 – Figure 1.

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Disclosure of Interests: Yuji Yoshida: None declared, Shiro Ohshima Grant/research support from: AbbVie, Eisai, Asahikasei, Speakers bureau: AbbVie, Eisai, Bristol-Meyers, Novartis, Astellas, Nippon-Kayaku, Pfizer, UCB, Ayumi, Daiichi-Sankyo, Takeda, Tanabe-Matsubishi, Chugai, Eri Oguro: None declared, Kentaro Kuzuya: None declared, Yasutaka Okita: None declared, Hidetoshi Matsuoka: None declared, Satoru Teshigawara: None declared, Maiko Yoshimura: None declared, Kentaro Isoda: None declared, Yoshinori Harada: None declared, Jun Hashimoto: None declared, Yukihiko Saeki: None declared

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THU0110 DISEASE ACTIVITY AND PATIENT-REPORTED OUTCOMES IN PATIENTS WITH RA WITH SJÖGREN'S SYNDROME ENROLLED IN A LARGE OBSERVATIONAL US REGISTRY

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Background: Sjögren's syndrome (SS) is known to occur secondary to RA diagnosis, but its impact on RA outcomes is poorly understood. In the US-based Corrona registry, SS has a prevalence rate of 0.30 in patients (pts) with RA.[1]

Objectives: To compare disease activity and patient-reported outcomes (PROs) in pts with and without SS, in a national sample of pts with RA.

Methods: We identified adult pts with rheumatologist-diagnosed RA from a large observational US registry (Corrona RA), with at least one visit with known SS status between 22 Apr 2010 and 31 Jul 2018 and a visit 12 (±3) months after index date. SS status was captured using physician forms at enrollment and follow-up visits. The index date was the date of first capture of SS diagnosis, or first visit in which SS status was recorded for pts without a diagnosis of SS (non-SS pts). Both those with and without SS were required to have initiated a targeted synthetic (ts) or biologic (b)DMARD. Non-SS pts had to be enrolled for ≥12 months. Pts were frequency matched 1:1 based on RA duration prior to 1:1 propensity score matching (PSM) based on variables associated with treatment response. Outcomes 12 months after index visit were compared in pts with and without SS. Primary outcome was mean change in CDAI score from index visit to Month 12; secondary outcome was mean change in PROs (pain, fatigue, pt global assessment and morning stiffness).