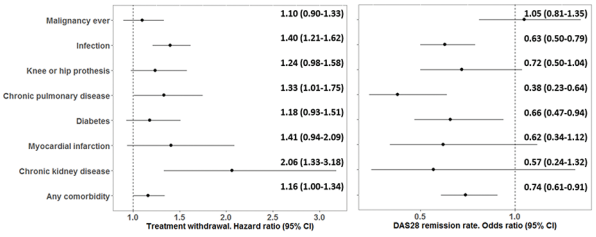
comorbidities (63% female, median age 68 (60-74) years). Only 70 patients (1.4%) had ≥2 comorbidities.
Patients with comorbidities had increased withdrawal rate of methotrexate with hazard ratios ranging from 1.10-2.06 (Figure). Similarly, patients with comorbidities had poorer remission rate with odds ratios ranging from 0.38-0.74 except for previous cancer.
Conclusion: In this nationwide cohort of >5000 RA patients treated with methotrexate in routine care, approximately 15% of patients had comorbidities at treatment start. Patients with comorbidities had higher rate of withdrawal and poorer remission rates. This warrants specific attention when treating these patient groups in routine care.
Acknowledgement: Thank you for the Danish departments of Rheumatology for reporting to DANBIO

Figure. Comorbidities in RA and impact on methotrexate withdrawal and DAS28 remission (6 months)



Time interval for identifying comorbidities (ambulatory or hospitalized) : Malignancy: 0-ever, other comorbidities: 0-5 years previously
Prevalence of comorbidities: Malignancy 8.8%, Infection 7.1%, Prothesis 4.7%, Pulmonary disease 3.3%, Diabetes 4.8%, Myocardial infarction: 1.6%, Kidney disease: 1.0%, Any comorbidity, yes: 15.5%.
All analyses are reported with 'no comorbidity' as reference group.
Abbreviations: CI: confidence interval, DAS28: disease activity score based on 28 joints, RA: rheumatoid arthritis, csDMARD: conventional synthethic disease modifying drug

Abstract THU0134 – Figure 1

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THU0135 DETERMINANTS OF DISCORDANCE IN PATIENT'S AND PHYSICIAN'S GLOBAL ASSESSMENTS OF DISEASE ACTIVITY OF RHEUMATOID ARTHRITIS IN THE "REAL" STUDY – BRAZIL

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Background: Discordance between the patient's global assessment of disease activity (PGA) and examiner's global assessment (EGA) has been described in rheumatoid arthritis (RA) (1,2). Understanding the reasons for this discrepancy is essential in the context of treat-to-target treatment strategy.
Objectives: To assess the determinants of PGA and EGA and factors associated with discordance between them.
Methods: The REAL study included RA patients from Brazilian public health centers. Clinical, laboratory and outcomes measures were collected. PGA and EGA were rated on a visual analog scale and analyzed. Three groups were defined: no discordance (a difference between PGA and EGA within 3 cm), positive discordance (PGA exceeding EGA by >3 cm), and negative discordance (PGA less than EGA by >3 cm). Multivariate regression analysis was used to identify determinants of PGA and EGA and their discordance.
Results: 1115 patients (89,4% female, mean age 56.7y and median disease duration of 12.7y) were enrolled. Two factors were associated with PGA in the final multivariate model: one point increase in the pain scale (PS) leads to an increase of 0.62 in PGA; one point increase in HAQ increases by 9,25 points the PGA. The factors associated with EGA were: PS, number of tender and swollen joints (NTJ and NSJ), RF, ESR, HAQ and use of corticosteroids. Discordance between patient and physician was found in 30.52%: positive discordance (PD) in 24.6% and negative discordance (ND) in 5.92%. An increase of one point in the NSJ was associated with a 12% increase in the chance of ND. The chance of PD increased by 90% and 2% for each unit increased in HAQ and PS respectively. Finally, the chance of PD decreased by 3% for each point increased in NTJ and by 15% for each point increased in NSJ.
Conclusion: In one-third of the assessments, there was disagreement between PGA and EGA (a PD in 80% of them). Pain and function were determinants for patients to estimate disease activity, while swollen joints were the main factor related to a worse examiner´s evaluation. These data show how different can be the perspectives of patients and assistants.

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THU0136 TNF INHIBITORS IN PREGNANCY: STOP, REDUCE OR CONTINUE? – OBSERVATIONS FROM A PREGNANCY OUTPATIENT CLINIC

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Background: Women with active Rheumatoid Arthritis (RA) are more prone to relapses and complications during pregnancy. The potential risks of disease activation and treatment during gestation should be weighed in a shared decision prior to conception. An increasing number of women who wish to conceive are being treated with TNF inhibitors (TNFi). Some wish to discontinue or at least reduce therapy while pregnant and require information on opportunities and risks.

Objectives: To study the outcome of pregnancies in women with RA who either discontinued, reduced or maintained their TNFi treatment after conception.

Methods: Pregnancies from an outpatient pregnancy clinic were evaluated before conception, during each trimester and postpartum. Clinical characteristics, disease activity (DAS28-CRP), medication use and pregnancy outcome were analysed. A flare was defined as increase in clinical activity leading to intensified treatment (new treatment with prednisolone or increase in dosage ≥5 mg/day and/or treatment with intraarticular glucocorticoids and/or (re-)treatment with DMARDs/TNFi). All women received extensive counselling before pregnancy based on current knowledge and subsequently decided to continue or stop TNFi at conception. If they stayed on TNFi and were in remission, women received the suggestion to stretch the therapy intervals in a disease activity guided manner.

Results: After exclusion of one miscarriage, 56 completed pregnancies were enrolled and grouped according to their decision to stop (group 1) or continue (group 2) TNFi therapy during pregnancy. The latter were subdivided into those who could stretch the therapy intervals (group 2a) and those who could not (group 2b). Group 1 also contained seven women who received Tocilizumab or Rituximab until conception.

Despite low disease activity (DAS ≤ 3.2) at conception in all groups, a higher flare rate during pregnancy and postpartum was observed after discontinuation of TNFi. In addition, a higher dose of oral prednisolone and more frequent intraarticular therapy was reported in group 1 (table 1). Postpartum, 38.9% restarted TNFi therapy. About half of the women who chose to stay on therapy during gestation were able to stretch the injection interval of their TNFi, which was either Adalimumab (every 3.0 weeks), Certolizumab (median every 4.0 [min 4.0, max 5.0] weeks) or Etanercept (median every 3.0 [min 2.0, max 6.0] weeks) (Table 2). Relapse rate as well as prednisolone consumption was comparable between group 2a and group 2b.

Abstract THU0136 –Table 1.

	TNFi exposure until conception (N=37)	Pregnancies with ongoing TNFi exposure (N=19)	
		Successful reduction (N=9)	No reduction possible (N=10)
Patient characteristics at conception			
Age (years), median (IQR)	32 (29-36)	32 (30-34)	36 (34.25-36.75)
Disease duration (months), median (IQR)	80 (48-204)	96 (84-276)	70 (54-109.5)
Seropositivity, n (%)	21 (56.8%)	5 (55.6%)	8 (80.0%)
DAS28, median (IQR)	2.8 (2.5-3.1)	2.9 (2.5-3.0)	2.7 (2.6-2.9)
Prednisolone (mg/day), (median, IQR)	5.0 (5.0-7.0)	5.0 (3.5-5.0)	5.0 (3.5-5.0)
Sulfasalazine, n (%)	2 (5.4%)	3 (33.3%)	-
HCQ, n (%)	1 (2.7%)	2 (22.2%)	3 (30.0%)
Pregnancy outcomes			
DAS28-CRP ≤ 3.2, n (%)			
1st trimester	23 (62.2%)	8 (88.9%)	8 (80.0%)
2nd trimester	16 (43.2%)	8 (88.9%)	8 (80.0%)
3rd trimester	23 (62.2%)	8 (88.9%)	8 (80.0%)
3 months postpartum	18 (48.6%)	7 (77.8%)	7 (70.0%)
6 months postpartum	28 (76.5%)	7 (77.8%)	8 (80.0%)
Flare during pregnancy, n (%)	25 (67.6%)	-	2 (20.0%)
Flare postpartum, n (%)	19 (51.4%)	2 (22.2%)	2 (20.0%)
Preterm birth[*1], n (%)	10 (27.0%)	1 (11.1%)	-
Low birth weight[*2], n (%)	7 (19.0%)	-	-
Breastfeeding, n (%)	25 (67.6%)	9 (100.0%)	9 (90.0%)
Glucocorticoid use during pregnancy			
Prednisolone (mg/day), (median, IQR)			
1st trimester	10.0 (5.0-10.0)	5.0 (5.0-5.75)	5.0 (3.5-5.0)
2nd trimester	10.0 (10.0-15.0)	5.0 (5.0-5.75)	5.0 (3.5-7.0)
3rd trimester	10.0 (9.5-13.0)	5.0 (5.0-5.0)	5.0 (3.5-7.0)
Of those taking prednisolone – taking ≥ 10mg/d, n (%)			
1st trimester	15 (65.2%)	1 (16.7%)	2 (20.0%)
2nd trimester	23 (85.2%)	-	2 (20.0%)
3rd trimester	18 (75%)	-	1 (10.0%)
Intraarticular prednisolone therapy, n (%)	17 (45.9%)	-	1 (10.0%)

[*1] delivery ≤ 36+6 weeks of gestation, [*2] birth weight < 2500g, HCQ = hydroxychloroquine

Table 1

Abstract THU0136 –Table 2.

	No TNFi	Adalimumab	Certolizumab	Etanercept
Women on therapy at preconception				
All Groups, n (%)	7 (12.5%)	7 (12.5%)	18 (32.1%)	23 (41.1%)
Group 1, n (%)	7 (18.9%)	4 (10.8%)	8 (21.6%)	18 (48.6%)
Group 2a, n (%)	-	1 (11.1%)	5 (55.6%)	3 (33.3%)
Group 2b, n (%)	-	2 (20.0%)	6 (60.0%)	2 (20.0%)
Women of group 2a during pregnancy				
Therapy interval (weeks), median (min-max)	-	3.0	4.0 (4.0-5.0)	3.0 (2.0-6.0)

Conclusion: Women with RA who discontinue TNFi at conception face a higher risk of flares during pregnancy and often have an increased demand for steroids to control disease activity. When in remission under ongoing TNFi therapy during pregnancy, it seems possible and safe for women to reduce the frequency of injections in a disease activity guided manner. These real-world data will help to provide women with comprehensive advice on treatment options and risks regarding TNFi therapy at pregnancy counselling.

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THU0137 SUBCLINICAL THYROID DYSFUNCTION IS A CARDIOVASCULAR DISEASE RISK IN FEMALE RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a multisystem autoimmune disease that proved to be associated with other autoimmune diseases particularly hypothyroidism. Subclinical hypothyroidism had been reported in RA. As well, RA patients are at double the risk of cardiovascular diseases (CVD). The increased risk of CVD is not fully explained by the

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