THU0294

TREATMENT PATTERNS, DISEASE BURDEN AND OUTCOMES IN PATIENTS WITH GIANT CELL ARTERITIS AND POLYMYALGIA RHEUMATICA

Gary Craig^{1,2}, Keith Knapp², Bob Salim³, Shalini Mohan⁴, Margaret Michalska⁵.

¹Arthritis Northwest, Spokane, United States of America; ²Discus Analytics, Spokane, United States of America; ³Axio Research, Seattle, United States of America; ⁴Genentech, Inc., South San Francisco, United States of America; ⁵Genentech, Inc., South San Francisco, United States of America

Background: For patients with giant cell arteritis (GCA) and/or polymyalgia rheumatica (PMR), glucocorticoids are the mainstay of treatment. However, due to the chronic nature of these diseases, patients may require continued glucocorticoid treatment to achieve treatment targets or prevent disease relapse, over time resulting in high cumulative doses and associated adverse events.

Objectives: To assess patterns of glucocorticoid use and outcomes in patients with GCA, PMR or both.

Methods: This retrospective cohort study used electronic medical records from a single US community-based rheumatology clinic utilizing the Joint-Man rheumatology software application. Patients age ≥ 50 years with a diagnosis of either GCA or PMR and ≥ 1 entry for glucocorticoid following the diagnosis were included and followed until lost to follow-up or the end of the study period (30 Nov 2017). The index date was defined as the date of first glucocorticoid prescription received at or after the earliest GCA or PMR diagnosis date. Outcomes at 2 years included the proportion of patients achieving remission (defined as not receiving steroids for ≥ 6 months), time to remission, persistence of remission (defined as not receiving steroids for ≥ 6 months and still not receiving steroids at 2 years) and prednisone dose at follow-up, and were compared between patients with GCA only, PMR only or both GCA and PMR. *P* values are reported using F-test (ANOVA) for continuous variables and Chi-squared test for categorical variables.

Results: We identified 81 patients with GCA only, 779 with PMR only and 97 with GCA and PMR. Mean (SD) age was 70.0 (9.1) years; 64.2% were women. Mean (SD) daily prednisone dose at the index date was 46.7 (30.9) mg for patients with GCA only, 20.1 (14.2) for PMR only and 29.0 (23.4) for patients with both GCA and PMR. Two years after the index date, 32% of patients with GCA only, 32% with PMR only and 27% with GCA and PMR had achieved remission; 17%, 23% and 18% were in persistent remission, respectively (Table 1), with no significant differences between groups. Among patients who achieved remission, overall median time to first remission was 202.5 (0-635) days and was shorter for patients with both GCA and PMR (157 [0-619] days) vs GCA (213 [0-577] days) or PMR (203.5 [0-635] days) only. Kaplan-Meier estimates of time to remission for each group are shown (Figure 1). Most patients required a daily prednisone dose at 2 years, with similar doses observed between groups (Table 2).

Conclusion: Patients with either GCA and/or PMR are exposed to significant doses of prednisone. In this study, fewer than one-third of patients with GCA and/or PMR achieved remission; the majority of patients continued to require prednisone therapy for at least 2 years after its initiation. These data highlight the need for the use of more efficacious and steroid-sparing therapies in patients with GCA and/or PMR.

Abstract THU294 – Table 1. Outcomes at 2 Years Post-Index Date

Total patients	GCA Only (N = 81)	PMR Only (N = 779)	GCA and PMR (N = 97)	Total (N = 957)	<i>P</i> Value
Achieved remission, n (%)	26 (32.1)	248 (31.8)	26 (26.8)	300 (31.3)	0.7921
Persistent remission, n (%)	14 (17.3)	176 (22.6)	17 (17.5)	207 (21.6)	0.5139
Time to remission, days*					
Mean (SD)	224.3 (171.7)	226.5 (198.6)	208.4 (186.6)	224.7 (194.9)	0.0361
Median (range)	213 (0-577)	203.5 (0-635)	157 (0-619)	202.5 (0-635)	

* Among patients who achieved remission.

Abstract THU294 – Table 2. Prednisone Dose at 2 Years Post-Index Date

	GCA Only (N = 26)	PMR Only (N = 341)	GCA and PMR (N = 60)	Total (N = 427)	<i>P</i> Value
Prednisone dose, mg/day*					
Mean (SD)	9.5 (10.6)	8.8 (9.2)	12.6 (15.9)	9.4 (10.5)	0.0819
Median (range)	5 (0-40)	5 (0-66)	7.5 (0-80)	5 (0-80)	

* Among patients who had prednisone dose information available at 2 years.

Figure 1. Time to Remission Following Initiation of Glucocorticoids

Abstract THU0294 – Figure 1

Disclosure of Interests: Gary Craig Shareholder of: co-owner of Arthritis NW, PLLC and Discus Analytics, LLC, Consultant for: advisory board for Premera Blue Cross, Speakers bureau: Bristol-Myers Squibb, Eli Lilly, Genentech, Celgene, AbbVie, Novartis, and Sandoz, Keith Knapp Employee of: Discus Analytics, Bob Salim Employee of: Axio Research, Shalini Mohan Shareholder of: Genentech, Inc., Employee of: Genentech, Inc, Margaret Michalska Employee of: Genentech, Inc.

DOI: 10.1136/annrheumdis-2019-eular.551

THU0295

POLYMYALGIA RHEUMATICA ASSOCIATED WITH GIANT CELL ARTERITIS CONFIGURES A SUBTYPE WITH LOWER MORTALITY WITHIN GIANT CELL ARTERITIS

Carmen de Frutos Fernández¹, Maria Angeles Martinez Huedo², Irene Monjo³, Eugenio de Miguel³. ¹Medicine Student Universidad Autónoma de Madrid.

²Rheumatology service, Hospital Universitario la Paz-IdiPaz., Madrid, Spain; ³U.

Docencia e Investigación. Hospital Universitario La Paz. Madrid, Madrid, Spain;

³Rheumatology service, Hospital Universitario la Paz-IdiPaz., Madrid, Spain

Background: Giant cell arteritis (GCA) is the most frequent systemic vasculitis in older than 50 years old, with marked general state involvement or ischemic phenomena that can cause blindness to the patient's death. Its form of presentation is heterogeneous however the therapeutic approach tends to be homogeneous. In recent years, the possible existence of subtypes of the disease has been pointed out and this can have important repercussions in the prognosis and approach of the disease. Two studies have suggested that the coexistence of GCA and Polymyalgia rheumatica (PMR) identifies a subgroup of patients at low risk for developing cranial ischemic symptoms. However, this was refuted by three other studies that did not find that effect.

Objectives: To study if, excluding the articular manifestations, the GCA against the association of PMR with ACG presents a phenotype with clinical differences relevant in clinical practice.

Methods: Retrospective observational study based on data from the Database of Hospital from the Spanish National Health Service with primary or secondary diagnostic of GCA between January 1st, 2005 and December 31st, 2015. In this substudy the data demographics and comorbidities and mortality, presenting patients with GCA were collected and compared with patients with GCA and PMR.

Results: The study cohort included 29.576 patients with GCA, of whom 4,189 had PMR as an associated diagnosis. The comorbidities associated with ACG and ACG/PMR and the statistical significance of the differences can be seen in the table. As a relevant fact, a lower risk of mortality was observed in patients presenting GCA along with PMR (OR 0.682 IC95% 0,581-0,801) and a lower frequency of cerebrovascular events and ischemic optic neuropathy.

Table 1. Differences between GCA associated with PMR vs ACG without PMR

		WITHOUT PMR		WITH PMR	
		N	%	N	%
Sex*	Men	9533	37,6%	1474	35,2%
	Woman	15853	62,4%	2715	64,8%
Age group*	≤ 74	5646	22,2%	997	23,8%
	75-79	5779	22,8%	954	22,8%
	80-84	6789	26,7%	1210	28,9%
	≥ 85	7173	28,3%	1028	24,5%
DM2*		6486	25,5%	1131	27,0%