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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8562

FRIDAY, 14 JUNE 2019

15:30:00 – 17:00:00

The multiple rheumatological faces of PsA (or PsA is more than just poly-arthritis? – Consequences for management in daily practice)

SP0142 CASE 1 PRESENTER: A PATIENT WITH PERSISTING MONO/OLIGO-ARTHRITIS (EITHER AT START OR REMAINING AFTER TREATMENT OF POLY-ARTICULAR DISEASE)

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Background: The varied clinical phenotypes of psoriatic arthritis present treatment challenges in clinical practice. The dominant phenotype represented in clinical trials is polyarthritis with little representation of oligoarticular or monoarticular disease.

Objectives: To review the phenotypes of psoriatic disease and treatment of resistant oligo/monoarthritis in the context of a clinical case.

Methods: Clinical case history

Conclusion: The clinical phenotype of articular disease in psoriatic arthritis can evolve over time. There is limited data to inform the treatment of resistant oligo/monoarthritis

Disclosure of Interests: William Tillett Grant/research support from: AbbVie, Celgene, and Lilly, Consultant for: AbbVie, Celgene, Lilly, Novartis, and Pfizer, Speakers bureau: AbbVie, Celgene, Lilly, Janssen, Novartis, UCB, and Pfizer

DOI: 10.1136/annrheumdis-2019-eular.8602

SP0143 CASE 1 DISCUSSANT: HOW IS TACKLING OLIGO-ARTICULAR DISEASE DIFFERENT FROM POLYARTHRITIS? CAN WE USE TRIAL RESULTS FROM POLY-ARTICULAR PSA IN A PATIENT WITH MONO/OLIGO-ARTHRITIS?

Laura C Coates. University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom

Background: Oligoarthritis is a well recognised phenotype in psoriatic arthritis (PsA) where less than 5 joints are involved with active arthritis. In cohort studies, the proportion of patients presenting with mono/oligoarthritis varies from 20-70% depending on the timeframe studied and duration of disease. However most studies of therapeutic agents in PsA have focused on polyarticular disease. Although the majority of studies accept a minimum of 3 active joints for inclusion, the average tender and swollen joint counts are usually over 10 at baseline.

Objectives: To review data supporting treatment of psoriatic mono/oligoarthritis including comparisons of response rates in therapeutic trials in PsA and the differential performance of outcome measures in this subtypes of disease.

Results: When considering the applicability of RCT data to mono/oligoarthritis in PsA it is important to address the populations included in these studies. Nearly all large therapeutic studies exclude monoarthritis, and while some oligoarthritis patients are eligible for inclusion in most RCTs, the demographics of the population included suggest that this is a minority. Unfortunately most clinical trials have not reported the efficacy results separately for oligoarthritis and polyarthritis patients. The other key consideration is that the outcome

measures used in the majority of trials are developed and validated on patients with polyarticular PsA. Thus assessing effectiveness of therapies may be limited in the oligoarthritis population as the response measures are less sensitive to change.

Conclusion: Although data from polyarticular RCT populations is often used to choose therapies in oligoarticular PsA, there is a real paucity of data to ensure that we are treating these patients optimally. Future research is needed to address the variable prognosis seen in mono/oligoarticular PsA, to ensure that appropriate outcome measures are used to test different therapies and to provide clear evidence on the efficacy of drugs in this important subtype of disease.

Disclosure of Interests: Laura C Coates Grant/research support from: AbbVie, Celgene, Lilly, Novartis and Pfizer, Consultant for: AbbVie, Amgen, BMS, Celgene, Galapagos, Gilead Sciences Inc., Janssen, Lilly, Novartis, Pfizer, Prothena Corp and UCB

DOI: 10.1136/annrheumdis-2019-eular.8448

SP0144 CASE 2: SOLITARY ENTHESITIS AS A THERAPEUTIC CHALLENGE

Philippe Carron. Ghent University Hospital, Rheumatology, Gent, Belgium

The enthesis is a site crucial for mobility of the musculoskeletal system yet it is also commonly a target of inflammation, especially in spondyloarthritis. Because the enthesis is prone to high biomechanical forces, it has been hypothesized that biomechanical forces may be implicated in the onset of the enthesitis and spondyloarthritis in general. However, treatment recommendations involve exercise therapy which at first glance appears to pose a paradox. Using a case, we will discuss the current knowledge on enthesitis, the link with mechanical stress and the implications thereof in diagnosis and management of spondyloarthritis.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8442

SP0145 CASE 2 DISCUSSANT: ENTHESITIS AND THE CONCEPT OF MECHANICAL STRESS

Dirk Elewaut. Ghent University Hospital, Rheumatology, Ghent, Belgium Philippe Carron and Dirk Elewaut, VIB Inflammation Research Institute, Ghent University and Department of Rheumatology, Ghent University Hospital

The enthesis is a site crucial for mobility of the musculoskeletal system yet it is also commonly a target of inflammation, especially in spondyloarthritis. Because the enthesis is prone to high biomechanical forces, it has been hypothesized that biomechanical forces may be implicated in the onset of the enthesitis and spondyloarthritis in general. However, treatment recommendations involve exercise therapy which at first glance appears to pose a paradox. Using a case, we will discuss the current knowledge on enthesitis, the link with mechanical stress and the implications thereof in diagnosis and management of spondyloarthritis

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8468

FRIDAY, 14 JUNE 2019

15:30:00 – 17:00:00

Cannabis for arthritis: hype or hope?

SP0146 BENEFITS OF CANNABIS TO YOUR JOINTS: HYPE OR HOPE?

Serge Perrot. France, France

Cannabis-based medicines have been approved for pain management in a number of countries. However, there are uncertainties and controversies about their role and the appropriate use of these medicines for the management of chronic pain, particularly in musculoskeletal conditions. These ancient drugs are now being rediscovered and considered as modern analgesic approaches in the context of cannabis legalization in more and more countries. The fight for cannabis legalization is frequently confused with the search for new analgesics in a medical context. Furthermore, there is a confusion between herbal cannabis, medical cannabis and cannabinoids. Therefore, it is important to differentiate products and

situations and look beyond prejudice and misconceptions, to discover whether there are pharmacological and clinical data to support the use of medical cannabis and cannabinoids in musculoskeletal conditions and arthritis. Aside from media and social discussions, we will try to answer to the current hot question for a clinician is "Is it possible to recommend medical cannabis as a new analgesic option in musculoskeletal conditions?"

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8557

SP0147

ETHICAL ISSUES IN MEDICAL CANNABIS USE

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Background: The human history of *Cannabis* is chequered.

We have evidence from the Ebers papyrus of ancient Egypt (1450 BCE) that 'shm-shm-t' was used as a medication for what appears to have been topical inflammatory issues. In the Atharva Veda (~1500 BCE), 'bhang' was considered one of the five sacred plants of India. The Old Testament refers to 'kaneh-bosm' as a component of a ceremonial anointing oil. In the UK's Elizabethan era, *Cannabis*, as hemp, was grown widely for fibre to make rope and sail for the Royal Navy. In Victorian times, WB O'Shaughnessy brought back from India to the UK the medicinal use of *Cannabis* preparations for its reputed analgesic, anti-emetic, anti-inflammatory and anti-convulsant properties. In the modern era, *Cannabis* is a Schedule 1 drug in many countries - a legal status defined as having high abuse potential with no currently accepted medical value.

Objectives: To consider the ethical issues associated with the use of Cannabis-derived preparations for medicinal purposes.

Conclusion: *Cannabis* is unique among the Schedule 1 list, because extracts from the plant are licensed medicines in different parts of the world. The two most widely-researched metabolites from the plant are Δ^9 -tetrahydrocannabinol and cannabidiol (THC and CBD). The clinical uses of nabiximols (THC:CBD 1:1, combined with other minor cannabinoids) and nabilone (a synthetic THC analogue) for multiple sclerosis and antiemesis, respectively, as well as cannabidiol and dronabinol ((-)-*trans*-THC) for childhood intractable epilepsy and cachexia, respectively, identify that *Cannabis*-derived medicinal products have therapeutic value.

Cannabis or THC in acute administration has a remarkably low association with mortality, however, there are a number of potential issues in the use of *Cannabis* itself rather than the above-mentioned extracts/compounds. Long-term heavy use of *Cannabis* is associated with the risk of addiction in about 10% of individuals. Severe anxiety attacks and psychotic episodes have been linked to higher doses of THC, although this has not been systematically identified. Both THC and CBD have identified metabolic profiles which might influence the turnover of other drugs.

A major feature of the use of *Cannabis* itself is the variability observed. In part, this derives from the natural product nature of the plant and the associated variation in the metabolites between different parts of the plant, different plants, different methods of harvesting, storage as well as method, dose and frequency of administration, the subject's prior exposure to *Cannabis* and the immediate environmental context. Even with the well-controlled clinical trials, there has been identified a variability in plasma levels of the administered agents. In those countries where medicinal *Cannabis* is more freely available, there are also concerns about patient use of black market sources.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8415

FRIDAY, 14 JUNE 2019

15:30:00 – 17:00:00

Reproductive issues in rheumatology

SP0148

DOES PREGNANCY REALLY AMELIORATE DISEASE ACTIVITY OF WOMEN WITH CHRONIC ARTHRITIS? OLD BELIEFS VS NEW PARADIGMS

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Rheumatoid arthritis (RA) and Spondyloarthritis (SpA) are chronic inflammatory diseases whose onset can occur during childbearing age. Juvenile Idiopathic Arthritis (JIA) can be active still during adulthood. Therefore, the disease course during pregnancy has been a topic of interest over the decades [1]. The approach towards the management of pregnancy in the rheumatic diseases has greatly changed in the last 30 years, as it became evident that active maternal disease is associated with adverse pregnancy outcomes, such as miscarriage, pre-term

birth, small-for-gestational age babies. A well-controlled maternal disease during pregnancy is associated with a better pregnancy outcome: the key-point is the treatment of maternal disease with drugs which are not harmful for the fetus. To achieve this "ideal setting" is of fundamental importance to perform a preconception counselling a tailor the management of the patient according to the individual risk stratification [2].

Historically, pregnancy has been considered to have a beneficial effect upon RA, with around 90% of women improving and up to 75% going into remission, followed by flares in puerperium in about 80% [3]. Modern prospective studies using validated measures of disease activity reveal less impressive ameliorative effects of pregnancy on RA [4]. A recent systematic review of prospective studies, using serial and objective evaluations of inflammatory disease, reported that RA improves in 60% of patients through pregnancy and flares in 46.7% of cases after delivery [5].

What are the possible explanations for this shift in the course of RA during pregnancy over decades? 1) methodological issues are obviously present (different study design; different patient population in terms of disease subset, duration, and severity); 2) disease activity as a "self-reported outcome" vs use of validated indices [6]; 3) change in treatment strategies over time: in the '80s women with RA were likely to be treated with steroids only and probably those women with active disease despite treatment were not able to carry out a pregnancy, therefore it is possible that only patients with mild-moderate form of RA were observed during pregnancy. Conversely, the current wide therapeutic armamentarium allows to reach disease remission also in patients with aggressive forms of RA, therefore it is likely to observe disease flares (rather than amelioration) during pregnancy if the drug is stopped at conception. Interestingly, among 75 prospectively-followed RA pregnancies, in patients treated with tumor necrosis factors inhibitors (TNFi) before conception, the discontinuation of the TNFi early in pregnancy resulted in increased risk for disease flares during pregnancy [7]. On the other hand, if disease is well controlled with drugs which are maintained during pregnancy, then there is little room to detect any improvement during pregnancy.

Spondyloarthritis (SpA) is a heterogeneous group of diseases and limited data are available about the disease course of different subsets (axial SpA –axSpA– and Psoriatic Arthritis –PsA–) during pregnancy. Recently, prospective data from the RevNatus registry showed that the majority of women with r-axSpA had stable or low disease activity from preconception period to 1 year after delivery with a small increase in the second trimester [8]. Previous studies reported that axSpA tend to be stable or to get worse [9]. Only one small retrospective work showed that the majority of women with AS displayed a decrease in disease activity during pregnancy [10]. In a recent report of 61 pregnant women with axSpA prospectively followed the discontinuation of TNFi early in pregnancy was a risk factor for flare [7]. Regarding PsA, data are scarce. The only two prospective studies demonstrated improvement during pregnancy and deterioration in the postpartum period [11, 12]. Similarly to axSpA, discontinuation of TNFi at conception is associated with an increased number of flares during pregnancy [13].

In general, it seems that the changes in management of chronic arthritis has determined a shift in paradigm in the disease course during pregnancy. The major determinant of this change has been the growing confidence in using anti-rheumatic drugs during pregnancy and breastfeeding. The increasing evidence about the safety of the majority of anti-rheumatic drugs has been recognized by many national and international working groups under the umbrella of scientific societies which endorsed guidelines and points to consider about this topic [14, 15].

Regarding biologic agents (bDMARDs), they can differ in molecular structure; however, they are all big size proteins which cannot passively diffuse and reach the fetus during the first trimester of gestation. Based on this assumption, unintended pregnancies exposed to these drugs are not a problem. As the active transport of IgG immunoglobulins across the placenta becomes significant after week 16 of gestation, it is understood that those bDMARDs which are IgG monoclonal antibodies will be transferred to the fetus. It was demonstrated that the drug concentration of monoclonal antibodies was higher in the newborn as compared to the mother, as expected for any IgG. Therefore, it is recommended to stop bDMARDs (with different timing according to their structure) in the second trimester – early third trimester in order to minimize the exposure to the drug and avoid that the new born will be immunosuppressed because of the drug received from the mother [14, 15]. Among TNFi, certolizumab pegol (CTZ) does not have the Fc portion needed for transplacental passage and no to minimal drug was detectable in the blood of neonates whose mothers received the drug until delivery [16]. Regarding breastfeeding, it is possible to consider bDMARDs as a homogenous class. They are all large proteins, which are unlikely excreted into breastmilk due to their high molecular weight. But even if they were present in breastmilk, bDMARDs will be degraded in the newborn's digestive tract with no chance for absorption (consider that bDMARDs are administered intravenously or subcutaneously, not orally). CTZ was shown to be absent in the breastmilk and breastfed children did not show any particular adverse event [17].

The exposure to immunosuppressive drugs, especially to bDMARDs, during late pregnancy poses the question about the immune competence of the neonate and the approach towards vaccinations. Data from large administrative US databases showed that children exposed during the third trimester to TNFi did not have an