DISEASE BURDEN IN OSTEOARTHRITIS (OA) IS SIMILAR TO RHEUMATOID ARTHRITIS (RA) FROM THE PATIENT’S PERSPECTIVE, SLIGHTLY HIGHER IN RA AT PRESENTATION, SIMILAR ONE YEAR LATER, AND SLIGHTLY HIGHER IN OA TWO YEARS LATER AT ONE PRIVATE PRACTICE SETTING

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Background: Disease burden traditionally has been regarded as considerably greater in rheumatoid arthritis (RA) versus osteoarthritis (OA). However, recent reports of cross-sectional data indicate similar disease burden in OA vs RA according to MDHAQ/RAPID3 (multidimensional health assessment questionnaire/routine assessment of patient index data). One concern is that these findings may reflect only better treatment for RA, and initial disease burden may be considerably higher in RA vs OA.

Objectives: To analyze disease burden in patients with OA vs RA at baseline and 1- and 2-year follow-up according to MDHAQ/RAPID3 scores in routine care at a single rheumatologist private practice site.

Methods: All patients seen in routine care at this site complete an MDHAQ at each visit in the waiting area prior to seeing the rheumatologist. The MDHAQ includes three 0-10 scores for physical function, pain visual analogue scale (VAS), and patient global VAS; compiled into a 0-30 RAPID3. In addition, 0-10 fatigue VAS, and 0-48 self-report painful joint count scores. Mean MDHAQ scores were compared in OA versus RA patients at 1st visit and visits 1 and 2 years later, using t tests, adjusted for age and body mass index (BMI) using analysis of variance (ANOVA).

Results: Among 101 OA and 175 patients with RA, at first visit, all MDHAQ scores except pain VAS were statistically significantly higher in RA vs OA, e.g., mean 0-30 RAPID3 was 11.9 in OA and 13.7 in RA. However, none of these differences appear clinically significant (Table). After 1-year, all scores were improved, but more in RA vs OA patients (Table), e.g., mean RAPID3 of 11.5 in OA and 10.9 in RA: no differences between OA and RA were statistically or clinically significant. After 2-years, mean RAPID3 was 11.9 in OA vs 9.0 in RA, indicating continued improvement in RA but little change in OA. All scores other than fatigue VAS were higher in OA, including the self-report painful joint count. Differences between OA and RA were explained only by age and BMI.

Conclusion: Most MDHAQ/RAPID3 scores were higher in RA than in OA at the first visit, indicating greater severity of RA, although OA was almost as severe. One year later, scores were similar with no statistically significant differences. Two years later, most scores were higher in OA. These findings most likely reflect superior treatments for RA vs OA. At an individual level, severity of disease burden in OA appears almost as great as in RA, and becomes greater over the next 2 years, likely as a result of better treatment. The severity of OA is underrated, suggesting a need for increasing resources for research toward better treatment for OA.

Disclosure of Interest: Martin Bergman Shareholder of: Johnson and Johnson (parent company of Janssen), Consultant for: AbbVie, Amgen, BMS, Celgene, Genentech/Roche, Janssen, Merck, Novartis, Pfizer, and Sanofi/Regeneron, Mariam Riad: None declared, Theodore Pincus: None declared


EFFECT MODERATION OF ANALGESIC TREATMENT OUTCOMES BY DEPRESSION IN PERSONS WITH OR AT-RISK FOR SYMPTOMATIC KNEE OSTEOARTHRITIS

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Background: Depression often accompanies knee osteoarthritis (OA), exacerbates pain severity, and may negatively affect analgesic treatment outcomes.

Objectives: To determine whether depression moderates the effect of analgesics on pain severity in persons with or at-risk for symptomatic knee OA.

Methods: Participants (n=2059) were from the Osteoarthritis Initiative, with or at-risk for symptomatic knee OA, and had complete data on selected measures at baseline and four annual follow-up visits. Analgesic initiation (acetaminophen, non-steroidal anti-inflammatory drugs, opioids) was assessed at three annual follow-up visits in those who were not analgesic users at baseline. Depression was evaluated concurrent to assessment of analgesic use with the Center for Epidemiological Studies Depression (CES-D) scale using the corresponding CES-D screening threshold (CES-D score ≥ 16). Pain severity at the fourth annual follow-up visit was the outcome and measured with the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) pain scale (rescaled range = 0-100).

Results: Among 101 OA and 175 patients with RA, at first visit, all MDHAQ scores except pain VAS were statistically significantly higher in RA vs OA, e.g., mean 0-30 RAPID3 was 11.9 in OA and 13.7 in RA. However, none of these differences appear clinically significant (Table). After 1-year, all scores were improved, but more in RA vs OA patients (Table), e.g., mean RAPID3 of 11.5 in OA and 10.9 in RA: no differences between OA and RA were statistically or clinically significant. After 2-years, mean RAPID3 was 11.9 in OA vs 9.0 in RA, indicating continued improvement in RA but little change in OA. All scores other than fatigue VAS were statistically or clinically higher in RA vs OA, e.g., mean 0-30 RAPID3 was 11.9 in OA and 13.7 in RA. However, none of these differences appear clinically significant (Table). After 1-year, all scores were improved, but more in RA vs OA patients (Table), e.g., mean RAPID3 of 11.5 in OA and 10.9 in RA: no differences between OA and RA were statistically or clinically significant. After 2-years, mean RAPID3 was 11.9 in OA vs 9.0 in RA, indicating continued improvement in RA but little change in OA. All scores other than fatigue VAS were higher in OA, including the self-report painful joint count. Differences between OA and RA were explained only by age and BMI.

Conclusion: Most MDHAQ/RAPID3 scores were higher in RA than in OA at the first visit, indicating greater severity of RA, although OA was almost as severe. One year later, scores were similar with no statistically significant differences. Two years later, most scores were higher in OA. These findings most likely reflect superior treatments for RA vs OA. At an individual level, severity of disease burden in OA appears almost as great as in RA, and becomes greater over the next 2 years, likely as a result of better treatment. The severity of OA is underrated, suggesting a need for increasing resources for research toward better treatment for OA.