THU0649

PHENOTYPIC CLUSTERS OF RHEUMATIC/SYSTEMIC IMMUNE-RELATED ADVERSE EVENTS INDUCED BY CANCER IMMUNOTHERAPIES (IMMUNOCANCER INTERNATIONAL REGISTRY)

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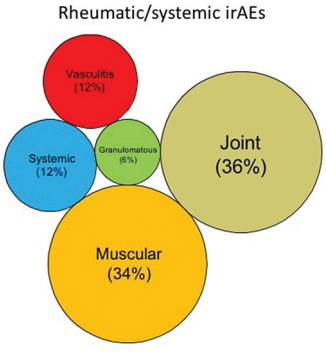
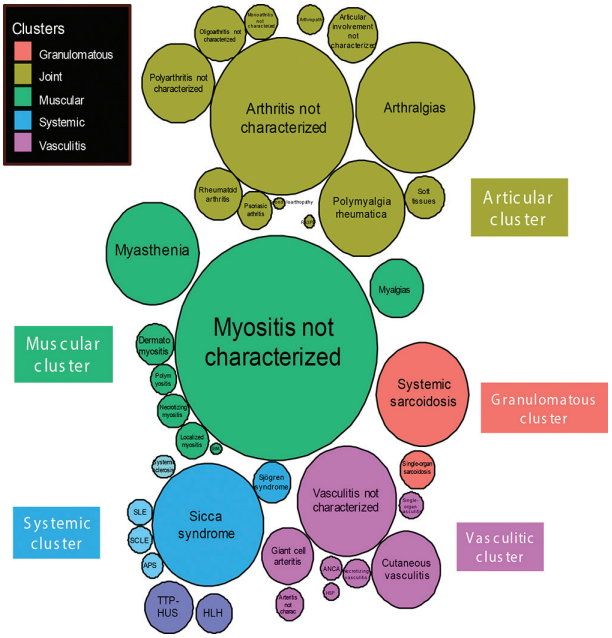
Background: The ImmunoCancer International Registry is a Big Data-Sharing multidisciplinary network focused on the research of the immune-related adverse events (irAEs) related to cancer immunotherapies (CIs).
Objectives: To analyse the worldwide scenario of rheumatic/systemic autoimmune diseases (RSirAEs) associated with the use of CIs during the last 20 years.
Methods: The first objective was to develop a systematic literature review crossing the CIs terms with rheumatic and systemic autoimmune diseases using MedDRAVR 15.0 terms.
Results: RSirAEs were identified in 11% of 12648 patients with irAEs, including 1435 cases (30% fulfilled criteria for a systemic disease) that were classified in 5 phenotypic clusters:





: Non-characterized cases included myositis (25%), arthritis (12%), arthralgias (8%), sicca syndrome (7%) and vasculitis (6%); sarcoidosis (6%), myasthenia gravis (5%), polymyalgia rheumatica (4%), leukocytoclastic vasculitis (3%) and giant cell arteritis (2%) were the most frequent systemic diseases identified:
: In comparison with patients with organ-specific irAEs, RSirAEs were more frequently associated with combined therapies (OR 2.46, CI 2.16-2.81), checkpoint inhibitors -ICis- (OR 4.01 vs TKis, CI 3.26-4.92), and PD-1is (OR 2.46 vs CTLA4is, CI95% 2.16-2.81)
Conclusion: Rheumatic/systemic irAEs can be divided into 5 phenotypic clusters: articular, muscular, granulomatous, vasculitic and systemic. These findings must be confirmed in real-life patients, and an international data-sharing ICIR registry is planned to be launched.

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THU0650 COMPLEMENTARY AND ALTERNATIVE MEDICINE IN RHEUMATOLOGY: A SURVEY OF ITS USE FOR COMMON RHEUMATOLOGICAL CONDITIONS AMONG MULTI-ETHNIC PATIENTS IN LEICESTERSHIRE

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Background: The use of complementary and alternative medicine (CAM) is common in patients with chronic disease.[1] However, the usage of CAMs among patients with rheumatological conditions has been understudied. A significant proportion of primary care trusts are now providing therapies such as acupuncture and osteopathy to some of the 9 million users of CAMs in the United Kingdom (UK).[2] As the NHS serves a varied patient populace, it is important to appreciate the perceptions and utilisation of CAM amongst multi-ethnic groups.

Objectives:

1. To identify the different types CAMs utilised by Rheumatology patients.
2. To identify Rheumatology patients' views towards the role and use of CAMs in managing their condition(s).
3. To identify locations where patients receive CAM and to determine patient's spending practices.

Methods: A cross-sectional survey on CAMs, and its use for common rheumatological conditions was conducted among multi-ethnic patients in Leicestershire, UK, through convenience sampling. The initial questionnaire was created by a multi-disciplinary input, with a patient-centred focus. Thereafter 10 questionnaires were piloted and revised accordingly. The data subsequently underwent statistical analyses.

Results: A total of 107 patients completed the survey over a 3-month period with a response rate of 90%. Most of the respondents (91.8%) were over the age of 35 (age range 19 to 78 years, mean age 50.512.8SD). Among the respondents, 66% were women and 34% were men. 72.9% were of white British or European ethnicity and 20.6% of South Asian ethnicity (17.8% Indian and 2.8% Pakistani). Majority of the patients (66.4%) had rheumatoid arthritis (RA), followed by psoriatic arthritis (11.2%) and ankylosing spondylitis (4.7%). The respondent demographics were consistent with known epidemiology of common rheumatological conditions, with a higher prevalence among women than in men (female-to-male ratio of 3:1 in RA).

31.8% used CAM for managing symptoms related to their condition(s). Almost half of these respondents (41.2%) used CAM products and/or practices daily, with up to 64.7% spending between £10- £100. The majority of respondents (82.4%) received CAM therapy within the UK, followed by India (17.6%). Commonly used CAM products include: ginger (35.3%), fish oil supplements (32.4%), turmeric (32.4%) and cannabidiol (CBD) oil (23.5%). The most common CAM therapies were acupuncture (44.1%), yoga (14.7%), chiropractice (14.7%), meditation (2.9%) and stretch-fit (2.9%). Many respondents (64.7%) used more than one product and/or practice. 60% of the respondents that used CAMs had RA. 9 out of 34 (26.5%) respondents found CAM therapies to be beneficial for their condition(s), with seven (20.6%) finding it to be useful for pain control/relief. Up to 17.8% of all respondents, including those with no prior experience of CAM, perceived potential benefits. However, 65.4% reported neutral views towards CAM.

Conclusion: In our local multi-ethnic population, it is evident that a notable proportion of patients have utilised CAM to supplement the management of their condition. Healthcare professionals need to be aware of the CAMs available, particularly when informing and treating their patients. Effective communication is required in this area to maintain patient's confidence and safety. Further qualitative research should consider the reasons for the use of CAMs.

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THU0651 AN INDIVIDUALIZED DECISION-AID FOR DIVERSE WOMEN WITH LUPUS NEPHRITIS (IDEA-WON): A RANDOMIZED CONTROLLED TRIAL

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Background: Medication decision-making is challenging in lupus. No validated, effective decision-aids are available to assist patients with medication decision-making.

Objectives: Our objective was to assess the effectiveness of an individualized, culturally-tailored, computerized decision-aid for immunosuppressive medications for lupus nephritis.

Methods: In a multicenter, randomized controlled trial, diverse adult women with lupus nephritis, largely racial/ethnic minorities with low socioeconomic status, were randomized to decision-aid vs. American College of Rheumatology lupus pamphlet (1:1 ratio). Co-primary outcomes were change in decisional conflict and informed choice regarding immunosuppressive medications.

Results: Of 301 randomized women, 47% were African-American, 26% were Hispanic, and 15% White. Mean age (standard deviation [SD]) was 37 (12) years, 57% had annual income of <$40,000, and 36% had a high-school education or less. Compared to the pamphlet (n=147), participants randomized to the decision-aid (n=151) had: (1) a clinically meaningful and statistically significant larger decrease in decisional conflict, 21.8 (standard error [SE], 2.5) vs. 12.7 (SE, 2.0; p=0.005); and (2) a clinically meaningful difference in informed choice, statistically non-significant in the main analysis, 41% vs. 31% (p=0.08), but significant in sensitivity analysis (net values for immunosuppressives positive [in favor] vs. negative [against]), 50% vs 35% (p = 0.006). Respectively, unresolved decisional conflict post-intervention was significantly lower, 22% vs. 44% (p<0.001). Significantly more patients in decision-aid vs. pamphlet group rated information to be excellent for understanding lupus nephritis (49% vs. 33%), risk factors (43% vs. 27%), medication options (50% vs. 33%; p≤0.003 for all); and the ease of use of materials higher (51% vs. 38%; p=0.006).

Conclusion: An individualized decision-aid was effective in reducing decisional conflict for immunosuppressive medications in diverse women with lupus nephritis.

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