1. Treat-to-target strategies of RA aiming to reach sustained clinical remission (as defined by the American College of Rheumatology (ACR)) EULAR Boolean or index criteria) or low disease activity.
2. Implement comprehensive shared care, self-management, and education are very critical in treatment strategy.
3. Regular close monitoring of RA patients every 1.3 months then every 3.6 months after achieving treatment target to assess disease activity and damage, functional ability, comorbidities and complications is very important.
4. Ultrasound may have an important role in RA diagnosis, monitoring activity, damage and response to treatment.
5. Start treatment goals of treatment strategy with methotrexate. Shared decision making is advisable to agree which methotrexate administration form is preferable (oral vs subcutaneous vs intramuscular).
6. In patients with a centralisation to MTX or on show intolerance to it, start leflunomide or sulfasalazine as first line of treatment strategy.
7. When the treatment target (remission or low disease activity) has not been achieved despite dose escalation by 3 months, adding another/CIMARD or use combination (CDMARD therapy).
8. Short-term glucocorticoids should be considered when initiating or changing CDMARD.
9. Consider and NSAIDs when control of pain or stiffness is inadequate, offer the lowest effective dose for the shortest possible time considering the comorbidities.
10. If the treatment target not achieved after 6 months of CIMARD combination therapy; addition of a SONARD should be considered without addition MTXs.
11. The cutoff point of starting biologic therapy is High Disease Activity (DAS-28 > 3.1), if DAS-28 > 4.2 and associated with 3 or more poor prognostic factors.
12. First line biologic therapy: Use TNF inhibitors or IL-6 inhibitor. TNF-inhibitors have been given a slight preference over other biologics due to availability of long-term registry data worldwide.
13. Significant improvement using SONARDs should be achieved by 3 months and the target should be achieved by 6 months.
14. An alternative TNF or a inhibitor may be considered for patients in whom treatment is withdrawn due to an adverse event.
15. If the patient has a primary failure to TNF or a inhibitor, prescription of an alternative TNF or a inhibitor is not advised. Switch out of therapeutic class considering a drug with other working mechanisms.
16. In case of secondary failure to anti TNF or a agent; adding a SONARD or alternatively switch to another anti TNF or a or switch to SONARD with other therapeutic class of SONARD.
17. A bio-similar (biSTDARD) of any of the reference biSTDARDs should be used if the respective biSTDARD (or another biSTDARD of the same molecule) has failed to induce sufficient efficacy or vice versa.
18. If target not achieved after 6 months; treatment, change to a non TNF or a SONARD (IL-6 inhibitors, rituximab or abstact) with/without CDMARD.
19. If improvement still not achieved; try another SONARD or use Targeted synthetic CIMARDs or TNF or a inhibitors (infliximab, adalimumab) or other non-TNF or a SONARDs as third line SONARDs till reach remission.
20. Non-pharmacological management (physical therapy, occupational therapy, psychotherapy and nutritional therapy are important to improve functional, psychological and health status of RA patient.
21. Referral of RA patient for surgical opinion has certain time and indications for getting maximum benefits.

REFERENCES:


Disclosure of Interests: None declared

Figure 1: Forest Plot of Mean Treatment Difference and 95% CI of VAS (mm)

Subgroup Analysis of Injection-Site Pain Data Collected Immediately After Injection at Day 1

RESULTS:

Data were analyzed from a total of 2007 assessments in 1001 subjects. A linear mixed model of the VAS in mm, for the RP versus FKB327 across all 4 studies showed a 12.6-point lower pain score for FKB327 versus the RP (95% confidence interval [CI], –14.3 to –10.8; P <.001). For the AI and PFS used for FKB327 administration, AI showed a 1.7-point lower pain score in the VAS compared with PFS (95% CI, –3.3 to –0.1; P = .035). Gender, age, body weight, and population (healthy subject or patient) were not identified for differences in injection-site pain intensity.

Conclusion: FKB327 showed a significant advantage in terms of injection-site pain intensity compared with the RP, as well as lack of inferiority for both AI and PFS versus RS.

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REFR0076 THE RISK OF TUBERCULOSIS IN PATIENTS WITH IMMUNE-MEDIATED RHEUMATIC DISORDERS RECEIVING BIOLOGICAL THERAPY: A 15-YEAR EXPERIENCE IN A ROMANIAN COHORT

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Background: The risk of tuberculosis (TB), either reactivation of latent TB or de novo infection, remains a point of interest in patients with immune-mediated rheumatic pathology in biological therapy; particularly TNFα inhibitors.

OBJECTIVES: We aimed to evaluate the risk and to identify predictors for TB in biologics users among patients with rheumatoid arthritis (RA), involved a single subcutaneous dose of either FKB327 or the RP. Study FKB327-004 was a similar study in healthy Japanese volunteers (n = 180), involved a single subcutaneous dose of either FKB327 or the RP. Study FKB327-004 was a similar study in healthy Japanese volunteers (n = 180) Study FKB327-002 was a randomized (FKB327 with RS or the RP), double-blind, multiple-dose study in patients with active RA. This was followed by Study FKB327-003, in which patients were rerandomized to receive either FKB327 with PFS or the RP in the randomization phase, followed by an open-label extension phase of the study, in which AI was introduced. As patients continued receiving treatment or switched treatments during the course of the FKB327-002 and -003 studies, injection-site pain was assessed at the first dosing occasion of FKB327 or the RP (n = 691). Data from all 4 studies were examined by meta-analysis of the visual analog scale (VAS) using a 100-mm horizontal scale for FKB327 versus the RP and for comparison of AI, PFS, and RS.

RESULTS: Data were analyzed from a total of 2007 assessments in 1001 subjects. A linear mixed model of the VAS in mm, for the RP versus FKB327 across all 4 studies showed a 12.6-point lower pain score for FKB327 versus the RP (95% confidence interval [CI], –14.3 to –10.8; P <.001). For the AI and PFS used for FKB327 administration, AI showed a 1.7-point lower pain score in the VAS compared with PFS (95% CI, –3.3 to –0.1; P = .035). Gender, age, body weight, and population (healthy subject or patient) were not identified for differences in injection-site pain intensity.

Conclusion: FKB327 showed a significant advantage in terms of injection-site pain intensity compared with the RP, as well as lack of inferiority for both AI and PFS versus RS.

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