Yearly progression of mTSS (n = 116)

To investigate prognostic factor for CRRP, clinical data in baseline, 6, 12 months between ten patients with CRRP and 82 patients with structural remission were compared. As shown in Table 1, longer disease duration, more SJC ($P < 0.05$), High CRP level ($P < 0.005$) were prognostic for CRRP in IGU treated patients.

Conclusion: Iguratimod suppressed not only clinical activities but also joint destruction in RA patients resistant to csDMARDs therapy.

Table 1. Prognostic factor for CRRP

	$\Delta mTSS > 3$ (n=10)	$\Delta mTSS \leq 0.5$ (n=82)	P value
Age(yrs)	63.2(12.2)	63.8(11.3)	N.S
Sex(F)	8(80%)	59(72%)	N.S
Disease duration (M)	152.2(28.9)	89.1(88.1)	0.0427*
MTX dose (mg/w)	5.4(1.5)	6.2(4.7)	N.S
PSL dose(mg/d)	2.8(3.2)	2.2(2.2)	N.S
ACPA(U/ml)	210.8(97.5)	212.5(311.3)	N.S
RF(IU/ml)	183.9(137.8)	164.0(285.4)	N.S
MMP3(ng/ml)	183.2(42.5)	165.3(213.1)	N.S
DAS28-ESR	4.6(1.2)	4.3(1.1)	N.S
DAS28-ESR(6M)	3.9(0.4)	3.6(1.2)	N.S
DAS28-ESR(12M)	4.2(1.3)	3.6(1.2)	0.1812
CDAI	17.4(9.5)	16.2(8.5)	N.S
CDAI(6M)	14.3(6.2)	11.5(7.7)	N.S
CDAI(12M)	12.9(7.3)	11.0(9.2)	N.S
mHAQ	0.7(0.6)	0.5(0.6)	N.S
mHAQ(6M)	0.5(0.4)	0.4(0.5)	N.S
mHAQ(12M)	0.4(0.3)	0.4(0.6)	N.S
CRP(mg/dl)	11.6(28.0)	1.5(2.5)	0.0014*
ESR(mm/hr)	44.0(25.6)	30.2(22.5)	0.0743
TJC	2.7(1.7)	4.4(4.7)	N.S
SJC	6.3(4.6)	4.2(2.9)	0.0480*
patient VAS	43.5(8.0)	39.2(25.3)	N.S
mTSS	78.1(87.4)	37.1(67.2)	0.0826
mTSS/y	6.6(5.2)	8.5(13.9)	N.S

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SAT0147

EFFICACY AND SAFETY OF IGURATIMOD AS FIRST-LINE DISEASE-MODIFYING ANTIRHEUMATIC DRUG THERAPY FOR PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Although methotrexate is the anchor drug, it took some days to check contraindications, such as interstitial pneumonia, hepatitis B virus infection, and latent tuberculosis infection. Therefore, we sometimes start rheumatoid arthritis (RA) treatment with other disease-modifying antirheumatic drug (DMARD) in daily clinical setting. Iguratimod (IGU) is a newly developed DMARD approved in Japan in September 2012, and the efficacy of IGU for DMARD naïve patients has not been thoroughly evaluated.

Objectives: The aim of this prospective single-center study was to demonstrate the efficacy and safety of IGU when used as a first-line daily DMARD for patients with RA in a clinical setting.

Methods: Enrolled patients included those diagnosed with RA according to the 2010 American College of Rheumatology/European League against Rheumatism (ACR/EULAR) classification criteria who took IGU as a first-line DMARD at Niigata Rheumatic Center between April 2016 and December 2018 (IGU group). There were no constraints regarding the addition or withdrawal of other DMARDs. Details of the patients' background, clinical parameters, and laboratory findings were obtained, including C-reactive protein (CRP) level, erythrocyte sedimentation rate (ESR), matrix metalloproteinase-3 (MMP-3), rheumatoid factor (RF), Disease Activity Score for 28-joint counts based on the erythrocyte sedimentation rate (DAS28-4[ESR]), Clinical Disease Activity Index (CDAI), and Health Assessment Questionnaire Disability Index (HAQ-DI). The efficacy of IGU was evaluated at week 24. The IGU group's data were then compared with 64 patients who took salazosulfapyridine or bucillamine as first-line DMARD in our hospital (other DMARD group). The data were expressed as median values. Comparisons between the parameters were performed using nonparametric method.

Results: Forty-three patients (15 males, 28 females) received IGU as a first-line DMARD for RA. The age was 69.0 years and the duration of disease was 2.0 months. Twenty patients received prednisolone (PSL) concomitantly at a median dose of 5.0 mg/day. At 24 weeks medications were utilized in patients as follows: IGU in 36 (83.7%), methotrexate in 18 (41.2%), PSL in 17 (39.5%), BUC in 10 (23.2%), and biological DMARD in 7 (15.2%) patients. Although 7 patients discontinued taking IGU due to liver enzyme elevation (n=4), nausea (n=1), creatinine elevation (n=1), and skin rash (n=1) during the 24-week period, serious adverse events requiring hospitalization were not observed. Clinical parameters that improved from baseline after 24 weeks of treatment included: ESR from 42.0 mm/h to 16.0 mm/h with $p < 0.001$; CRP from 0.70 mg/dL to 0.10 mg/dL with $p < 0.001$; MMP-3 from 136 ng/mL to 91.5 ng/mL with a p value of 0.11; RF went from 18.0 IU/mL to 8.00 IU/mL with $p < 0.001$; DAS28(4)-ESR dropped from 5.13 to 2.73 with $p < 0.001$; CDAI dropped from 20.0 to 5.00 with $p < 0.001$, and HAQ-DI decreased from 0.55 to 0.00 with $p < 0.001$. Patients who achieved a good or moderate response based on EULAR response at 24 weeks, included 90.7% in the IGU group versus 70.5% in the other DMARD group (Fisher's exact test, $p=0.046$). The retention rate of the IGU group was 81.4%, roughly equivalent to the 81.2% retention rate in the other DMARD group (Log-rank test, $p=0.733$).

Conclusion: Our study indicates IGU is safe and effective for DMARD naïve RA patients. Starting treatment with IGU might be a new and effective strategy for RA patients without previous use of a DMARD.

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SAT0148

TAPERING OF CONVENTIONAL SYNTHETIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS IN SUSTAINED RHEUMATOID ARTHRITIS REMISSION: RESULTS FROM A RANDOMIZED CONTROLLED TRIAL

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