patient outside of a hospital. In this study, the patients with early RA (less than 2 years of disease duration) who participated in the survey for the first time from 2001 to 2012 were included and observed for five years from the date of the initial visit. We classified patients into group A (enrolled in 2001-2006) and B (enrolled in 2007-2012). Five-year survival rate and standardized mortality ratio (SMR) were calculated for each group. SMR was calculated using the life tables in Japanese general population reported by the Ministry of Health, Labour and Welfare, Japan. The effects of loss to follow-up cases were evaluated by multiple imputation method as a sensitivity analysis of SMR.

Results: A total of 3,217 patients with early RA were analyzed. The number of patients was 1,609 (79.4% female) in the group A and 1,608 (81.8% female) in B. The median age at baseline was 55 in both groups. Among a total of 3,217 patients, 486 (15.1%) patients were lost during 5-year follow-up; 213 (13.2%) in the group A and 273 (17.0%) in B, respectively. During the observational period, deaths were confirmed in 47 cases (2.9%) in the group A and 45 (2.8%) in B. Major causes of death included malignancies (28% in the group A, 38% in B), respiratory involvement (23% in the group A, 40% in B), cerebrovascular disorders (11% in the group A, 2% in B), and cardiovascular disorders (11% in the group A, 0% in B). The five-year survival rate was 88.8% for the group A and 87.6% for B, and the SMR was 0.81 (95% CI: 0.59-1.08) for the group A and 0.78 (0.57-1.04) for B when assuming all the lost to follow-up patients were alive for 5 years. In the sensitivity analysis assuming that the mortality rate of patients who were lost to follow-up was twice as that of the general population, the SMR was 0.90 (0.68-1.19) for the group A and 0.92 (0.68-1.23) for B.

Conclusion: The mortality of patients with early RA in the past twenty years has been comparable to that of the Japanese general population. In addition, the SMR and the five-year survival rate did not change overtime.

References:

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Background: EULAR- recommendations for management of early arthritis formulated that patients should be referred to, and seen by a rheumatologist, within 6-weeks after symptom onset. The mentioned period of ≤6-weeks after symptom onset is shorter than ≤12-weeks, the period that is generally considered as the ‘window-of-opportunity’. Because implementation provides challenges, and evidence supporting that referral ≤6-weeks is better than e.g. <12-weeks is missing, we investigated if ≤6-weeks relates to improved long-term outcomes.

Objectives: We used an observational study design to investigate in two cohorts if time-to-encounter (TE) a rheumatologist ≤6-weeks, compared to >7-12-weeks, results in better disease long-term outcomes, measured with sustained DMARD-free remission (SDFR) and radiographic progression.

Methods: Consecutive 1987-RA patients of the Leiden EAC (n=1025) and ESPOIR (n=514) were studied during median 7 and 10 years follow-up. Patients were categorized on duration between symptom onset and first encounter with a rheumatologist: ≤6-, 7-12-; and >12-weeks. Multivariable Cox regression (SDFR), linear mixed models (radiographic progression), and meta-analyses were used.

Results: Leiden RA-patients encountered the rheumatologist within ≤6-weeks obtained SDFR more often than patients seen within ≤7-12-weeks (HR 1.59, 95% CI:1.02-2.49), and >12-weeks (HR 1.54, 95% CI:1.04-2.29). In ESPOIR, similar but non-significant effects were observed; meta-analysis showed that within 6-weeks was better than 7-12-weeks (HR 1.69, 95%CI: 1.10-2.57, Figure 1-A) and >12-weeks (HR 1.67, 95% CI:1.08-2.58). Patients encountered the rheumatologist within ≤6-weeks had similar radiographic progression than those seen >7-12-weeks, in any cohort, or meta-analysis (Figure 1-B).

Conclusion: Scientific evidence underlying the first EULAR recommendation depends on the outcome of interest: visiting a rheumatologist within 6-weeks of symptom-onset had clear benefits for achieving SDFR, but not for radiographic progression.

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Figure 1 Meta-analyses of time-to-encounter the rheumatologist and the chance of achieving sustained DMARD-free remission (A) and radiographic progression (B)

Conclusion: Scientific evidence underlying the first EULAR recommendation depends on the outcome of interest: visiting a rheumatologist within 6-weeks of symptom-onset had clear benefits for achieving SDFR, but not for radiographic progression.

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