Prediction of response were assessed using the area under the receiver-operator characteristic (AUROC) and sensitivity/specificity. Sub-analyses were performed for primary and secondary non-responders. Correlations between ADL and ADA presence and clinical variables were also cross-sectionally explored.

Results: 137 patients were included, 47 of whom switched to a second TNFi and 90 to a non-TNFi. Sensitivity and specificity of the proposed ADA and ADL reference values were low (table 1). The AUROC did not differ appreciably and 90 to a non-TNFi. Sensitivity and specificity of the proposed ADA and ADL were analyzed for primary and secondary non-responders. Correlations between ADL and ADA characteristic (AUROC) and sensitivity/specificity. Sub-analyses were performed for primary and secondary non-responders to adalimumab.

Table 1. Predictive values of ADA and ADL for response to a subsequent bDMARD in TNFi and non-TNFi switches.

<table>
<thead>
<tr>
<th></th>
<th>ADA presence (&gt;12AU/mL)</th>
<th>low ADL (&lt;5mg/L)</th>
<th>18</th>
<th>75</th>
<th>0.46</th>
<th>0.32-0.59</th>
<th>32</th>
<th>69</th>
<th>0.50</th>
<th>0.29-0.71</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>non-TNFi switches</td>
<td></td>
<td>32</td>
<td>70</td>
<td>0.52</td>
<td>0.42-0.63</td>
<td>50</td>
<td>52</td>
<td>0.50</td>
<td>0.34-0.65</td>
</tr>
</tbody>
</table>

Higher ADL (Spearman's $\rho = -0.68$, $p = 0.00$) but not ADA ($p = 0.23$, $p = 0.28$) was associated with a lower DAS28 at the time of switching to a subsequent bDMARD, but not with follow-up DAS28 after starting the subsequent bDMARD ($p = -0.29$, $p = 0.17$, and $p = 0.10$, $p = 0.65$, respectively). In addition, higher ADA were associated with lower baseline CRP ($p = -0.67$, $p = 0.00$) and ESR ($p = -0.546$, $p = 0.006$) and higher ADA correlated with higher baseline ESR ($p = 0.49$, $p = 0.01$).

Conclusion: No predictive value for response to a second TNFi or non-TNFi was found for either ADA or random timed ADL. Limitations of this study are the retrospective design and random timed serum sampling. An ongoing randomized blinded test-treatment trial will provide more definitive answers [4].

References:

Disclosure of Interests: None declared.

AB0188 COMPARISON OF COMPOSITE INDICES FOR DETECTING REMISSION ON ULTRASOUND

R. Fakhfakh1, N. El Amri1, K. Baccouche1, H. Zeglaoui1, E. Bouajina1, Farhat Hached Hospital, Rheumatology, Sousse, Tunisia

Background: Several studies have shown the greater sensitivity of ultrasound (US) to detect B-mode synovitis and syovial Doppler activity in a high percentage of rheumatoid arthritis (RA) patients in clinical remission, assessed by different composite indices. The aim of the study was to compare the accuracy of composite indices to detect remission in ultrasound B-mode and power Doppler (PD) in RA patients that are in remission according to the DAS28 ESR.

Methods: Cross-sectional study including patients with RA in clinical remission defined by: DAS28ESR ≤ 2.6, without disease flare or changes in therapy in the previous 6 months. Each patient underwent B-mode and PD assessments of 36 joints and 20 tendons in the Rheumatology Department over a period of 6 month. B-mode and PD signal for synovitis and tenosynovitis were defined according to the Outcome Measures in Rheumatology Clinical Trials (OMERACT). A global score for B-mode and a global score for PD signal were calculated for each patient. DAS28, CDAI, SDAI and the Boolean 2010 ACR/EULAR remission criteria were compared.

Results: Thirty two patients were enrolled, the mean age was 53.7±13.4 and the sex ratio M/F was 0.3. The mean disease duration was 15.0 years ± 8.8. According to the SDAI, 68.8% of patients were in remission. These were lower for the CDAI (62.5%) and the Boolean criteria (23.3%). Syovial hypertyrophy and tenosynovitis in B mode was detected in 100% with the Boolean remission criteria, in 93.8% with a DAS28, in 90.9% with a SDAI ≥ 3.3 and in 90% with a CDAI ≤ 2.8 (p=0.05). The PD signal was detected in 62.5% with a DAS28, in 59.1% with a SDAI ≤ 3.3, in 57.1% with the Boolean remission criteria and in 55.1% with a CDAI≤ 2.8 (p=0.05). The mean B-mode global score was higher for the DAS28 ESR (8.2±6.8) and lower for the Boolean remission criteria (6.2±5.4). For a CDAI ≤ 2.8, the mean global score for B-mode was 7.6±5.9 and for a SDAI ≤ 3.3, it was 7±4.5. The median PD global score was similar for the DAS28, SDAI≤ 3.3 and Boolean remission criteria (10-12). It was higher for a CDAI ≤ 2.8 (1.5 [0-12]). The global score for PD signal was correlated with DAS28 ESR (r=0.42 p=0.02). There were no significant correlations between the other indices and the mode B and PD global scores.

Conclusion: The CDAI least detected subclinical synovitis and tenosynovitis in B mode and in power Doppler signal but it showed higher scores of power Doppler.

References:
Disclosure of Interests: None declared
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AB0189

ASSESSMENT OF POWER DOPPLER SYNOVITIS IN RHEUMATOID ARTHRITIS PATIENTS WITH CLINICAL REMISSION

R. Fakhfakh1, N. El Amr1, K. Baccouche1, H. Zeglaoui1, E. Bouajina1, 1Farhat Hached Hospital, Rheumatology, Sousse, Tunisia

Background: Ultrasound-detected synovitis, mainly synovial Doppler signal, has shown predictive value in relation to radiographic damage progression and disease flare or relapse in rheumatoid arthritis (RA) patients with clinical remission.

Objectives: The aim of the study was to analyze the correlation between power Doppler scores and clinical/laboratory and radiographic data in clinical remission RA patients.

Methods: Cross-sectional study including patients with RA in clinical remission defined by: DAS28ESR ≤ 2.6, without disease flare or changes in therapy in the previous 6 months. Each patient underwent ultrasound: B-mode and PD assessments of 36 joints and 20 tendons in the Rheumatology Department over a period of 6 months. Synovitis and tenosynovitis were defined and scored according to the Outcome Measures in Rheumatology Clinical Trials (OMERACT). Radiological measurements included the modified Sharp/van der Heijde method (SHS). Functional capacity was assessed by the Health Assessment Questionnaire (HAQ).

Results: Thirty-two patients were enrolled, the mean age was 53.5 ± 13.4 and 75% were female. The mean disease duration was 15 years ± 8.8. Subclinical synovitis were the most frequent in wrist (56.3%), 2nd metacarpophalangeal joints (28.1%) and 2nd metatarsophalangeal joints (29%). The mean subclinical synovitis/tenosynovitis numbers were 4 ± 3.1 per patient. Synovial hypertrophy and B mode tenosynovitis were detected in 93.8%: 71.3% had a grade ≥ 2 and 98.8% had a grade ≥ 3. Total B mode score was correlated only with the SHS score in the feet (r: 0.4, p: 0.03). PD signal was detected in 62.5% of patients: 37.5% had a grade = 2 and 9.4% had a grade = 3. Total PD score was correlated with DAS28 (r: 0.42, p: 0.02), the SHS score in the hands (r: 0.39, p: 0.03) and in the feet (r: 0.5, p: 0.007), synovial hypertrophy (r: 0.6, p: 0.0001) and HAQ (r: 0.32, p: 0.06). No correlation was found with CDAI, SDAI, swollen joint counts, tender joint counts, patient global health assessment, erythrocyte sedimentation rate, C-reactive protein, rheumatoid factor and anti-cyclic citrullinated peptide, biological treatment.

Conclusion: Synovial hypertrophy and PD signal were frequent in RA remission. PD signal was associated with RA activity, radiologic damage and functional capacity.


Disclosure of Interests: None declared
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AB0190

DO IT FAST! EARLY ASSESSMENT BY A RHEUMATOLOGIST INCREASES THE CHANCES OF RHEUMATOID ARTHRITIS BEING TREATED WITHIN THE “WINDOW OF OPPORTUNITY”

C. Albuquerque1, 1A.P. Gomidas2, A. B. Vargas-Santos3, C. Breno4, L. Pereira5, K. Bonfiglioli1, M. Bertolo6, M. F. Guimarães7, M. Sauma8, P. Louzada Jr9, R. Giorgi10, 10R. Giorgi, 11R. Hadzimarkovic, 1L. Mota, 1G. Castelan-Pinheiro, 1Escola de Medicina, Univ. de Brasília, Brasília, Brazil; 2Universidade do Rio de Janeiro, Rio de Janeiro, Brazil; 3Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil; 4Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil; 5Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil; 6Universidade Estadual de Campinas, Campinas, Brazil; 7Universidade Federal de Minas Gerais, Belo Horizonte, Brazil; 8Universidade Federal do Pará, Belém, Brazil; 9Universidade Federal de São Paulo - Ribeirão Preto, Ribeirão Preto, Brazil; 10Hospital do Servidor Público Estadual de São Paulo, São Paulo, Brazil, 11Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil

Background: The current concept of treating rheumatoid arthritis RA patients emphasizes the importance of early diagnosis and early initiation of disease-modifying drugs (DMARD) for a better prognosis of these patients.

Objectives: To evaluate the impact of rheumatological evaluation on the diagnosis of RA patients, as well as on the initiation of DMARD and on the clinical control of disease activity of these patients under real-life conditions.

Methods: The REAL study included RA patients attending eleven public hospitals, from different regions of Brazil. All subjects met the ARA (1987) or ACR/