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AB0189

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

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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 month. Synovitis and tenosynovitis were defined and scored according to the Outcome Measures in Rheumatology Clinical Trials (OMER-ACT). 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 53.7 $\pm$ 13.4 and 75% were female. The mean disease duration was 15 years $\pm$ 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 was 4 $\pm$ 3.1 per patient. Synovial hypertrophy and B mode tenosynovitis were detected in 93.8%: 71.3% had a grade = 2 and 9.8% 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, biologic treatment.

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

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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"

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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 rheumatologic 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/

EULAR (2010) RA classification criteria. Subjects were submitted to clinical interview with physical exam and review of medical records. Specialized assessment was defined as sequentially "early", when the rheumatologist was the 1st or 2nd consulted physician, and sequentially "late", when the rheumatologist was consulted after two or more other doctors. Welch's t, Mann-Whitney's U, chi-square and Spearman's rho tests were used to test hypotheses, at significance level of 0.05. The study was approved by local ethics committees and all participants granted informed consent.

Results: 1057 RA patients were assessed; 89.4% (n=945) female; 56.5% (n=597) white; mean (SD) age of 56.9 (11.5) years; mean (SD) disease duration of 173.1 (114.5) months. Median [IQR] delay from symptoms onset to RA diagnosis and to the first DMARD both equaled 12 [6, 36] months. Only 28.7% received a DMARD within 6 months of symptoms onset, and 13.1% within 3 months. Most patients (64.6%) sought a general practitioner first, but 80.7% were finally diagnosed only upon rheumatologist consultation. For 28.8%, the rheumatologist was consulted after two or more other doctors. Early specialized assessment resulted in higher chances of receiving a DMARD within 6 months (OR 2.77; 95%CI [1.93, 3.97]) and within 3 months (OR 2.57; 95%CI [1.54, 4.27]) of RA onset. Late assessment was associated with lower chances of being in remission or low disease activity upon study inclusion (OR 0.53; 95%CI [0.39, 0.72]). Patients assessed early by the rheumatologist, compared to those assessed late, showed lower (mean [SD]) HAQ scores (0.877 [0.715] vs. 1.074 [0.857]; p<0.001) and DAS28-CRP scores (3.20 [1.32] vs. 3.45 [1.48]; p=0.02), and shorter delays to RA diagnosis (26.9 [46.7] vs. 44.6 [60.1] months; p<0.001) and to use the first DMARD (32.5 [58.5] vs. 50.6 [69.9] months; p<0.001). The delay to initiate a DMARD was strongly correlated to that of diagnosing RA (rho 0.816; p < 0.001).

Conclusion: Most RA patients missed the window of opportunity to early treatment. Treatment delay strongly correlated with delay in diagnosis, which critically depended on the input from the rheumatologist. Late rheumatologist assessment was associated with lower chances of early RA treatment and with worse outcomes. Failure in direct transition from primary to specialized care was a common problem that needs to be solved.

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AB0191

DECREASING DELAY TO DIAGNOSIS AND TREATMENT OF RHEUMATOID ARTHRITIS: STILL DIFFICULT TO TREAT WITHIN THE WINDOW OF OPPORTUNITY

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Background: The need for early rheumatoid arthritis (RA) treatment for better outcomes is widely accepted. Is that goal being achieved in real-life settings?

Objectives: To evaluate changes in the delay to RA diagnosis and treatment, and in the proportions of patients being treated early along the last decades in Brazil.

Methods: This study was drawn from the REAL cohort, designed to assess RA management under real-life conditions. Patients ≥ 18 years old attending public hospitals in Brazil and meeting RA classification criteria were included. Subjects were stratified according to the year their symptoms began. Delays from symptoms onset to RA diagnosis and treatment were inquired. Early RA diagnosis and treatment was assessed using three different cut points: ≤ 3 , ≤ 6 and ≤ 12 months of symptoms onset. Mann-Kendall's trend test, chi-square tests, Welch's ANOVA and Games-Howell's post-hoc tests were used to test hypotheses, at 0.05 significance level.

Results: 1116 RA patients were included; 89.4% female; 56.8% white; mean (SD) age 57.1 (11.5) years. A downward trend was found in the delay to RA diagnosis ($\tau = -0.677$, $p < 0.001$) and treatment ($\tau = -0.695$, $p < 0.001$) from 1990 to 2015 (Figures 1 and 2). The year of symptoms onset was associated with the frequency of early treatment for all defined cut points: ≤ 3 months ($\chi^2 = 11.25$, $p = 0.001$), ≤ 6 months ($\chi^2 = 34.84$, $p < 0.001$), and ≤ 12 months ($\chi^2 = 64.79$, $p < 0.001$). The more recent the year of symptoms onset, the higher the proportions of individuals treated early (Table 1). Groups stratified according to successive periods of symptoms onset differed in the mean delay to RA treatment [$F(5, 372.8) = 41.9$; $p < 0.001$]. Patients with symptoms initiated more recently (2011-2015) had significantly lower delays compared to all other groups. Nonetheless, only 36.3% of these patients with more recent disease started treatment within 6 months of symptoms onset, and 17.2% within 3 months.

Table 1. Proportions of individuals with RA receiving the first DMARD within different time intervals from symptoms onset, according to the year their symptoms began.

Symptoms beginning (year)	Interval from symptoms onset to first DMARD			N
	≤ 3 months	≤ 6 months	≤ 12 months	
≤ 1990	8.5%	14.9%	33.3%	141
1991 – 1995	5.3%	15.8%	34.7%	95
1996 – 2000	12.3%	24.7%	44.5%	146
2001 – 2005	11.5%	26.3%	49.8%	217
2006 – 2010	17.2%	38.9%	61.1%	239
2011 – 2015	17.2%	36.3%	72.0%	157

Figure 1. Rheumatoid arthritis diagnostic delay according to the year of symptoms beginning, from 1990 to 2015 in Brazil

Figure 2. Rheumatoid arthritis treatment delay according to the year of symptoms beginning, from 1990 to 2015 in Brazil.

Conclusion: Delays to RA diagnosis and treatment have decreased, and more patients have been treated within defined windows for early RA management in the last decades in Brazil. Despite all improvements, it was still difficult to attain early RA treatment. Additional efforts are warranted in pursuit of that goal.

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