Disclosure of Interests: Laurette van Boheemen: None declared, S.A. Turk: None declared, M.H. van Beers - Tas: None declared, W.H. Bos Grant/research support from: abbvie, sanofi, roche, celgene, ucb, novartis, Speakers bureau: abbvie, Sanofi, eli lilly, Diane Marsman: None declared, E.N. Griep: None declared, M. Starman: None declared, C.D. Popa: None declared, A.M. van Sijl: None declared, Maarten Boers: None declared, Michael Nurmohamed Grant/research support from: Not related to this research, Consultant of: Not related to this research, Speakers bureau: Not related to this research, Dirkjan van Schaardenburg: None declared

DOI: 10.1136/annrheumdis-2020-eular.2805

AB0231

RHEUMATOID ARTHRITIS PATIENTS TREATED WITH ABATACEPT AT A COMMUNITY RHEUMATOLOGY CLINIC AND WHO ARE POSITIVE FOR ANTICYCLIC CITRULLINATED PEPTIDE ANTIBODIES HAVE MORE SUSTAINED CLINICAL RESPONSES THAN PATIENTS NEGATIVE FOR THE MARKER

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Background: Treating Rheumatoid Arthritis (RA) patients to target (T2T) has been shown to result in better outcomes in patients with RA [1]. There are now a number of therapeutic options to accomplish this goal, but determining which agent to select for each individual has not been defined.

Objectives: The purpose of this post hoc analysis was to assess if Anticyclic Citrullinated Peptide Antibody (anti-CCP) status effects outcomes following treatment of RA patients with Abatacept.

Methods: Patients at a community based rheumatology clinic undergo disease activity measure assessments on a routine basis as part of the implementation of T2T strategy with ongoing assessments on at least a yearly basis. Over the past 15 years there have been 78 patients initiated on treatment with Abatacept at this clinic. Anti-CCP and Rheumatoid factor status is routinely obtained when patients are first seen in the clinic. A patient was considered to be Anti-CCP positive if the test was 20 u/ml or greater. As a comparison, the 53 patients in the clinic started on Tofacitinib were also analyzed.

The difference in sustained clinical response rates between seropositive and seronegative patients were determined for these two groups. Sustained clinical response was defined as remaining on treatment for at least three years. Patients who were lost to follow up or who died, while on treatment for less than three years, were not included. Statistical analysis was performed with IBM SPSS V. 25 using chi square tests and logistic regression incorporating pretreatment gender, DAS28CRP, CDAI, rheumatoid factor, Multi-biomarker disease activity score, and a power Doppler joint count.

Results: Fifty anti-CCP positive patients and twenty-two anti-CCP negative patients treated with Abatacept were clinically assessed and results of the post hoc analysis are shown in Table one. Chi square risk estimate 4.61 Clinical sig p= 0.01. Logistic regression: Unadjusted Risk ratio (95% CI) 4.86 (1.54, 8.18) Clinical sig p= .01. Adjusted Risk Ratio (95% CI) 4.21 (1.23, 7.19.) Clinical sig = 0.03.

Results of the post hoc analysis for patients treated with Tofacitinib are shown in Table two. Chi square risk estimate 1.75 (not clinically significant.) Unadjusted Risk 1.70 (not clinically significant). Adjusted Risk 1.42 (not clinically significant).

CCP * Responder Crosstabulation Abatacept

			Responder		Total
			yes	no	
CCP	ccp positive	Count	29	21	50
		% within CCP	58.0%	42.0%	100.0%
	ccp negative	Count	5	17	22
		% within CCP	22.7%	77.3%	100.0%
Total	Count		34	38	72
	% within CCP		47.2%	52.8%	100.0%

Conclusion: Rheumatoid Arthritis patients who are Anti-CCP positive and who are treated with Abatacept in a community rheumatology clinic have a significantly greater number of sustained clinical responses than patients who are Anti-CCP negative.

CCP * Responder Crosstabulation Tofacitinib

			Responder		Total
			yes	no	
CCP	ccp positive	Count	21	8	29
		% within CCP	72.4%	27.6%	100.0%
	ccp negative	Count	9	6	15
		% within CCP	60.0%	40.0%	100.0%
Total	Count		30	14	44
	% within CCP		68.2%	31.8%	100.0%

This difference for patients treated with Tofacitinib was not clinically significant in this clinic, though a higher percentage of Anti-CCP positive patients treated with Tofacitinib responded (72% vs 60%).

Anti-CCP positivity could be used as a clinical marker to select patients with rheumatoid arthritis to be treated with Abatacept.

References:

[1] Smolen, J. et al. Ann. Rheum Dis 2010;69:638-643

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.2223

AB0232

PAIN SCORE WITH VISUAL ANALOG SCALE OF 30MM OR MORE IS A RISK FACTOR OF WORSENING CLINICAL DISEASE ACTIVITY INDEX (CDAI) AT THREE MONTHS AFTER ATTAINING CDAI REMISSION IN PATIENT WITH RHEUMATOID ARTHRITIS

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Background: In treating with rheumatoid arthritis (RA), it is needless to say essential treatment goal with first priority. On the other hand, patient's pain influences on clinical indices deeply, however, pain score is not been regarded as most important despite that correlates with patient reported outcome.

Objectives: Clinical significance of remnant pain score for clinical outcome although attaining remission in clinical disease activity index (CDAI) statistically.

Methods: RA patient who have attained remission with CDAI were picked up. These patients were divided into two groups whether CDAI at three month after the first CDAI remission attained; namely CDAI-R or CDAI-F. Background data such as sex, age at onset, age, anti-cyclic citrullinated polypeptide antibodies (ACPA), rheumatoid factor (RF), Sharp/van der Heijde Score (SHS), clinical disease activity score (CDAI), C-reactive protein (CRP), modified Health Assessment Questionnaire score (mHAQ), and pain score with visual analog scale (PS-VAS) at first consultation, time span from the first consultation to first CDAI remission were compared between the two groups using Mann-Whitney U-test. CDAI, CRP, mHAQ, PS-VAS, and QOL value calculated from EuroQOL-5 dimension questionnaire (EQ-5D) at the time of CDAI were also statistically compared with Mann-Whitney U-test. Parameters that demonstrated statistical significance within 5% were picked up, and odds ratio for CDAI remission were calculated with binary logistic regression analysis. Moreover, parameters that demonstrated statistical significance with p-value within 5% were evaluated with receiver's observational characteristics (ROC) analysis, and cut-off index (COI) was calculated.

Results: A total of 907 patients with 594 CDAI-R and 313 CDAI-F were recruited. Demographic characteristics of the two groups were shown in Table 1. SHS at first consultation and time span from first consultation to CDAI remission attained demonstrated significantly less in the CDAI-R than the CDAI-F group, while the other parameters demonstrated no significant difference. CRP, CDAI, mHAQ, PS-VAS, and QOL at CDAI remission demonstrated significant difference between the CDAI-R and CDAI-F groups. With binary logistic regression analysis, CRP, CDAI, and PS-VAS demonstrated significant regression for CDAI-R with 1.68, 0.71, and 0.78 in odds ratio, respectively. COI for CDAI remission was 0.4, 1.0, and 30 for CRP ($p=2.4 \times 10^{-4}$), CDAI ($p=3.0 \times 10^{-32}$), and PS-VAS ($p=2.4 \times 10^{-4}$), respectively.

Conclusion: PS-VAS at the moment of CDAI remission is suggested to be predictive factor for sustaining CDAI remission at three months thereafter as well as CRP value and the CDAI score.