13. Rheumatoid arthritis - comorbidity and clinical aspects

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Background: Homocysteine (Hcy) has been implicated in atherosclerosis. High homocysteine level can predict cardiovascular events, including death. Atherosclerosis has a high incidence in patients with Rheumatoid Arthritis (RA).

Objectives: The aim of this study is to evaluate the relationship between serum homocysteine levels and carotid atherosclerosis in patients with RA and anti-TNF therapy.

Methods: Our study included 80 RA patients divided into two groups: 45 patients were with anti-TNF-alpha therapy (Adalimumab, InflixiNam, Etanercept) and 35 RA patients with disease-modifying antirheumatic drugs (DMARDs). The patients were diagnosed with RA using ACR/EULAR 2010 Classification Criteria. We measured carotid intima-media thickness (CIMT) using high-resolution Doppler ultrasound at baseline and then at 12 months. CIMT above 0.9mm is an atherosclerosis marker.

Results: 45 patients received anti-TNF-alpha therapy (mean age 45.50±6.99 years) and 35 RA patients had treatment with DMARDs (mean age 48.3±8.9 years). High Hcy levels were found on 34% patients in DMARDs group and 21% patients in anti-TNF group. After 12 months of treatment, patients with high levels of Hcy and anti-TNF therapy had a significant decrease in CIMT. CIMT in patients with low Hcy level the decrease in CIMT was insignificantly significant. In DMARDs group atherosclerotic plaque was detected to 26 patients (74.29%) and 21 (46.66%) patients were detected into anti-TNF group. After 12 months CIMT was significantly higher in DMARDs group and the difference was statistically significant compared to baseline and to anti-TNF group (p=0.0002).

Conclusion: Increased Hcy levels were associated with increased CIMT values in both groups. In RA patients with anti-TNF therapy and high Hcy levels, reduction of CIMT was statistically higher than in patients with DMARDs treatment.

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Denosumab increase the bone mineral density regardless of disease activity, the biological disease-modifying antirheumatic drugs, the concomitant type of vitamin D, and pretreatment of osteoporosis in patients with rheumatoid arthritis.

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Background: Osteoporosis is one of the major comorbidities in patients with rheumatoid arthritis (RA). There are a lot of evidence that denosumab increase bone mineral density (BMD) in patients with osteoporosis. However, there are few reports investigated the influence of denosumab in patients with RA.

Objectives: We evaluated the BMD change in patients with RA treated denosumab and assessed the effect of various factors, such as disease activity, biological disease-modifying anti-rheumatic drugs (bDMARDs) use, concomitant medications of osteoporosis and pretreatment of osteoporosis.

Methods: This study included 140 consecutive RA patients (135 female, mean age was 70.6 ± 8.6 years) who fulfilled the criteria of osteoporosis and treated with denosumab. BMD at the lumbar spine, proximal femoral and femoral neck were evaluated by dual energy X-ray absorptiometry at baseline and one year after treatment. We evaluated the influence of disease activity, bDMARDs use, anti-TNF therapy, and the concomitant type of vitamin D, as well as pretreatment of osteoporosis.

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ATTAINING CDAI REMISSION IS THE FIRST GATEWAY TO ATTAIN BOOLEAN REMISSION

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Background: Boolean remission is most stringent but most comparable remission status for the patient with rheumatoid arthritis (RA). Clinical remission evaluated with clinical disease activity index (CDAI) is also one of the most popular index for evaluation of RA treatment. These two criteria often overlap, but some are split.

Objectives: Clinical significance of attaining CDAI remission before attaining Boolean remission was investigated.

Methods: Patient with RA were treated in the institute since August 2010 under treat to target (T2T) strategy. In accordance with T2T, RA patients were monitored from the first consultation with parameter such as tenderness joint count (TJC), swollen joint count (SJC), patient’s global assessment (PGA), evaluator’s global assessment (EGA), C-reactive protein (CRP), anti-cyclic citrullinated polypeptide-antibodies (ACPA), radiograph at baseline and then at 12 months. CIMT above 0.9mm is an atherosclerosis marker. We considered high levels of homocysteine in the serum above 15 μmol/L.

Results: 255 of CDAI-R, 160 of CDAI-F, and 28 of CDAI-F were picked up and divided according to change of disease activity. Among these three groups, mean age, sex, education level, job style, anti-cyclic citrullinated polypeptide antibodies (ACPA), rheumatoid factor (RF), the HAQ score, PS-VAS and QOL were compared.

Conclusion: Attaining CDAI remission previously is extremely important, both for attaining Boolean remission and more stable clinical course after attaining Boolean remission. This study included 140 consecutive RA patients (135 female, mean age was 70.6 ± 8.6 years) who fulfilled the criteria of osteoporosis and treated with denosumab. BMD at the lumbar spine, proximal femoral and femoral neck were evaluated by dual energy X-ray absorptiometry at baseline and one year after treatment. We evaluated the influence of disease activity, bDMARDs use, anti-TNF therapy, and the concomitant type of vitamin D, as well as pretreatment of osteoporosis.
Differences and determinants of physician’s and patient’s perception in global assessment of rheumatoid arthritis

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Background: Patient's Global Assessment of Disease Activity (PtGA) and Physician's Global Assessment of Disease Activity (PhGA) are assessed as part of commonly used measures of disease activity in RA. Both are important measures in treat-to-target strategies in Rheumatoid Arthritis (RA), but often provide discordant results. This can provide an erroneous assessment of disease activity in patients under biologic treatment and mislead treatment decisions, namely switches.

Objectives: To assess differences and determinants of PtGA and PhGA in RA patients under biologic treatment.

Methods: Cross-sectional study, including 46 patients with RA diagnosed according to the ACR/EULAR criteria, under biologic treatment, consecutively evaluated in day-care unit. Participants completed patient-reported outcomes (PROs), including PtGA, and sociodemographic characteristics. Physicians collected comorbidities and parameters of inflammatory activity (erythrocyte sedimentation rate [ESR] and C-reactive protein [CRP]) and completed PtGA and disease activity score 28 with ESR (DAS28). SPSS was used for statistical analysis and significance level was defined as 2-sided p<0.05.

Results: Clinical and laboratory characteristics of patients are shown in table 1. PtGA and PhGA were significantly different (36.1±27.6mm vs 8.7±14.2mm, p<0.001) and a positive discordance (PtGA>PhGA, more than 25mm in visual analogue scale [VAS]) was found in 54.3% of cases. PtGA had a correlation with PROs (Pain VAS, 36-item Short Form Health Survey [SF-36], Health Assessment Questionnaire [HAQ], Functional Assessment of Chronic Illness Therapy [FACIT], EuroQol [EQ5D] and Hospital Anxiety and Depression Scale [HADS]), CRP, tender and swollen joint counts and an association with comorbidities like fibromyalgia or osteoarthritis (OA). No association was found between PtGA and age, sex, education level, profession, employment status, extra-articular manifestations, positivity of rheumatoid factor, ESR, years of disease evolution or number of biologic treatments. In multivariable analysis including SF-36, CRP, tender joints count and OA (R² adjusted=0.672), the main predictors of PtGA were lower SF36, concomitant OA and higher CRP level. PtGA had a correlation with PtGA, pain VAS, CRP, tender and swollen joints. No association was found between PtGA and patient or physician age, patient or physician sex, extra-articular manifestations, positivity of rheumatoid factor, ESR level, years of disease evolution or number of biologic treatments. In multivariable analysis including ESR, tender and swollen joints count and CRP (R² adjusted=0.800), the main predictors of PhGA were swollen joint count and higher CRP level.

Conclusion: This study showed the variability implied on global assessment of RA activity. Overall PtGA is based on function and also in subjective and emotional experience of pain, whereas the PhGA is based on more objective measures, related to disease activity.

References:

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ARE THERE DIFFERENCES IN CLINICAL PROFILE AND TREATMENT AMONG 2 DIFFERENT INTERCONTINENTAL COHORTS OF PATIENTS WITH RHEUMATOID ARTHRITIS-ASSOCIATED INTERSTITIAL LUNG DISEASE?

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Background: Rheumatoid Arthritis (RA) is characterized by persistent joint synovitis causing progressive destruction of the cartilage and bone. Intestinal lung disease (ILD) is a frequent extra-articular manifestation of RA. Clinical profiles of patients with RA-associated ILD may vary.

Objectives: To describe the clinical characteristics and radiological patterns and evaluate the different clinical profile between two different cohorts of patients (pts) with RA-associated ILD.

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