Confidence interval [CI]: 1.02-4.61; p = 0.045), initial serum KL-6 > 551 U/mL at RA-ILD onset (HR: 2.48; 95% CI: 1.17-5.43; p = 0.018), increasing serum KL-6 levels > 10% before AE onset compared to the previous year (ΔKL-6 > 10%/year) (HR: 2.17; 95% CI: 1.71-11.84; p < 0.001). Initial serum KL-6 > 551 U/mL at RA-ILD onset and ΔKL-6 > 10%/year before AE were also significant prognostic factors for AE when we analyzed only in non-UlP patients (HR: 2.84; 95% CI: 1.15-7.35; p = 0.024, HR: 9.49; 95% CI: 3.02-36.25; p < 0.001, respectively). Conversely, median age at RA-ILD diagnosis, positive ratio of anti-CCP antibody, smoking habits, respiratory comorbidities, SDAI score, and therapeutic drugs at both RA-ILD and AE onset had no significant associations with AE. Patients with initial serum KL-6 > 551 U/mL at RA-ILD onset and ΔKL-6 > 10%/year before AE had a significantly worse AE-free survival rate compared to others (p < 0.001). (Figure 1). Moreover, patients with AE had significantly lower overall survival rate (p < 0.001) and respiratory-related deaths-free survival rate (p < 0.001) than those without AE.

Conclusions: Serum KL-6 levels at the disease onset and its sequential changes may be able to predict AE in the near future and support the early detection of AE in RA-ILD patients.

References:


THU0117 PERSONS AT RISK OF RHEUMATOID ARTHRITIS OR AXIAL SPONDYLOARTHRITIS HAVE DIFFERENT PERCEPTIONS ON PREVENTIVE INTERVENTION THAN RHEUMATOLOGISTS
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Background: Persons at risk of developing rheumatoid arthritis (RA) may benefit from lifestyle1 or pharmacological2 intervention aimed at primary prevention. Although less studied, the same may apply to persons at increased risk of axial spondyloarthritis (axSpA)3. Patients’ perceptions and physicians’ views of risk and benefit have an important influence on patients’ willingness to use treatment as previously shown in axSpA.

Objectives: Our aim was to investigate and compare the willingness of individuals at-risk of RA or axSpA and rheumatologists to initiate preventive intervention.

Methods: Individuals at risk of RA, defined as arthralgia and anti-citrullinated protein antibodies (ACPA; >10 kU/l) and / or rheumatoid factor (RF; >5 kU/l) without arthritis (Reade pre-RA cohort; n=100), healthy first degree relatives with HLA-B27 positive axSpA patients (Amsterdam UMC pre-SpA cohort; n=38) and Dutch rheumatologists (n=49) completed a survey on preventive intervention in the at risk phase of RA (pre-RA cohort and rheumatologists) or axSpA (Pre-SpA cohort). The survey included questions on lifestyle intervention, disease perception and scenarios varying in disease risk, treatment effectiveness and side effects of hypothetical preventive medication.

Results: Overall participants depicted RA and axSpA to be a serious disease (RA: median VAS (0-10) 6.5, IQR 5-8; SpA: median VAS 6, IQR 4-8). Despite some concern about their increased risk, most persons did not expect to develop the disease (both: median VAS 3, IQR 1-5). Persons who considered RA to be a serious disease were more likely to start preventive intervention (OR 1.14, 95%CI 1.00;1.31). 94% of at risk patients were willing to change at least 1 of 13 lifestyle

Figure 1. KL-6 was measured at RA-ILD onset. ΔKL-6 means the annual variation ratio of KL-6 before AE. The survival curve using the Kaplan Meier method (Log rank test).

Conclusion: These results highlight that the importance of medical consultation to patients and its impact on disease control should not be under-estimated. Administrative duties, time and economic constraints undermine the patient-physician relationship that is central to clinical care. The limited time spent for medical consultation is directly related to patient dissatisfaction, which in turn, may influence the patient’s perception about the absence of disease activity and could be one of motives behind the worse evaluation of PGA.

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components: i.e. smoking, alcohol consumption, exercise and diet and in total a medium number of 7 (pre-RA: IQR 4-10, pre-SpA: IQR 5-8) while 35% of rheumatologists gave lifestyle advice to ≥50% of at risk patients (most often smoking cessation).

At 30% disease risk, the willingness to use 100% effective preventive medication with no side effects was 53% (pre-RA), 55% (pre-SpA) and 74% (rheumatologists) which increased at 70% disease risk to 69% (pre-RA) and 92% (pre-SpA and rheumatologists). At 30% disease risk and minor side effects, willingness was 26% in pre-RA, 29% in pre-SpA and 31% by rheumatologists and at 70% disease risk 40%, 66% and 76% for pre-RA, pre-SpA and rheumatologists respectively. Differences between rheumatologists and persons at risk are shown in table 1. Of the rheumatologists 16% indicated that a 30% RA risk in 3 years was needed to start preventive therapy and another 16% preferred a 70% risk before starting medication.

Table 1. Willingness to use preventive medication

<table>
<thead>
<tr>
<th>Disease risk</th>
<th>% of persons at risk for RA at 30% disease risk</th>
<th>% of persons willing to use medication</th>
<th>% of rheumatologists willing to use medication</th>
<th>Difference between rheumatologists and persons at risk for RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% effective medication, no side effects</td>
<td>53%</td>
<td>55%</td>
<td>74%</td>
<td>p = 0.017</td>
</tr>
<tr>
<td>30%</td>
<td>69%</td>
<td>92%</td>
<td>92%</td>
<td>p = 0.002</td>
</tr>
<tr>
<td>100% effective medication, minor side effects</td>
<td>30%</td>
<td>29%</td>
<td>31%</td>
<td>p = 0.554</td>
</tr>
<tr>
<td>70%</td>
<td>40%</td>
<td>66%</td>
<td>76%</td>
<td>p &lt; 0.001</td>
</tr>
</tbody>
</table>

Conclusion: Disease risk perception and willingness to start preventive intervention were comparable between pre-SpA and pre-RA patients. They seem willing to make several lifestyle changes to decrease disease risk and were generally willing to use medication in case of a clearly increased risk. Rheumatologists were overall more likely than at risk individuals to start preventive medication. Lifestyle advice was given less frequently by rheumatologists contrasting with individuals’ high willingness to adjust lifestyle.

References:

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Figure 1. The improvement rate of T2T in the subgroups with assessment frequency

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