Figure 2. SScEntry features.

Conclusion: Novel Narrative-based Medicine approaches are getting increasing attention to enhance the mutual understanding between patient and physician, reinforcing the therapeutic adherence at the core of health-care. This is particularly important with chronic and disabling diseases like SSc. Involving patients in disease management with SScEntry will increase their compliance and confidence, with benefits on psychological well-being. Expected benefits for rheumatologists include better evaluation of target therapy and outcomes, as no data on disease activity is lost during the patient clinical history.

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THU0629-HPR COULD THE ASAS HEALTH INDEX BE A USEFUL INSTRUMENT IN ASSESSING PATIENTS WITH PSORIATIC ARTHRITIS?

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Background: At present, there is a growing tendency to use instruments that capture, in the best possible way, the impact that the spondyloarthritis (SpA) generate on patients' lives. For that purpose, tools such as the Psoriatic Arthritis Impact of Disease (PsAID), for psoriatic arthritis (PsA), and the Assessment of SpondyloArthritis international Society-Health Index (ASAS-HI), for SpA, have been recently developed and validated. However, the performance of the ASAS-HI to assess the impact of disease in psoriatic arthritis is barely known.

Objectives: To determine the possible application of ASAS HI to assess PsA by comparing its results to other PsA measurement tools.

Methods: In this observational, cross-sectional study, 89 consecutive patients with PsA (CASPAR criteria) were included. The convergent validity of ASAS-HI (Spearman's rho) and its discriminative validity (ROC curves) was analyzed against other PsA measures (DAPSA and PsAID).

Results: ASAS HI showed a high convergent validity both against DAPSA (rho 0.78, $p < 0.0001$) and PsAID (rho 0.80, $p < 0.0001$). PsAID and DAPSA also showed high convergent validity (rho 0.79, $p < 0.0001$). ASAS HI showed a high discriminative capacity for both DAPSA remission [optimal criterion ≤ 2 , area under the ROC curve 0.92 (95%CI: 0.85-0.97), sensitivity 73%, specificity 94%, $p < 0.0001$] (fig 1) and DAPSA low activity state [optimal criterion ≤ 10.6 , area under the ROC curve 0.87 (95%CI: 5-10.6), sensitivity 93%, specificity 61%, $p < 0.0001$]. PsAID also demonstrated a high discriminative capacity for DAPSA

remission [optimal criterion ≤ 0.8 , area under the ROC curve 0.94 (95%CI: 0.55-0.95), sensitivity 76%, specificity 100%, $p < 0.0001$] and DAPSA low activity [optimal criteria ≤ 4.9 , area under the ROC curve 0.83 (95%CI: 3.4-5.2), sensitivity 92%, specificity 61%, $p < 0.0001$].

Figure 1. ROC curve analysis between DAPSA remission and ASAS HI

Conclusion: ASAS HI could be used as an appropriate tool in the assessment of patients with PsA.

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THU0630-HPR ADVERSE EVENTS, ADVERSE REACTIONS AND MEDICATION-RELATED PROBLEMS ASSOCIATED WITH THE USE OF MEDICINES IN RHEUMATOID ARTHRITIS

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Background: According to the Third Consensus of Granada of the WHO an adverse event (AE) is an unfortunate situation/event that occurs during the pharmacological treatment of a disease and that may not necessarily be related to the use of one or more medications. An adverse reaction (AR) is an unfortunate situation/event that is directly related to the use of a medicine. A medication-related problem (MRP) is an unexpected result in the treatment with a certain medication, resulting in the appearance of adverse events/reactions.

Objectives: Determine and analyze the incidence of adverse events, adverse reactions and medication-related problems in patients treated for rheumatoid arthritis.

Methods: Of a large cohort of approximately 6,000 patients with rheumatoid arthritis (RA) in a specialized center, between 2018 and 2019 pharmaceutical chemist intervention was performed on those patients who reported AEs, ARs and MRPs during their treatment. These reports were made by the treating doctors, the pharmaceutical chemist and directly by the patients to the treating institution. Interaction between medications, adherence to them, patient lifestyles during pharmacotherapy, sociodemographic variables and support relative networks were monitored and investigated. The severity of the events and reactions was evaluated using the Dader method of therapeutic drug monitoring, Morisky Green test to measure adherence and the variables of the Naranjo algorithm in order to characterize them as AEs, ARs or MRPs and determine level of damage

GENDER				TYPE OF EVENT/REACTION				Men	
44	15%	convDMARDs	178	BIOLOGICS	118			Women	
252	85%	Cardiovascular	5	Cardiovascular	23	p< 0.05		AGE	
		Dermatological	37	Dermatological	55	p< 0.05		Betw 20 and 40 yo	
74	25%	Digestive	84	Digestive	9	p< 0.05		Betw 45 and 50 yo	
68	23%	Inflammatory	23	Inflammatory	16			Betw 51 and 70 yo	
33	11%	Non-adherence	15	Non-adherence	8			Betw 70 and 79 yo	
107	36%	Neurological	8	Neurological	0	p< 0.05		Betw 80 and 99 yo	
14	5%	Respiratory	6	Respiratory	7			TYPE OF THERAPY	
		convDMARDs	181		61%	Biologics	115	39%	
CAUSALITY			Probable		236	79%	Possible	46	
16%	Unlikely	14	5%						

to the patient. The cases were analyzed in the pharmacovigilance committee of institution and their causality is defined giving solution to the cases and their follow-up according to relevance.

Results: The analysis yielded a cohort of RA 296 patients (44 men-15%, 252 women-85%) who reported AEs, Ars and MRPs. 181 patients (61%) in management with conventional DMARDs and 115 patients (39%) in biological therapy were identified. The highest incidence occurs in ages between 70 and 79 years (36% of cases); more commonly in women (85% of cases); more commonly using convDMARDs (61% of cases), all this being statistically significant ($p < 0.05$). The classification resulted in 66 (22%) AEs, 117 (40%) ARs and 35 (12%) MRPs. The reported causality was probable in 236 cases (79%), possible 46 cases (16%), unlikely: 14 cases (5%) according to the classification of the Naranjo algorithm.

Classification of AEs, ARs and MRPs

Conclusion: The range of population where AEs, ARs and MRPs most occur are in people over 70 years old; are more common in women and in those who are in conventional DMARDs therapy. The most common AEs, Ars and MRPs with conventional therapy are digestive disorders and in case of biological therapy are dermatological reactions with a mainly probable causality. More studies are needed to clarify these results.

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THU0631-HPR EARLY ARTHRITIS GLOBAL ASSESSMENT: WHAT DIFFERENCES EXIST BETWEEN PATIENTS AND PHYSICIANS?

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Background: In recent years there is a growing interest in the assessment of rheumatoid arthritis through patient reported outcomes measures (PROMs). Nonetheless, discrepancies in the disease global disease assessment reported by patients (PtGA) or physicians (PhGA) have been previously described.

Objectives: Our aim was to evaluate differences between PtGA and PhGA and their predictors in an early arthritis cohort.

Methods: Cross-sectional study analyzing data from the baseline visit of patients included in the PEARL study (Princess Early Arthritis Register Longitudinal Study) in which demographic, laboratory and clinical characteristics including PtGA and PhGA (0-100 mm) are systematically collected.

The main variable was the difference between PtGA and PhGA (Δ GA). The descriptive analysis was performed using the Kruskal-Wallis, Mann-Whitney or Pearson correlation tests as appropriate.

A multivariate linear regression model was developed with Δ GA as a dependent variable. All those predictors available at the baseline visit reaching a $p < 0.15$ in the univariate analysis were included in the initial model. The final one was obtained through the progressive elimination of those variables not showing an improvement in the model as assessed by the adjusted R^2 parameter considering those that had a $p > 0.15$. To categorize the dependent variable, differences between PtGA and PhGA were considered relevant when greater than 5 points.

Results: 530 patients were included, 422 (79.6%) were women with a mean age of 55.3 $\pm$ 16 years, 21.2% current smokers, 54% and 50.4% rheumatoid factor and anti-CCP positive respectively. A 43.3% had moderate activity and 33.6% high, measured by DAS28-VSG.

The median of Δ GA was 4, (interquartile range; -10 to 18; see figure 1). In 22% of the cases patients and physicians scored the same, in 46.5% the patients' scores were higher and physicians' were so in 31.5% of the cases.

The variables that explained Δ GA after adjusting the multivariate model were pain [$\beta = 0.36$ (95%CI 0.28 to 0.44)], number of swollen joints [$\beta = -3.19$ (95%CI -3.7 to -2.7)] and ESR [$\beta = -0.11$ (95%CI -0.2 to -0.03)]. Pain had a greater influence on patients' opinion while the number of swollen joints and ESR were more relevant for physicians. Other variables such as race, marital status, profession, sex, smoking, seropositivity or disease activity were not relevant in the prediction of Δ GA.

Conclusion: In our cohort, disagreements between PtGA and PhGA were observed. Patients scored higher based on painful perception and physicians did so relying on objective evidence of inflammation.

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