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STRATEGIES REGARDING GOAL SETTING AND SELF-MANAGEMENT IN DIFFICULT-TO-TREAT RHEUMATOID ARTHRITIS: PRELIMINARY RESULTS OF A SYSTEMATIC LITERATURE REVIEW INFORMING THE 2020 EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF DIFFICULT-TO-TREAT RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) patients treated according to European League Against Rheumatism (EULAR) recommendations failing ≥ 2 biological or targeted synthetic disease-modifying antirheumatic drugs with a different mode of action who still have complaints which may be suggestive of active disease and for whom management is perceived as problematic by patient and/or rheumatologist have been defined as suffering from 'difficult-to-treat RA'. A mismatch in goal setting between patient and health care professional, and suboptimal self-management may contribute to this disease state, while specific management recommendations regarding these factors are currently lacking.¹

Objectives: To systematically summarise evidence in the literature on the identification and optimisation of a mismatch in goal setting and suboptimal self-management in difficult-to-treat RA patients, informing the 2020 EULAR recommendations for the management of difficult-to-treat RA.

Methods: A systematic literature review (SLR) was performed: PubMed, Embase and Cochrane databases were searched up to December 2018. Relevant papers were selected and appraised. Effect sizes were extracted or calculated.

Results: Three studies were selected on the identification and four on the optimisation of a mismatch in goal setting (Figure 1). No accurate measures were found to identify a mismatch in goal setting, but patients expressed a desire to take their quality of life goals more explicitly into account. Education was found to improve goal setting (4 of 4 studies, effect size not calculable).

Five studies were selected on the identification and 31 on the optimisation of suboptimal self-management (Figure 1). Although formal evaluations in high quality studies were lacking, the Arthritis Self-Efficacy Score was found to be the most reliable tool to identify suboptimal self-management. Patients were found to desire more education on nutrition, the disease and the diagnostic process to be able to improve self-management. Self-management programs, educational and psychological interventions were found to improve self-management (Table 1).

Table 1: Effect sizes of studies on the optimisation of self-management

Outcome	Type of intervention	Benefit of intervention compared to control ¹ in n of n selected studies	Studies with effect size (n)	Effect size per study ²
Self-efficacy	Self-management programs	12/13	6	0.18–0.39; 0.23–0.67; 0.37; 0.43–0.53; 0.49; ³ 7.52–8.25
	Education	6/6	3	0.05–0.17; 0.22–0.59; 1.23
	Psychological	2/2	2	0.20–0.35; 0.45
Anxiety	Psychological	1/2	1	0.17 ³
Depressive symptoms	Psychological	1/2	1	0.15–0.33 ³
RA knowledge	Education	3/3	2	0.34–0.47; 0.84

n: number of studies; RA: rheumatoid arthritis.

1. Mostly usual care or wait list; 2. If different outcome measures were used the range in effect sizes over these measures is reported; 3. Pooled effect size, reported in systematic literature review.

Conclusion: In difficult-to-treat RA patients, limited evidence was found on a mismatch in goal setting and suboptimal self-management, especially regarding their identification. Non-pharmacological interventions were found to improve goal setting and self-management.

References:

[1] Smolen JS *et al. Ann Rheum Dis* 2020. Epub ahead of print.

Figure 1. Flow charts of search and selection of studies: (a) The identification of a mismatch in goal setting and (b) optimisation of goal setting, and (c) the identification and (d) optimisation of suboptimal self-management.

n: number of studies; RA: rheumatoid arthritis; SLR: systematic literature review.

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NUMBER NEEDED TO TREAT TO ACHIEVE MINIMUM CLINICALLY SIGNIFICANT DIFFERENCES IN PATIENT-REPORTED OUTCOMES IN PATIENTS TREATED WITH BARICITINIB

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Background: Baricitinib (BARI) provided rapid and sustained improvements in patient-reported outcomes (PROs) in randomized, controlled trials (RCTs) in patients (pts) with active rheumatoid arthritis (RA) and inadequate responses (IR) to methotrexate (MTX) (RA-BEAM; NCT01710358)^{1,2} and biologic DMARDs (bDMARD-IR; RA-BEACON; NCT01721044)^{3,4}.

Objectives: To determine the number needed to treat (NNT) to report improvements $\geq$ minimum clinically important differences (MCIDs) in multiple PROs at Week (Wk) 12 after treatment with BARI 4-mg in RA-BEAM and BARI 2-mg or BARI 4-mg in RA-BEACON. NNTs ≤ 10 vs placebo (PBO) are considered clinically meaningful.

Methods: Evaluated PROs with respective MCID definitions included Patient Global Assessment of Disease Activity (PtGA, 0-100 mm visual analog scale [VAS], MCID ≥ 10 mm), pain (0-100 mm VAS, MCID ≥ 10 mm), physical function (Health Assessment Questionnaire-Disability Index, MCID ≥ 0.22 points), fatigue (Functional Assessment of Chronic Illness Therapy-Fatigue [FACIT-F], MCID ≥ 4.0), and health-related quality of life (SF-36 physical component summary [PCS; MCID ≥ 2.5] and domain scores: physical function [PF], role physical [RP], bodily pain [BP], general health [GH], vitality [VT], social functioning [SF], role emotional [RE], mental health [MH], MCID ≥ 5.0).⁵ The percentages of pts reporting improvements $\geq$ MCID were determined at Wk 12. NNTs were calculated as 1/difference in response rates between BARI 2-mg or 4-mg and PBO.

Results: At Wk 12, percentages of pts reporting clinically meaningful improvements were greater and statistically different from PBO ($p < 0.01$) with BARI 2-mg and 4-mg across most PROs in both RCTs. Most NNTs were ≤ 10 . (Figure)

Conclusion: Across different populations, MTX-IR and bDMARD-IR pts with active RA reported clinically meaningful improvements in PROs after BARI treatment. The NNTs in these analyses indicate that < 10 pts need to be treated with BARI 2- or 4-mg to report a clinically meaningful benefit.

References:

- [1] Taylor *et al. NEJM*, 2017;376: 652-62
- [2] Keystone *et al. Ann Rheum Dis*, 2017;76:1853-61
- [3] Genovese *et al. NEJM*, 2016; 374: 1243-52
- [4] Smolen *et al. Ann Rheum Dis*, 2017; 76: 694-700
- [5] Strand *et al. J Rheumatol*, 2011; 38: 1720-27