Conclusion: There are still 14% of patients with RA were difficult-to-treat in real world in spite of intensive treatment. Their characteristics are distinct by the cause of difficulty to treat, suggesting the approach to difficult-to-treat RA should be personalized.

References:

Disclosure of Interests: Satoshi Takanashi: None declared, Yuko Kaneko

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FR10080 CLINICAL CHARACTERISTICS OF PATIENTS WITH ELDERLY-ONSET RHEUMATOID ARTHRITIS (EORA)
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Background: The onset of rheumatoid arthritis (RA) occurs usually between 35-50 years of age. Since the general population is ageing, beginning of RA in older age is more common. The term elderly onset of rheumatoid arthritis (EORA) describes the disease with onset at age over 60. The term younger-onset rheumatoid arthritis (YORA) refers to the disease with typical, earlier onset. Observational studies indicate, that substantial differences do occur between the two RA subtypes (EORA and YORA).

Objectives: The goal of the study was to analyze the course of disease and treatment in EORA in comparison to YORA patients.

Methods: The study was conducted in consecutive RA patients, treated in the Department of Rheumatology and Connective Tissue Diseases, Medical University of Lublin, Poland. The study group consisted of 113 patients (93 patients women, 20 men), with the mean (SD) age 59.4 (19.0), disease duration 12.9 (10.3) years.

The cut off between EORA and YORA was set at 60 years of age. There were 63 (55.8%) EORA and 50 (44.2%) YORA patients. Demographic and clinical information was obtained through structured interview, review of medical records and laboratory tests. Disease activity was assessed based on joint counts and Disease-Activity Score of 28 joints (DAS28).


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FR10081 WERE FRAIL RA PATIENTS AT YOUNGER AGE MORE LONELY, DEPRESSED OR ANXIOUS THAN NON-FRAIL RA PATIENTS?
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Background: Frailty is a state that reflects reduced reserve and resistance to stressors among elderly persons. A preceding study showed that 38 out of 90 (42%) RA patients aged ≥55 years who visited our outpatient clinic were frail. Presence of frailty was not age-dependent. Patients were mainly classified as frail because of positive answers on single items that report on depressive feelings (73.7%), anxiety (57.9%), missing people around (65.8%) and emptiness (63.2%) [1]. It is unclear whether frailty is a cause, consequence or comorbidity of poor psycho-emotional health. Alternatively, they could also be congruent conditions. Exploring whether poor psycho-emotional health might be a longitudinal predictor of frailty, might shed light upon the relation between frailty and psycho-emotional health. The prevalence of joint erosions, extra-articular manifestations and antibodies typical for RA (rheumatoid factor, RF-IgM and/or anti-citrullinated peptide, ACPA) did not differ significantly between the groups.

Conclusion: In our study group, EORA patients were characterized by higher proportion of men, higher inflammatory parameters and higher disease activity, in comparison with YORA. In patients with EORA we also found unfavorable metabolic parameters and higher incidence of comorbid diseases, which could affect the method of treatment (less common use of GC and biological DMARDs).

Disclosure of Interests: A. van Moerbeke: None declared, F. Cleutjens: None declared, A. Boonen: Consultant of: Amgen, Sanofi, Roche, Recombinate, Speakers bureau: Amgen, Sanofi, Roche.


Semi-structured interviews took place in an age-stratified sample to explore how the diagnosis of RA has influenced patients' life. Items of questionnaires were compared using the chi-square test. Interviews were annotated by two independent readers. Codes were taxonomically organized and linked to themes using NVivo 12.

Results: 32 (36%) of the 90 invited patients participated and 28 completed all psycho-emotional questionnaires. Twelve out of 32 patients (37.5%) were classified as frail by the GFI. On the GDS at current age, 6/12 frail patients had signs of depression compared to 2/17 non-frail patients (p=0.04) (Table 1). More frail patients had signs of an anxiety disorder on the HADS, both at current age and age 40. 7/11 frail patients versus 0/0 non-frail patients, p<0.01; Table 1). Results on the individual level were more blurred: 3 (42%) out of 7 frail patients were anxious at age 40, but not at current age. The loneliness, social support and HADS depression questionnaires showed no difference between frail and non-frail patients, both at current age and age 40. A stratified sample of 10/32 (31%) patients were interviewed of which 5 (50%) were frail patients. Frail patients more often expressed anxious feelings at current age. Since the diagnosis of RA, frail patients worried more about the future, i.e. about the progression of RA. Non-frail patients tended to be more optimistic. In the interviews, patients expressed not having feelings of depression and anxiety at age 40.

Conclusion: Although it is difficult to disentangle the causal conundrum between psycho-emotional health and frailty, frail patients were on a group level more anxious at younger age on the HADS in our study. Psychiatric symptomatology might be misinterpreted for frailty at current age. Limitations of our study include a high chance on amplified memory bias.

References:

Disclosure of Interests: A. van Moerbeke: None declared, F. Cleutjens: None declared, Annelies Boonen Grant/research support from: AbbVie, Consultant of: Galapagos, Lilly (all paid to the department), Marloes van Onna: None declared

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Table 1. Number of frail and non-frail patients per questionnaire at current age and age 40.

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Frail</th>
<th>Non-frail</th>
<th>Total</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS now</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No depression</td>
<td>6</td>
<td>15</td>
<td>21</td>
<td>0.04</td>
</tr>
<tr>
<td>Depression</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>GDS age 40</td>
<td>9</td>
<td>17</td>
<td>26</td>
<td>0.06</td>
</tr>
<tr>
<td>No depression</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>HADS anxiety now</td>
<td>6</td>
<td>17</td>
<td>23</td>
<td>0.01</td>
</tr>
<tr>
<td>Indication anxiety</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>HADS anxiety age 40</td>
<td>4</td>
<td>17</td>
<td>21</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Indication anxiety</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Individuals experiencing no problems, developing problems, improving or always having problems with their sleep at 1 and 3 years after diagnosis of RA.

<table>
<thead>
<tr>
<th>No problems at any time point</th>
<th>Improved</th>
<th>Developed problems</th>
<th>Problems at both 1 and 3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>118 (9%)</td>
<td>112 (11%)</td>
<td></td>
</tr>
<tr>
<td>Not getting enough sleep</td>
<td>102 (8%)</td>
<td>113 (11%)</td>
<td></td>
</tr>
<tr>
<td>Problems with sleep in general</td>
<td>270 (22%)</td>
<td>231 (22%)</td>
<td></td>
</tr>
<tr>
<td>Sleep quality affecting health</td>
<td>238 (19%)</td>
<td>197 (19%)</td>
<td></td>
</tr>
<tr>
<td>Poor sleep quality</td>
<td>218 (17%)</td>
<td>209 (20%)</td>
<td></td>
</tr>
<tr>
<td>Problem with non-restorative sleep</td>
<td>218 (17%)</td>
<td>154 (14%)</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion: In a population-based early RA cohort receiving today's standard care, 30% of the patients reported some type of sleep problem during the first 3 years. Although this is a lower rate than has been reported in established RA, this is a significant proportion of RA patients, and these findings warrant further studies to closer identify the course of sleep problems and the factors influencing it such as pain.

References:
[1] Bourguignon C et al PMID 14596374

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FR10083

GLUCOCORTICOID USE IS ASSOCIATED WITH DETERIORATION OF MUSCLE QUALITY AND FUNCTION: FROM THE CHIKARA STUDY

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Background: Muscle wasting is an important aspect of rheumatoid arthritis. Glucocorticoids (GCs) are known to cause skeletal muscle wasting and their use is associated with a higher rate of muscle wasting. In a recent clinical study, an increase in the rate of muscle wasting and a decrease in muscle function were demonstrated, which could be an important target for new therapies. The Chikara Study, an ongoing clinical study, provides an opportunity to examine the effects of GCs on muscle wasting and muscle function. In this study, we aimed to investigate the effects of GCs on muscle wasting and muscle function.

Methods: A total of 143 patients with early rheumatoid arthritis were enrolled in the study. The patients were divided into two groups: one group received GCs and the other group did not receive GCs. The patients were assessed at baseline and 1 year after the start of the study. The primary endpoint was the change in muscle function, measured by the Short Physical Performance Battery (SPPB), and the secondary endpoint was the change in muscle wasting, measured by the thigh circumference.

Results: The results showed that the group receiving GCs had a significant decrease in muscle function compared to the group not receiving GCs. The change in muscle function was -0.46 (95% CI: -0.64 to -0.27) in the GC group and -0.19 (95% CI: -0.37 to -0.02) in the non-GC group. The change in muscle wasting was -0.54 (95% CI: -0.72 to -0.36) in the GC group and -0.21 (95% CI: -0.39 to -0.03) in the non-GC group.

Conclusion: The results of this study suggest that GCs are associated with muscle wasting and muscle function deterioration in patients with early rheumatoid arthritis. Further studies are needed to investigate the mechanisms underlying these effects and to develop new therapies to prevent muscle wasting and muscle function deterioration.