reports have demonstrated that tocilizumab (TCZ) may be efficacious for refractory and relapsing PMR.

Objectives: To determine the real-world efficacy of the 2015 EULAR/ACR algorithm for the management of PMR plus introduction of TCZ for refractory and relapsing PMR.

Methods: Patients who had been diagnosed with PMR according to the 2012 EULAR/ACR provisional classification criteria for PMR were recruited in the study. Registered variables included demographic data, disease characteristics, prednisolone (PSL) dosage and duration, addition of methotrexate (MTX) and TCZ, adverse effects, and clinical outcomes.

Results: There were 101 patients who had originally diagnosed as PMR (50 males and 65 females) and followed up for at least one year; the mean $\pm$ SD age at onset was 73 ± 11 years at onset, with the mean observational period being 44 ± 26 months. Their treatments were initiated with PSL of 15.5 ± 4.3 mg/day. 41 patients experienced disease recurrence after 9.6 ± 6.7 months (median 9 month) of GC therapy, while receiving PSL at 5 ± 4.5 mg/day (3.7 mg/day). Baseline factors that were associated with relapse in our cohort were higher-grade thrombocytosis and higher-dose of initial GC by multivariate analysis. In 30 of the 41 patients who failed GC monotherapy, MTX was added. Five patients reached GC-free remission, but 25 patients failed GC tapering. In such refractory patients to a combination of GC plus MTX, 8 patients agreed to add TCZ therapy, and 5 of them reached drug-free remission. At present, 67 of the total 101 patients maintained drug-free remission, but most others were still receiving low-dose GC and/or MTX ($n=17$). No significant adverse effects did not occur during therapy, except for GC-related adverse effects such as diabetes, dyslipidemia and osteoporotic fractures.

Conclusion: Our experience indicated that there is notable heterogeneity across PMR patients in terms of drug response, and the patients with severe inflammation, e.g. thrombocytosis, may need higher-dose of initial GC and addition of biologics such as TCZ on the 2015 EULAR/ACR algorithm.

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FRI0267

CLINICAL CORRELATES AND RELEVANCE OF UCLA GIT 2.0 FOR ESOPHAGITIS AND INDICATION FOR ESOPHAGOGASTRODUODENOSCOPY IN REAL-LIFE PATIENTS WITH SYSTEMIC SCLEROSIS

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Background: The gastrointestinal (GI) tract is frequently involved in systemic sclerosis (SSc). The University of California Los Angeles Scleroderma Clinical Trial Consortium Gastrointestinal Tract Instrument 2.0 (UCLA GIT 2.0) is validated to capture GI morbidity in patients with SSc (1). The routine clinical investigation of GI involvement in these patients is not standardized and there is no consensus about when and how frequently an esophagogastroduodenoscopy (EGD) should be performed.

Objectives: The main aim of this study was to analyze the capacity of UCLA GIT 2.0 to identify patients with erosive esophagitis in an unselected, real-life SSc patients' cohort. Secondary aim was to determine whether the UCLA GIT 2.0 could discriminate SSc patients for whom an expert rheumatologist would recommend an EGD.

Methods: We selected patients fulfilling the ACR/EULAR 2013 criteria for SSc from the Zurich cohort, having completed at least once the UCLA GIT 2.0 questionnaire. We reviewed the medical charts of SSc patients from 2013 to 2019 and recorded data on EGD. We analyzed by univariable logistic regression several parameters, including UCLA GIT 2.0, considered as potentially associated with 1) the referral to EGD and 2) macroscopic esophagitis according to the Los Angeles criteria.

Results: We identified 346 patients (82.7% female, median age 63 years, median disease duration 10 years, 23% with diffuse cutaneous SSc) satisfying the inclusion criteria, who filled in 940 UCLA GIT 2.0 questionnaires.

From 940 visits, 31 were excluded because EGD was done within 3 months before completing the UCLA GIT 2.0. In the 909 remaining visits, EGD was recommended by the expert rheumatologists in 128 cases. In logistic regression, UCLA GIT 2.0 total score and some of its subscales, but also the modified Rodnan skin score (mRSS) and esophageal and stomach symptoms by past medical history, associated with the referral to EGD (Table 1).

Table 1. Logistic regression of factors associated with referral to EGD

	OR (95% CI)	p-value
mRSS	1.04 (1.01 - 1.06)	0.009
Hemoglobin (Hb)	1.00 (0.96 - 1.04)	0.978
Proton pump inhibitor (PPI)	0.37 (0.12 - 1.15)	0.086
Esophageal symptoms	3.37 (2.28 - 4.96)	<0.001
Stomach symptoms	2.93 (2.02 - 4.26)	<0.001
Reflux subscale	2.04 (1.52 - 2.73)	<0.001
Distention/bloating subscale	1.53 (1.24 - 1.89)	<0.001
Social functioning	2.20 (1.57 - 3.07)	<0.001
Emotional wellbeing	1.42 (1.03 - 1.97)	0.034
Total score of UCLA GIT 2.0	2.27 (1.55 - 3.32)	<0.001

We found data on 177 EGD performed in 150 patients, meaning that 49 EGD were performed on indication by another physician. In logistic regression, mRSS and esophageal symptoms correlated with esophagitis, while neither the total UCLA GIT 2.0 score nor the reflux subscale or any of the other subscales showed an association with esophagitis (Table 2).

Table 2. Logistic regression of factors associated with esophagitis

	OR (95% CI)	p-value
mRSS	1.09 (1.03 - 1.15)	0.001
Hb	1.03 (0.99 - 1.06)	0.126
PPI	0.52 (0.27 - 1.03)	0.059
Esophageal symptoms	2.92 (1.29 - 6.61)	0.010
Stomach symptoms	1.60 (0.80 - 3.21)	0.183
Reflux subscale	1.07 (0.60 - 1.93)	0.816
Distention/Bloating subscale	0.63 (0.39 - 1.01)	0.054
Social functioning	0.65 (0.31 - 1.35)	0.245
Emotional wellbeing	0.77 (0.36 - 1.61)	0.483
Total score of UCLA GIT 2.0	0.67 (0.28 - 1.60)	0.367

Conclusion: In a real-life setting, UCLA GIT 2.0 subscales (reflux, distention/bloating, social functioning, emotional wellbeing) and total score strongly associated with expert interpretation of gastroesophageal symptoms and consecutive referral to EGD. However, they showed no correlation with esophagitis on EGD. The main clinical association of esophagitis was the presence of esophageal symptoms.

References:

- [1] Khanna D, et al. Reliability and validity of the University of California, Los Angeles Scleroderma Clinical Trial Consortium Gastrointestinal Tract Instrument. *Arthritis Rheum.* 2009;61(9):1257-63.

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Spondyloarthritis - treatment

FRI0268

REMISSION IN AXIAL SPONDYLOARTHRITIS: IS THERE A DIFFERENCE BETWEEN NSAIDS AND BIOLOGICS IN THE REAL LIFE?

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Background: Randomized-controlled trials (RCTs) done in axial spondyloarthritis (AxSpA) patients have shown that remission in AxSpA and nonradiographic