Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2020-eular.4249

FRI0527 THE EFFECT OF A NURSE-LED PREDNISOLONE TAPERING REGIME IN POLYMYALGIA RHEUMATICA: A RETROSPECTIVE COHORT STUDY

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Background: The cornerstone treatment of polymyalgia rheumatic (PMR) is prednisolone, which has several side effects such as osteoporosis and type 2 diabetes [1]. Therefore, the duration of prednisolone treatment should be as short as possible. Previous studies indicate that only 10-30% has discontinued prednisolone after 1 year and approximately 50% after 2 years [2].
Objectives: To investigate the efficacy of a nurse-led prednisolone tapering regime in patients with PMR compared to usual care.
Methods: The study is a single center retrospective cohort study with a 2-year follow-up. Prednisolone dose was evaluated after 1 and 2 years.
A nurse-led PMR clinic was introduced June 1st, 2015 and patients diagnosed until June 7th, 2017 were included. Patients were diagnosed by a physician, and subsequently managed by nurses according to a specific protocol, with prednisolone tapering from 15 mg to discontinuation after 52 weeks. Regularly blood tests and telephone interviews were performed and a rheumatologist was involved if deemed necessary.
Patients diagnosed with PMR between June 1st, 2012 and June 1st, 2015 served as controls. They received standard care by a rheumatologist.
The Danish guidelines for managing PMR remained unchanged throughout the study period.
The study population was identified by searching the electronic patient journal for the PMR diagnosis. Data collection was performed by four experienced reumatologists. Data were obtained from the Electronic Patient Journal of Central Denmark Region and recorded in the RedCap database.
Results: Five hundred and seventy patients were screened. Patients not diagnosed with PMR, with simultaneously giant cell arteritis, with relapse of known PMR, or prednisolone treatment for more than 4 weeks prior to the diagnosis were excluded. Sixty eight patients received standard care and 107 nurse-led care. There was no statistical difference between groups regarding reason for exclusion.
At baseline there was no difference between patients receiving standard care and nurse-led care regarding gender, mean age (70.7 years vs. 72.2 years), clinical findings, symptoms, level of C-reactive protein (43.4 mg/L vs. 39.7 mg/L), anti-citrullinated protein antibody and reumatoid factor status. Median (IQR) prednisolone starting dose in the standard care group was 15 mg (15-25) vs. 15 mg (15-15) in the nurse-led care group (p=0.008).
After 1 year 29.4% of patients receiving standard care had discontinued prednisolone vs. 35.5% receiving nurse-led care (p=0.403). Median (IQR) prednisolone dose after 1 year was 3.75 mg (0-5) in the standard care group and 1.25 mg (0-3.75) in nurse-led care group (p=0.004). After 2 years 60.3% of patients receiving standard had discontinued prednisolone vs. 82.2% receiving nurse-led care (p=0.001). Median (IQR) prednisolone dose after 2 years was 0 mg (0-2.5) in the standard care group and 0 mg (0-0) in the nurse-led care group (p=0.004). There was no difference between groups regarding relapse of PMR and initiation of MTX treatment in either year 1 or 2.
Conclusion: A tight and systematic approach to prednisolone tapering in PMR is more effective than usual care. The results should be confirmed in a prospective setting.
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Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2020-eular.6179

FRI0528 INDICATORS OF EFFECTIVENESS AFTER 6 YEARS OF FOLLOW-UP OF PATIENTS IN THE FLS DR. NEGRIN

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Background: Data on the effectiveness of FLS in the medium and long term in Spain are needed
Objectives: To analyze the indicators of long-term persistence to treatment, refracture and mortality in our Fracture Liaison Service (FLS)
Methods: Throughout 2019, the medical records of patients with an indication of treatment to prevent new fractures whose baseline visit took place between 2012 and 2014 were reviewed. The data included those of the baseline visit (age, sex, type of index fracture, FRAX scale and DXA results) and for the follow-up (death and date, refracture including revision of spine x-rays - it was considered only the first refracture and, in the case of several fractures the most serious was chosen-, prescribed treatment, persistence of treatment trough electronic prescription on the date of review or death, and MPR or proportion of days covered by treatment).
Results: 399 patients were included, 335 of them women (84%), mean age 73.8 years (range 51-93) and average follow-up of 6 years (range 5.5-7 years).
Baseline visit.- The average FRAX was 15 and 7 for major fracture and femoral fracture respectively. DXA was normal in 22 patients (5.5%), osteopenia in 143 (35.8%) and osteoporosis in 234 (58.6%). 78 patients (19.5%) had a previous fragility fracture.
Type of fracture index: femur 126 (31.5%), forearm 119 (29.8%), humerus 76 (19%), vertebra 24 (6%), others 54 (13.5%). 80 patients (20%) had received prior treatment for osteoporosis.
Follow-up.- The persistence of treatment was assessed in 394 patients; 245 patients (62%) were prescribed a treatment on the most recent date, 200 (51%) with MPR≥80%. When analyzing patients with prescribed treatment, in 176 cases (72%) it was a bisphosphonate in a sustained manner, in 23 cases (9%) a bisphosphonate was prescribed and subsequently changed to denosumab, while in 45 cases (18%) it was initiated and maintained denosumab.
71 of 397 patients presented a new fracture (17.8%). The type of incident fracture was as follows: femur in 24 patients (34%), vertebra in 20 patients (28%), forearm in 9 patients (12%) and other fractures in 18 patients (25%). Refracture occurred in 9 patients in the first year, 16 in 2nd, 12 in the 3rd, 9 in 4th, 14 in 5th, 6 in 6th and 3 in 7th year. The persistence of treatment with MPR≥80% was similar in patients with and without refracture (52 vs 51%). The average baseline age and FRAX for major fracture in the fractured and non-fractured were 75 vs. 73 years (p = 0.10) and 17 vs. 14 respectively (p <0.01).
92 patients (23%) died, 25% of them in the two years that followed the baseline visit and 61% in the following 4 years. The persistence of treatment was 37% in those who died and 69% in those who remained alive (p <0.01).
Conclusion: After an average of 6 years after the assessment in an FLS, the persistence of treatment was 62% (MPR≥80% in 51%), the mortality was 23% and the percentage of refractured patients was 17%.
Disclosure of Interests: Antonio Naranjo Grant/research support from: amgen, Consultant of: UCB, Speakers bureau: AMGEN, Amparo Molina Speakers bureau: AMGEN, STADA, Cristina Sepúlveda: None declared, Francisco Rubiño: None declared, Soledad Ojeda Speakers bureau: AMGEN, LILLY, GEBRO
DOI: 10.1136/annrheumdis-2020-eular.763

FRI0529 IS COTRIMOXAZOLE PROPHYLAXIS AGAINST PNEUMOCISTIS JIROVENCII PNEUMONIA RECOMMENDED IN PATIENTS WITH SYSTEMIC AUTOIMMUNE DISEASES REQUIRING IMMUNOSUPPRESSIVE THERAPIES? A SYSTEMATIC LITERATURE REVIEW.

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Background: The incidence of Pneumocistis jirovencii pneumonia (PCP) has increased substantially during the past years in patients with systemic autoimmune diseases (SAD). Mortality associated to PCP was reported to be up to 20 to 58%, particularly in those receiving immunosuppressive therapy, such as tumoral necrosis antagonist factors or glucocorticoid therapy. Though, there is clear evidence of the effectiveness of Cotrimoxazole against PCP, the risk of adverse effects is important, increasing morbidity and mortality. Up to date, there is no consensus about the need of PCP prophylaxis in SAD patients with immunosuppressed therapies.
Objectives: To analyse the efficacy and safety of Cotrimoxazole prophylaxis against PCP in SAD adult patients receiving immunosuppressive therapies.
Methods: We performed a comprehensive literature search, screening different databases, MEDLINE, EMBASE and Cochrane Library up to April 2019. Outcomes covered prevention of PCP or other infections, morbidity, mortality and safety. All categories of studies were included. Two reviewers selected and