RHEUMATOID ARTHRITIS AND SLEEP QUALITY

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Background: Consequences of rheumatoid arthritis (RA) are many and varied: physical, psycho-affective and financial.

Objectives: The objective of our study is to evaluate the impact of RA on sleep quality.

Methods: We conducted a cross-sectional study including 49 RA patients. An evaluation of sleep quality using the MOS-Sleep Scale was performed.

Results: The mean age of patients was 54.1 years, with a female predominance (89.8%). The mean duration of RA was 11.43 ± 7.32 years with a mean time to diagnosis of 2.35 years. Rheumatoid factor was positive in 77.8% of cases. A atlanto-axial dislocation was found in 4.1% of cases and coxitis in 8.2% of cases. All patients were on symptomatic treatment, 57.1% of whom were on corticosteroid therapy. 83.67% of patients were on cs-DMARDs and 14.2% were on biologics. At inclusion, sleep was optimal in 63.2% of cases and the mean Sleep Problem Index was 26.19 ± 22.77. The index of sleep problems was higher in older subjects and in those with long diagnostic delays. The prevalence of co-morbidities and atlanto-axial dislocation and/or coxitis was associated with impaired sleep quality. Also, VAS pain and EPG were associated with an increase in the sleep problem index. In the multivariate study, EPG, the presence of co-morbidities and atlanto-axial dislocation and/or coxitis were the independent factors affecting sleep quality.

Conclusion: The impact of RA on the patient’s quality of life and especially the quality of sleep is confirmed by several studies in the literature. A global management of the patient is necessary in order to adapt well to his disease.

Disclosure of Interests: None declared

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Table 1. The odds of patients with a molecular signature of non-response failing to achieve an ACR50 response 6 months after TNF inhibitor therapy initiation

<table>
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<th>Odds ratio (95% confidence interval)</th>
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<tr>
<td>Anti-CCP positive</td>
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<td>Anti-CCP negative</td>
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Conclusion: The MSRC test evaluates RA disease biology and accurately stratifies patients based on their likelihood of having an inadequate response to TNF inhibitor therapies, regardless of being positive or negative for anti-CCP autoantibodies. Rheumatologists can use the results of the MSRC test to inform targeted therapy selection for RA patients, instead of their anti-CCP serostatus, eliminating the variability inherent to the anti-CCP measurement and its inability to consistently predict TNF therapy incompatibility. With the MSRC test, providers can rely on a more predictable and accurate assessment of TNF inhibitor therapy success or failure when coordinating patient management.

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SOCIOECONOMIC STATUS (SES) AND MEDICATION USE IN RHEUMATOID ARTHRITIS (RA): A SCOPING REVIEW

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Background: Socioeconomic status (SES) influences disease outcomes in rheumatoid arthritis (RA) patients. (1, 2) Differences in medication use could partly explain this association. (3) A scoping review was used to identify research conducted on this topic and determine what knowledge gaps remain.

Objectives: To determine what research has been conducted on this topic, how this research has defined SES and medication use, and establish what knowledge gaps remain.

Methods: MEDLINE, EMBASE and PsychInfo were searched from their inception until May 2019 for studies which assessed SES and medication use as outcome variables. Studies were included if they measured medication use and incorporated an SES measure as a comparator variable.

Results: 1464 studies were identified by this search from which 74 studies were selected for inclusion, including 52 published articles. Studies’ publication year ranged from 1994-2019, and originated from 20 countries; most commonly from the USA. Studies measured a median of 4 SES variables (IQR 3-6), with educational attainment the most frequently recorded. SES was defined using any of the “PROGRESS” framework variables (4) including patients’ stated gender, age, educational attainment, employment, occupational class, personal income, marital status, health insurance coverage, area- (neighbourhood) level SES, or patients’ stated race and/or ethnicity. Medication use was broadly defined as either prescription or dispensation of a medicine, medication adherence, or delays in treatment. Data was extracted on studies’ primary objectives, measurement of specific SES measures, patients’ medication use, and whether studies assessed differences in patients’ medication use according to SES variables.

Conclusion: Multiple definitions of SES are used in studies of medication use in RA patients. Despite this, most identified studies found evidence of a difference in medication use by patient groups that differed by an SES variable, although how mediation use differed was found to vary between studies. This latter observation may relate to contextual factors pertaining to differences in countries’ healthcare systems. Further prospective studies with clearly defined SES and medication use measures may help confirm the apparent association between SES and differences in medication use.

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