AB0271

COMPARISON OF DOSE REDUCTION METHODS BETWEEN RAPIDLY AND GRADUALLY DE-ESCALATION IN RHEUMATOID ARTHRITIS TREATED WITH BARICITINIB OVER 15 MONTHS

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Background: However tsDMARDs and treatment strategies have improved the outcomes of rheumatoid arthritis (RA), it is unknown who can taper or stop tsDMARDs and strategies for de-escalation.

Objectives: We analyze predictors of de-escalation in RA patients treated with baricitinib over 15 months in each group who start baricitinib with 4mg/day and 2mg/day.

This study will assess and compare (1) characteristic of patients who achieve remission (REM) or low disease activity (LDA) as who can taper baricitinib and (2) two de-escalation methods, rapidly and gradually de-escalation in patients who respond first-line therapy.

Methods: Cases were recruited to SHin-yokohama Arthritis Register (SHARE) between 2015 and 2020 (n=3,961). Patients were diagnosed according to ACR/EULAR 2010 classification criteria and treated with baricitinib started with 4mg/day (n=42) or 2mg/day (n=108) over 15 months. 45 cases fulfilled EULAR definition for difficult-to-treat RA (D2T-RA). In 150 (Male 25, Female 125 cases, RA duration 12.5±5.9 years) cases, Clinical Disease Activity Index (CDAI), Health Assessment Questionnaire-Disability Index (HAQ-DI), anti-CCP2 and clinical parameters were analyzed. Two de-escalation methods were compared in this study. In rapidly de-escalation methods, baricitinib were stopped in patients with stable REM/LDA with no swollen joint over 12 weeks. In gradually de-escalation methods, baricitinib were decreased to 50%, 42%, 28%, 14% in order with stable REM/LDA with no swollen joint over 12 weeks.

Results: (1) "Detect predictors who can achieve REM/LDA with no swollen joint as starting de-escalation baricitinib" In patients started with baricitinib 4mg/day group, 17 patients achieved REM/LDA with no swollen joint (40.5%), there were no differences in duration of RA, onset age of RA, biologics and/or JAK inhibitors naïve, anti-CCP2 titer and CDAI at the start baricitinib between REM/LDA and non-achieved cases. In patients started with baricitinib 2mg/day group, 59 patients achieved REM/LDA with no swollen joint (54.6%). In 2mg/day group, biologics and/or JAK inhibitors naïve was predictor for achieving REM/LDA with no swollen joint. In 2mg/day group, D2T-RA patients was negative predictor.

(2) "Comparison of sustained REM and/or LDA rate between rapidly and gradually de-escalation of baricitinib in rheumatoid arthritis" In whole patients, 15 patients were tapered baricitinib with rapidly de-escalation methods and 61 patients were with gradually de-escalation. Gradually de-escalation methods showed less relapse rate compared with rapidly de-escalation after tapered baricitinib (33.3% vs. 93.8%, p<0.0001). Particularly in 2mg/day group, 12 patients were tapered baricitinib with rapidly de-escalation methods and 47 patients were with gradually de-escalation. Gradually de-escalation methods showed less relapse rate compared with rapidly de-escalation after tapered baricitinib for 32.7 months (33.3% vs. 80.9%, p<0.0001). However 2 cases in 4mg/day group and 8 cases in 2mg/day showed increase of CDAI, all these cases regain LDA after increasing baricitinib.

Conclusion: Tapering baricitinib using gradually de-escalation methods may help to succeed deduction of baricitinib in RA patients with sustained clinical REM and/or LDA with no swollen joint in each group who start baricitinib with 4mg/day and 2mg/day.

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AB0272

CAN NONSTEROIDAL ANTI-INFLAMMATORY DRUGS CONTROL THE SYMPTOMS OF MODERATE RHEUMATOID ARTHRITIS?

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Objectives: to evaluate the efficacy of long-term pain therapy with nonsteroidal anti-inflammatory drugs (NSAIDs) in patients with rheumatoid arthritis (RA) with an initially moderate disease activity (DAS 28 <5.1).

Methods: the study included 404 RA patients, disease duration was more than 1 year, mean DAS 28 3.7±1.6, mean age 58.6±10.0 years, 69% women, 76.7% RF "+", 81.5% ACPA "+". 91.2% of the patients received conventional DMARDs (methotrexate), 8.8% - biological agents. All patients received NSAIDs (aceclofenac) to control their symptoms. The follow-up period was 6 months. We evaluated the dynamics of the DAS 28 index, the level of pain and patient global health on a 100-mm visual analog scale (VAS).

Results: the level of pain (VAS) decreased from 63.1 ± 15.4 to 46.3 ± 8.3 (p=0,001) by 3 months of follow-up and up to 39.5 ± 11.2 (p= 0,001) by 6 months

of follow-up. The patient global health (VAS) also improved from 58.2 ± 13.4 at baseline to 40.3 ± 11.2 (p=0,001) at 3 months and to 35.5 ± 9.7 (p=0,001) at 6 months of follow-up. The mean DAS 28 remained within the moderate disease activity and decreased from 3.7±1.5 to 3.4 ±1.1 (p=0,01) after 3 months, and to 3.1 ± 0.9 (p=0,01) after 6 months.

Conclusion: long-term NSAID therapy allows to control the disease activity in patients with moderate RA. This should be taken into account when planning therapy, including deciding whether to "switch" DMARDs and prescribing biological agents.

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AB0273

HYPERSENSITIVITY REACTIONS TO NON STEROID ANTI INFLAMMATORY DRUGS: A BOUT 87 CASES

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Background: Non-steroidal anti-inflammatory drugs (NSAIDs) are one of the leading causes of hypersensitivity reactions to drugs. The pathogenesis may be immunological mechanisms (allergic reactions) or non specific immunological reactions often incriminated in cross reactivity independently of chemical structure of these molecules. Understanding of the underlying mechanism is necessary for prevention and choice of safe alternatives [1, 2].

Objectives: Analyze all cases of non-steroidal anti-inflammatory drugs cutaneous eruption reported to sfax pharmacovigilance service since January 2015 to December 2020 and evaluate the possibility of cross-reactions between different molecules in this class.

Methods: We conducted a retrospective study of all cases reported to sfax pharmacovigilance department. An enquiry of pharmacovigilance was performed in patients who presented side effects to AINS. The imputability study was carried out by the French method of Imputability. Medical history specifies if there is a re-administration to assess tolerance and cross-reactivity.

Results: Our study included 87 patients whose average age was 45, 8 years. The sex ratio (F/M) was 1.18. lysine salicylate acetyl is the most incriminated (31%), then mefenamic acid (19.5%), diclofenac (19.5 %), ketoprofen (9.2%), piroxicam (6.9 %), ibuprofen (5.4%), celcoxib (3.4%), tiaprofenic acid (1.1%) and naproxen 1.1% of cases. The most common skin injury was urticaria in 29 cases (33.3%). Fixed drug eruption was observed in 17 cases. Maculopapular rash was observed in 19 cases, anaphylaxis in 5 cases and 4 cases of photosensitivity were observed. In our study we found cross-reactivity between (NSAIDs) in 8 patients.

Conclusion: The diagnostic approach is often based on the controlled administration of the drug to assess tolerance and to identify safe alternatives. In cases of intolerance to COX 1 inhibitors, cross-reactions to selective cox 2 inhibitors are very rare [3].

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AB0274

METHOTREXATE INTOLERANCE IN MOROCCAN RHEUMATOID ARTHRITIS PATIENTS

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Background: Methotrexate intolerance is a principal reason for treatment discontinuation, hence the interest in a more in-depth study.

Objectives: We aimed to study the prevalence of methotrexate gastrointestinal intolerance and determine its associated factors in rheumatoid arthritis (RA) patients.

Methods: We designed a cross-sectional study on our RA patients recruited in January 2021 at our rheumatology department. Methotrexate Intolerance Severity Score (MISS) [1], previously validated in juvenile idiopathic arthritis