AB0234 POTENTIAL CREDIBILITY IN RHEUMATOID ARTHRITIS PATIENT REPORTED DAS28 SCORES

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Background: Due to COVID-19 and the reduction of face to face clinic, the rheumatology telephone advice line service has been an integral part in identifying patients that need assessment the most (1). This however means relying on a patient’s ability to conduct their own disease activity score (DAS28), which clinicians conduct to help drive patients with rheumatoid arthritis (RA) into remission. Current literature suggests that patient self-assessed joint counts are reliable and when compared to the joint count of the physician, have an acceptable level of accuracy (2-5). We present data from an NHS audit where we incidentally found that patients could conduct their own joint counts.

Objectives: Our objective was to compare self-reported DAS28 scores with the clinical opinion of physicians during a face-to-face appointment.

Methods: We identified 10 patients with RA who attended a face-to-face appointment following a call to the helpline where a telephone DAS28 score was undertaken (with guidance from rheumatologist specialist nurses). These scores were contrasted against the clinician’s assessment of whether synovitis was present or not in a face-to-face consultation. Co-morbidities: fibromyalgia (FM), osteoarthritis (OA) or both, were also recorded to examine whether these conditions influenced a patient’s ability to perform an accurate DAS28 score.

Results: There were 10 patient self-reported DAS 28 scores in total. 70% (7/10) of patients DAS 28 scores were over 4.01. In all these cases, clinicians confirmed evidence of synovitis during their face-to-face consultation. 30% (3/10) of patients self-reported DAS 28 score was <4.01. Of these patients 2/3 have no evidence of synovitis according to their clinician. When considering co-morbidities, one individual also suffered from OA. This individual’s self-assessed DAS28 score was over 4.01 and was also evidenced to have synovitis during their consultation with the clinician.

Conclusion: This regional NHS audit found that patients who self-reported DAS28 scores over 4.01 accurately identified a flare up, as confirmed by a diagnosis of synovitis at a face-to-face appointment. This is significant as it demonstrates that patients who score above 4.01, can reliably assess their own joint count. This may enable the Rheumatology service to become more patient-driven, empowering patients to accurately assess their condition.

REFERENCES:


Disclosure of Interests: None declared


AB0235 TREAT TO TARGET PATHWAY (T2T) IN INFLAMMATORY ARTHRITIS-DESIRABLE RESULTS? AND IF CERTAIN GROUPS RESPOND TO TREATMENT BETTER?

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Background: There is established evidence that treat to target strategy in inflammatory arthritis helps achieve early remission rates or low disease activity. This approach is more effective for improved outcomes at no additional costs and more likely to achieve rapid and sustained disease control. It is important to aim for early diagnosis to limit the structural damage that occurs with prolonged inflammation. Commencing disease modifying anti-rheumatic drugs (DMARD) therapy and glucocorticoids as early as possible and titrating therapy as appropriate improves clinical outcomes.

Objectives: Aim of this study was to analyse ACR20 response within different subgroups of inflammatory Arthritis patients enrolled in Treat to Target program.

Methods: Data collection was performed by assessing electronic medical records of 374 inflammatory arthritis patients who participated in Treat to Target pathway for inflammatory arthritis between 2014 to 2020. In total 374 patients were enrolled in treat to target inflammatory pathway led by Rheumatology ANP with consultant supervision. Majority of the patients had diagnosis of Rheumatoid arthritis as per ACR/Eular criteria, 213 (51%) were sero-positive RF+, 83 (19.9%) were seronegative RF-, 44 (10.5%) were diagnosed as psoriatic arthritis, and 34 (8.1%) were labelled as undifferentiated inflammatory arthritis. In terms of age and gender, 158 (42%) were under 50, and 216 (58%) were aged 50 and over, majority females 207 (55%). Smoking status 118 (32%) current, 211 (56%) never, 45 (12%) ex-smokers. DMARD started at baseline was Methotrexate only and Starting dose was 15mg for all patients. 326 (88%) were on oral methotrexate and only 48 (12%) were on SC form between weeks 1-20. ACR 20,50,70 responses were analysed for these subgroups with majority (61%) seen at week 6 for their visit 1 after starting T2T pathway while all patients seen by week 20.

Results: ACR 20, 50 and 70 responses were calculated for all subgroups enrolled in T2T program. The results showed that ACR 20 response rate was same among patients aged under and over 50 (67% responders), ACR 50 (38.3%) responders and ACR 70 (20.1%) responders. There was no significant difference in ACR 20 response among females and males (66.9% response) both groups. In terms of seropositivity, 75% responded to treatment in RF+ group vs 60% in RF-group. Higher response rates were seen among not current smokers vs active smokers (70%/65%). ACR 20 response was greater in patients on Sc form of methotrexate. Overall, 65 % achieved remission within 15 months of starting T2T pathway while remaining achieved low disease activity. Further analysis and discussion will follow.

Conclusion: Treat to target strategy in inflammatory arthritis are consistent with real world data in achieving early response rates with methotrexate (ACR responses) and specific subgroups within T2T cohort respond better to treatment.

Disclosure of Interests: None declared