CLINICAL MANAGEMENT OF SERONEGATIVE AND SEROPositIVE RHEUMAtoid ARTHRITIS: A COMPARATIVE STUDY

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Background: Both rheumatoid factor (RF) and anti-cyclic citrullinated peptide antibody (ACPA) are associated with poor radiologic outcomes in patients with rheumatoid arthritis (RA). In general, RA patients positive for RF or ACPA (SPRA) antibody (ACPA) are associated with poor radiologic outcomes in patients with seronegative RA patients (SNRA). However, the relationship between seropositivity and measures of disease severity other than radiologic outcome is disputed.

Methods: A total of 241 patients diagnosed with DMARD-naive RA under either 1987 American College of Rheumatology (ACR) criteria or 2010 ACR/European League Against Rheumatism (EULAR) criteria were identified (40 with SNRA and 201 with SPRA). We investigated the disease activity measures including ESR, CRP, patient VAS, 28 tender/swollen joint count (28 TJC, 28 SJC) and DAS28 as well as radiologic outcomes at baseline, 1 and 2 years after conventional treatment with DMARD.

Results: Age, sex and disease duration were similar between SNRA and SPRA. However, the baseline 28 TJC (4.7±2.9 vs. 3.3±2.7, p=0.004), 28 SJC (4.3±3.0 vs. 2.9±2.3, p=0.001) and DAS28 (5.1±1.0 vs. 4.7±1.0, p=0.043) components were significantly higher in SNRA than in SPRA. Over 2 years of similar treatment with DMARDs, all disease activity measures significantly improved in both groups. Notably, ΔDAS28 from baseline at 1 year was significantly greater in SNRA compared with SPRA (−2.9±1.2 vs. −2.2±1.8, p=0.002). Radiologic outcomes at baseline and at 1- or 2 year follow-up were similar between the 2 groups.

Conclusions: SNRA patients manifested more active disease at baseline, but showed a better response to treatment compared with SPRA. SNRA does not appear to be a benign subtype of RA.

Disclosure of Interest: None declared

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ASSOCIATION BETWEEN ANTI-CITRULLINATED PROTEIN ANTIBODY STATUS, EROSIVE DISEASE AND HEALTHCARE RESOURCE UTILISATION IN PATIENTS WITH RA

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Background: Anti-citrullinated protein antibody (ACPA) is a highly specific biomarker for RA and ACPA-seropositive patients have a tendency toward severe erosive disease and more rapid disease progression. Little is known regarding the impact of poor prognostic factors, such as ACPA and erosive disease, on healthcare resource utilisation (HCRU).

Objectives: To characterise the rate of HCRU between anti-cyclic citrullinated peptide (anti-CCP; a surrogate of ACPA) positive (+) patients with or without erosions who initiated biologic (b)DMARD treatment.

Methods: This analysis included patients aged ≥18 years, who were enrolled in a large sequential RA registry (October 2001–August 2017) and who had known erosions, as measured by radiography, and anti-CCP status at or prior to bDMARD initiation visit and a 12 month (±3 months) follow-up visit. Anti-CCP + was defined as ≥20 U/mL. Rates of HCRU, including all-cause hospitalisations, all joint surgeries (total and partial; all sites), radiographic procedures and use of assistive devices, were estimated over 12 months of follow-up from the bDMARD initiation visit in anti-CCP + patients with or without erosions. Rates of HCRU per 100 patient-years and risk ratios, adjusted by baseline age, were estimated over 12 months of follow-up from the bDMARD registry. Our data confirm the efficiency of therapy with a biologic.

Disclosure of Interest: The aim of this evaluation was to elucidate long term disease activity in patients with RA who are treated with a biologic. We checked data at baseline and at control-visits every six months after inclusion in Bioreg

Methods: Data were extracted from the Austrian Bioreg registry (http://www.bioreg.at) which was initiated in 2009 to document patients treated with one of the biologics approved in Austria. Patients with ongoing biologic therapy as well as biologic-naive patients starting biologic therapy can be included (baseline, BL).

Further documentation is recommended about every 6 months (V2, V2 up to V12), Until September 2017, 2132 patients (1157 RA, 497 SpA, 401 PsA, 77 other diseases) have been documented.

Estimation of disease activity was done using DAS-28, RADAi-5, HAQ as well as ESR and CRP.

Results: DAS-28 (median values of BL; V2; V4; V10;V12) of our patients with RA are 3.30; 2.51; 2.33; 2.49; 2.58, the respective RADAI-5 values are 3.20; 2.20; 2.00; 2.00; 2.40 and values of HAQ are 0.75; 0.50; 0.50; 0.50; 0.63. Median values of inflammation’s laboratory markers (ESR in mm/1st hour and CRP in mg/l) were always within or close to the normal range (ESR and CRP in RA 15; 12; 11.5; 13.5; 11 and 2.1; 2.0; 2.0; 2.4; 3.0

Conclusions: Our data confirm the efficiency of therapy with a biologic. During 6 years of continuous treatment more than half of the patients with RA are continuously in remission or low disease activity with a DAS-28 below 2.6, RADAi-5 equal or below 2.40 and normal values of ESR and CRP.