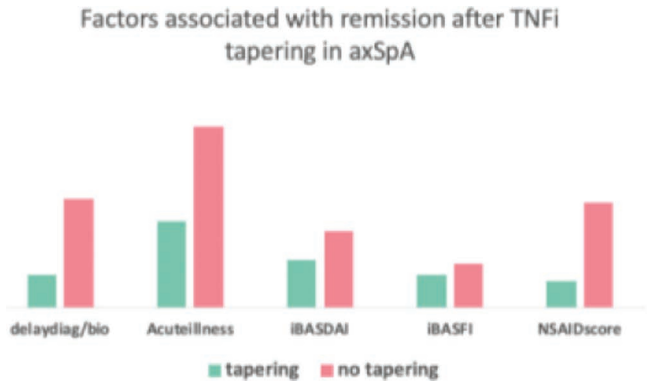

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AB0765

ANALYSIS OF THERAPY IN PATIENTS WITH EARLY AXIAL SPONDYLOARTHRITIS WHO ACHIEVED THE ASAS PARTIAL REMISSION AND THE CLINICAL-LABORATORY REMISSION AT THE 3RD YEAR OF FOLLOW-UP

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Background: The main goal of "T2T" strategy for spondyloarthritis (SpA) is to achieve clinical remission or inactive disease. In 2001, the ASAS formulated criteria for partial remission [1], and the Russian Expert Group for Study of SpA (ExSpA) in 2018 identified clinical-laboratory remission (absence of clinical manifestations of the disease that persists for 6 months with normal values of CRP and ESR) [2].
Objectives: to analyze the therapy in patients with early axial spondyloarthritis who achieved the ASAS partial remission and the clinical-laboratory remission at the 3rd year of follow-up.
Methods: The study included patients with early axSpA (ASAS criteria 2009 with inflammation back pain duration less than 5 years) from the CORSAR cohort (Cohort of Early SpondyloArthritis), formed at the V.A. Nasonova Research Institute of Rheumatology. The cohort includes 175 patients with axSpA. The analysis included 66 patients followed for at least 3 years, of which 37 (56%) were men. The average age of patients was 31.5 (5.7) years, the average duration of the disease was 22.1 (17.0) months, 63 (95.4%) patients were HLA B27 positive. The criteria for clinical-laboratory remission include the following indicators (at least during 6 month): ASDAS≤1,3, BASDAI ≤1,0, morning stiffness<30 min., absence of swollen joints, absence of enthesitis, nocturnal pain ≤1,0 (NRS), spinal pain≤1,0 (NRS), no active extra-articular manifestations, normal levels of CRP and ESR [2]. The criteria for ASAS partial remission include a value not above 2 units in each of the 4 domains: patient global, pain, function, inflammation [1].
Results: Initially, no patients met the ASAS partial remission and the clinical-laboratory remission criteria. By the 3rd year of follow-up, the clinical-laboratory remission was achieved by 21 (31.8%) patients; the ASAS partial remission - 29 (44.0%) patients. When analyzing therapy at the 3rd year of follow-up of patients with early axSpA who achieved the clinical-laboratory and the ASAS partial remission, it was revealed that patients more often achieved remission when taking NSAIDs, a quarter of patients achieved remission on combined therapy with biologics and NSAIDs (Table 1). It is noting that a quarter of patients canceled therapy on their own.

Table 1. Therapy of patients with axSpA who achieved the clinical-laboratory and the ASAS partial remission at 3 years of follow-up.

	The ASAS partial remission (n=29)	The clinical-laboratory remission (n=21)	p
NSAIDs, n (%)	14 (48,2%)	9 (42,8%)	p>0,05
NSAIDs+sulfasalazine, n (%)	0	1 (4,7%)	p>0,05
Biologics, n (%)	2 (6,8%)	0	p>0,05
Biologics+NSAIDs, n (%)	6 (20,6%)	5 (23,8%)	p>0,05
Biologics+sulfasalazine, n (%)	0	1 (4,7%)	p>0,05
Biologics+sulfasalazine+NSAIDs, n (%)	1 (3,4%)	0	p>0,05
Without therapy, n (%)	6 (20,6%)	5 (23,8%)	p>0,05

Conclusion: 1. In the 3d year of follow-up 32% of patients with early axSpA achieved the clinical-laboratory remission and 44% - of the ASAS partial remission.
2. More than 40% of patients with early axSpA achieved remission while taking NSAIDs.

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AB0766

BIOLOGIC DRUG PREFERENCES OF TURKISH RHEUMATOLOGISTS IN SPONDILOARTROPATHY PATIENTS WITH ADVANCED CHRONIC RENAL DISEASE

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Background: Biological therapies are the main treatment options for patients with active spondyloarthropathy (SpA) who do not respond to nonsteroidal anti-inflammatory drugs or conventional synthetic disease-modifying drugs. Kidney diseases are not a contraindication to biologic therapies. However, there are some safety concerns for these drugs for patients with advanced chronic kidney disease. De novo infection or recurrence of infections are the main challenges in patients with multiple comorbidities during biologic treatments. Neverthless, physicans should initiate these treatments in active and resistant diseases.
Objectives: Here, we evaluated which biologic therapies clinicians' first option to initiate in SpA patients with advanced chronic kidney disease (CRD).
Methods: Total 140 patients of TREASURE database who fullfield axial and/or peripheral ASAS SpA criteria with glomerular filtration rate < 60 ml/dk (stage 3,4 or 5 CRD according to The National Kidney Foundation classification) were included to the study. Renal stages of the patients were evaluated when biologic therapy was initiated. Five anti-TNF (adalimumab, certolizumab, etanercept, golimumab, infliximab) and an interleukin-17A blocker (secukinumab) were on the market during the study. We evaluated physicans' first choice for biologic therapy for patients with stage 3,4 and 5 CRD respectively.
Results: More than two thirds of the patients had stage 3 CRD. Anti-TNF drugs were the first choice of biologic treatment in the patients with advanced CRD. Etanercept was started at most to the patients in general, in stage 3 and in stage 5 CRD groups. However, adalimumab was the first choise in stage 4 CRD. Both etanercept and adalimumab were the first drug of choise in three fourth of the stage 4 and stage 5 patients. All two patients on Il-17A blocker had stage 3 CRD (Table 1).

Table 1. Drug of choise in the SpA patients with advanced chronic renal diseases

	N	Total n (%)	N	Stage 3 n (%)	N	Stage 4 n (%)	N	Stage 5 n (%)
Adalimumab	140	44 (31.4)	108	30 (27.8)	20	9 (45.0)	12	5 (41.6)
Etanersept		52 (37.1)		41 (38.0)		5 (25.0)		6 (50.0)
Golimumab		9 (6.0)		7 (6.5)		2 (10.0)		0 (0)
Infliksimab		28 (20.0)		23 (21.3)		4 (20.0)		1 (8.4)
Secukinumab		3 (2.1)		3 (2.8)		0 (0)		0 (0)
Sertolizumab		4 (2.8)		4 (3.7)		0 (0)		0 (0)

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Conclusion: We show that rheumatologists in the TREASURE group prefer to initiate anti-TNF drugs first in all advanced CRD stages. Etanercept was the first choice in these patients.

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AB0767 COMPARISON OF THE CLINICAL-LABORATORY REMISSION AND THE ASAS PARTIAL REMISSION IN PATIENTS WITH EARLY AXIAL SPONDYLOARTHRITIS

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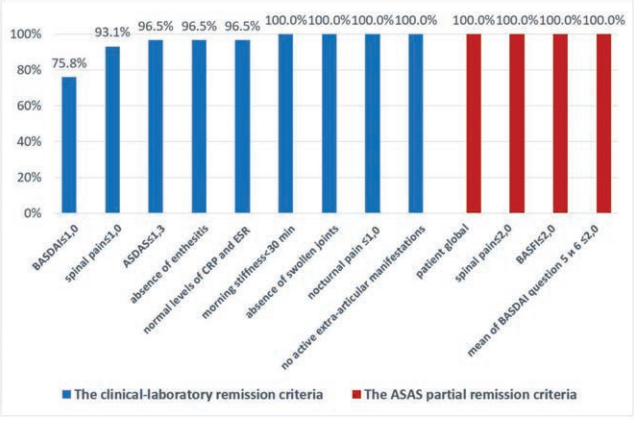
Background: The main goal of "T2T" strategy for spondyloarthritis (SpA) is to achieve clinical remission or inactive disease. In 2001, the ASAS formulated criteria for partial remission [1], and the Russian Expert Group for Study of SpA (ExSpA) in 2018 identified clinical-laboratory remission (absence of clinical manifestations of the disease that persists for 6 months with normal values of CRP and ESR), MRI remission and complete remission (a combination of clinical-laboratory and MRI remission) [2].

Objectives: to compare the ASAS criteria for partial remission and the clinical-laboratory remission in patients with early axial SpA (axSpA) at 3rd year of follow-up.

Methods: The study included patients with early axSpA (ASAS criteria 2009 with inflammation back pain duration less than 5 years) from the CORSAR cohort (Early SpondyloArthritis Cohort), formed at the V.A. Nasonova Research Institute of Rheumatology. The cohort includes 175 patients with axSpA. The analysis included 66 patients followed for at least 3 years, of which 37 (56%) were men and 29 (44%) - women. The average age of patients was 31.5 (5.7) years, the average duration of the disease was 22.1 (17.0) months, 63 (95.4%) patients were HLA B27 positive. The criteria for clinical-laboratory remission include the following indicators (at least during 6 month): ASDAS≤1,3, BASDAI ≤1,0, morning stiffness<30 min., absence of swollen joints, absence of enthesitis, nocturnal pain ≤1,0 (NRS), spinal pain≤1,0 (NRS), no active extra-articular manifestations, normal levels of CRP and ESR [2]. The criteria for ASAS partial remission include a value not above 2 units in each of the 4 domains: patient global, pain, function, inflammation [1].

Results: Initially, no patients met the ASAS partial remission clinical-laboratory criteria. At 3 year of follow-up, the clinical-laboratory remission was achieved by 21 (31.8%) patients; the ASAS partial remission - 29 (44.0%) patients.

We matched patients who achieved the ASAS partial remission (n=29) to criteria for clinical-laboratory remission and, conversely, patients who achieved the clinical-laboratory remission (n=21) to criteria for ASAS partial remission. When comparing the criteria for clinical-laboratory remission to the group of patients who achieved the ASAS partial remission, it turned out that the criteria were achievable (more than 93%), the fewest patients with ASAS partial remission achieved BASDAI≤1.0 (75.8%) (graph 1). All patients with early axSpA who achieved clinical-laboratory remission met the ASAS criteria for partial remission (graph 1).



Graph 1. Comparison of the clinical-laboratory remission and the ASAS partial remission in patients with axSpA at 3 y. of follow-up.

Conclusion: The criteria for clinical-laboratory remission are comparable to the ASAS criteria for partial remission in patients with early axSpA and can be used in a practice of rheumatologists. Further research is needed to analyze the various remission criteria for axSpA and their applicability in a practice.

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AB0768 INFLUENCE OF CONTINUOUS NON-STEROIDAL ANTI-INFLAMMATORY DRUGS INTAKE ON BONE MARROW EDEMA IN NON-RADIOGRAPHIC SPONDYLOARTHRITIS

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Background: The concept of non-radiographic axial spondyloarthritis (nr-axSpA) has revolutionized the classical understanding of axSpA. Indeed, it facilitated the classification of patients with axSpA who did not present substantial structural damage as it was only detectable on magnetic resonance imaging of the sacroiliac joints (MRI-SIJ) [1]. Continuous non-steroidal anti-inflammatory (NSAIDs) intake has been reported as a potential factor reducing the sensitivity of MRI-SIJ to detect bone marrow edema (BME).

Objectives: The aim of the study was to investigate the effect of continuous NSAIDs intake on BME in nr-axSpA.

Methods: We undertook a cross-sectional study including nr-SpA according to the ASAS criteria and treated with NSAIDs at baseline. Socio demographic data as well disease characteristics were recorded. Disease activity parameters were also collected including the duration of morning stiffness, night awakenings, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI). MRI-SIJ was performed for all the patients. All the images were screened for bone marrow edema with the corresponding sequence (short tau inversion). Patients were grouped according to NSAIDs intake: G1: continuous versus G2 occasional. The level of significance was fixed for p<0.05.

Results: The study included 43 nr-axSpA patients. There was a female predominance with a sex ratio of 0.43. The mean age of the patients was 42±12 years [20-71] and the mean disease duration was 17±9.7 years [4-38]. The mean morning stiffness duration was 47.3±45.6 [15-240] minutes. The mean spinal VAS was 5.9±2.6 [0-10]. Nearly 41% of the patients had an active disease with a mean BASDAI of 4.7± 2.1 [0-8.6]. The prescribed NSAIDs were as follows: Diclofenac (44 %), Indomethacin (8%), Ketoprofen (18%), Meloxicam (3%), Celecoxib (3%), Piroxicam (3%) and Naproxen (21%). Nearly half of the patients were continuously taking NSAIDs (52.6%) versus occasional intake (47.4%). Four patients failed two NSAIDs and were treated with a third one. Both groups were comparable for age (p=0.193), sex (p=0.386), and disease duration (p=0.4). Similarly, there were no statistically significant differences regarding disease activity parameters between both groups: numerical rating scale of pain (p=0.713), ESR (p=0.314), CRP (p=0.644), morning stiffness (p=0.428), night awakening (p=1), as well as BASDAI (p=0.514). Regarding MRI-SIJ findings, hyper signal in STIR sequence was comparable between both groups (G1: 35% vs G2:33%, p=0.914). Moreover, the increased signal with Gadolinium injection on T1-weighted images was similar between both groups (p=0.113).

Conclusion: Our study showed that continuous NSAIDs intake was not associated with significant changes in MRI-SIJ features. This study suggests that a NSAID-free period is not necessary before assessing bone marrow edema on MRI-SIJ.

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