E37 THE EARLY INFLAMMATORY ARTHRITIS CLINIC: WHO DO WE SEE AND CAN WE PREDICT BIOLOGIC USE?

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Background: The early inflammatory arthritis (EIA) clinic was commenced to identify patients with inflammatory arthritis, allowing early review and treatment. We aimed to assess the eventual diagnosis of patients seen in the clinic and establish any early predictors for future use of biologic therapy in those patients diagnosed with rheumatoid arthritis (RA).

Methods: Data was collected on all patients referred between November 2013 and November 2014 to the EIA clinic at Doncaster Royal Infirmary. The eventual diagnosis, DAS-28 scores, initial management and biologic use was reviewed. We then proceeded to establish which patients with RA were likely to progress on to biologic therapy.

Results: In total, 104 patients were seen in the EIA clinic. Of these, 53% were female and 47% were male. The average waiting time for an appointment was 2.57 weeks. Forty-one patients (39%) had RA, 26 (25%) had other inflammatory arthritides or auto-immune disease. The remainder had non-inflammatory conditions. Subgroup analysis of RA patients (n = 41) revealed that the mean waiting time to clinic review was 2.1 weeks (range 0.7 to 4 weeks). The mean DAS-28 erythrocyte sedimentation rate (ESR) score on presentation was 5.5. The mean DAS-28 C-reactive protein (CRP) was 5.03. One patient did not attend appointments to commence therapy therefore was excluded from further analysis. Twenty patients (50%) were commenced on methotrexate (MTX) and hydroxychloroquine (HCQ) combination therapy. Sixteen patients (40%) were commenced on MTX monotherapy. Sulphasalazine (SS2), as monotherapy or in combination with HCQ was used in 4 patients (10%). The mean follow-up time was 25 months. In Year 1, 2.5% (n = 1/40) were on biologics, whereas 11.1% were on biologics in Year 2 (n = 4/36) and 23.1% Year 3 (n = 6/26). Of those patients diagnosed with RA in the EIA clinic, 15% (n = 6) eventually required biologic therapy. The mean DAS-28 score on presentation was higher for the patients on biologic therapy at 6.8 (DAS-28 ESR) and 6.4 (DAS-28 CRP). All patients who required biologics were on MTX however 3 patients had to discontinue MTX due to side effects or intolerance. Four patients (67%) were seropositive.

Conclusion: Our results show that we are meeting standards set by the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis by reviewing patients within three weeks of referral and ensuring patients are offered prompt treatment. The majority of patients diagnosed with RA are having MTX with combination therapy. Our biologic commencement rate for the duration of follow-up is 15% although it is uncertain how this compares to the national average. Although the average DAS-28 scores were higher in patients commenced on biologics and several of these patients were intolerant of MTX, it is unclear whether there is a clear association between these factors and commencement of biologic therapy.

Disclosures: The authors have declared no conflicts of interest.