P272 HOW WELL ARE CONVENTIONAL DMARDS TOLERATED IN PSA: A REAL-WORLD STUDY

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Background: NICE guidelines recommend the first line use of DMARDs in psoriatic arthritis (PsA). However, studies show that many conventional treatments like methotrexate are poorly tolerated. There is hitherto no published real-world data addressing the tolerability of DMARDs in PsA. Our objective was therefore to assess the drug management in PsA with focus on tolerability and the reasons for therapy cessation.
Methods: We conducted a retrospective analysis of all PsA patients enrolled in electronic database up to April 2019 at our university teaching hospital. We had access to full patient records including details on co-morbidities, drugs and disease management.
Results: 335 patients were identified with a formal diagnosis of PsA. Mean age of the cohort was 46 years (13-81) and 58% were female. 9% of the individuals had diabetes and 18% had concurrent cardiovascular disease. $1/10^{th}$ reported to be current smokers and 8% had a diagnosis of depression. 48% of the group had clinically active disease. Same percentage were taking a single DMARD. 10% had trialled 3 or more drugs. 62% of patients had discontinued one or more DMARDs prior. The mean duration before discontinuing a DMARD was 9.9 months. Methotrexate was the best tolerated and on average discontinued after 13.4 months (range: 4 days to 10.9 years). Sulfasalazine and hydroxychloroquine were discontinued after an average of 8.4 (11 days to 4.27 years) and 12.5 months (1.3 months to 2.88 years) respectively. Leflunomide was the least tolerated DMARD and stopped after an average of 5.5 months (7 days to 2.53 years). The main reason for stopping a medication was gastro-intestinal symptoms which accounted for 42% of all the reported side effects. This applied to both methotrexate (43%) and sulfasalazine (46%) discontinuation. The leading reasons for discontinuing hydroxychloroquine were jointly GI symptoms and other side effects at 43% each. Leflunomide was stopped in 50% of cases due to neurological symptoms.
Conclusion: To our knowledge, this is the first report confirming poor retention rate of oral DMARDs in a real world PsA cohort managed over 20 years. In the context of chronic disease, the median duration of treatment is short. Our analysis did not include patients who suffer from side effects but continue therapy thereby impacting treatment adherence and hence the true scale of the issue is likely higher. Though NICE guidelines stipulate the need of an adequate trial of minimum two DMARDs prior to therapy escalation, these drugs are not well tolerated and thus pose a challenge to clinicians. One potential solution is earlier adoption of biological therapies, which are increasingly cost effective and have been shown to be better tolerated.
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