conditions like ankylosing spondylitis (AS). Despite good treatment options such as tumor necrosis factor alpha (TNFα) inhibitors in AS, it is seen that patients have applied for CAM use for many reasons including local regulatory funding requirements, potential risks and accessibility of biological treatments. Few studies have examined the frequency of CAM use, and associations between demographic and disease-related factors of it in AS.

Objectives: To investigate the CAM usage of patients with AS and to determine the associated factors.

Methods: Total of 123 patients with AS, who were being followed in a tertiary rheumatology outpatient clinic, were included to the study. The demographic and clinical features along with the behaviors about the CAM usage of the patients agreeing to participate were recorded to the "Patient Assessment Form". The activity of the disease were determined with doctor global assessment (numeric visual analog scale (nVAS; 0–10), and Routine Assessment of Patient Index Data (RAPID)-3 score. The treatment adherence of the patients was assessed with the Morisky Green Levine Scale.

Results: One hundred eleven patients (%90.2) were male, and mean age was 36.5±8.8 years. The mean disease duration and mean delay in diagnosis were 10.9±6.4, and 3.7±3.9 years, respectively. The mean RAPID3 score, doctor and patient global assessment were; 9.9±5.3, 2.8±1.9, and 4.6±2.7, respectively. While 79 patients (%64.2) were on anti-TNF treatment, 76 patients were receiving NSAIDs, and 35 patients (%28.5) reported an adverse event related with the treatment. Forty-five patients (%36.6) reported to use any CAM (previous or current) (Table1). The reasons reported by the patients for the usage of CAM; media in %13, recommendations from family members or relatives in %10.6. It has been found that in married patients, the ones with lower the Morisky Green Levine Scale score (high adherence), CAM usage was statistically high ($p<0.05$). Receiving NSAIDs or anti-TNF agents was not statistically associated with CAM usage. The underlying expectations for the usage of CAM were; considering it might be helpful in %27.6; considering it might heal in %17.9; to relieve the pain in %14.6; and preventing to deteriorate the disease status in %12.2.

Table 1. Types of CAM use

CAM Type	n*	%
Plants and herbs	31	25.2
Massage	13	10.6
Spa	10	8.1
Praying/spiritual approach	6	4.9
Cupping	3	2.4
Imagining	2	1.6
Naturapati	2	1.6
Acupuncture	1	0.8

CAM, complementary and alternative medicine. *There are patients marked the method more than one.

Conclusions: In our study, we found that approximately one third of our AS patients were using CAM. When compared with the literature related with other diseases, CAM usage in AS patients was somewhat lower. Our results have demonstrated that treatment adherence was higher in those using concomitantly CAM in their therapy.

Disclosure of Interest: None declared

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AB0699 EFFECTS OF GLOBAL POSTURAL REEDUCATİON EXERCISE AND ANTI-TNF TREATMENTS ON DISEASE ACTIVITY, FATİGUE, MOBİLİTY, SLEEP QUALİTY AND DEPRESSİON IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS (PROSPECTIVE-CONTROLLED TRIAL)

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Background: Ankylosing spondylitis (AS) is chronic inflammatory disease that affects primarily the spine and the sacroiliac joints. ASAS/EULAR guidelines describe regular exercise as the cornerstone of non-pharmacological treatment and pharmacological treatments including non-steroidal anti-inflammatory drugs as first-line therapy, and a tumour necrosis factor (TNF) alpha inhibitor (anti-TNFα) as second-line medication in patients with persistently high disease activity despite conventional pharmacological treatment in patients with AS.

Objectives: The purpose of this study was to investigate the effects of combination therapy with global postural reeducation exercise (GPR) and Anti-TNF treatments on pain, disease activity, mobility, fatigue, sleep quality, and depression in patients with active AS.

Methods: 60 active AS patients who meet the criteria of Modified New York and/or ASAS axial spondyloarthropathy were included in the study. Patients were divided into 3 groups. The first group was given anti-TNF therapy plus GPR exercise program. The 2nd group was given anti-TNF and conventional exercise therapy. The 3rd group was given routine exercise program along with their existing treatments (NSAIDs and/or SLZ). Following inventories are used for clinical evaluation: for disease activity – Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), for functionality – Bath Ankylosing Spondylitis Functional Index (BASFI), for mobility – lumbar Schober, chest expansion, hand-finger to floor distance, for fatigue – fatigue Multidimensional Assessment Questionnaire (MAF), for sleep quality – Pittsburgh sleep quality index (PSQI), for depression – Beck depression Inventory (BDI). All patients were evaluated before treatment and at 3 months.

Results: The demographic characteristics of the patients were compared and there was no significant difference between the groups. The improvements in all parameters were better in both groups receiving exercise and anti-TNF therapy than in the control group after treatment compared with baseline. The Anti-TNF + GPR exercise therapy resulted in greater improvements than the anti TNF+ conventional exercise therapy in pain, and mobility parameters.

Conclusions: Anti-TNF therapy and exercise were efficient in both groups on improving pain, disease activity, fatigue, sleep quality, and depression. However, the improvements in pain and mobility were greater in the active AS patients with GPR exercise method. Therefore motivated patients should be encouraged to perform this exercise program.

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AB0700 EFFICACY AND DRUG SURVIVAL OF ANTI-TUMOUR NECROSIS FACTOR-ALPHA THERAPIES IN PATIENTS WITH SPONDYLO-ARTHRITIS: ANALYSIS FROM THE THAI RHEUMATIC DISEASE PRIOR AUTHORIZATION (RDPA) REGISTER

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Background: Treatment recommendations for patients with spondyloarthritis (SpA) who inadequately respond to non-steroidal anti-inflammatory drugs (NSAIDs) and/or traditional disease-modifying antirheumatic drugs (DMARDs) are anti-tumour necrosis factor-alpha therapy (TNFi). There has been no data on the long-term efficacy and safety of TNFi in Thai patients with SpA.

Objectives: To evaluate the long-term efficacy and safety of the first TNFi in real-life practice and to identify the risk factors related to drug discontinuation in Thai patients with SpA from the RDPA registry.

Methods: Patients who fulfilled the 1984 Modified New York criteria for ankylosing spondylitis (AS), CASPAR criteria or Moll and Wright criteria for psoriatic arthritis (PsA) and the European Spondyloarthropathy Study Group Criteria or Modified Amor criteria for undifferentiated SpA (uSpA), and were prescribed the first TNFi between December 2009 and October 2014 in the RDPA registry were enrolled. Baseline demographic and clinical data were retrieved. A Cox proportional hazard model was used to identify the factors associated with discontinuation. The P-value of <0.05, two-sided was considered statistically significant.

Results: Of the 142 patients included, 97 had AS, 41 had PsA, and 4 had uSpA. Most AS patients were male (54.6%) with mean (SD) age of 44.6 (10.6) years, median (P_{25}–P_{75}) baseline BASDAI was 6.5 (5.6, 8.2) [from a 10-cm visual analog scale (VAS)], and median baseline patient global assessment (bPGA) was 7.2 (P_{25}–P_{75} 6.0, 8.0) (from a 10-cm VAS). For PsA patients, most were female (68.3%) with mean age of 52.6 (SD 12.2) years, median baseline BASDAI was 6.6 (P_{25}–P_{75} 4.9, 7.4) in patients with active axial involvement and median baseline number of joint involvement was 13.5 (P_{25}–P_{75} 6, 18.3) joints per patient with active peripheral joint involvement. The Efficacy of the TNFi treatment was good and it was increased over time in AS and PsA patients (figure 1). During the 5-year follow-up, AS, PsA, and uSpA patients had comparable discontinuation rate of their first TNFi treatment [25 (26%) in AS, 14 (34%) in PsA, and 1 (25%) in uSpA; p=0.82]. In univariate analysis, leflunomide use, and bPGA <3 comparing to >6 (from a 10-cm VAS) were associated with the discontinuation of TNFi in AS patients with hazard ratio (HR) (95% CI) of 2.56 (1.13, 5.81) and 8.59 (1.82, 40.65), respectively. For the patients with PsA, only infliximab use was associated with TNFi discontinuation with HR of 4.79 (95% CI 1.33, 17.20) in univariate analysis. The reasons for TNFi discontinuation were good response (38%), serious adverse effects (SAE) (30%), non-adherence (20%), and lack of efficacy (13%). Among SAE, 58% was infectious causes (57% tuberculosis and 43% non-mycobacterium infections). The others were non-infectious causes.