*Table 1 Patient characteristics and group distribution*

| | General n = 100 | Group 1 (No intervention) n = 49 | Group 2 (Lifestyle changes) n = 18 | Group 3 (LLD) n = 33 | p |
|---|---|---|---|---|---|
| Female gender, n (%) | 96 (96) | 47 (95.9) | 18 (100) | 31 (93.9) | 0.58 |
| Age (years), mean ± SD | 56.7 ± 9.7 | 52.2 ± 8.8 | 62.4 ± 9.9 | 60.2 ± 7.6 | < 0.001 |
| Disease duration (years), median (IQR) | 10.3 (4.2 – 17.9) | 10.1 (3.8 – 16.2) | 13.8 (9.3 – 21.5) | 9 (3 – 19.7) | 0.181 |
| Disease activity (DAS28-CRP), median (IQR) | 3.2 (1.9 – 4.1) | 2.9 (1.9 – 4.1) | 3.7 (2.2 – 4.2) | 3.4 (1.8 – 4.2) | 0.639 |
| RF IgG (IU/ml), median (IQR) | 8.8 (4.1 – 22.9) | 8.4 (4.1 – 24.7) | 7.25 (4 – 15) | 11.5 (4.8 – 31.7) | 0.381 |
| RF IgM (IU/ml), median (IQR) | 145.9 (52 – 200) | 160.1 (35.4 – 200) | 160.7 (57.8 – 200) | 100 (48.9 – 200) | 0.933 |
| RF IgA (IU/ml), median (IQR) | 44.3 (14.3 – 148.6) | 41 (13.1 – 144.9) | 38.3 (15.3 – 187.2) | 67.1 (16.4 – 116.7) | 0.935 |
| ACPA (IU/ml), median (IQR) | 99.2 (4.5 – 198.4) | 100 (4.1 – 196.6) | 18.4 (5.2 – 199.1) | 114.4 (5 – 198.6) | 0.970 |

SD: Standard deviation, IQR: Interquatile range, DAS28-CRP: Disease activity scale using 28 joints – C-reactive protein, RF: Rheumatoid factor, ACPA: Anti-cyclic citrullinated peptide antibodies. LLD: Lipid-lowering drug.

activity and autoantibody levels, only age added statistically significantly to the prediction (p<0.001).

**Conclusions:** There was indication for preventive intervention in more than half of our patients. Age is a determinant factor that increases CV risk in RA patients independently from disease-specific factors. Treatment to lipid targets is essential to reduce their risk of CV morbidity and mortality (3). A prospective study evaluating treatment success rate is needed to further evaluate the intervention of the clinic.

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**AB0310** | **PREVALENCE OF COMORBIDITIES OF RHEUMATOID ARTHRITIS IN A MEXICAN MESTIZO POPULATION**

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**Background:** Patients with rheumatoid arthritis (RA) have an increased risk of developing comorbid conditions which are associated to increased mortality, hospital admissions, higher costs of care and inability to work (1, 2).

**Objectives:** To evaluate the prevalence of comorbidities in a Mexican mestizo population of RA patients.

**Methods:** We performed a cross-sectional study in which RA patients who were admitted to our outpatient clinic between August 2014 and December 2016 were consecutively enrolled. We collected data regarding demographics, disease characteristics (activity, severity, treatment), comorbidities (cardiovascular, infections, cancer, and osteoporosis), and performed blood tests at the time of the patient's visit to the clinic.

**Results:** We analyzed 225 patients. Their characteristics are shown in Table 1. Age, 55.7±8.3 years (mean ± SD); disease duration, 9.5 (4 – 15.5) (median (IQR)); female gender, 93.7%; Disease Activity Score using 28 joints–C-reactive protein (DAS28-CRP), 3 (2 – 4) (median (IQR)); past or current methotrexate use, 84.9%; past or current use of any other conventional disease modifying anti-rheumatic drug (cDMARD), 52.4%; past or current use of biological agents, 8%. The most frequently associated diseases were: hypertension, 29.8%; dyslipidemia, 27.1%; osteoporosis, 19.1%; diabetes, 12.4%; hypothyroidism, 6.2%; solid malignancies (excluding basal cell carcinoma), 4.4%. Risk factors were also evaluated, the most prevalent was overweight (BMI ≥25 <30) present in 101 (44.9%) of our patients. A total of 71 (31.6%) had obesity (BMI ≥30). The systematic evaluation of our patients allowed us to detect abnormalities in vital signs, such as elevated blood pressure in 12.4%, and to identify conditions that manifest as laboratory test abnormalities, such as hyperglycemia in 27.1% and hyperlipidemia in 49.8%.

**Conclusions:** This study confirms the high prevalence of comorbidities in RA patients. Among our cohort, 63.5% had at least one comorbidity, being those associated with cardiovascular disease the most common. With a systematic

*Table 1 Demographic characteristics*

| Variable | Result |
|---|---|
| Women, n (%) | 211 (93.8) |
| Age (Years), mean ± SD | 55.71 ± 8.38 |
| Disease duration (years), median (IQR) | 9.57 (4 – 15.58) |
| BMI (kg/m2), median (IQR) | 27.41 (25.16 – 31.62) |
| Normal, n (%) | 53 (23.6) |
| Overweight, n (%) | 101 (44.9) |
| Obese, n (%) | 71 (31.6) |
| Smoking, n (%) | 20 (8.9) |
| DAS28-CRP, median (IQR) | 3.01 (2.04 – 4.08) |
| Joint surgery due to RA, n (%) | 25 (11.1) |
| Medication, n (%) | |
| Prednisone | 135 (60) |
| Methotrexate | 191 (84.9) |
| Other non-biologic DMARDs | 118 (52.4) |
| Biologic DMARDs | 18 (8) |

assessment (3) including a thorough physical examination, vital signs and laboratory tests, it is possible to detect comorbid conditions that would otherwise remain unrecognized.

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**AB0311** | **RESULTS OF SCREENING FOR TUBERCULOSIS INFECTION IN PATIENTS WITH RHEUMATOID ARTHRITIS BEFORE AND ON TREATMENT WITH BIOLOGICAL DMARDS**

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**Background:** The prevalence of tuberculosis infection in Russia is much higher than in Western Europe. Therefore, screening for TB infection in patients with RA before therapy with biological agents is of particular importance. At the same time, reliable information on the results of screening are very few.

**Objectives:** Explore the results of the application of different methods of diagnosis of tuberculosis infection in RA patients before and during treatment with biological agents.

**Methods:** We used the data from the Russian register "Observational REgister of arthritis in cLinical practice" (OREL). 1471 RA patients were screened for TB infection before prescribing biologics, of whom 829 patients were exposed to TB infection monitoring on therapy by biologics. The group included 21.1% men, 78.9% women; at the time of initial screening age was 50,0±0,4 years, the duration of the disease 8,5±3,8 yrs, 68,3% RF +, 85.1% anti-CCP +, DAS28-ESR 5,7±1,1, 95,7% used synthetic DMARDs, 60,1% used systemic steroids. We used PPD (Mantoux) test, Diaskin test (intradermal test with tuberculosis recombinant allergens CFP10-ESAT6) and QuantiFERON-TB Gold (QFT) test (in some patients), chest X-ray, chest CT scan (if needed), all the patients were consulted by phthisiatrician. PPD and Diaskin test results were considered positive if the papule was ≥5 mm. Duration of treatment with biologics (anti-TNFs and others) varied widely (2–154 months), making a total of 2552,4 patient-years.

**Results:** At screening, we got 40,3% positive results of PPD test (significantly more in younger patients and patients who did not receive steroids), 16,5% positive results of Diaskin test (with no significant correlations with age and steroids). Positive results matched in 19.9% of cases, negative - in 51.9%. Discordant results in 217 patients were in 92,2% cases related to negative results of Diaskin in PPD-positive persons. Active TB was found after additional examination in 3 (0,2%) patients, inactive TB-related changes were revealed in 124 (8,8%) patients. Positive PPD and Diaskin results, but not QFT, correlated with signs of inactive TB lesions. Positive results of PPD and QFT tests matched in 36.5% of cases, negative - in 18.7%, Diaskin and QFT – in 33,6% and 41,1% of cases resp. As a result of screening, 224 pts were treated by isoniazid or combination of anti-TB drugs before initiation of biologics. On treatment with biologics, 114 (13,7%) pts became PPD-positive and 56 (6,8%) Diaskin positive, active TB was diagnosed in 8 (0,97%) pts.

**Conclusions:** In carrying out TB screening before prescribing biologics in high-