higher risk grading than the predominantly expert-opinion based SOC. Construct validation of the ERIKO-Score is ongoing.

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THU0151 ACPA ARE ASSOCIATED WITH LOW BONE MINERAL DENSITY IN RHEUMATOID ARTHRITIS

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Background: Several studies have related ACPA with the presence of bone erosion in rheumatoid arthtitis patients as they induce the differentiation and activation of osteoclasts

Objectives: Our main aim is to evaluate the association of ACPA with bone mineral density (BMD) in RA

Methods: Case-control study of 73 RA patients (2010 EULAR criteria) and a long standing disease of 5 years. Demographic and clinical variables were collected. BMD values using densitometry at the lumbar (CL), hip (CT) and femoral neck (CF) were collected. The presence of low bone mineral density (osteopenia: tscore$\leq$-1) and ACPA levels were compared using logistic regression analysis, adjusting variables related to BMD: age, sex, menopause, body mass index (BMI), habit Smoking, disease duration, daily corticoid doses, methotrexate treatment and inflammatory disease activity (DAS28)

Results: A group of 73 patients were included (14 men) with a mean age of 66,45±10,41 years, mean body mass index 28,48±5,22 kg/m^2, mean long standing disease of 2,28±1,75 years and mean DAS 28 of 3,17±1,18. A total of 29 patients were negative for ACPA compared to 44 patients that were positive for ACPA. Osteopenia in lumbar spine was found in 82.2% of patients 65.8% hip and 75.3% in femoral neck. Logistic regression was performed without finding statistically significant association between osteopenia and inflammatory activity (DAS 28), vitamin D levels and positive rheumatoid factor, adjusted for variables that can modify BMD. ACPA Positive (any titer) were associated with the presence of lumbar spine osteopenia (OR 7.19, 95% CI 1.77–29.17) (p=0.006), hip (OR 15.17, 95% CI 3.96–58.18) (p=0.001) and femoral neck (OR 3.76; 95% CI 1.20–11.82) (p=0.023). In addition, a simple variance analysis (ANOVA) was performed to compare T scores and ACPA levels divided into three categories: $\leq$25U/mL, 25–300U/mL and$>$300U/mL. ACPA group $\leq$25U/mL differed in mean T score values in lumbar spine, hip and femoral neck. No differences were found between ACPA positive patients with low and high levels for T score values.

Conclusions: ACPA positivity in RA is associated with an increased risk of osteopenia in lumbar spine, hip and femoral neck independently of other variables that may modify bone mineral density. These data suggest that ACPA may play a role in bone remodeling

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THU0152 WHO ARE THE PATIENTS WITH RHEUMATOID ARTHRITIS (RA) WHO ARE GETTING COMORBIDITY SCREENING PROCEDURES IN ACCORDANCE WITH GUIDELINES? A STUDY OF 769 ESTABLISHED RA PATIENTS

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Background: Patients with RA are either more at risk of, or less well screened for, several comorbidities including cardiovascular (CV) risk, cancer, infections and osteoporosis.[1] Recommendations have been developed on how and at what frequency to screen for comorbidities in RA patients.[2]

Objectives: to characterise patients who are being screened correctly (i.e., in accordance with recommendations).

Methods: *Study design:* This was an open long-term (3 years) extension of the COMEDRA 6 month randomized controlled trial in which patients with definite, stable RA were visiting a nurse for comorbidity assessment and screening counselling.[3] For this analysis, only the final visit data were used cross-sectionally. *Assessment of comorbidity screening:* A score was developed to quantify comorbidity screening procedures in accordance with guidelines:[4] this score gives 50 points to CV risk screening, 20 points to cancer screening, 20 points to pneumococcus and influenza vaccination and 10 points to osteoporosis screening. The score ranges 0–100 and 0 indicates optimal screening. *Factors associated with optimal screening:* demographic and disease characteristics were compared between patients considered well-screened (lowest tertile for screening score) versus other patients. *Statistical analysis:* Variables with p$<$0.20 in univariate analysis were entered into the multivariate analysis using a backward stepwise logistic regression.

Results: 769 patients were assessed: mean (±SD) age 62 (±11) years, mean disease duration 17 (±10) years; 614 (80%) were women and 535 (70%) were receiving a biologic. Disease was well-controlled (mean DAS28 2.8±1.3). The mean comorbidity screening score was 24.3 (±17.8) (range, 0–100). The 316 patients (41% of all patients) in the lowest tertile for this score (i.e., with a score $\leq$15) were less often smokers: odds ratio [95% confidence interval] 0.45 [0.28 – 0.72], were more often treated for hyperlipidemia (2.58 [1.85 – 3.61]), and were more often treated with a biologic (1.97 [1.4 – 2.76]).

Conclusions: Comorbidity screening is suboptimal in RA. Patients who were better screened were more frequently already followed-up for hyperlipidemia and were more frequently receiving biologics but more less frequently smokers. Thus it seems getting optimal screening may reflect both patient characteristics but also physician attention to comorbidity in certain situations. Empowering patients to be responsible for the comorbidity screening reminders should be explored.

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THU0153 VASCULAR MORBIMORTALITY IN RHEUMATOID ARTHRITIS (RA) PATIENTS AND ITS RELATION WITH VASCULAR STUDY

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Background: RA patients have a higher risk of vascular events, especially cardiac ones. Besides, mortality in these patients is 54% higher than the general population. Nowadays, we have non-invasive techniques that allow us to detect subclinical vascular damage.

Objectives: To describe subclinical vascular affection in a sample of RA patients and to explore its relationship with mortality and with the development of vascular events.

Methods: Ambispective observational study with analytical components. We included, consecutively, RA patients controlled in a tertiary hospital. We gathered demographic (sex, age, body mass index [BMI]), clinical (traditional vascular risk factors, previous vascular events), and analytical variables (atherogenic index, glomerular filtration [GF] [MDRD], CRP, ESR). Other variables were collected retrospectively from the electronic medical record. We estimated the modified SCORE. We explored the extracranial branches of the carotid artery with an Esaote MyLab70XVG ultrasound device with a linear probe (7–12mHz) and an automated program measuring intima media thickness (IMT) by radiofrequency ("Quality intima media thickness in real-time, QIMT"), and the presence of atheroma plaques, as per the Mannheim consensus, was registered. We also determined pulse wave velocity (PWV) by a validated MobilOGraph® device. We considered an IMT$>$900 $\mu$and a PWV$\geq$10m/s as pathologic values. We prospectively collected mortality and the development of new vascular events over three years. Statistical analysis was performed using SPSS 17.0 software.

Results: We included 198 patients, excluding 13 because of previous vascular events. The mean age was 65,8 years (DE 13,3) and most of them were women (76,2%). The mean BMI was 27,29 (DE 4,84). 27% were smokers, 42,7% hypertensive, 46,7% dyslipemic and 10,8% were diabetic. The mean duration of RA was 17,37 years. 74,6% of patients were seropositive (RF and/or ACPA) and 75, 5% had erosions. 74,6% received glucocorticoids, 58,4% NSAIDs, 98,9% DMARDs and 35,7% biologic therapies. The mean CRP and ESR were 9,45mg/L (DE: 32,2) and 14,04mm/h (DE:14,46), respectively. The mean modified SCORE was 1,81 (DE: 1,79).

Regarding the vascular study, 48,6% of the patients had atheroma plaques, 31,7% had a pathologic PWV with a mean value of 9,13 (DE 2,12), and 16,7% had a pathologic IMT with a mean value of 754 μ(DE 168,52).

During 3 years of follow up, we registered 26 (14,1%) vascular events: 9,7% cardiac, 2,1% cerebral and 2,2% peripheral. There were 5 deaths: 3 vascular, 1 infectious and 1 respiratory. The development of vascular events was related with the presence of atheroma plaques (p 0,008) and with pathologic PWV (p