Conclusions: Despite treatment, patients with pSS still experience a high disease burden. Here we have provided novel insights into the higher treatment cost and increased healthcare utilisation burden of pSS compared with the sicca-free cohort, in particular for patients with extra-glandular disease manifestations.
Acknowledgements: Study funded by GSK. Jennie Frain, PhD, Fishawack Indicia Ltd, UK, provided editorial assistance funded by GSK
Disclosure of Interest: S. Perera Shareholder of: GSK, Employee of: GSK, L. Ma Shareholder of: GSK, Employee of: GSK, R. Punwaney Shareholder of: GSK, Employee of: GSK, S. Ramachandran Shareholder of: GSK, Employee of: GSK
DOI: 10.1136/annrheumdis-2017-eular.2352

FRI0764-HPR MORTALITY IN PATIENTS WITH RHEUMATOID ARTHRITIS AND END STAGE RENAL DISEASE

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Background: Cardiovascular related mortality is higher in patients with rheumatoid arthritis (RA) compared to the general population, and accounts for more than half of all deaths in end stage renal disease (ESRD). The prevalence of ESRD is increasing and there are an increasing number of older patients with RA. Our recent study demonstrated approximately 1% of patients with ESRD have RA. The implications of ESRD on RA relative to the burdens of cardiovascular diseases, cardiovascular and all-cause mortality are not known.
Objectives: To determine whether patients with RA who have ESRD are at increased risk for cardiovascular disease (CVD) events, cardiovascular mortality and all-cause mortality compared to the general population of patients with ESRD.
Methods: Retrospective cohort study of adult patients (age 18 and older) with ESRD receiving renal replacement therapy (hemodialysis or peritoneal dialysis) in the United States Renal Data System (USRDS) who initiated dialysis between 2005 and 2008 followed for up to five years. Patients with an ICD-9 diagnostic code for RA on or before the start of dialysis and a 5% random sample of those without RA were included. Incident cardiovascular events, cardiovascular related mortality and all-cause mortality was determined in those with RA compared to those without RA.
Results: There were 2,824 subjects including 407 with RA and 2,417 without RA included in the analyses. There was no significant difference in the total number of incident CVD events by RA status (n=311 (76.4% RA) vs. n=1936 (80.1% without RA) (p=0.09). 76 patients with RA (18.7%) died from a CVD related cause compared to 403 without RA (16.7%), (p=0.32). Overall mortality was significantly higher in those with RA (n=226 (55.5%) vs. n=970 (40.1%) ($p<0.01$). Compared to those without RA, those with RA had a significantly shorter mean time in months from start of dialysis to any incident CVD event (17.5 (12.4)) vs. 21.2 (14.1) ($p<0.01$), CVD death, (34.2 (12.5) vs.37.9 (12.6) p=0.02), or all-cause mortality (33.1 (13.0) vs. 37.8 (12.6) ($p<0.01$). In final adjusted models, RA was associated with an increased risk for both CVD related mortality (aHR=1.23 (95% CI 1.05–1.43)) and all-cause mortality (aHR=1.22 (1.05 – 1.42) within five years. Risk factors for CVD and overall mortality included older age, a higher Charlson comorbidity index, tobacco use, needing assistance with ADLs and living in a nursing home. Black race and Hispanic ethnicity was associated with significantly less CVD and all cause-related mortality.
Conclusions: Physicians treating patients with RA and ESRD should be aware that these patients are at increased risk for cardiovascular related mortality and all-cause mortality compared with the general population of ESRD patients. Patients with ESRD and RA at higher risk for mortality can be identified by both demographic risk factors as well as overall health status.
Acknowledgements: Funding for this work was supported by the Translational Research Program (TRP) at the Medical College of Georgia and the Medical and Graduate Student Preceptorship award from the Rheumatology Research Foundation, Atlanta, Georgia.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.1152

FRI0765-HPR PREVALANCE OF SARCOPENIA IN ELDERLY WITH OSTEOARTHRITIS OF LARGE JOINTS

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Background: Lean muscle mass and strength decline starting approximately at 40 years of age to become 25% of body weight at 75–80 years old [1]. Within the existing literature, sarcopenia is a highly prevalent condition in older people. The prevalence of sarcopenia increases considerably with age ranging from 5% to 13% in 60 to 70 years, from 11% to 50% for the population aged 80 years and older. In older persons, sarcopenia is related to falls and physical disability leading to reduced quality of life [2]. The prevalence of osteoarthritis increases with age so that 30 to 50% of adults over the age of 65 years suffer from this condition [3]. Age-related factor that contributes includes to the development of OA include a decline in muscle strength. People with lower extremity OA had a two to five times increased incidence of falls than age-matched healthy controls [4].
Objectives: Conduct analysis of condition of muscle strength and muscle functioning in older persons with osteoarthritis.
Methods: Prospective study of 159 patients aged 74±13,3 years was held. Condition of sarcopenia was estimated by lean body mass (LBM) in accordance with criteria of sarcopenia EWGSOP. Muscle strength was estimated by a hand dynamometer and muscle functioning was estimated on the basis of SPPB tests. Amount of pain was estimated by VAS.
Results: Sarcopenia was revealed in 31,45% of older persons with osteoarthritis. Cases of falls were observed in 28,30% (95% CI 21,5 - 36,0) in patients with osteoartritis with sarcopenia (average number of falls – 1,93) and in 16,98% of patients without sarcopenia (95% CI 11,5 – 23,7) (average number of falls – 0,48). Level of pain in patients with osteoartritis with sarcopenia amounted 3,16 points, in patients without sarcopenia – 3,49 points ($p>0,05$). Muscle strength in patients with sarcopenia was 14,36 kg, in patients without sarcopenia was significantly higher – 18,53 kg ($p<0,05$). Common point of SPPB tests in patients with sarcopenia was 6,9, in patients without sarcopenia significantly higher – 7,85 ($p<0,05$).
Conclusions: Patients with sarcopenia in the presence of osteoarthritis were observed to have significant decrease of muscle strength and muscle functioning, increase of frequency of falls which raises risk of repeated falls and their frequency, and consequently, deteriorates condition of musculoskeletal system in older persons.
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Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.3097

FRIDAY, 16 JUNE 2017

HPR professional education, training and competencies

FRI0766-HPR DOWN'S ARTHROPATHY - CLINICAL AND RADIOLOGICAL FEATURES OF ARTHRITIS IN CHILDREN WITH TRISOMY 21

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Background: Down's Arthropathy (DA) was first reported in the literature in 1984. Crude estimates suggest higher incidence and prevalence rates of DA compared with Juvenile Idiopathic Arthritis (JIA), (JIA prevalence 1/1000, estimated DA prevalence 8.7/1000). Despite this fact, there remains a paucity of data on this condition. DA is rarely recognised at onset, & remains under-diagnosed. As a direct consequence children with DA are presenting with significant joint damage and disability at diagnosis.
Objectives: Perform a musculoskeletal examination on children with Trisomy 21 (T21) aged 0–20 years
Methods: Children with T21 were invited to attend a screening clinic. Screening involved completion of a health questionnaire & a comprehensive musculoskeletal examination. DA cases detected were investigated & managed as per normal clinical practice. Data on a convenience sample of 33 newly diagnosed children with JIA was collected to create a comparison group.
Results: 503 children with T21 have been screened for DA, 22 new cases have been diagnosed. All of these children had poor language skills or were non-verbal. Only 11% of the parents suspected that their child may have arthritis prior to attending our screening clinics, and this was only after reading our recruitment literature. In total, we now have 33 children attending our centre with DA (combining cases attending pre-dating the start date of the study). This suggests the prevalence of DA in Ireland is 18–21/1000.
The majority of children presented with a polyarticular pattern of disease. No cases of uveitis have been observed to date. 88% of the DA cohort had small joint involvement of the hands, significantly higher than that observed in the JIA comparison group. Erosive changes were reported on X-Ray in 29.2% of the DA cohort (9.5% in the JIA Cohort). Methotrexate-associated nausea was a significant barrier to treatment with this DMARD in DA. There was a significant delay in diagnosis of DA, 1.7 years v 0.7 years in the JIA cohort.
Conclusions: Children with T21 are at increased risk of developing arthritis. There is a lack of awareness of this risk among health care professionals & the general public at large. This almost certainly contributes to poor recognition of the disease and a delay in diagnosis. The predominant pattern of disease is polyarticular small joint arthritis. Treatment with standard protocols used in JIA