Background IHD is the commonest single cause of death in RA.¹ Having RA is an independent risk factor for the development of IHD.² Classical risk factors are also important, contributing a baseline risk as they do in the general population. The baseline risk can be calculated using general population data,³ and its modifiable component may be an important therapeutic target in RA.

Objectives To identify the absolute baseline risk in a hospital RA population, determine its modifiable and non-modifiable components, and assess the relative contribution of each of the modifiable risk factors.

Methods 63 random hospital outpatients with RA (40 females, 23 males, age: 59.75 (10.58) years) were assessed using the Cardiac Risk Analysis Body Manager Version 1.24 Software. Absolute risk value was calculated for each individual; this was subdivided into modifiable risk (calculated from weight, systolic BP, total cholesterol, smoking and exercise habits) and non-modifiable risk (calculated from gender, age and family history of IHD).

Results Total population mean (SD): Systolic BP: 145.95(22.54) mmHg; Total Cholesterol: 5.73(1.01) mmol/l; BMI: 28.12 (4.07); smokers: 19.05% [male: 21.74% vs. female 17.5%; $p < 0.01$]. 22.2% of patients (males > females, $p < 0.05$) were at high absolute risk, 68.3% at moderate risk and 10% at average or low risk of having a major cardiovascular event in the next 6–8 years. The mean absolute risk for the group was moderate 30.89(5.03)%. Most of the absolute risk was modifiable [60.89 (9.83)%] the remaining 39.17(9.78)% being non-modifiable. The largest contributors to the modifiable component were exercise 36.68(9.28)% and weight 24.24(9.68)%; Systolic BP, total cholesterol and smoking contributed much less [18.44(7.61)%, 16.32(10.34)%, and 4.02(9.42)% respectively].

Conclusion 90% of hospital RA patients have a moderate or high baseline cardiovascular risk to develop a major event in the next 6–8 years. Two thirds of this risk is modifiable, and two thirds of the modifiable component is due to reduced exercise and increased weight. We suggest that all RA patients should have their classical IHD risk factors assessed and appropriately targeted in the routine clinical setting.

REFERENCES

- 1 Wolfe F, Mitchell DM, Sibley JT, et al. The mortality of rheumatoid arthritis. *Arthritis Rheum.* 1994;**37**:481–94
- 2 Banks M, Flint J, Bacon PA, Kitas GD. Rheumatoid arthritis is an independent risk factor for ischaemic heart disease. *Arthritis Rheum.* 2000;**43**(9):S385
- 3 Liao Y, McGee DL, Cooper RS, Sutkowski MB. How generalizable are coronary risk prediction models? Comparison of Framingham and two national cohorts. *Am Heart J.* 1999;**137**:837–45

THU0130 SYSTEMIC AA AMYLOIDOSIS IN RHEUMATOID ARTHRITIS – THE INFLUENCE OF SEPTIC INFECTION, TUBERCULOSIS OR ASSOCIATED MALIGNANT TUMOURS. A RETROSPECTIVE STUDY

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Background Systemic secondary (reactive) AA amyloidosis (AAa) is one of the most important complications of rheumatoid arthritis (RA). The AA amyloid precursors are produced by the liver, basically determined by the chronic relapsing inflammation of RA. The disease may be complicated by other inflammatory

phenomena, such as generalised septic infection, chronic active tuberculosis, or may be accompanied by malignant tumours and consequent inflammation.

Objectives The aim of this study was to determine the role of lethal, generalised septic infection, or associated diseases like tuberculosis, and malignant tumours on the development and course of amyloidosis.

Methods A randomised autopsy population of 161 in-patients (female 116, average age of 64.9 years; male 45, average age of 66.2 years at death) with rheumatoid arthritis (RA) was studied.¹

AA amyloidosis (AAa), lethal septic infection (SI), inactive post-primary tuberculosis (Tb), or active miliary tuberculosis (mTb), and malignant tumours (mTu) was post mortem diagnosed histologically.

The links between AAa and coexisting complications (SI, Tb, mT, and mTu) were analysed by χ^2 -test.

Results AAa was observed in 34 (21.1%), SI in 22 (13.7%), Tb in 13 (8.1%), mTb in 6 (3.7%) and mTu in 13 (8.1%) of 161 RA patients.

AAa was associated with SI in 1, with Tb in 2, with mTb in 2, with mTu in 3 of 34 cases.

There was a negative association between AAa and SI (value of association coefficient was negative: -0.7346).

There was no significant correlation between AAa and SI ($\chi^2 = 3.1279$, $p < 0.07$), Tb ($\chi^2 = 0.0302$, $p < 0.86$), mTb ($\chi^2 = 0.05638$, $p < 0.81$), or mTu ($\chi^2 = 0.0302$, $p < 0.86$).

Conclusion AAa may be considered a direct consequence of RA.

Coexistent inflammatory complications (SI, Tb, or mTb, mTu) did not influence statistically the frequency of AAa in our autopsied RA patients. Post-primary tuberculous scars did not represent an active inflammation, and did not have a statistically significant influence on amyloidosis. Miliary dissemination of tuberculosis (endogenous reactivation of post-primary tuberculosis) must be considered a terminal pre-mortem phenomenon, which ? because of its terminal onset – did not have a statistically significant effect on prevalence of AAa.

Based on the negative value of association coefficient between AAa and SI may guess a diminished reactivity of the vessels and tissues infiltrated by amyloid. This effect is nearly significant ($\chi^2 = 3.1279$, $p < 0.07$).

REFERENCE

- 1 Bély M. Krankheitsmodifizierende Faktoren bei chronischer Polyarthrit. D. Sc. Acad. Sci. Hung. Thesis. Budapest, 1993

THU0131 VERY LONG-TERM FUNCTIONAL (HAQ) STATUS OF RA

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Background Only a few studies have attempted to determine the HAQ level of rheumatoid arthritis twenty years after onset, and how often those patients consider that RA has 'burned-out' by then.

Objectives To determine how often patients with long-lasting RA (more than 10 years' duration) consider themselves in remission and to assess their HAQ level after mean follow-up of 20 years.

Methods A questionnaire was sent to 122 patients with typical RA (100% erosive, 79% positive for rheumatoid factor) of more than 10 years' duration who had been randomly selected from the charts of 4 office-based-rheumatologists (N = 61) or a university hospital rheumatology unit (N = 61). The outcome of