on matters such as privacy, the quality and trustworthiness of information and personal interaction with healthcare providers prevailed.

Conclusions: For most RA patients, informational support regarding medication use is the most important (unmet) need. High-quality, unambiguous information about their medication use was emphasised. Moreover, this information should be provided by healthcare providers on an ongoing basis and tailored to their personal situation. Eliminating RA patients' concerns regarding eHealth interventions should be a first priority before such interventions are applicable to address these informational needs. These findings need to be confirmed in a sample of younger RA patients.

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Disclosure of Interest: None declared

THURSDAY, 15 JUNE 2017

RA: really a systemic disease?

OP0146 | **DECREASE IN CARDIOVASCULAR EVENT EXCESS RISK IN RHEUMATOID ARTHRITIS SINCE 2000': A META- ANALYSIS OF CONTROLLED STUDIES**

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Background: Compared with the general population, patients with rheumatoid arthritis (RA) have an increased risk of cardiovascular disease or events (CE): stroke, Myocardial Infarction (MI), Congestive Heart Failure (CHF) and Cardiovascular Mortality (CVM). Systemic inflammation is the cornerstone of both RA and atherosclerosis. Over the past fifteen years, new treatment strategies such as tight control, treat to target, methotrexate optimization, biologic DMARDs use has allowed a better control of this inflammation.

Objectives: The aim of this systematic review was to assess the excess risk of presenting a CE in RA patients as compared to general population, before and after the 2000s.

Methods: We systematically searched literature (via Pubmed, Cochrane and abstracts from recent ACR and EULAR congresses) up to March 2016 for observational studies providing data about the occurrence of a CE (among stroke, MI, CHF, CVM) in patients with RA and in a control group. A meta-analysis of the relative risk (RR) concerning patients with RA in relation to the control group was performed for each cardiovascular event and for each period (before and after the 2000s).

Results: Out of 5714 screened references, 28 studies were included. For studies published before 2000, an increased risk of CEs was observed in RA patients:
– RR=1.12 [95% CI 1.04; 1.21], p=0.002 for stroke
– RR=1.25 [1.14; 1.37], p<0.00001 for CHF
– RR=1.21 [1.15; 1.26], p<0.00001 for CVM
– RR=1.32 [1.24; 1.41], p<0.00001) for MI.
For all studies published after the year 2000, the increased risk was not retrieved for CHF (RR=0.58 [0.11; 3.55], p=0.52) and CVM (RR=1.07 [0.74; 1.56], p=0.71). The excess risk of MI was reduced in comparison with the period before 2000: RR=1.18 [1.14; 1.23], p<0.00001.The excess risk of stroke was stable: RR=1.23 [1.06; 1.43], p=0.006.
Discussion: This meta-analysis confirms an increased risk of CEs among people with RA relative to the general population. It also appears that this excess risk is less prevalent than prior to 2000s. This might have two explanations: a better management of the cardiovascular risk in patients with RA and a better control of chronic systemic inflammation thanks to new therapeutic strategies.

Conclusions: The cardiovascular excess risk of RA patients relative to the general population has decreased since 2000s. This suggests that the recent improvements in RA management may have a positive impact on cardiovascular comorbidities.

Disclosure of Interest: None declared

OP0147 | **TRENDS IN MORTALITY, CO-MORBIDITY AND TREATMENT AFTER ACUTE MYOCARDIAL INFARCTION IN PATIENTS WITH RHEUMATOID ARTHRITIS 1998-2013**

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Background: Rheumatoid arthritis (RA) patients have increased mortality due to cardiovascular disease (CVD). Case fatality after an acute myocardial infarction (AMI) has been reported to be increased. Whether the prognosis after AMI has changed over time in RA is unknown.

Objectives: To study the one-year mortality after a first AMI in RA versus non-RA patients during the time period 1998–2013. To identify time trends in mortality, co-morbidities and secondary preventive treatments and to explore any characteristics associated with mortality.

Methods: We identified all patients with a first time AMI in the Swedish Register of Information and Knowledge about Swedish Heart Intensive Care Admissions (RIKS-HIA) between 1998–2013. We used the National Patient Register (NPR) to identify AMI patients with RA (RA defined as ≥2 visits to a Rheumatology or Internal Medicine department with a diagnosis of RA). In total 245376 AMI patients were identified, 4268 of them had RA. To study trends over time, the study period was divided into five consecutive time periods. Multivariate Cox regression analysis was used to identify variables associated with mortality.

Results: The one-year mortality in RA patients was stable and lower compared to non-RA patients during the first time periods but thereafter increased above the non-RA patients. In non-RA patients, mortality decreased over time and stabilised during the last time period (Figure). In RA patients the mean age at admission increased from 69 to 73 years, whilst in non-RA patients it was unchanged, 71 years. Atrial fibrillation (AF) was initially more common in non-RA patients but the prevalence decreased over time (from 19.2% to 17.5%). In RA patients, AF increased over time from 15.6% to 21.4%. The prevalence of congestive heart failure (CHF) during hospitalisation decreased markedly more in non-RA (from 41.5% to 22.7%) than in RA patients (from 36.0% to 29.2%). The most important secondary preventive treatments were similar in RA and non-RA patients. In a multivariate Cox model including data from the last time period, 2011–2013, age, CHF during hospitalisation, ST-elevation AMI (STEMI), AF, prior diabetes mellitus, a diagnosis of RA and oral anticoagulation were significantly associated with higher one-year mortality (Table).

Multivariate Cox analysis for the last time period 2011–2013

		P<0,05	95% CI
Age	1,042	0,000	1,039–1,046
CHF	2,101	0,000	1,998–2,220
STEMI	1,848	0,000	1,738–1,965
Prior diabetes	1,370	0,000	1,294–1,450
AF	1,321	0,000	1,248–1,398
RA diagnose	1,257	0,012	1,051–1,502
Oral anticoagulation	1,120	0,000	1,096–1,145

One-year mortality during the consecutive time periods
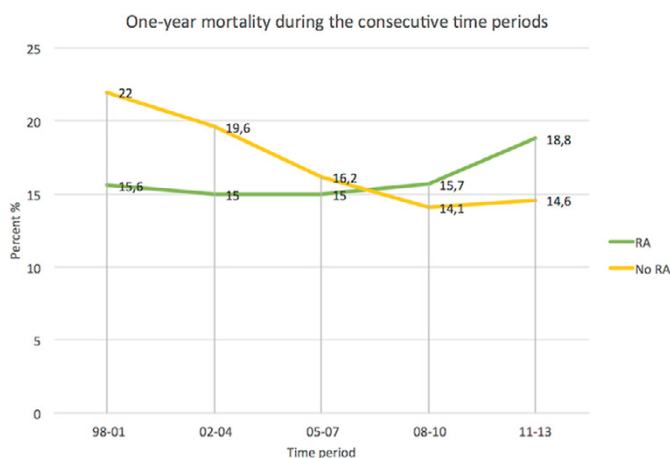
Conclusions: The marked decrease in one-year mortality after AMI seen over time in non-RA patients was not applicable in RA patients. Our finding might to some extent be explained by an increased age at AMI onset and unfavourable trends for AF and CHF in RA. However, RA *per se* was significantly associated with a worse prognosis during the last years of the study period. Secondary preventive treatment was similar in RA and non-RA patients. Further analyses including RA treatments are necessary to gain further insight into reasons behind the discrepant prognosis in RA vs. non-RA patients.

Disclosure of Interest: None declared