and 120 had anti-citrullinated peptide (anti-ccp) positive. Erosions were present in 106 RA patients. The prevalence of neoplasms was similar in RA and non-RA groups ($n=24$ vs 23 , $p=0.8$) and 5 of the deaths occurred in the RA-neoplasm group were due to the cancer. Of the 24 neoplasms in RA group, 9 appeared after the RA diagnosis was established (mean 10 years) and 17 before (mean 9.65 years). In RA patients correlation was found between male sex and neoplasm ($p=0.04$) as well as absence of RF rheumatoid factor and neoplasm ($p=0.049$). No correlation was found between the presence of neoplasm and anti ccp presence or erosions ($p=0.3$ and $p=0.51$ respectively). In this study, the overall risk of neoplasms in patients with RA was not associated with conventional or biological DMARDs. No differences were found between the type of tumour in RA patients vs non-RA, except for colon cancer, more prevalent in RA patients ($p=0.03$). Only 21 non-RA patients vs 19 RA patients were smokers and for so, it wasn't possible to establish any correlations.

Conclusions: In this study we found a prevalence of colon cancer in RA patients, as was found in other studies whoever, the increased risk for lung cancer and lymphoma often reported, was not found. It seems that male sex and the absence of rheumatoid factor are responsible for an increased risk. However we have several limitations: a very small sample, the population of the study was predominately Caucasian. Further studies examining specific aspects such as treatments, smoking or other lifestyle factors are needed to investigate the underlying mechanisms for the increased or decreased risk of specific cancers observed in patients with RA compared with the general population.

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AB0335

ARE EULAR RHEUMATOID ARTHRITIS (RA) MANAGEMENT RECOMMENDATIONS APPLICABLE AT THE COUNTRY LEVEL? SIMILARITIES AND DIFFERENCES WITH THE RECENT FRENCH RA MANAGEMENT RECOMMENDATIONS

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Background: Recently, EULAR updated the rheumatoid arthritis (RA) management recommendations.^{1,2} In 2018, the French Society of Rheumatology (SFR) updated their recommendations regarding the management of RA.³ This gave us the opportunity to compare the recommendations.

Objectives: To update the 2014 French recommendations for the management of RA and to compare them to the EULAR recommendations.

Methods: The SFR approach was based on the literature and on expert opinion. A systematic literature review (SLR) was performed by 2 fellows, collecting data to answer 11 questions. The previous (2014) recommendations were updated by a committee including 11 rheumatologists, 2 patients and 1 healthcare professional, during a 1 day meeting in January 2018. The recommendations were compared to the recently issued EULAR recommendations.^{1,2}

Results: The SLR included 137 papers. The consensus process led to 4 overarching principles and 15 recommendations. The overarching principles emphasise the need for shared decisions between the rheumatologists and the patient and the importance of a global approach of RA including pharmaceutical and non-pharmacological management. The recommendations address the diagnostic phase of RA, early initiation of disease-modifying antirheumatic drugs (DMARDs) and the usefulness of regular disease activity assessments through validated composite indices with a target of clinical remission or low disease activity. As first strategy, the expert committee recommends methotrexate (MTX). In case of intolerance or inadequate response to MTX, treatment must be optimised. If unfavourable prognostic markers are present, adding a targeted treatment (either biologic or synthetic) can be proposed, at best in combination with MTX; if not, switching to another conventional synthetic DMARD (csDMARD) or combined csDMARDs therapy can be proposed. While waiting for csDMARDs efficacy, short term (less than 6 months) glucocorticoids (GC) can be proposed. Second-line and further treatments and management of remission are also addressed, as well as the importance of managing comorbidities and of non-pharmacological measures.

Conclusions: These recommendations are designed to improve the management of RA and are concordant with the recent EULAR recommendations on several items. Main differences concern the place of GC and of combined csDMARD therapy, as well as additional points on diagnosis, non-pharmacological measures, comorbidities and the importance of a global approach.

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AB0336

HEPATITIS B VIRUS REACTIVATION IN RHEUMATOID ARTHRITIS PATIENTS WITH HBSAG-NEGATIVE/ANTI-HBC-POSITIVE STATUS

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Background: Hepatitis B virus (HBV) reactivation in rheumatoid arthritis (RA) patients with positive hepatitis B surface antigen (HBsAg+) is one of the treatment-related complications. The risk of reactivation in patients with negative hepatitis B surface antigen but positive anti-hepatitis B core antibody (HBsAg-/anti-HBc+) is less well defined compared to their HBsAg+ counterparts.

Objectives: This retrospective, single centre study aimed to study the prevalence of HBV reactivation (defined as HBV DNA becoming detectable) among RA patients with HBsAg-/anti-HBc+ status, and to investigate any factors predicting reactivation.

Methods: RA patients attending the rheumatology specialist clinic in a local tertiary hospital between 1st January 2011 and 31st December 2016 were included if they had of¹ HBsAg-/anti-HBc+ status and² undetectable HBV DNA at baseline. Demographic data, clinical parameters including treatments for RA and any use of antiviral prophylaxis, and laboratory results including anti-hepatitis B surface antibody (anti-HBs) and serial HBV DNA levels were obtained. Chi-square (or Fisher exact test if number was less than 5) was used for analysis of categorical variables. Student's t-test and Mann Whitney test were used for analysis of parametric and non-parametric continuous variables respectively.

Results: Majority (80%) of the 107 included patients included were female and the mean age was 62.5-year-old (SD 12.09). All the patients were receiving disease modifying anti-rheumatic drugs (DMARDs), 43% of which ($n=46$) were on biological therapy (with or without concomitant synthetic DMARDs) and the remaining ($n=61$) were only on conventional synthetic DMARDs (8 on monotherapy, 53 on combination therapy). As antiviral prophylaxis was not mandatory in HBsAg-/anti-HBc+ patients according to local guideline, only 13 patients (12.1%) were on antiviral cover (12 on entecavir and 1 on lamivudine).

Ten patients (9.3%) experienced HBV reactivation during their disease course. Three of them were on antiviral prophylaxis and four had positive anti-HBs. All of these reactivations were only transient low-grade viraemia with HBV DNA level <20 IU/ml. Spontaneous resolution of viraemia in less than 12 months' time were observed in all of these patients. None of the reactivation resulted in any adverse clinical event including acute hepatitis, hepatic failure or mortality.

Among all synthetic and biological DMARDs, only the use of methotrexate was found to be a significant predictor of HBV reactivation ($p<0.05$). Other parameters including age, the lack of antiviral prophylaxis, negative anti-HBs status and anti-HBs titre did not predict HBV reactivation.

Conclusions: HBV reactivation among RA patients with HBsAg-/anti-HBc+ status and undetectable HBV DNA at baseline was infrequent. Reactivation may occur in patients with positive anti-HBs or on antiviral prophylaxis, but was unlikely to be associated with adverse clinical outcome. The use of methotrexate was a predictor of HBV reactivation in these patients.

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AB0337

ASSESSMENT OF NUTRITIONAL STATUS IN WOMEN WITH RHEUMATOID ARTHRITIS MEASURED BY DUAL ENERGY X-RAY ABSORPTIOMETRY

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Background: As many other chronic diseases, rheumatoid arthritis (RA) has been related to an impairment of the nutritional status of multifactorial etiology. Even if Body Mass Index (BMI) has traditionally been used, it is not always a valid method, and there are still lots of questions without answer in how to evaluate ideally the nutritional status in these patients. Only very few studies had evaluated it by Dual Energy X Ray Absorptiometry (DXA).

Objectives: 1) To evaluate the nutritional status in women with RA and to compare with a population of same age women without RA using DXA for the analysis of whole body composition, 2) differences between the prevalence of alterations of the nutritional status measured by DXA and by the classical methods used in clinical care, 3) relation of RA time of evolution, inflammatory activity, physical function and dietary intake on altered nutritional status evaluated by DXA.

Methods: Case-control study including 89 patients that were diagnosed with RA and a control group (100) composed by patients affected by other non-inflammatory rheumatic diseases as soft tissue diseases. All the clinical charts were revised in order to record the following data: age, BMI, RA duration, history, activity and disability, serum albumin, Dietary intake, Whole body DXA assessment and Skeletal muscle index (SMI).

Results: Mean age of patients was 62±8 years. Mean duration of RA was 13.7±9.3 years. Mean DAS28 was 3.7±1.4 and mean Health Assessment Questionnaire was 0.88±0.77. BMI of the patients was 27.43±5.16 and 27.78±3.98 in controls (p: ns). Albumin was within normal range in all patients.

RA patients presented a statistically significant lower lean mass than controls in all locations and lower fat mass in limbs, along with a higher fat trunk.

RA duration was found to be inversely correlated to BMI and lean mass and directly correlated with fat mass.

Neither BMI nor albumin correlated with DXA parameters.

RA patients fulfilled criteria of sarcopenia in 44% of de cases vs 19% of controls (p<0.001). In RA patients, regarding SMI, BMI showed a high specificity to detect sarcopenia (94% of the patients with low BMI had sarcopenia) but low sensitivity (47% of the patients with normal or overweight BMI had sarcopenia).

Conclusions: RA patients have an impairment of nutritional status associated to time of evolution that resembles sarcopenia and that is not predicted by BMI.

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AB0338

CLINICAL CHARACTERISTICS OF PATIENTS WITH RHEUMATOID ARTHRITIS WHO USED COMPUTER TERMINALS FOR SELF-ASSESSMENT OF DISEASE ACTIVITY AND QUALITY OF LIFE

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Objectives: To present the clinical features, pharmacotherapy, activity and quality of life in pts with rheumatoid arthritis (RA) who used computer terminals for self-assessment of pts with rheumatic diseases.

Methods: The study included 976 RA patients from the cohort of "TERMINAL" multicenter study, envisaging pts' self-assessment of disease activity and quality of life using a designated computer system ("Computer terminals for self-assessment of pts with rheumatic diseases) before the visit to the rheumatologist. Mean age 52.3±13.3 years, mean disease duration 10.2±8.5 years, 85% female. Baseline clinical parameters and pharmacotherapy were assessed, as well as disease activity (using DAS 28 and RAPID-3), and quality of life (using HAQ and EQ-5D).

Results: 83% of pts were RF positive, and 60% ACCP positive. Almost all (91,2%) pts received conventional DMARDs. 70,2% of them received methotrexate: 56,7% 15 mg/week and 13,5% >15 mg/week (from 17,5 to 40 mg/week). 20,5% pts were treated earlier with low doses of glucocorticoids. 6,6% pts received Infliximab, 16,4% – Rituximab and 9,8% pts were treated with more than 1 biological agent in anamnesis. 46,2% of pts had high disease activity, 40,9% moderate, 4,5% low and 1,5% pts achieved clinical remission (mean DAS28 score 4,2±1,8, RAPID 13,6±3,6). Only 14,3% pts achieved general population HAQ values. The remaining showed significant reduction in the quality of life (mean HAQ 1,7±0,9, EQ-5D 0,6±0,2). 7,4% of the pts had prosthetic joints.

Conclusions: In the studied population almost all patients were treated with DMARDs (mostly methotrexate), and about 30% received biological agents. High to moderate disease activity and reduction in quality of life were typical for this population. Persistence of disease activity and functional insufficiency in pts who received DMARD therapy may be explained by poor monitoring in real clinical practice. The introduction of computer system for self-assessment of disease activity and quality of life in the out-patient facilities will improve the interaction

between doctors, nurses and patients, providing better control of therapy efficacy in RA patients.

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AB0339

SARCOPENIA AND EARLY FRAILTY SYNDROME IN RHEUMATOID ARTHRITIS

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Background: Sarcopenia and frailty are common in older persons and pose particular challenges for health and social care systems.

Sarcopenia, the loss of skeletal muscle mass, is a core component of physical frailty that together impact negatively on an individual's capability to live independently.

Frailty is defined as a syndrome of physiological decline in late life, characterised by marked vulnerability to adverse health outcomes. Frail adults are less able to adapt to stressors such as acute illness or trauma than non-frail adults. This increased vulnerability contributes to increased risk for multiple adverse outcomes, including procedural complications, falls, institutionalisation, disability, and death.

Rheumatoid arthritis (RA) is a chronic disabling disease, which leads to functional limitations and diminishes health-related quality of life. The presence of comorbidity and polypharmacy are both related to RA severity.

Objectives: The aim of this study was to assess the prevalence of sarcopenia and frailty syndrome in patients with RA.

Methods: Cross-sectional, observational and descriptive study in patients with RA (ACR criteria) older than 50 years.

Sarcopenia was defined as per the European Working Group on Sarcopenia in Older People definition as Skeletal muscle mass index (SMI) ≤8.87 kg/m² in men and ≤6.42 kg/m² in women. Body composition analysis was performed using bioelectrical impedance analysis (BIA).

Fragility was measured according to the 5 criteria proposed by Fried, using the Frail scale, and it was considered fragile to the patient who met at least 3 and pre-fragiles to those who met at least 2.

Frail scale: Based on five items, reflecting performance, self-reports and common co-morbidities (Morley JE et al. J Nutr Health Ageing 2012;16(7):601–8).

FRAIL SCALE

Did you feel worn out? or Did you feel tired?

Ability to climb one flight of stairs

Ability to walk 100 m

Self-report of >5% wt loss

≤5 of: dementia; heart Disease; depression; arthritis; asthma; bronchitis/emphysema; diabetes; hypertension; osteoporosis; stroke.

Results: 283 consecutive RA patients were included, 83.4% were female. Mean age was 63.3 years and mean disease duration was 10.4 years.

Mean number of comorbidities was 1.48, with systemic hypertension and obesity as the most frequent ones (33.8% and 26.4%, respectively). Polypharmacy was found in 96.8% and 64.7% received more than five drugs simultaneously.

31% presented some degree of sarcopenia. 21.5% met frailty criteria (42% in ≥65 years old patients).

Conclusions: Prevalence of sarcopenia and frailty syndrome in this study was high. Rheumatologists should make an early detection of signs of frailty.

The screening and early detection of frailty can spur reforms to make routine care less hazardous, can focus on outcomes most relevant to patients and can aid in understanding effectiveness of health care interventions, including at the population level.

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AB0340

ASSOCIATION BETWEEN MICROALBUMINURIA AND METABOLIC SYNDROME IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is an autoimmune, symmetrical polyarticular disease characterised by chronic inflammation of the synovial joints. Microalbuminuria (MA) occurs as a leakage of small amounts of albumin into the urine. Metabolic syndrome (MetS) describes risk factors for cardiovascular diseases such as dyslipidaemia, obesity, hypertension and diabetes.