AB0358

PHENOTYPES OF SECONDARY SARCOPENIA IN PATIENTS WITH RHEUMATOID ARTHRITIS

R. Yatsyshyn, I. Stoika. Internal Medicine #1, Ivano-Frankivsk National Medical University, Ivano-Frankivsk, Ukraine

Background: Secondary sarcopenia may be caused by low physical activity, eating disorders, chronic inflammation. In patients with rheumatoid arthritis (RA), sarcopenia co-occurs with osteoporosis as well as obesity and, in most cases, both osteoporosis and obesity co-occur with sarcopenia. Therefore, 3 phenotypes of sarcopenia can be identified: sarco-osteoporosis, sarcopenic obesity, osteosarcopenic obesity.

Objectives: The aim of the research was to study the features of sarcopenia and her phenotypes in patients with RA. There were examined 40 women with stage II-III RA, Rtg stage II-III, functional limitation stage II. The patients average age was 40.7±2.25 years.

Methods: The algorithm for diagnosing phenotypes of sarcopenia recommended by the European Working Group on Sarcopenia in Older People (2009) was used. Body mass index was determined. Dynamometry (the measurement of hand-grip strength using handgrip dynamometer) was performed and the evaluation of physical fitness. Serum levels of leptin and creatine phosphokinase MM (CPK MM) fraction were determined. The dual-energy X-ray absorptiometry DEXA (to calculate a T-score) was performed

Results: According to the results of laboratory tests and methods of evaluating functional muscle disorders, 87.5% of patients were diagnosed with sarcopenia. The mean values of dynamometry were within 18.3±0.7 kg being significantly lower as compared to healthy individuals – 28.3±0.5 kg. After the evaluation of physical fitness, the average score was 7.9±0.7, while in healthy individuals, it was 11.3±0.4. The mean CPK MM concentration was 175±2.34 U/L, while in healthy individuals, it was 144±3.5 U/L. The average T-score were within the limits (–1.83±0.17) SD and was significantly lower than in healthy (–0.56±0.10) SD. After conducting studies in 17 patients were diagnosed with osteosarcopenic obesity in 11 – sarco-osteoporosis, 7 – sarcopenic obesity, 5 patients sarcopenia has not been diagnosed.

Conclusions: RA leads to muscle metabolism disorders which result in the development of secondary sarcopenia. Therefore, a high-protein diet, physical exercise, namely aerobic exercise (swimming, cycling) and medical preparations that improve muscle metabolism should be included in therapeutic measures and preparations of calcium.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2305

AB0359

CLINIC PROFILE OF PATIENTS WITH RHEUMATOID ARTHRITIS AND PULMONARY AFFECTON IN A COHORT FROM A UNIVERSITY HOSPITAL

I. Casafont Solé¹, Á. Prior-Español¹, S. Hologado¹, J. Roca¹, L. Mateo¹, Y. García-Mira¹, J. Camins¹, L. Gifre¹, A. Riveros¹, M. Martínez-Morillo¹, M. Aparicio¹, A. Olivé¹. ¹Rheumatology, ²Epidemiology, Hospital Universitari Germans Trias i Pujol, Badalona, Spain

Background: Pulmonary affection is a serious complication in Rheumatoid Arthritis (RA) with an important impact on mortality and morbidity.

Objectives: To describe the clinical and radiographic characteristics of patients with RA in our centre, and specifically from those with interstitial lung disease (ILD).

Methods: Retrospective analysis of patients with RA and pulmonary affection from a University Hospital with a referral area of 85.000 inhabitants. Clinical, laboratory, imaging and pulmonary function test (PFT) data was recorded.

Results: Data from 85 patients, 37 (43.5%) male and 48 (56.5%) female, were recorded. The mean time from RA diagnosis to pulmonary disease was 9.2 years, with mainly erosive (58.8%) and seropositive (84.7%) were positive rheumatoid factor (RF) and 84.2% anti-citrullinated protein antibodies (ACPA) disease. The 56.5% of the patients were smokers or ex-smokers. PFT results were documented in 75.3% of the patients: diffusing capacity for carbon monoxide (DLCO) baseline values were over 60% in a 38.8% of cases and forced vital capacity (FVC) baseline values were over 50% in a 69.4% of patients. The most frequent High Resolution CT scan pattern was the presence of bronchiectasis (64.7%), followed by ILD (31.8%) and, specifically, the Usual Interstitial Pneumonia pattern (UIP, 66.6%); lung infections (25.8%), rheumatoid lung nodules (22.4%), pleural effusion (15.3%), lung tumours (9.4%) and bronchiolitis (5.8%). The presence of extra articular manifestations as rheumatoid nodules (27%), episcleritis (2.3%) and vasculitis (9.4%) was registered. The coexistence of Chronic Obstructive Pulmonary Disease (COPD) was recorded too (24.7%). Related to treatment, 84.7% of patients had received Methotrexate and in a 40% of cases, at least one

biological disease-modifying antirheumatic drug had been administrated. Though the causes were not registered, a 25.9% of deaths were documented. In parallel we did a subanalysis of ILD related to RA cases, summarised in table 1 (n=27):

Conclusions: Bronchiectasis is the most common pulmonary manifestation of RA patients in our area. The most frequent clinical profile is a non-smoker woman with seropositive disease.

ILD affects approximately one third of RA patients in our area and is an underdiagnosed entity. We consider that it is necessary to establish a screening program to diagnose and treat it early.

Abstract AB0359 – Table 1

Gender, male (%)	44.4%	
RA – pulmonary affection time of evolution (years), mean ±SD	7.5±7.7	
ACPA positive (%)	Yes (88.9%)	No (7.4%)
RF positive (%)	Yes (92.6%)	No (7.4%)
Erosive disease (%)	Yes (59.3%)	No (40.7%)
Smoker or ex – smoker (%)	Yes (48.1%)	No (51.9%)
Baseline FVC (%)	<50% (3.7%)	≥50% (66.7%)
Baseline DLCO (%):<40%	7.4%	
41%–59%	18.5%	
≥50%	40.7%	

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.5696

AB0360

LEFT ATRIAL DILATION IS INCREASED IN PATIENTS WITH RHEUMATOID ARTHRITIS: A CASE-CONTROL STUDY

D.A. Galarza-Delgado¹, J.R. Azpiri-López^{1,2}, I.J. Colunga-Pedraza¹, J.A. Dávila-Jiménez², E.E. Abundis-Márquez¹, A.H. Guillén-Lozoya¹, F.J. Torres-Quintanilla², R.E. Ramos-Cázares¹, R. Vera-Pineda², J.A. Cárdenas-de la Garza¹.

¹Rheumatology; ²Cardiology, Hospital Universitario "Dr José E. Gonzalez", UANL, Monterrey, Mexico

Background: Rheumatoid arthritis (RA) is a chronic, systemic inflammatory disease, which mainly affects synovial joints.¹ Heart structural abnormalities are more prevalent in RA-patients than in general population, such as pericarditis, increased left ventricle mass and valvular disease.² Left atrial (LA) dilation predicts atrial fibrillation and congestive heart failure. It also increases the risk of developing thromboembolic events.³

Objectives: The aim of this study was to determine the prevalence of LA dilation in RA-patients and compare it with matched controls.

Methods: An observational, cross-section, case-control study was designed. Patients who fulfilled 1987 ACR and/or 2010 ACR/EULAR classification criteria for RA, 40–75 years old, with no overlap syndromes or atherosclerotic cardiovascular disease were included. The control group was matched by age, gender and comorbidities. A standard transthoracic echocardiogram was performed by a board-certified cardiologist. LA structure alterations were evaluated according to the American Society of Echocardiography guidelines.

Results: A total of 63 RA-patients and 41 control subjects were included. Demographic characteristics are shown in table 1. LA dilation, defined as a LA indexed volume (LAIV) >34 mL/m², was found in 9 (14.3%) patients of the RA-group, whereas no control subjects presented that condition (p=0.011). Mitral regurgitation was detected in 39 (62%) RA-patients and 7 (17%) control subjects (p<0.001).

Abstract AB0360 – Table 1. Demographic characteristics

	RA (n=63)	Control (n=41)	P
Age, mean±SD	55.26±8.32	53.71±6.16	0.277
Disease duration (years), mean±SD	10.84±8.95	-	-
DAS-28 CRP, mean±SD	11.21±9.36	-	-
Women, n (%)	61 (96.8)	36 (87.8)	0.109
Hypertension	24 (38)	8 (19.5)	0.052
Body Mass Index, mean±SD	28.63±5.04	28.58±4.71	0.964
Active smoking, n (%)	6 (9.5)	3 (7.3)	>0.999
Type 2 Diabetes mellitus, n (%)	6 (9.5)	6 (14.6)	0.533
DAS-28 CRP – Disease activity score 28 using C-reactive protein.			