flares occurring six months before/after their introduction, using medical files and phone inquiry.

Results: Twenty-three patients were included in this study. Data about RA treatments and SCD flares could be collected for 15 patients. Middle age at RA diagnostic was 32.9 years-old, sex ratio was 4.75F/1M. 74% of the patients were RF positive, 65% were ACPA positive. 74% of the patients had articular damages. Among them, 100% had severe carpite which appears to be the major radiological expression of RA in SCD patients, occurring sometimes without finger bone erosion. 100% received at least one specific drug for RA, 35% a biotherapy. There was no significant difference in the number of crisis before and after methotrexate introduction ($p=1$) or anti TNF alpha drugs ($p=0.35$ IC95% [-1.26;0.51]). Methotrexate had to be stopped for 3 patients because of acute chest syndrome, which did not occur with anti TNF. No infection was noticed.

Conclusions: In conclusion, in SCD, RA occurs sooner in life course and to be more severe with a particular pattern: carpite and tarsite without finger bone erosion. The use of biotherapy appears to be safe, with a close monitoring.

Disclosure of Interest: None declared

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AB0364

REMARKABLE INTERNATIONAL VARIABILITY IN REASONS FOR NON-PARTICIPATION IN THE GLORIA TRIAL

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Background: GLORIA is an ongoing large pragmatic trial that examines harm, benefit and costs of low-dose glucocorticoids added to the standard treatment of RA patients of 65 years or older. The eligibility criteria are non-restrictive: RA, age ≥ 65 years, disease activity score (DAS28) of ≥ 2.6 , and no current glucocorticoid treatment. Patients with comorbidity are expressly included, and the impact of trial procedures on normal care is minimal. Nevertheless, inclusion proves to be challenging. We have prospectively sampled all the reasons for ineligibility across a number of centres in different countries participating in the GLORIA trial.

Methods: Rheumatologists from 8 centres in Germany, Hungary, The Netherlands, Portugal and Romania screened the patient list of at least two full clinic days. For each patient, the eligibility and all possible reasons of exclusion were recorded.

Abstract AB0364 – Table 1. Percentage of patients ineligible for the GLORIA trial, per reason (patients can have more than one reason)

Center	n	Percent ineligible for:				
		Age	Disease Activity	Current Temporary GC	Other	
Total	370	58	58	28	5	11
The Netherlands						
Amsterdam	156	54	70	22	5	11
Rotterdam	43	63	58	12	2	9
Leeuwarden	46	51	70	11	4	19
Germany, Berlin	23	52	52	65	0	17
Portugal						
Coimbra	21	58	21	8	4	17
Lisbon	10	60	60	80	80	10
Hungary, Debrecen	46	75	43	55	0	2
Romania, Bucharest	18	56	22	44	0	6

Results: In total, 385 patients were screened. Of these patients, 15 (4%) were eligible to participate in the GLORIA trial. In Germany, Romania and Portugal (Lisbon) none of the screened patients proved eligible.

The most common reasons for ineligibility were inactive disease and age (both 58%) (table 1). Current glucocorticoid use was reported in 28%, 5% had a temporary reason (i.e. recent switch of therapy or glucocorticoid use), and 51% had more than one reason for ineligibility. We found remarkable differences between the sites in the distribution of the main reasons for ineligibility (table 1).

Of the eligible patients, 1 was already participating, 3 were included after this screening, and 2 were currently considering participation; 9 declined participation (most common reasons: fear of glucocorticoids, not interested to participate, preference for GC injections or declining additional therapy).

Conclusions: In this prospective study, we found remarkable differences between countries in reasons for non-participation in our ongoing GLORIA trial. The willingness of eligible patients to participate was low in this elderly population, despite the pragmatic design. Earlier studies also showed that it is challenging to include elderly patients in a clinical trial.^{1,2} Pre-screening of patients in potential sites can provide important information on the potential to recruit patients in a trial, but the actual willingness of patients to participate remains hard to predict.

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AB0365

THE INSULIN RESISTANCE, METABOLIC SYNDROME AND TYPE 2 DIABETES MELLITUS DEVELOPMENT RISK ASSESSMENT IN RHEUMATOID ARTHRITIS PATIENTS

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Background: The insulin resistance (IR) is the known risk factor of type 2 diabetes mellitus (DM) and potential cardiovascular complications. But it's not feasible in routine practice to calculate special indices to determine IR, as insulin levels monitoring is not a standard procedure in RA pts. Metabolic syndrome (MS) criteria and questionnaires designed to assess the risk of DM development can help to differentiate a subgroup of pts, requiring more accurate evaluation of their IR status.

Objectives: To determine how IR relates with MS and DM development risk assessment in RA patients.

Methods: A total of 46 RA pts (39 women, 7 men, 57 [39; 64] years old) without established DM were enrolled in the study, including 14 pts with IR and 32 pts without IR, matched by age and sex. IR was defined as Homeostasis Model Assessment of Insulin Resistance (HOMA-IR) index >2.77 . National Cholesterol Education Program/Adult Treatment Panel III (NCEP/ATPIII) and International Diabetes Federation (IDF) criteria were used to confirm MS. The abdominal obesity was determined as waist circumference (WC) ≥ 80 cm for women and ≥ 94 cm for men (by IDF), and WC ≥ 88 cm for women and ≥ 102 cm for men (by NCEP/ATPIII). If the total score of questionnaire Finnish Type 2 Diabetes Risk Assessment Form (FINDRISK) was ≥ 12 , the DM development risk was considered as moderate or high.

Results: The body mass index was higher in pts with IR than in those without IR (28,5 [24,8; 32,5 kg/m² vs 22,4 [20,1; 25,4 kg/m², $p<0.001$). Abdominal obesity was documented in 100% pts with IR and in 41% pts without IR by IDF criteria ($p=0.002$), in 64% and 22% pts, respectively, by NCEP/ATPIII criteria ($p=0.01$). There were no differences in DAS28, CRP and ESR values and glucocorticoids users proportions. MS by IDF criteria was diagnosed in 57% pts with IR and 19% pts without IR ($p=0.02$), and MS prevalence by NCEP/ATP III criteria was similar in both groups (36% vs 16%, respectively, $p=0.2$). Higher rates of moderate and high risk for DM development were found in pts with IR compared to pts without IR (71,4% vs 31,2%, $p=0.03$).

Conclusions: The FINDRISK and IDF questionnaires, but not the NCEP/ATP III criteria of MS, can be helpful in selecting RA pts with potential IR. Abdominal obesity was the key factor indicative of IR in RA pts. On the other hand, IR may not be there even in the presence of several traditional DM risk factors. Therefore further clarification of potential contribution of RA-related risks is needed.

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