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FRI0014 LOW-DOSE ASPIRIN MAY HAVE A ROLE AS PRIMARY PROPHYLAXIS OF CARDIOVASCULAR EVENTS IN RHEUMATOID ARTHRITIS: EVIDENCE FROM AN ITALIAN MULTICENTRIC RETROSPECTIVE STUDY

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Background: Cardiovascular (CV) morbidity and mortality are significantly greater in Rheumatoid Arthritis (RA) patients than in the general population. Acetylsalicylic acid (ASA) is known to be associated with a significant decrease in the incidence of CV events in patients at high CV risk, as we have recently demonstrated in patients with Systemic Lupus Erythematosus, but its effectiveness as primary prophylaxis in RA patients has not yet been addressed.

Objectives: To investigate the role of ASA in reducing the incidence of CV events in an Italian multicentre RA cohort from the GIRRCS (Gruppo Italiano di Ricerca in Reumatologia Clinica e Sperimentale).

Methods: The clinical charts of RA patients consecutively admitted to 4 GIRRCS centres for their 1st visit from November 1st 2000 to December 31st 2015, who, at admission, satisfied 2010 ACR/EULAR criteria for RA and had not experienced any CV event, were analysed. The incidence of CV events during follow-up was recorded at December 2016. Kaplan Meier curve and log-rank test were used to investigate differences in event-free survival. Cox regression analysis served to identify factors associated with CV event occurrence.

Results: Seven hundred and forty-six consecutive RA patients were enrolled and followed up for a median of 5.6 years (range 2.9–8.9 years). The incidence rate (IR) of CV events was 7.8/1000 person-years (pys) in the overall cohort. Patients were subdivided into two groups, namely ASA- (242 patients) and non-ASA-treated (504 patients). The IR of CV events was significantly lower in the ASA-treated with respect to the non-ASA-treated group (IR 1.7 vs 11.5/1000 pys; $p=0.0002$). Furthermore, the CV event-free rate was longer in ASA-treated than in non-ASA-treated patients (log-rank test 12.3; $p=0.0004$). Figure 1.

At multivariate analysis hypertension and metabolic syndrome (HR 5.6, 95% CI: 1.2–26.3; $p=0.03$ and HR 3.7, 95% CI: 1.3–9.8; $p=0.009$) resulted to be the only positive predictors; ASA treatment (HR 0.04, 95% CI: 0.06–0.33; $p=0.02$) the only negative one.

Conclusions: The incidence rate of CV events in our Italian multicentric cohort was lower than that reported in other European and non European cohorts. Low-dose ASA may have a role in the primary prophylaxis of CV events in RA patients.

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FRI0015 TREATING RHEUMATOID ARTHRITIS TO TARGET: IS LOW DISEASE ACTIVITY GOOD ENOUGH?

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Background: Treat-to-target (T2T) principles in rheumatoid arthritis (RA) are now widely recognised as effective in achieving optimal disease outcomes.

Objectives: To examine for differences in outcomes between low (LDAS) and remission (RDAS) disease activity score (DAS) categories, addressing the question: is LDAS a 'good enough' treatment target in RA?

Methods: Data from two consecutive UK multi-centre RA inception cohorts with similar design were used: the Early RA Study (ERAS) and Early RA Network (ERAN). Recruitment figures/median follow up for ERAS and ERAN were 1465/10 years (maximum 25 years), and 1236/6 years (maximum 10 years) respectively. Standard demographic and clinical variables were recorded at baseline and then annually until the end of study follow up. Disease activity was categorised by mean DAS28 score between years 1–5 as remission [mRDAS <2.6] or low [mLDAS 2.6–3.2]; as sustained low/remission DAS (sLDAS/sRDAS) based on DAS persisting in each of the two categories at years 1–2 and as Boolean remission (years 1–2). Change in HAQ and SF36 (physical [PCS] and mental [MCS] components) for each disease activity category were modelled using linear mixed models with time incorporated as a linear spline with change-point at 12 months. Year of onset, age, gender and use of steroids or conventional DMARDs at first visit were included as covariates.

Results: Out of 2701 patients, 468 (17%) were in mRDAS, 284 (11%) in mLDAS in the first five years of disease. Lower proportions had achieved sRDAS (8%), sLDAS (6%) and Boolean (2%) remission. Mean age was similar across categories; more women were in low vs remission DAS. Compared to mLDAS or sLDAS, inflammatory markers, DAS, functional (HAQ, PCS) and mental (MCS) scores tended to be better in the mRDAS, sRDAS or Boolean remission categories (figure 1). Significant differences ($p<0.05$) were noted between the mRDAS and mLDAS between years 1–5 for all outcomes; for sRDAS compared to sLDAS, the difference was significant at one year but not by five years.

Conclusions: The results demonstrate striking differences between remission and low DAS categories, suggesting worse functional and SF36 outcomes over