regression to estimate the risk of loosening with increasing SDAI, stratified for TKA and THA.

Results: Data of 49 RA patients and 88 OA patients were available for analysis. The rate of APL was 36.7% in the RA and 13.6% in the OA group ($p=0.002$). This was explained by a much higher rate of APL in the TKA group (RA: 34.4%; OA: 6.5%; $p=0.001$), while the rates in the THA group were only numerically different (RA: 41.2%; OA: 30.8%; $p=0.528$).

In the RA group one year time integrated SDAI was significantly higher prior to loosening than in controls without loosening ($p=0.043$). In the Cox model, SDAI was also significantly related to time to APL with a Hazard ratio of 1.125 (95% CI 1.021–1.241) ($p=0.018$). Figure 1 depicts cox regression adjusted for AUC SDAI 3, 13 and 26 separately for TKA and THA.

Conclusions: RA is not only a risk factor for infectious complications after TJA, but also for APL after THA or TKA. This effect might—at least partly—be explained by systemic and local inflammation in RA patients as depicted by higher levels of disease activity in RA patients with APL. In the context of treatment-to-target of RA, the presence of an arthroplasty should be considered as an indication for even more stringent control of disease activity.

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Rheumatoid arthritis – comorbidity and clinical aspects

FRI0052 HIGHER URIC ACID IS ASSOCIATED WITH A LOWER DISEASE ACTIVITY IN RHEUMATOID ARTHRITIS PATIENTS

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Background: An association between serum uric acid (UA) and disease activity in rheumatoid arthritis (RA) patients has not been well studied.

Objectives: We describe RA patients with high and normal UA and study its association with RA activity.

Methods: Adult RA patients from The Kuwait Registry for Rheumatic Diseases (KRRD) who satisfied the ACR classification criteria for RA from four major hospitals were studied from February 2013 through April 2017. Patients with recorded

UA were identified. Visits with documented UA levels were included. UA of ≥ 357 $\mu\text{mol/L}$ (6 mg/dL) was considered high. Statistical correlations were made.

Results: A total of 564 RA patients with 2710 hospital visits and available UA were identified, 353 (62.6%) females. Mean age 50.8 ± 11.5 years and disease duration 10.5 ± 2.9 years. Mean DAS28 was 2.9 ± 1.2 and mean HAQ-DI 0.77 ± 0.67 . Rheumatoid factor (RF) was positive in 431/564 (76.4%) and anti-cyclic citrullinated peptide antibodies (ACPA) in 374/564 (66.3%).

Mean UA was 271 ± 78 $\mu\text{mol/L}$ with 12.7% readings being high. There were more males among patients with high UA than with normal UA (56% vs 36%, $p<0.01$) with no difference in age.

UA was negatively correlated with DAS28 ($p<0.001$), CDAI ($p<0.001$), SDAI ($p=0.038$), ESR ($p=0.034$), VAS pain ($p=0.049$), morning stiffness ($p=0.033$), patient's global assessment ($p=0.006$), physician's global assessment ($p=0.033$), number of tender joints ($p<0.001$) and number of swollen joints ($p<0.001$). There was no significant correlation with RF, ACPA or HAQ. The use of steroid, synthetic and biologic antirheumatic drugs, either individually or as a class, was similar among patients with high and normal UA.

Conclusions: RA patients with a higher UA had a lower disease activity despite using similar antirheumatic drugs. Reasons behind such association need to be further studied.

Disclosure of Interest: None declared

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FRI0053 THE CHANGING FACE OF RHEUMATOID ARTHRITIS AT THE END OF THE 20TH CENTURY – A COMPARATIVE POSTMORTEM CLINICOPATHOLOGIC STUDY OF 237 RHEUMATOID ARTHRITIS PATIENTS WITH AA AMYLOIDOSIS AND SYSTEMIC VASCULITIS

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Objectives: Most clinicians accept that the course of rheumatoid arthritis (RA) has changed in the last decades. The aim of this study was to verify this clinical impression characterised by systemic vasculitis (SV) and AA amyloidosis (AAa).

Methods: At the National Institute of Rheumatology 12 138 patients died between 1969 and 2000; among them 237 with RA, who were autopsied.

RA was complicated in 53 (22.36%) by SV, and in 49 (20.68%) of 237 patients by AAa. RA was confirmed clinically according to the criteria of the American College of Rheumatology.¹ The presence of SV and of AAa was determined histologically. The "severity" of vasculitis and the extent of amyloid A deposition/patient was evaluated by semi-quantitative visual estimation on a 0 to 3 plus scale.² The average prevalence of SV and AAa was calculated in percentage of the number of RA patients, who died during four periods of time (8–8–8–8 years) covering 32 years (between 1969 and 2000).

Results: During these four periods of time (from 1969 to 2000) the average age of RA patients with SV continuously increased from 57.00 to 68.00 years, and with AAa from 56.71 to 64.08 years. The prevalence of SV and AAa and the proportion of severe cases in % of RA patients are demonstrated on figure 1.

Conclusions: According to our data RA became more aggressive with higher prevalence of SV and AAa at the end of the last century.