FRI0060

ARE OLDER RA PATIENTS FRAIL, OR LONELY AND DEPRESSED?

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Background: The average rheumatoid arthritis (RA) patient has approximately 2 comorbidities, and this number increases with age. Both comorbidity and ageing are considered risk factors for frailty, a physiological syndrome characterised by reduced functional reserves and resistance to 'stressors' due to a cumulative decline of physiological and psychosocial systems. Frailty results in adverse health outcomes including hospitalisation and increased risk of mortality. The extent to which frailty is a relevant problem in elderly RA patients remains unknown.

Objectives: (1) To assess the prevalence of frailty and (2) to identify which factors are associated with frailty in elderly patients with RA.

Methods: Consecutive patients of the outpatient clinic were invited to participate in a study on ageing while ensuring equal representation of patients in three pre-defined age groups: 55–64, 65–74, and ≥75 years. Rheumatologists recorded the number of comorbidities. Patients rated their overall health on a visual analogue scale (0–100; 100 very bad health) and completed the validated Groningen Frailty Indicator (GFI), which contains 15 questions on the loss of functions and resources across 4 domains: physical (mobility functions, multiple health problems, physical fatigue, vision, hearing), cognitive (cognitive dysfunction), social (emotional isolation), and psychological (depressed mood and feelings of anxiety). Scores on items are dichotomized, "1" indicating a problem or dependency. Prevalence of problems/dependency was compared among the 3 age-groups using a Kruskal-Wallis test. Characteristics of patients classified as frail (GFI score ≥4) or non-frail (GFI score <4) were compared using a chi-square test for categorical data or the independent samples t-test for continuous data.

Results: The prevalence of frailty across age groups was respectively 43.3%, 40.0% and 43.4%. Frail RA patients were more often female, had a lower subjective health status. Remarkable, patients classified as frail identified problems in the social and psychosocial domains. Of interest, there were no differences regarding age, polypharmacy, number of comorbidities, and cognitive domain (figure 1).

Table 1 Comparison of demographics, clinical characteristics, and number of patients with problems/dependency per frailty domain between frail and non-frail elderly rheumatoid arthritis patients.

	Frail (n=38)	Non-frail (n=52)	p-value
DEMOGRAPHICAL CHARACTERISTICS			
Male	8 (21)	22 (42)	0.035
Age, mean (SD)	69.9 (9)	69.6 (7)	0.878
CLINICAL CHARACTERISTICS			
Patient global health (0–100), mean (SD)	45.7 (20)	34.5 (16)	0.004
Comorbidities, mean number (SD)	0.6 (1)	0.5 (1)	0.862
FRAILTY DOMAIN SCORES			
Physical domain GFI; problem or dependency: n (%)			
Grocery shopping	5 (13)	2 (4)	0.103
Walk outside the house	3 (8)	0 (0)	0.039
Getting (un)dressed	2 (5)	0 (0)	0.094
Visiting restroom	1 (3)	0 (0)	0.239
Vision	5 (13)	2 (4)	0.103
Hearing	6 (16)	6 (12)	0.558
Nutrition	6 (16)	1 (2)	0.015
Use of 42 medication types	30 (79)	38 (73)	0.522
Subjective physical fitness	23 (61)	13 (25)	0.001
Cognitive domain GFI; problem or dependency: n (%)			
Memory complaints	10 (26)	6 (12)	0.070
Social domain GFI; problem or dependency: n (%)			
Emptiness	24 (63)	2 (4)	<0.001
Missing the presence of people around	25 (66)	4 (8)	<0.001
Feelings of loneliness	21 (55)	0 (0)	<0.001
Psychosocial domain GFI; problem or dependency: n (%)			
Feelings of depression	28 (74)	6 (12)	<0.001
Nervous or anxious feelings	22 (58)	8 (15)	<0.001

Data are presented as number (percentage) of patients unless stated otherwise.

Conclusions: Using validated questionnaires, frailty is highly prevalent in all RA patients older than 55 years and seems to be a distinctive health construct which is not necessarily related to increasing age, polypharmacy and comorbidity in patients with RA. An alternative explanation of our findings is that rheumatologists seem to miss symptoms of depression and loneliness among RA patients.

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FRI0061

CARDIOVASCULAR RISK FACTOR AND DISEASE BURDEN IN BELGIAN PATIENTS WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES OF NORTH AFRICAN COMPARED TO EUROPEAN DESCENT

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Background: Patients with rheumatic and musculoskeletal diseases (RMDs) from developed populations often experience increased atherosclerotic cardiovascular disease (ACVD) risk. In European countries, increasing proportions of inhabitants originate in developing countries and are therefore reportedly at an earlier epidemiological transition stage, which is associated with reduced ACVD.¹

Objectives: This study aimed to determine whether population origin specific cardiovascular risk management is indicated in Belgian patients with RMDs.

Methods: We recorded major conventional cardiovascular risk factors included in the Systematic Coronary Risk Evaluation (SCORE) or/and Framingham score equation, other conventional and non-conventional cardiovascular risk factor profiles and the prevalence of subclinical ACVD comprising arterial stiffness (pulse pressure >60 mmHg) and established ACVD (coronary artery disease, ischaemic cerebrovascular disease or/and peripheral artery disease) in 673 consecutive patients with RMDs; 126 and 547 were of North-African and European ancestry, respectively. Cardiovascular risk factors and disease were compared between patients of North African and European descent in multivariable logistic and linear regression models.

Results: Patients of North African descent tended to have less frequently inflammatory RMDs (OR (95% CI)=0.69 (0.45–1.04)) including rheumatoid arthritis (RA) (OR (95% CI)=0.46 (0.19–1.09)), and had more often fibromyalgia (OR (95% CI)=2.93 (1.84–4.65)). Patients of North African descent were younger than their European descent counterparts (mean (SD)=47.5 (14.7) vs 55.7 (16.5) years, p<0.0001). In age, sex and inflammatory RMD adjusted analysis, North African descent patients had less prevalent hypertension (OR (95% CI)=0.54 (0.33–0.87)) and more frequent diabetes (OR (95% CI)=3.69 (2.00–6.80)); North African descent patients exercised ((OR (95% CI)=0.34 (0.20–0.57)) and used alcohol (OR (95% CI)=0.05 (0.02–0.12)) less often, and had a less frequent family history of ACVD (OR (95% CI)=0.64 (0.41–0.99)), smaller body height (mean (SD)=1.64 (0.09) vs 1.66 (0.11) m, p<0.0001) and larger the Arthritis Impact Measurement Scales Depression score (mean (SD)=4.4 (1.9) vs 3.7 (2.0), p=0.009). These findings translated into a frequencies of having ≥1 major cardiovascular risk factor, overall 10 year high risk for any (Framingham score ≥20) and fatal (SCORE ≥5) ACVD, and prevalence of subclinical and established ACVD that were as large in RMD patients from North African compared to European descent. European League Against Rheumatism multiplier² application in patients with RA did not alter these findings.

Conclusions: Consistent disparities exist in ACVD risk factor profiles between RMD patients of North-African and European descent. However, the overall cardiovascular risk factor and disease burden is currently as large in RMD patients of North African compared to European ancestry. Adequate ACVD risk management in RMD patients should be performed irrespective of population origin.

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FRI0062

CORTICOSTEROID INJECTION FOR PLANTAR HEEL PAIN: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: Plantar heel pain is one of the most common conditions affecting the foot in adults, with prevalence estimates between 4% and 7%.^{1,2} Corticosteroid injection is a common intervention used to treat plantar heel pain,³ however there is limited high quality evidence to support this practise. Because corticosteroid injection is frequently used for plantar heel pain, it is important that health professionals understand whether the evidence-base supports the use of this intervention.