Conclusions: Iron deficiency anaemia is prevalent in RA patients. A combination use of serum ferritin and TSAT is the most simple, accurate parameter now to differentiate both. Log ferritin, transferrin or transferrin ratio may be promising new parameters in diagnosis of IDA in general population but their use in inflammatory diseases like RA still has a limitation so we suggest further large studies to be done in order to assess their accuracy.

REFERENCES:

Disclosure of Interest: None declared


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**ADJUSTMENT OF THE THRESHOLD MAY IMPROVE CARDIOVASCULAR RISK STRATIFICATION IN PATIENTS WITH RHEUMATOID ARTHRITIS**

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Background: Rheumatoid arthritis (RA) is associated with increased cardiovascular (CV) risk. Besides monitoring of the disease activity, identification of high CV risk patients is of great importance.

Objectives: The aim of the study was to assess the abilities of 3 risk models (SCORE, QRisk 2 and 10 year ASCVD) in detecting high CV risk RA patients.

Methods: 56 patients with RA (ACR/EULAR 2010) without known CV disease were examined (84% females, age 58±14.1 (M±SD) years, BMI 26.1±5.4 kg/m², smokers 9%, arterial hypertension (AH) 64%, dyslipidemia 57%, diabetes 7%). Median duration of RA was 7 years (IQR 2–14). Seropositive RA was diagnosed in 73% of patients. Median hsCRP was 7.8 mg/dl (IQR 2.2–14), rheumatoid factor (RF) – 6.1 IU/ml (IQR 18.5–71.9), mean DAS-28 (CRP) – 3.7±1.2. All patients received disease-modifying antirheumatic drugs. SCORE, QRisk2 and 2013 ACC/AHA 10 year ASCVD risk and EULAR recommended modified versions were calculated. Patients with SCORE >5%, QRisk2 >20% and ASCVD risk >7.5% were classified as having high CV risk. Carotid intima-media thickness (CIMT) >0.9 mm and/or carotid plaques detected by ultrasonography were used as the gold standard test for high CV risk. p<0.05 was considered significant.

Results: The median SCORE, QRisk2 and ASCVD were 2.2% (IQR 0.6–4.9), 10.2% (3.4–19.2) and 4.9% (1.5–12.8) respectively. The proportion of high-risk patients was as follows: 14 (25%), 13 (23%) and 24 (43%) for SCORE, QRisk2 and ASCVD. Mean CIMT was 0.76±0.24 mm. US criteria for subclinical atherosclerosis (US) were found in 27 (48%) pts. Discriminating capacities for the indexes were as follows: AUC 0.723 (CI 0.956–0.821) for SCORE, AUC 0.705 (CI 0.956–0.804) for QRisk2 and AUC 0.837 (CI 0.757–0.917) for ASCVD. The percentages of high-risk patients in US-group were as follows: 13 (48%), 12 (44%) and 21 (78%) respectively, (p<0.05 compared to ASCVD). After multiplying by 1.5 EULAR 2016 mASCVD reclassified 2 (7.4%) and mSCORE – 4 (14.8%) pts from moderate to high risk. Use of lower cut-off values for risk indices (SCORE >1%, QRisk2 >10% and ASCVD >5%) resulted in better detection of US+pts (100%, 85% and 85% respectively).

Conclusions: The 2013 ACC/AHA 10 year ASCVD risk estimator is better than the SCORE and QRisk2 indices for the detection of high CV risk RA patients. Adjustment of the threshold may be a better modification of risk scales than use of the EULAR multiplier factor.

REFERENCES:

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