DAS-28. The secondary objective is to validate the accuracy of different parts of the CDAI and DAS-28. Comparison with the patient's joint count is done as well.

Methods: The trial was conducted in a private clinic. The patient was examined at first by the physician and afterward by the nurse. The 2 nurses participating to the trial were trained for joint count during a 14 hours course. Finally, a brief training was given to the patient who performed a self-evaluation. The study consisted of one visit where all the different information was collected. The different data collected concerned: the patient's medical history, medication, diagnostic, joint count by the nurse and the physician, VAS by nurse and physician. The patient's self-joint count was done for a subgroup of the patients. The Rho of Spearman was used for the correlation analysis.

Results: The overall correlation between the patient DAS-28 and physician DAS-28 was good ($r=0,701$) and it was very good between the nurse and the physician ($r=0,846$). The correlation between the nurse CDAI and the physician CDAI was also very good ($r=0,765$). The correlation between the different parts of the DAS-28 was less impressive. But in the same way, the correlation was better between the nurse (nr) and the physician, than between the patient (pt) and the physician (MD) and the least between the patient and the nurse. Respectively the correlation for TJC pt-nr is $r=0,452$, pt-MD is $r=0,537$, nr-MD is $r=0,693$, for the SJC the correlation is with pt-nr= $0,390$, pt-MD= $0,414$, nr-MD= $0,699$. The VAS-pt correlates poorly with both the nurse and the doctor VAS, respectively $r=0,428$ and $r=0,392$. No significant difference was found between the two nurses.

Conclusion: The primary end point is attained. There is a very good correlation between the nurse and the physician's evaluation. These results are congruent with those of previous studies³. So, this study is another argument to work with a nurse assistant and to use DAS-28 or CDAI in order to save time as we can be confident that the results of the nurse examination is accurate and valuable. This team work is a way to improve patient care following the guidelines. Treat to Target is possible even in remote areas lacking of resources.

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AB0308 THE ASSOCIATION OF PARKINSON DISEASE WITH RHEUMATOID ARTHRITIS

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Background: Parkinson disease (PD) is a progressive neurological disease, characterised with tremor, spasticity, arthrosis, dementia, loss of mobility and generalised pain. PD affects mainly elderly population. Activity of PD patients is restricted because of spasticity and severe arthrosis. Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease which can cause disability in elderly population. Patients with can admit to rheumatology clinics with generalised pain or restricted mobilisation. In contrast, in some PD patients with generalised pain on joints, RA may be overlooked

Objectives: We aimed in this study to evaluate the characteristics of patients with RA and Parkinson patients.

Methods: 842 RA patients screened retrospective for PD from the patient files. 10 patients with both RA and Parkinson disease were included to study. 3 female and 7 male patients with mean age 76,4 (with a standard deviation 5,4) were evaluated. The characteristics of patients are evaluated from the patient files.

Results: All patients were older than 75 years. Mean RA duration time was 14 months and PD duration time was 34 months. All patients admitted outpatient clinic with leg pain and inability to walk. 4 of 10 patients had mild dementia. Median ESR was 36 mm/h and median CRP value was 0,68 mg/dl. 6 of 10 patients had positive ANA result with 1/100 ratio, but rheumatoid factor and anti CCP were negative.

Conclusion: PD is one of the disorder that may cause severe disability in very old ages. RA may be an additional factor for pain and loss of function in PD patients. Patients with generalised pain and difficulties with walking should be evaluated for PD especially in old ages. PD patients with generalised pain on joints should be evaluated for inflammatory arthritis.

Disclosure of Interests: None declared

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AB0309 THE FREQUENCY OF HEMATOLOGICAL MALIGNANCIES IN AUTOIMMUNE RHEUMATIC DISEASES

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Background: Autoimmune rheumatic diseases are associated with increased risk of hematological malignancies. The pathogenesis of autoimmunity can cause of malignancies or immunosuppressive agents may increase the risk of malignancies.

Objectives: We aimed in this study to determine the frequency, type and characteristic of hematological malignancies in rheumatology practice.

Methods: 1640 rheumatology outpatient patient with autoimmune rheumatic diseases (Rheumatoid arthritis (RA), SLE, Sjogren's syndrome (SjS), myositis, systemic Sclerosis, undifferentiated connective tissue diseases (UCTD)) are screened for hematological malignancies. 16 patients are found with hematological diseases. The characteristics of these patients are reported retrospective from their outpatient clinic case files.

Results: The frequency of hematological diseases was found 0.04 in study group. 4 patients had myeloproliferative diseases (1 polycythemia vera (PV), 1 primary myelofibrosis (MyF), 2 patients with essential thrombocythemia (ET)). Patients with PV and MyF had severe rheumatoid arthritis and because of unresponsiveness of MTX, they used rituximab for severe disease activity. Patient with ET had only minimal arthralgia and are followed under HCQ therapy. As lymphoproliferative diseases 4 patients had chronic lymphoid leukemia (CLL). 3 of them had RA and 1 of them had (SjS). 2 patients had non-Hodgkin lymphoma and these patients are seen after autolog bone marrow transplantation because of arthralgia, but not detected arthritis. 1 patient had Hodgkin disease in her history, and had both RA and SjS, and receiving MTX therapy. 2 patients had multiple myeloma (MM). One of them is new diagnosis arthritis plus elevated sedimentation rate. Second one was seen with arthralgia after MM treatment and autologous bone marrow transplantation. 3 patients had mycosis fungoides, 1 of them had UCTD and received hydroxychloroquine. The other patient had RA under MTX therapy and one patient received rituximab therapy for severe RA activity.

Conclusion: Hematological malignancies are rare diseases in rheumatology practice, although expected high rate because of using immunosuppressive treatment and autoimmunity. The increased frequency of lymphoproliferative disorders are expected and associated with autoimmunity, but we don't found a high rate for lymphoproliferative malignancies. Myeloproliferative malignancies possibly not associated with the pathogenesis of autoimmune rheumatic diseases.

Disclosure of Interests: None declared

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AB0310 THE INCIDENCE OF EXTRA-ARTICULAR MANIFESTATIONS IN SOUTHERN CHINESE PATIENTS WITH INFLAMMATORY JOINT DISEASES

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Background: Inflammatory joint diseases (IJDs) are chronic arthritis, but frequently present with co-morbidities of other organs and systems, which is known as extra-articular manifestations (EAMs) ¹. It is still unclear which clinical characteristics or bio-markers can predict the development of EAMs².

Objectives: The aim of this study was to estimate the proportion of EAMs in southern Chinese patients with IJDs and to explore the risk factors.

Methods: This was a retrospective cohort study of a total 1135 IJDs patients, including 788 rheumatoid arthritis (RA) patients, 307 ankylosing spondylitis (AS) patients and 40 psoriatic arthritis (PsA) patients. Demographic data, disease characteristics, laboratory blood tests, medical imaging, and the presence of EAMs were recorded.

Results: We found 459 (40.44%) of them presented with EAMs: 30.84% had cardiovascular; 7.67% had pulmonary, 5.29% had osteoporosis/low bone mineral density, 2.29% had ocular, 0.79% had gastrointestinal and 0.26% had renal involvements. Multivariate logistic regression showed older age (OR: 1.05, $P<0.001$) and higher anti-cyclic citrullinated peptide antibody (anti-CCP) levels (OR: 1.003, $P=0.011$) were independent risks of EAMs in RA patients. In AS group, older age (OR: 1.07, $P<0.001$) and higher disease activity (OR: 2.06, $P<0.001$), were independent risks of EAMs. As in PsA group, longer disease duration (OR: 1.01, $P=0.046$) and higher disease activity (OR: 1.15, $P=0.011$) were independent risks.

Conclusion: These results suggested the high prevalence of EAMs, and it is important to regularly screen on EAMs, as it influences treatment decision and impacts on patients' quality of life.

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AB0311 HEMOSTASIS IN AFRICAN BLACK COMPARED TO WHITE PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Aberrant hemostasis is implicated in the increased CVD risk experienced by patients with rheumatoid arthritis (RA) (1). Large circulating concentrations of plasminogen activator inhibitor-1 (PAI-1) predict cardiovascular event rates (2). PAI-1 levels are markedly smaller in American and African black populations than in those of European descent (3,4). Whether this protection persists in black persons who have RA is unknown.

Objectives: This study compared hemostasis factors among African black and white RA patients

Methods: PAI-1, tissue factor pathway inhibitor (TFPI) and tissue plasminogen activator (t-PA) levels were measured by ELISA in 236 (114 black; 122 white) African RA patients. Data were analysed in mixed regression models.

Results: In age and sex adjusted analysis, PAI-1 concentrations were larger in black compared to white patients with RA (median (interquartile range (IQR))=12.4 (3.1-28.7) versus 5.4 (1.5-25.0) ng/ml, $p=0.006$). In all patients, body mass index (BMI) (β (SE)=0.022 (0.007), $p=0.003$), waist circumference (β (SE)=0.007 (0.003), $p=0.04$) and tetracycline use (β (SE)=0.291 (0.133), $p=0.03$) were associated with logarithmically transformed PAI-1 levels. Population grouping did not influence these relationships (interaction $p>0.8$) but impacted rheumatoid factor (RF) positivity- and azathioprine use-PAI-1 level associations (interaction $p=0.03$ and 0.004 , respectively). In stratified analysis, RF positivity was associated with PAI-1 levels in white (β (SE)=0.344 (0.139), $p=0.01$) but not black patients (β (SE)=-0.102 (0.143), $p=0.5$), and azathioprine use was associated with PAI-1 levels in black ($\beta=0.400$ (0.155), $p=0.01$) but not white patients (β (SE)=0.305 (0.184), $p=0.1$). In age, sex, BMI, RF positivity and azathioprine and tetracycline use adjusted analysis, black population origin remained associated with PAI-1 levels (β (SE)=0.175 (0.091), $p=0.05$). In age and sex adjusted analysis, TFPI and t-PA levels did not differ in black compared to white RA patients (median (IQR)=221.0 (149.8-410.5)

versus 225.0 (130.4-357.2) pg/ml, $p=0.6$, and 6.7 (4.9-9.1) versus 7.4 (4.4-10.0) pg/ml, $p=0.3$).

Conclusion: PAI-1 concentrations are substantially larger in African black compared to white patients with RA.

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AB0312 CARDIOVASCULAR RISK FACTOR'S BEHAVIOR AND CARDIOVASCULAR RISK IN HISPANIC EARLY RHEUMATOID ARTHRITIS PATIENTS: A COHORT STUDY

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Background: Rheumatoid arthritis (RA) patients present an increased risk of cardiovascular (CV) morbidity and mortality compared to the general population¹. Patients from Latin-America exhibit younger age, female preponderance, less severe disease and dyslipidemia, which are relevant when assessing CV risk². In order to impact CV morbidity/mortality, control of reversible CV-risk factors need to be achieved³. Cohorts allow prospective evaluation of long-term outcomes. In 2004 we initiated an early RA cohort. Up to June 2018, the cohort comprised 185 RA patients with prospective assessments of CV risk and at least one year of follow-up.

Objectives: To monitor CV risk-factor's behavior during the first year of follow-up and to identify if traditional CV risk scores predict major CV events (MACE) in our population.

Methods: Once enrolled patients had complete rheumatic evaluations at regular intervals. Baseline CV-risk factor's assessments included age, gender, ethnicity, physical activity and history of first-degree relatives with premature heart disease. CV-risk factors assessments at baseline and at least 6 months apart included blood pressure, serum total cholesterol (CHO) and HDL cholesterol (Castelli ratio CHO/HDL was derived), serum glucose (GLU, in mg/dL), body mass index (BMI), CRP (in mg/dL) and (at least) the following comorbidities: Hypertension (HT), and HT treatment, diabetes mellitus (DM), advanced chronic kidney failure (CKF) and atrial fibrillation (AF). Smoking status was assessed at baseline and last follow-up. Incident MACE were defined according to standard definitions⁴. Cox regression's model identified predictors of incidental MACE. Patients gave written informed consent.

Results: At cohort entry, the 185 patients (all Hispanic) which data were analyzed were primarily middle-aged females (87.6%) and had 5.3 months (3.3-7.1) of disease duration. Most prevalent CV risk factors were CRP >1 mg/dL (90%), Castelli ratio > 3 (84%) and low HDL levels (74%). During the first year of follow-up, smoking status, systolic blood pressure ≥ 140 mm Hg, diastolic blood pressure ≥ 90 mm Hg, low HDL, Castelli ratio > 3 , high CRP and patients with active disease progressively decreased; meanwhile, the opposite figure was true for BMI ≥ 30 kg/m² and patients on corticosteroids. At 12 months of follow-up, number of patients with incident CV risk factor was higher for Castelli-ratio > 3 (23%), low HDL (16.3%), high CHO (10.6%), BMI ≥ 30 kg/m² (10%), CRP >1 mg/dL (7.5%) and age ≥ 45 years old (3.3%).

During the first year of follow-up, 45.8% of the patients had age between 40-79 years old, required to apply American Heart Association (AHA) criteria; these identified 12 patients with high CV-risk.

Up to June 2018, the cohort had 1358 patient/years follow-up and 6 patients had incidental MACE after (median, IQR) 6.5 years of follow-up (3.3-9.5). High CV-risk score at baseline failed to predict incidental MACE. Meanwhile, BMI ≥ 30 kg/m² was a predictor of incidental MACE in our population.