THE PREDICTORS OF UNDIAGNOSED DYSGLYCAEMIA IN PATIENTS WITH ESTABLISHED RHEUMATOID ARTHRITIS

Hazlyna Baharudin1, Nur Ami Eddy Warman1, Azrilah Rosman2, Thuhairah Abdul Rahman3, Nurhidayah Ismail3, Rohana Abdul Ghani4, Universiti Teknologi MARA, Department of Medicine, Sungai Buloh, Malaysia; 2Hospital Selayang, Department of Medicine, Batu Caves, Malaysia; 3Universiti Teknologi MARA, Department of Pathology, Sungai Buloh, Malaysia; 4Universiti Teknologi MARA, Department of Public Health and Population Medicine, Sungai Buloh, Malaysia

Background: Rheumatoid arthritis (RA) is a chronic inflammatory disease with an increased risk of diabetes and insulin resistance.1, 2 The prevalence of type 2 diabetes mellitus (T2DM) were demonstrated to be 10.4% as compared to only 7.6% in controls matched for age, sex and geographical region, with an odds ratio of 1.4.3

Objectives: To determine the prevalence of dysglycaemia (T2DM, impaired fasting glucose (IFG) and impaired glucose tolerance (IGT)) and the factors associated with dysglycaemia in patients with established RA.

Methods: This is a cross-sectional study conducted in a rheumatology centre in Malaysia. Patients with established RA aged 30 years or more were included. Exclusion criteria were overlap syndrome, pre-existing diabetes or pre-diabetes, pregnant and within 6 weeks of post-partum period. An oral glucose tolerance test (OGTT) was performed for all patients. Comparison of various factors between dysglycaemia and normoglycaemia were analysed. Multivariate analysis was performed using logistic regression analysis to ascertain the true effects of significant factors found on univariate analysis.

Results: The mean age of patients was 57.2 ± 8.1 years and 87.7% were female. Of 155 patients included in this study, 55 (35.5%) were found to have dysglycaemia; 40 (72.7%) had IGT, 11 (20%) had T2DM, 3 had IFG and IGT (5.5%) and 1 had IFG (1.8%). Significant factors found to have dysglycaemia; 40 (72.7%) had IGT, 11 (20%) had T2DM, 3 had IFG and IGT (5.5%) and 1 had IFG (1.8%).

Conclusion: One third of 155 patients had dysglycaemia and majority had IGT. The predictors of dysglycaemia in patients with established RA aged 30 years and more, were previous or current smoker and raised triglycerides.

Table 1. Factors investigated for differences between dysglycaemia and normoglycaemia.

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Dysglycaemia</th>
<th>Normoglycaemia</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous or current smoker, n (%)</td>
<td>7 (13.0)</td>
<td>3 (3.0)</td>
<td>0.02</td>
</tr>
<tr>
<td>Waist circumference (cm), mean ± SD</td>
<td>89.0 ± 12.5</td>
<td>83.1 ± 9.6</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Weight (kg), mean ± SD</td>
<td>65.5 ± 12.3</td>
<td>60.7 ± 10.6</td>
<td>0.01</td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg), mean ± SD</td>
<td>134.5 ± 17.5</td>
<td>126.2 ± 18.1</td>
<td>0.04</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg), mean ± SD</td>
<td>79.7 ± 8.7</td>
<td>76.3 ± 10.5</td>
<td>0.04</td>
</tr>
<tr>
<td>High density lipoprotein (mmol/L), mean ± SD</td>
<td>1.4 ± 0.3</td>
<td>1.5 ± 0.4</td>
<td>0.02</td>
</tr>
<tr>
<td>Triglycerides (mmol/L), mean ± SD</td>
<td>1.3 ± 0.5</td>
<td>1.1 ± 0.5</td>
<td>&lt;0.01</td>
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</tbody>
</table>

REFERENCES


Acknowledgement: None

Disclosure of Interests: None declared


QUALITY OF LIFE IN WOMEN WITH RHEUMATOID ARTHRITIS DEPENDING ON ANXIETY AND DEPRESSION

Ekaterina Egorova, Nataya Nikitina, Andrey Rebrov, Saratov State Medical University named V. I. Razumovsky, Ministry of Health of Russia, Hospital Therapy Department, Saratov, Russian Federation

Background: Rheumatoid arthritis (RA) is a chronic autoimmune disease that causes joint damage, deformity, and pain. This can lead to loss of functionality and mobility, which entails a decrease in the quality of life and the possible occurrence of anxiety and depressive disorders[1].

Objectives: Assess the quality of life in women with RA, depending on the severity of anxiety and depression.

Methods: The study included 104 women with reliable RA according to the ACR1987 and/or EULAR/ACR2010 criteria (mean age 53.7 ± 10.9 years, mean duration of RA – 10.1 [4,14] years, DAS28 – 4.96 [4,27,5,77]). An assessment of the severity of anxiety and depression was conducted using a questionnaire for the hospital scale of depression and anxiety (HADS). Evaluation of the quality of life of patients with rheumatoid arthritis was performed using the EQ-SD index. Depending on the degree of functional impairment, according to the HAD questionnaire, were regarded as minimal (0,5-1 point), moderate (1-2) and pronounced (2-3 points), the population norm was 0-0,5 points. The severity of pain was determined by VAS: no pain (0–4 mm), mild pain (5–44 mm), moderate pain (45–74 mm), severe pain (75–100 mm). Statistical processing was performed using the program STATISTICA 10.0.

Results: The frequency of occurrence of anxiety-depressive disorders in patients with RA was determined: clinically significant anxiety was detected in 20 (19.2%) patients, depression - in 19 (17.3%); subclinical anxiety - in 26 (25%), depression - in 27 (25.9%) patients; the absence of reliably expressed symptoms of anxiety in 58 (55.8%) patients, depression - in 59 (56.8%) patients. HAD functional impairment was absent in 11 (10.6%) patients, minimal impairment was detected in 20 (19.2%), moderate - in 52 (50%), and pronounced in 21 (20.2%) patients.

Severe pain in the VAS was noted by 38 (36.6%) patients, moderate - in 51 (49%), in 15 (14.4%) patients the pain syndrome was weakly expressed.

The HAD and EQ-SD indices for women were 1.26 [0.88;1.75] and 0.41 [0.07;0.59], respectively. The relationships between the HAD and EQ-SD indices (r = 0.67, p <0.05), the HAD index and the age of the patients (r = 0.33, p <0.05), and the duration of the disease (r = 0.29, p <0.05), ESR indicator (r = 0.28, p <0.05), CRP (r = 0.37, p <0.05), the level of pain in VAS (r = 0.4, p <0.05), DAS28 index (r = 0.32, p <0.05), anxiety severity (r = 0.22, p <0.05), depression severity (r = 0.31, p < 0.05). The relationship between the EQ-SD index and the age of the patients (r = 0.29, p <0.05), with the duration of the disease (r = 0.22, p <0.05), CRP (r = 0.32, p <0.05), the level of pain in VAS (r = 0.45, p <0.05), the severity of anxiety (r = 0.28, p <0.05), the severity of depression (r = 0.35, p <0.05).

To clarify the relationship between the quality of life of patients and the level of depression and anxiety, two groups were identified: no anxiety-depressive disorders (N = 43) and the second group with their presence (N = 30). The EQ-SD index in the first group was 0.59 [0.52; 0.62] and in the group with anxiety and depressive disorders it was 0.27 [0.02; 0.52] (p = 0.005). The HAD index significantly differed in women without anxiety and depressive disorders 1.0 [0.625; 1.5] with the index in the other group 1.75 [1.0; 2.125] (p = 0.01).

Conclusion: Thus, every fifth patient with RA suffers from clinically significant anxiety and depression; subclinical anxiety and depression were found in 26% of patients with RA. Interrelations between the indicators of quality of life of patients with RA and the patient's age, duration, activity of RA, severity of anxiety and depressive disorders.
EVALUATION OF SLEEP QUALITY, FATIGUE AND SEXUAL PROFILE IN ELDERLY PATIENTS WITH RHEUMATOID ARTHRITIS

ACHIK Mohamed Amine EL, Amel Farhat, Saoussen Zitour, Ismail Beja, Mongi Touzi, Mahboubja Aqirum, Naceur Bergaozi. Fattouma Bourguiba University Hospital, Rheumatology, Monastir, Tunisia

Background: People over the age of 60 with rheumatoid arthritis (RA) often complain of fatigue, which is considered an extra-articular symptom. This problem has a multidimensional character and sounds on the quality of sleep and on the sexual profile.

Objectives: Our study consists in assessing the prevalence of fatigue and studying the quality of sleep and the sexual profile of patients over 60 years of age with RA compared to subjects suffering from the same illness of younger age.

Methods: This is a prospective study involving 100 patients at the Rheumatology department of Fattouma Bourguiba university hospital in Monastir over a period of 6 months: 40 patients more than 60 years of age with RA compared with 60 patients with RA of younger age.

Data collection was based on scales and specific questionnaires (Visual Analogue Fatigue Scale (VAS-F), Multidimensional Fatigue Inventory (MFI-20), Pittsburgh Sleep Quality Index (PSQI)), Female sexual Function Inventory (FSFI), Sexual Health Inventory for Men (SHIM).

Results: The average age was 55.8 years [25-84]. The most represented age group was over 60 (40%). The sex ratio was 5.6.

73% of our patients were married and 81% had children with an average number of 3 children in charge and extremes between 1 and 9. Fatigue, sleep quality and sexual profile were analyzed comparatively and respectively between RA patients and study group.

The average age was 55.8 years [25-84]. The most represented age group was over 60 (40%). The sex ratio was 5.6. 73% of our patients were married and 81% had children with an average number of 3 children in charge and extremes between 1 and 9. Fatigue, sleep quality and sexual profile were analyzed comparatively and respectively between RA patients and study group.

The average age was 55.8 years [25-84]. The most represented age group was over 60 (40%). The sex ratio was 5.6. 73% of our patients were married and 81% had children with an average number of 3 children in charge and extremes between 1 and 9. Fatigue, sleep quality and sexual profile were analyzed comparatively and respectively between RA patients and study group.

Conclusion: A multidimensional approach is needed to explore the different components of fatigue, sleep quality and sexual profile in patients with RA and its very diverse consequences. This should lead to an improvement in the quality of life in the current medical practice.

Disclosure of Interests: None declared

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Established Seronegative Rheumatoid Arthritis is Considered a Mild Form of the Disease. Also Will It Be the Same Regard for Very Early Seronegative Rheumatoid Arthritis?

Fajardo Hermosillo Luís Daniel, IMSS, Hospital Regional N 110, Rheumatology, Guadalajara, Mexico

Background: Established Seronegative Rheumatoid Arthritis (ESNRA) is considered a mild form of the disease with a good prognosis and response to therapy compared with seropositive (SP) form [1]. Lately evidence indicates that seronegative (SN) form of arthritis in early stage is serious and should not be underestimated in terms of disease activity, response to therapy and radiographic damage [2,3,4]. At present, the influence of SN status of clinical course and treatment choice in very early stages, in other words less than 3 months from time at onset of disease, is still controversial [5].

Objectives: To evaluate demographical, clinical and treatment differences between Very Early Seronegative Rheumatoid Arthritis (VESNRA) and Very Early Seropositive Rheumatoid Arthritis (VESPRA) in a Mexican cohort.

Methods: 64 patients with Very Early Rheumatoid Arthritis ([VERA], < 3 months from time at onset of clinical manifestations) that fulfilled ACR/EULAR 2010 criteria (>18 years) from a Mexican cohort recruited from 2015 to 2018 were examined and followed to 3, 6 and 12 months.

Patients without presence of rheumatoid factor (RF) and antinuclear protein antibodies (ACPA) were considered SN. Demographic factors, clinical features, disease activity measured using DAS28, functional status evaluated using HAQ, comorbidities and pharmacologic treatments were examined for patients with VESNRA and VESPRA. Charlson’s clinical comorbidity index was used to analyze comorbidities. Chi-square and Student t test was performed by univariate analysis and logistic regression was used by multivariate analysis, both were adjusted for age and gender. Statistical test were conducted at 5% level of significance.

Results: Of 64 patients with VERA 79% were women. The mean age [standard deviation (SD)] was 49.8 (13.5) years. The mean of time at onset of VERA (SD) was 77.8 (15.5) days. A total of 20 (31.2%) patients had VESNRA. In the univariable analyses VESNRA patients were more likely to have minor disease activity and better functional status during their follow-up to 3, 6 and 12 months [Table 1]. Moreover, VESNRA patients were more likely to present lesser work disability, lower comorbidities including fibromyalgia, to use fewer sulfasalazine, leflunomide, biologic agents and corticosteroids. As expected, the modified Charlson’s comorbidity index score was lower in VESNRA patients through all their follow-up. In multivariable analyses less frequently use of corticosteroids (OR 0.68, 95% CI 0.42-0.88, p=0.001) remained significant in VESNRA patients.

Conclusion: This study suggests that in very early stage of disease, SN form presents minor disease activity, better functional status, lower comorbidities, also require less aggressive therapy using biologic agents and corticosteroids than SP form in the course of one year. By these clinical and therapeutic differences should be considered VESNRA a mild form of the disease like as ESNRA. These observations must be confirmed in larger studies with further follow-up.

REFERENCES

Table 1. Disease activity and functional status in VESNRA and VESPRA Patients

<table>
<thead>
<tr>
<th>Feature</th>
<th>VERA</th>
<th>VESNRA</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease activity (DAS28), mean score (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>5.99 (0.85)</td>
<td>5.09 (0.76)</td>
<td>NS</td>
</tr>
<tr>
<td>3 months</td>
<td>3.43 (1.09)</td>
<td>2.42 (0.85)</td>
<td>0.003</td>
</tr>
<tr>
<td>6 months</td>
<td>2.76 (0.97)</td>
<td>2.04 (0.72)</td>
<td>0.008</td>
</tr>
<tr>
<td>12 months</td>
<td>2.25 (0.57)</td>
<td>1.74 (0.22)</td>
<td>0.003</td>
</tr>
<tr>
<td>Functional status (HAQ), mean score (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>2.19 (0.30)</td>
<td>1.72 (0.28)</td>
<td>NS</td>
</tr>
<tr>
<td>3 months</td>
<td>1.86 (0.32)</td>
<td>1.29 (0.33)</td>
<td>0.007</td>
</tr>
<tr>
<td>6 months</td>
<td>1.49 (0.42)</td>
<td>0.87 (0.35)</td>
<td>0.019</td>
</tr>
<tr>
<td>12 months</td>
<td>0.99 (0.36)</td>
<td>0.56 (0.17)</td>
<td>0.025</td>
</tr>
</tbody>
</table>

VESNRA: Very Early Seronegative Rheumatoid Arthritis; VESPRA: Very Early Seropositive Rheumatoid Arthritis; SD: Standard deviation; NS: Not significant

Disclosure of Interests: None declared

The Effect of Anemia on the Cardiac Function in Patients with Rheumatoid Arthritis

Lustija Feiskhunova1, Svetlana Lapshina2, Alina Yusupova3, Avgul Akhmetzhanova1,2, Kazan State Medical University, Kazan, Russian Federation; 3Kazan State Medical University, Kazan, Russian Federation

Background: Rheumatoid arthritis (RA) is a chronic disease that is characterized by defeat of the musculoskeletal system and is often accompanied by the anemia.

Disclosure of Interests: None declared

None declared

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