Results: A total of 90 RA patients (women, 83%; mean age, 67.2±12.1 years) were included. The median disease duration was 8.5 (interquartile range (IQR): 4.9, 17) years, the mean DAS28-ESR was 2.92±1.2, and the median MTX dose was 10 (IQR: 8, 12) mg/week. Nineteen patients (21%) used a biologic agent. There was a significant correlation between total hip BMD and bone mass ($r=0.64$, $p<0.001$). The details are shown in Figure 1. Bone mass was significantly correlated with femoral neck BMD ($r=0.62$, $p<0.001$), whole body BMD ($r=0.60$, $p<0.001$), and lumbar BMD ($r=0.49$, $p<0.001$). Bone mass was significantly lower by DEXA (1.9 ± 0.5 kg) than by BIA (2.0 ± 0.4 kg) ($P<0.001$).

Figure 1. Correlation between Bone mass and BMD

Figure 1

Conclusion: There was a significant correlation between bone mass by BIA and BMD by DEXA. Bone mass by BIA and total hip BMD had the strongest correlation. Bone mass is likely to be overestimated by BIA. Thus, we need to evaluate it with appropriate caution.

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AB0337 IS THE RADIAL DEVIATION ASSOCIATED WITH MEDIAN NERVE SWELLING IN PATIENTS WITH RHEUMATOID ARTHRITIS?

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Background: Rheumatoid arthritis (RA) and carpal tunnel syndrome (CTS) are known to be associated and also RA may lead to swelling of the median nerve without the presence of CTS.

Objectives: This study was conducted to test the hypothesis that one of the causes of this median nerve swelling may be radial deviation developing after wrist involvement of RA.

Methods: Of a total of 138 cases, 51 that met the inclusion criteria were included in the study. Electroneuromyography (ENMG) was performed on each patient and those with a CTS diagnosis were excluded from the study. Duruöz hand index, visual analog scale and painDETECT questionnaire was performed in clinical assessment. Radiographic measurements including radial inclination angle were performed with radiography. Using ultrasonography, the median nerve cross-sectional areas (CSAs) of the

patients were measured from the four levels of the distal 1/3 of the forearm, radioulnar joint, pisiform bone and hook of hamate, and the ulnar nerve CSAs were measured from the pisiform bone.

Results: The study completed with 102 hands of 51 patients. 27% of these RA patients without clinical and electrophysiological findings were diagnosed as CTS by ultrasonography. A negative correlation was found between the radial inclination (RI) and the median CSAs measured from the radioulnar joint ($R: -0.49$; $p: 0.00$), the pisiform bone ($R: -0.45$; $p: 0.00$), and hook of hamate ($R: -0.60$, $p: 0.00$). When the hands were divided into three groups according to the ranges of RI specified in the literature, the median nerve CSA was found to be significantly higher in the group with a low RI at these levels ($p < 0.001$).

Conclusion: The median nerve CSAs increased as the radial deviation increased in RA patients. The prevention of disease progression may prevent the increase in median nerve CSA by preventing deviations in patients with RA. And the development of CTS may also be prevented.

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AB0338 ELDERLY ONSET RHEUMATOID ARTHRITIS AND POLYMYALGIA RHEUMATICA: COMPARATIVE CLINICAL STUDY

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Background: Polyarthritis at the elderly people usually has a similar onset with an acute inflammatory character and scapular girdle involvement. Differentiating elderly onset rheumatoid arthritis (EORA) and polymyalgia rheumatica (PMR) can be a diagnostic challenge.

Objectives: To analyse the clinical and analytical differences between EORA and PMR.

Methods: Longitudinal observational study of patients older than 60 years newly diagnosed with EORA (ACR/EULAR 2010) and PMR (ACR/EULAR 2012). Inclusion: consecutive and voluntary. Follow-up time: 12 months. A single rheumatologist made all follow-up visits. The clinical-epidemiological and analytical characteristics were collected. The statistical study was performed with Stata 15.1.

Results: 45 EORA were recruited (53% women; mean age 74.8 ± 7.5) and 20 PMR (85% women; mean age 76.6±5.0).

75% of EORA had scapular girdle involvement, but only 44% of the pelvic girdle. All had peripheral arthritis, and the small joints of the hands were involved in 93.3%, with edema in 46.7%. Forty percent of EORA patients were seropositive (RF> 20 IU/mL and/or ACPA> 20 U/mL): 33% RF positive (132.8 ± 126 IU/mL), 28.9% for ACPA (2 cases [15.4%] from 100 to 250 U/mL and 11 cases [84.6%] above 250 U/mL) and in 10 patients [22.2%] double positive). All patients with PMR patients had shoulder girdle involvement and 90% of the pelvic girdle. None of them had peripheral arthritis. RF was positive in one patient (73 IU/mL) and ACPA in 2 patients (titers between 20-40 U/mL). No patient was double positive. Table 1 and 2.

	RA N = 45 n (%)	PMR N = 20 n (%)	p value
Fever	1 (2.2)	2 (10.0)	0.222
Weight loss	16 (35.6)	8 (40.0)	0.732
Asthenia	31 (68.9)	14 (70.0)	0.929
Anorexia	20 (44.4)	7 (35.0)	0.476
Morning stiffness	43 (95.6)	19 (95.0)	0.922
Oedema	21 (46.7)	0 (0)	<0.001
Shoulder girdle	34 (75.6)	20 (100)	0.014
Pelvic girdle	20 (44.4)	18 (90.0)	<0.001
Peripheral arthritis	45 (100)	0 (0)	<0.001
Small joint of the hands	42 (93.3)	0 (0)	<0.001

	RA N = 45 n [%]	PMR N = 20 n [%]	p value
RF positive	15 (33.3)	1 (5.0)	0.014
ACPA positive	13 (28.9)	2 (10.0)	0.095

After 12 months of follow-up, there was no difference between the dose of glucocorticoids received in patients with EORA and PMR ($p = 0.684$). There were also no differences in glucocorticoids adverse effects according to the diagnosis ($p = 0.734$).

Regarding the use of immunosuppressors, this was higher in patients with EORA (91% EORA and 20% PMR), according to the usual clinical practice guidelines.

The percentage of remission in PMR at 12 months was 95%. However, using DAS 28-VSG, only 40.9% of patients with EORA were in remission at 12 months ($p=0.003$).

Conclusion: The female predominance was higher in PMR than in EORA. The scapular girdle involvement, but especially the pelvic girdle, was more frequent in PMR. In contrast, involvement of peripheral joints and edema were more frequent in EORA. RF and ACPA were more frequent in EORA. There were no other analytical differences that would help their differential diagnosis. The mean and accumulated doses of glucocorticoids during the first 12 months were similar, as well as the percentage of side effects. Immunosuppressors are more frequently used in EORA than in PMR. Remission is achieved more commonly in PMR than in EORA.

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AB0339 HYPERURICEMIA AMONG A MOROCCAN POPULATION WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a known cause of cardiovascular disease (CVD). Several studies suggest that serum uric acid (SUA) is significantly associated with CVD in RA. However, the association between SUA and inflammation remains controversial.

Objectives: The aim of the present study is to determine the prevalence of hyperuricemia in RA patients, to assess its association with inflammation and to evaluate whether disease modifying anti rheumatic drugs (DMARDs) have a hypouricemiant effect.

Methods: We have conducted a cross-sectional study over four months in our department of rheumatology. A total of 204 RA patients receiving DMARDs in their treatment were enrolled. All patients fulfilled the RA ACR-EULAR criteria. SUA and inflammatory markers were studied. Hyperuricemia was defined as SUA>70mg/L for males and >60mg/L for females. Data analysis was carried out using the SPSS 20 Software. Univariate and multivariate regressions were performed to identify the impact of hyperuricemia in RA patients.

Results: The mean age was 51.76 ± 12.84 and the mean age at RA diagnosis was 42.5 ± 15.23 . Fourteen patients (6.9%) had hyperuricemia and the average rate of SUA was 41.99 ± 11.85 mg/L. All patients were taking Methotrexate, 34% received also Sulfasalazine, 6.4% Hydroxychloroquine and 77% steroids. Males and post-menopausal women had significantly higher SAU levels ($p<0.001$ and $p<0.0001$, respectively).

Univariate analysis showed a positive relationship between SUA levels and age ($p=0.004$), gender ($p=0.002$), age at RA diagnosis ($p=0.03$), smoking ($p=0.046$), use of alcohol ($p=0.025$), high body mass index (BMI) ($p=0.012$), elevated blood pressure ($p<0.0001$), dyslipidaemia ($p<0.001$) and high doses of steroids ($p=0.001$). The association between RA and gout was noted in one case. We found no correlation between inflammation, DMARDs, CVD and SUA. In multivariate regression In multivariate analysis adjusted for age, gender, BMI and steroids maintained a significant correlation with SAU.

Conclusion: The prevalence of hyperuricemia is low in our RA patients and similarly gout remains infrequent. However, RA patients must be screened for hyperuricemia. There is growing evidence that higher doses of steroids can cause hyperuricemia. Practitioners should be aware that these patients are at risk of having high SUA levels as well as more traditional cardiovascular risk factors. Thus, appropriate preventive interventions in these patients should be introduced.

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AB0340 PATIENTS WITH RHEUMATOID ARTHRITIS COMPLICATED WITH DEPRESSION HAVE A HIGHER FREQUENCY OF EXPERIENCING PHYSICAL DEPRESSIVE SYMPTOMS

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Background: Approximately 15% of patients with rheumatoid arthritis (RA) experience depression with an odds ratio of 1.42 (95% CI 1.3–1.5) compared to healthy people. Depression is related to disease activity and activities of daily living (ADL) of patients with RA. Previous studies have reported depressed mood, sleep disorder, and other such symptom separately with no reports addressing the factors constituting depression together.

Objectives: To examine the factors constituting depression in RA patients.

Methods: The subjects were 124 registered RA patients. The following patient characteristics were investigated: age, gender, body mass index, smoking history, and presence or absence of hypertension and diabetes. Baseline steroid dosage, methotrexate dosage, and serum matrix metalloproteinase-3 levels and creatinine level were examined. For evaluation, we used the simplified disease activity index (SDAI) for RA disease activity, the health assessment questionnaire disability index (HAQ-DI) score for ADL, and the Hamilton depression rating scale (HAM-D) score for depression status. Different items on the HAM-D scale were analyzed, and the correlation between HAM-D and each item was examined.

Results: Although 42 patients (33.9%) answered that they experienced "depressed moods", more than 50% of the patients answered that they had "anxiety somatic (79 patients, 63.7%)" and "somatic symptoms general (69 patients, 55.6%)". Patients, who responded that they had "work and activities (57 patients, 46.0%)", "hypochondriasis (53 patients, 42.7%)," and "genital symptom (49 patients, 36.5%)," exceeded the number of patients claiming to experience depression. "Depressed mood" correlated with SDAI ($r=0.31$, $p<0.01$) and HAQ-DI ($r=0.26$, $p<0.01$). "Somatic Symptoms General" correlated with SDAI ($r=0.30$, $p<0.01$) and HAQ-DI ($r=0.29$, $p<0.01$) as well. "Anxiety somatic" correlated with age ($r=0.24$, $p<0.01$) only and no other factor.

Conclusion: Patients with rheumatoid arthritis patients experiencing a depressed state of mind have a high chance of exhibiting physical symptoms as compared to patients with "depressed mood" alone. These factors are not necessarily associated with RA disease activity or HAQ-DI.