	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.

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AB0341 REASONS FOR DROP-OUT IN RHEUMATOLOGY SPECIALTY CARE OF ELDERLY RHEUMATOID ARTHRITIS PATIENTS

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Background: The difference between total and healthy life expectancies were 12.3 and 8.8 years for women and men respectively in 2016, in Japan. Rheumatoid arthritis (RA) not only reduces daily living activities due to joint symptoms but also deteriorates the life prognosis due to systemic inflammation. That is, patients with RA are short for both total and healthy life expectancy. In recent years, the need for rheumatologist to provide specialty medical care to elderly patients with RA has been expanding. However, some elderly patients drop out of specialty treatment and care. To date, there are little information concerning background of patients who drop out.

Objectives: To investigate reasons and characteristics of elderly RA patients who drop out from rheumatology specialty medical care.

Methods: Of RA patients who had been visited our rheumatology specialty facility in 2016, we defined as drop-out when the patients did not return to the hospital in 2017. We surveyed age, gender, disease activity, and reason for drop-out retrospectively from medical records and questionnaires.

Results: Of 2,092 patients with RA who visited to our department, 156 patients (7.5%, 95% confidential interval: 6.4 – 8.6%) dropped out. Among drop-out patients, 101 patients were older than 65. 37 patients (37%) dropped out due to comorbidities including death (group C), 32 (32%) patients were introduced certified rheumatologists near the patients' residences (group R). Twenty-two patients were due to unknown reasons, nine were due to remission, and one patient moved out to other area. Average age of both group C and R were eighty years old. Glucocorticoid user rate (C: 89%, R: 71%) and dose (C: 5.6 mg, R: 5.7 mg) were similar in the both two groups. Patients in group C showed less use of methotrexate (C: 19% vs R: 58%, $P < 0.01$) compared with group R patients. Simple disease activity index was similar, however, higher modified health assessment questionnaire was observed in group C patients (C: 1.13 vs R: 0.25, $p=0.01$).

Conclusion: Some elderly RA patients, especially may drop out from rheumatology specialty care due to comorbidities. Regional co-management should be constructed so that elderly patients could continue receiving RA specialized care.

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AB0342 DEPRESSION ON PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a chronic representative inflammatory autoimmune disease. The association of disease activity and pro-inflammatory cytokines with depression has not been sufficiently investigated.

Objectives: The aim of this study is to analyze the association between disease activity and depression using Patient Help Questionnaire (PHQ-9) in patients with rheumatoid arthritis (RA). We also examined the outcome of intervention on depression score and determined the prevalence of

depression and risk factors for depression and deterioration of depressive symptoms in RA patients.

Methods: 146 RA patients with a mean age of 51.3 ± 11.2 years were included in the study. Demographic and laboratory data were examined. Disease activity score 28-joint count C-reactive protein (DAS 28-CRP) was performed to assess disease activity of RA. PHQ-9 scores were collected at each clinic visit. Physicians assessed corresponding disease activity using Clinical Disease Activity Index (CDAI). Patients with at least moderate depression (PHQ-9 ≥ 10) were offered depression intervention, counseling or medications. PHQ-9 was re-administered after intervention.

Results: 119 of RA patients were females, the average disease duration was 6.8 ± 5.9 years. Depression was diagnosed in 38 of RA patients: 18 - mild, 13 - moderate and 7 - moderately severe. Severity of depression positively correlated with disease activity in RA patients ($p < 0.05$). RA patients with moderate/high CDAI had significantly higher PHQ-9 than those with low CDAI ($p < 0.001$). Of 7 patients who met criteria for depression intervention, 6 were treated and 1 - declined. With treatment 5 patients had improved PHQ-9 scores, 1 patient worsened, and 1 patient had no change in score. The risk of developing a depressive disorder is highest between 5 and 10 years of onset of the disease and depression is a better predictor of work disability than disease activity and response to treatment. Depression is associated with more pain, fatigue and impaired quality of life. Therefore, the risk to develop a depression is increased with impaired function as measured by the health assessment questionnaire (HAQ). Increased disease activity increases the risk for depression in RA. The severity of disease activity of RA, DAS 28-CRP [OR 1.75, 95% CI 1.08-2.64] and severity of fatigue (OR 1.32 95% CI 1.12-1.27) were associated with depression and deterioration of depressive symptoms in the multivariate analysis. Among the components of DAS 28-CRP, patient assessment for global health and abilities for daily performance were more related to depression. Depression unfavorably influences the response to therapy, the rate of remission is lower and the mortality is increased in RA patients. Taken together, this indicates that it is necessary to detect a depression in patients with RA as early as possible in order to initiate appropriate treatment of depression in such cases.

Conclusion: Our study shows depression in 19,18% of patients. Correlation between disease activity and depression score is found in RA patients. Depression intervention resulted in PHQ-9 improvement in some patients, supporting the benefit of depression screening and treatment in rheumatology practice. Depression was related with the level of fatigue and high RA disease activity, which was associated with impaired ability to perform activities of daily life. Strict control of fatigue and disease activity to improve one's capacity to perform daily life activities would be important to regulate depression. Depression is common and associated with worse outcomes among patients with RA.

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AB0343 ANTIRHEUMATIC THERAPY IS NOT ASSOCIATED WITH CHANGES IN CIRCULATING N-TERMINAL PRO-BRAIN NATRIURETIC PEPTIDE (NT-PROBNP) LEVELS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Patients with rheumatoid arthritis (RA) are predisposed to impaired cardiac function and heart failure (HF). While the pathophysiology has not been fully elucidated yet, inflammation is suspected to play an important role. However, the impact of disease-modifying antirheumatic drugs on cardiac dysfunction in RA remains controversial. Although anti-inflammatory drugs might have protective effects, some of them, i.e. tumour necrosis factor inhibitors (anti-TNF), might also negatively influence cardiac function. Serum NT-proBNP (s-NT-proBNP) is used as a biomarker of cardiac function, and levels ≤ 125 ng/L with high probability exclude HF¹.

Objectives: To examine effects of methotrexate (MTX) and anti-TNF regimens on s-NT-proBNP in patients with active RA, and to assess associations between s-NT-proBNP and endothelial function (EndoF).