ELDERLY-ONSET RHEUMATOID ARTHRITIS (EORA): DIFFERENCES ACCORDING TO CLINICAL DEBUT AND SEROLOGICAL POSITIVITY

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Background: In patients with Elderly-onset Rheumatoid Arthritis (EORA) has been described a clinical debut mimicking polyamyalgia rheumatica with rhizomelic pseudopolyarthritis, in contrast with the classical profile of patients with Rheumatoid Arthritis similar to younger patients. We compare in our study these two profiles of the disease.

Objectives: To describe and compare the differences according to clinical debut, serological positivity and its implications in terms of treatment and prognostic factors in patients with Elderly-onset Rheumatoid Arthritis (EORA).

Methods: Patients with a diagnosis of RA over 65 years of age according to ACR/EULAR 2010 criteria were included. A database was created including the age of onset, the presence of polyamyalgia-like symptoms (rhizomelic pseudopolyarthritis), the positivity of rheumatoid factor (RF) and anti-citrullinated protein antibodies (ACPAs), elevation of acute phase reactants (APR), the presence of erosions and the treatment required. Finally, data was analyzed according to clinical debut, serological positivity and prognostic factors.

Results: 83 patients diagnosed of EORA were included, with an average age of 73.8 years. 71.25% had positive RF (58.75% high titers) and 62.5% had positive ACPA (52.3% high titers). 24/83 patients (29%) debuted with a polyamyalgia-like symptoms. 47.5% had persistent APR elevation during follow-up. Regarding treatment, 15% were treated only with corticosteroids, 81.5% required treatment with DMARDs and 15% were receiving biological treatment. 42/83 patients (50%) had erosions on plain X-rays. Of those patients with a polyamyalgia-like profile, 52.2% (43/83) had positive RF but most of them had low titers (61%). On the other hand, patients without polyamyalgia-like symptoms had positive RF in 78% of the cases and most of them had high titers (66%, p = 0.01). In the first group there was less positivity for ACPAs (26%, p = 0.00004) and half of them had low titers. Erosions were observed in only 30% of the patients with polyamyalgia-like symptoms, while those without this profile had more erosions (58%, p = 0.02) and higher APR (50%, p = 0.026). Regarding treatment, in the group with polyamyalgia-like symptoms only 34% were treated with corticosteroids, 65% required DMARDs and no patients had received biological treatment, whereas in the non-polyamyalgic group, 88% required DMARDs and 21% required biologics (p = 0.01 for both results). Analyzing patients with positive RF and ACPAs at high titers, 93% received treatment with DMARDs and 24% required biological treatment. 65% had persistent elevation of APR and 48% presented erosions on plain X-rays. Only 2 patients with positive RF and ACPAs at high titers debuted with a polyamyalgia-like symptoms.

Conclusion: Patients with EORA with polyamyalgia-like symptoms tend to have less erosions and a higher prevalence of negative RF and ACPA or at low titers. These patients usually require less DMARDs and biological treatments to control the disease unlike patients with non-polyamyalgia symptoms. On the other hand, patients with high RF and ACPA titers have more erosions and elevated APR during follow-up but do not usually experience polyamyalgia-like symptoms.

REFERENCE

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HIGH PREVALENCE OF ANTICIPATORY AND ASSOCIATIVE SYMPTOMS OF METHOTREXATE INTOLERANCE IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Methotrexate (MTX) is the most widely used anti-rheumatic drug in the treatment of Rheumatoid Arthritis (RA) due to low costs, efficacy and an acceptable safety profile. However MTX has certain side effects. The most common side effects include the gastrointestinal tract not only after taking MTX, but also before MTX intake (anticipatory) and when thinking of MTX (associative).

Objectives: The aim of this study was to assess the prevalence of MTX intolerance and particularly the anticipatory and associative symptoms using the validated methotrexate intolerance Severity Score (MISS) (1).

Methods: We performed a cross-sectional descriptive study that involved patients with RA and treated by MTX for more than 3 months, compiled from Charles Nicolle hospital’s rheumatologic department. The tolerance of MTX was assessed by the MISS questionnaire. The MISS Questionnaire includes five elements: abdominal pain, nausea, vomiting, fatigue, and behavioral symptoms of restlessness, crying, irritability and drug refusal. Each symptom is evaluated after intake of MTX, before taking MTX (anticipatory) and on thinking about MTX (associative).

Results: A total of 100 RA patients (87 women and 13 men) with a mean age of 53.5 years. The MTX was administered by oral route in 91% of patients; the other 9% received it by intramuscular way. The average MTX weekly dose was 15.4mg. The average MTX duration was 76.7 months. All patients received folic acid with an average of 7.6 mg a week. MTX intolerance was found in 36% of patients. Abdominal pain was the most common symptom occurring in 55% of patients and up to 91.66% in MTX-intolerant patients, followed by nausea in 51% of patients and in 86.11% of MTX-intolerant patients and vomiting in 16% of patients and in 44.44% of MTX intolerant-patients. Anticipatory and associative abdominal pain affected 72.2% and 69.4 of intolerant-patients respectively. Anticipatory and associative nausea were found in 58.3% and 59% of intolerant-patients respectively. Anticipatory vomiting occurred in 16.6% of intolerant-patients. Overall, behavioral symptoms occurred in 75% of intolerant-patients, of whom 19.4% refused MTX. Older age was significantly correlated with better tolerance to MTX (p=0.02). There was no correlation between the dose of MTX, the duration of MTX intake and the route of MTX and the MISS score (respectively p=0.7, p=0.07 and p=0.2). Also, the use of other disease modifying drugs didn’t worsen the tolerance of MTX.

Conclusion: To conclude intolerance to MTX is frequently seen in RA. In addition to gastrointestinal symptoms after taking MTX, RA patients can suffer from anticipatory and associative gastrointestinal symptoms. We should screen these symptoms earlier using MISS questionnaire in order to improve MTX compliance.

REFERENCE

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WORSE OFFICE AND 24-HOUR BRACHIAL AND CENTRAL AORTIC BLOOD PRESSURE MONITORING PROFILE IN PATIENTS WITH RHEUMATOID ARTHRITIS COMPARED TO CONTROLS

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Background: Hypertension (HTN) contributes to increased cardio-vascular (CV) morbidity and mortality in RA. Recent European guidelines on the management of HTN encourage wider use of ambulatory blood pressure...
(BP) monitoring (ABPM) that provides more accurate information about BP control compared to conventional BP measurement. Central blood pressure (CBP) may be a better predictor of CV risk compared to brachial BP.

**Objectives:** To evaluate office and ambulatory brachial and central BP levels in patients with RA compared to the controls.

**Methods:** Study group included 85 patients with RA (77.6% females, age 59.7±14.3 years, HTN 65%, median HTN duration 6.6 years, RA duration - 7 years, seropositive RA 65%, DAS-28(CRP) 3.7±1.1, median hsCRP 10 mg/dL, RF 51.3 IU/mL, all received DMARDs) and control group (40 patients matched by gender, age and risk factors). All hypertensives received antihypertensive therapy. Office CBP was measured with application tonometry. CBP elevation was assessed according to individual reference values by gender and age. 24-hour ABPM of peripheral and central BP was performed with BPLab Vasotens. p<0.05 was considered significant.

**Results:** In patients without HTN mean office brachial and central BP levels were similar in RA and control groups. In patients with HTN corresponding BP levels were: 138±17/82±10 vs 130±16/74±11 mmHg (p=0.04 for SBP; p=0.001 for DBP), 132±20/82±10 vs 120±17/74±12 mmHg (p=0.01 for SBP; p=0.001 for DBP). Rate of BP control was 58% in RA and 67% in the controls (p=0.48). CBP elevation was observed in 42.4% of RA patients and 17.5% controls (χ²=14.9, p=0.001); 16.7% vs 0% in the normotensive group (χ²=6.0, p=0.01) and 56.4% vs 29.2% in HTN group (χ²=9.9, p=0.002), respectively. In the normotensives mean daytime, nighttime and 24-h BP levels were similar in RA and control groups. In HTN 24-h brachial SBP levels for RA and control group were 134±17 vs 125±9 mmHg for daytime (p=0.02); 128±17 vs 113±10 mmHg for nighttime (p=0.01) and 131±16 vs 123±19 mmHg for 24-h BP (p=0.02), respectively. The 24-h central BP levels were 124±14 vs 115±14 mmHg for daytime (p=0.02), 121±16 vs 111±10 mmHg for the nighttime (p=0.02) and 123±15 vs 115±8 mmHg for 24-h BP (p=0.02), respectively. Group with RA had higher incidence of masked and isolated nocturnal HTN compared to controls (35.3 vs 17.5% (p=0.05) and 29.4 vs 12.5% (p=0.04). In normotensives corresponding frequencies of masked and isolated nocturnal HTN were 33.3 vs 12.5% (p=0.05) and 26.7 vs 6.3% (χ²=3.3, p=0.04), respectively. In HTN group rate of masked uncontrolled HTN was 36.3 vs 2.5%, respectively, rate of uncontrolled night HTN-30.9 vs 2.7%.

**Conclusion:** Despite similar BP control rate, patients with RA were characterized by significantly higher levels of office brachial and central BP, worse control of CBP and higher frequency of masked and isolated nocturnal HTN compared to controls. Hypertensive RA patients had higher 24-h brachial and central SBP. This indicates the importance of 24-h blood pressure monitoring (ABPM) that provides more accurate information about BP control compared to conventional BP measurement. Central blood pressure (CBP) may be a better predictor of CV risk compared to brachial BP.

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- **CAROTID ULTRASOUND IS MORE EFFECTIVE THAN CORONARY CALCIIFICATION ASSESSMENT FOR DETECTING INDICATIONS TO STATIN THERAPY IN RHEUMATOID ARTHRITIS PATIENTS**

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**Objectives:** To compare the significance of the carotid ultrasound and the MDCT assessment of coronary calcification in the stratification of cardiovascular risk and the detection of indications for lipid-lowering therapy in patients with RA.

**Methods:** Ninety two patients with RA are included (ACR/EULAR, 2010), median age was 63 year old. 33% of them had breast cancer. 82% had centromere antibody and the median titer of the antibody were 1280. Interestingly, even in SjS patients, the same antibody was positive in 38%. In myositis, 4 out of 6 patients had ARS antibodies and their main symptom was intestinal pneumonia. No patients were positive for TIF-1y. Seeg from cancer side, 18% had colorectal cancer, 17% had breast cancer, 11% had lung cancer, 9% had gastric and uterine cancer.

**Conclusion:** Patients with cancer developed autoimmune diseases, and had different characteristics from primary autoimmune disease. This suggest that cancer itself and it’s therapy somehow influence to our immune systems.

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