(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 applanation 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) and 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 ($\chi^2 = 14.9, p = 0.0001$): 16.7% vs 0% in the normotensive group ($\chi^2 = 6.0, p = 0.01$) and 56.4% vs 29.2% in HTN group ($\chi^2 = 9.9, p = 0.002$), 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±9 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% ($\chi^2 = 3.7, p = 0.05$) and 29.4 vs 12.5% ($\chi^2 = 4.3, p = 0.04$). 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% ($\chi^2 = 3.3, p = 0.04$), respectively. In HTN group rate of masked uncontrolled HTN was 36.3 vs 2.5%, respectively, rate of uncontrolled night HTN-30.9 vs 20.8% ($p > 0.05$).

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 ABPM in RA.

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Disclosure of Interests: Elena Troitskaya: None declared, Sergei Velmakin: None declared, Svetlana Villevalde Speakers bureau: Servier, Novartis Pharma, Boehringer Ingelheim, Gedeon Richter, Astra Zeneka, Takeda, Berlin-Chemie AG, Zhanna Kobalava Speakers bureau: Servier, Novartis Pharma, Boehringer Ingelheim, Astra Zeneka, Takeda
DOI: 10.1136/annrheumdis-2019-eular.6306

AB0354

CAN CANCER TRIGGER AUTOIMMUNITY DISEASE? FEATURES OF AUTOIMMUNE DISORDER OF CANCER PATIENTS

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Background: Association between cancer and autoimmune diseases are reconsidered by frequent use of immune checkpoint inhibitor and its

adverse effects. In addition, the childhood cancer patients have the higher possibility of developing autoimmune disease than general population in previous research, though this may be related to cancer therapy. Furthermore the development of scleroderma in cancer patients harboring the rPOLAR3A cancer mutation suggests that cancer may directly induce autoimmune disease.

Objectives: We examine the features of autoimmune diseases in the patient with pre-existing cancer.

Methods: Data on clinical characteristics, laboratory features, and treatment response from patients with autoimmune disease in our hospital were analyzed retrospectively. We excluded patients who had diagnosed cancer more than 5 years ago, who use immune checkpoint inhibitor, whose symptom became clear by the drug toxicities and endocrine disease, and who had no symptoms but only test abnormalities.

Results: 149 patients consulted our department and 111 patients were included; their median duration of follow-up was 39 months. The median period of diagnosing cancer from autoimmune disease was 17 months, and median age of the patients with autoimmune diseases at diagnosis was 68 years. Baseline manifestations included rheumatoid arthritis (RA) 42%, polymyalgia rheumatica (PMR) 20%, systemic scleroderma (SSc) 10%, Sjogren syndrome (SjS) 7.3%, IgG4-related disease 6.3%, vasculitis 5.5%, polymyositis and dermatomyositis 5.5%, interstitial pneumonia 2.7%.

In patients with RA, 53% were positive for both rheumatoid factor (RF) and anti-CCP antibody (median RF 155IU/mL, anti-CCP antibody 380U/mL). The median age of diagnosis was 68 years, and 52% were female. The average serum C-reactive protein (CRP) was 1.7mg/dL. Patients who experienced only operation for previous cancer therapy was 44%. 39% patients developed RA symptoms within half year. As a treatment, MTX were used in 44%, SASP in 26%, PSL alone in 11%. The response to therapy was 70% overall. One patient who used MTX developed MTX-LPD (DLBCL) after 10 months.

In PMR, all cases were seronegative. The median age of diagnosis was 71 years, and 63% were female. The average CRP was 5.4mg/dL. 41% of patients had operation for previous cancer therapy and 32% had operation and chemotherapy. All cases started using PSL (15-40mg) and responded to treatment. They all tapered PSL.

In SSc, all cases were female and mean 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 interstitial pneumonia. No patients were positive for TIF-1 γ . Seeing 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 suggests that cancer itself and its therapy somehow influence to our immune systems.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.5277

AB0355

CAROTID ULTRASOUND IS MORE EFFECTIVE THAN CORONARY CALCIFICATION 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), 74% are women, the median of age is 54 [41.5; 60] years, median of disease duration - 6 [5; 21] months, median of DAS28 (ESR) - 5.2 [5.0; 6.0], without cardiovascular diseases and diabetes mellitus, severe chronic renal failure (GFR <60 ml/min x 1.73m²). Arterial hypertension was detected in 57% of patients, dyslipidemia - in 50%, 63% of women were in postmenopause. Initially, the cardiovascular risk was assessed using the mSCORE scale, and then again, taking into account the results of carotid ultrasound and MDCT assessment of coronary calcification.

Results: After assessing the cardiovascular risk on the mSCORE scale 41.3% of patients with RA were classified as low risk (n = 38), medium risk - 38% (n = 35), high risk - 15.2% (n = 14), very high risk- 5.5%