EVALUATION OF CARDIOVASCULAR RISK FACTORS AND PREVALENCE OF METABOLIC SYNDROME IN PATIENTS WITH DIAGNOSIS OF ANKYLOSING SPONDYLITIS:

Severino Correia Do Prado Neto, Erika Carvalho de Aquino, Joazelia Rêgo, Nilzio Da Silva, Fabiana Pina, Hospital das Clínicas de Goiânia – Universidade Federal de Goiás, Goiânia, Brazil; Universidade Federal de Goiás, Goiânia, Brazil.

Background: Cardiovascular events are the main causes of mortality in patients with Ankylosing Spondylitis. In addition, a higher prevalence of Metabolic Syndrome is reported in this group. With immunobiological therapy, much progress has been made in controlling the inflammatory process, but the cardiovascular risk remains high.

Objectives: To evaluate the prevalence of cardiovascular risk factors and Metabolic Syndrome in patients with Ankylosing Spondylitis at the Rheumatology Outpatient Clinic of HC-UFG and to correlate them with epidemiological, clinical, laboratory and radiographic characteristics of the disease.

Methods: Data from 59 patients were collected in medical records between July and August 2018. Clinical characteristics, cardiovascular risk factors and metabolic components were analyzed. Descriptive analyzes of the data were made, prevalences and their reasons were calculated. The associations between variables were assessed by chi-square test and Fisher’s exact test.

Results: 81.4% were male, 67.8% self-denominated non-whites, average age 46.7 years. Isolated axial joint involvement was the most frequently observed (54.2%). Enthesopathies were identified in 30.5% of the cases. Uveitis had higher prevalence (22.0%), 4.2 times higher in the subgroup with HLA-B27 positive (p=0.0002). HLA-B27 was present in 67.8%. Advanced sacroilitis (grades 3 and 4) and syndesmophytosis were identified in 61.1% and 49.2%, respectively, but didn’t presented significant correlation with the presence of HLA-B27. 64.4% were using anti-TNF alone or in combination. The majority of the patients (72.9%) were sedentary. Clinical comorbidities were reported in 66.1% of the cases, with dyslipidemia (45.8%), systemic arterial hypertension (37.6%) and diabetes mellitus (13.6%) being the most common. Metabolic Syndrome was diagnosed in 23.7% of the samples. Normal levels of triglycerides and fasting glycemia and lower prevalence of Metabolic Syndrome had a statistically significant association with the presence of HLA-B27 (p=0.006; 0.026 and 0.014, respectively). Patients with HLA-B27 present had 61% lower frequency of Metabolic Syndrome. There was no association between the syndrome and its components with anti-TNF therapy; BASDAI; BASFI; metric evaluation; uveitis; degree of sacroilitis and syndesmophytosis.

Conclusion: The prevalence of Metabolic Syndrome was below that is described in other populations. The presence of HLA-B27 was considered a protective factor for Metabolic Syndrome, triglyceride levels and fasting glycemia. This finding may be related to the presence of several HLA-B27 alleles, usually non-subtyped, and to the great ethnic miscenization of the Brazilian population. Our observation suggests that spondylitics should be routinely evaluated for cardiovascular risk factors.

REFERENCES

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of blood in RA were found significantly more often than in OA (respectively 14.4% and 5.7% of cases; P<0.001). The number of cases requiring cancellation of anticoagulant therapy in patients with RA was significantly higher compared with the OA group (6.6% and 1.4%, respectively). Slow wound healing in RA was more common (n = 56; 26.4%) than in OA (n = 14; 5.1%). In patients who underwent monotherapy with calcium nadroparin VTE occurred more often than when using combination therapy (p<0.001) and more often than in the group of dabigatran etexilate (p=0.054).

Conclusion: The frequency of VTE, the risk of bleeding and complications of postoperative wound in patients with RA and OA after THA were analyzed. So, our study determined the dependence of VTE complications and bleeding risk according to the patient's underlying nosology. Also the advantage of combined postoperative therapy over others was evaluated.

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Figure 1

Table 1. Performance of 7 different remission subtypes in defining the risk of damage accrual (upper part) and the goodness-of-fit of the model (lower part).

When PGA<0.5 was added to cSLEDAI, 198 (30.7%) patients lost 353 years in remission (1.8 years/patient); among them 195 (98.5%) showed a 0.5<PGA1 suggesting a low disease activity state (LDA). When PGA<0.5 was added to cSLEDAI =0 and PDN ≤5mg/day, 151 (23.5%) patients lost 254 years in remission (1.7 years/patient); among them 149 (98.0%) showed a 0.5<PGA1 suggesting again LDA. All remission subtypes were protective against damage (p<0.001), however cSLEDAI=0 showed the best performance (lower AIC) (Table 1). At multivariate analysis all remission subtypes lasting ≥2 consecutive years were protective against damage (p<0.001), except PDN≤5mg/day which was protective after 4 consecutive years.

Conclusion: The prevalence and extent of damage significantly decreased as the time spent in remission increased, irrespective of the remission subtype. The addition of PGA<0.5 to cSLEDAI=0 or to cSLEDAI=0 and PDN≤5mg/day results in a decrease in the time spent in remission without significant difference in damage accrual.

REFERENCES


Figure 1