$p < 0.01$), CRP ($r = 0.33$, $p < 0.01$) at baseline, Δ MMP3 ($r = 0.30$, $p = 0.02$), and Δ HAQ ($r = 0.25$, $p = 0.04$) on univariate analysis. Multivariate analysis identified no independent factors (Table 1)

Table 1. Risk factors for developing sarcopenia in patients with rheumatoid arthritis

	Univariate		Multivariate		
	R value	p value	Odds ratio	95% CI	P value
Male sex	0.28	0.02	-	-	-
Age	0.27	0.03	1.05	0.92-1.20	0.47
GC use >5mg/day	0.33	<0.01	10.20	0.45-229.0	0.14
Δ MMP3	0.30	0.02	1.02	0.99-1.04	0.08
Δ HAQ	0.25	0.04	1.26	0.94-1.67	0.11

GC: glucocorticoids, CI: confidence interval, Δ : change from baseline to 2 year

Conclusion: Male sex, old age, glucocorticoid use >5 mg/day, and high elevations of MMP3 and HAQ are associated with developing sarcopenia at 2 years in RA patients.

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THU0160

FEATURES OF LIPID PROFILE INDICATORS IN PATIENTS WITH RHEUMATOID ARTHRITIS IN CONNECTION WITH ARTERIAL HYPERTENSION

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Background: Patients with rheumatoid arthritis (RA) have an early development of endothelial dysfunction, an increase of the atherogenicity index (AI), and a high risk of fatal cardiovascular events. The presence of arterial hypertension (AH) in patients with RA accelerates the process of early atherogenesis and increases the risk of fatal cardiovascular events.

Objectives: To evaluate the dynamics of lipid profile changes in patients with RA in combination with AH.

Methods: It was examined 47 patients with RA in combination with AH (by all patients was discovered I stage/2 degree of AH). The age of the patients ranged from 18 to 72 years. Among the surveyed group dominated men (41 patients). All patients were assessed for the levels of total cholesterol (TC), low density lipoprotein (LDL), very low density lipoprotein (VLDL), triglycerides (TG), high density lipoprotein (HDL), AI (AI = TC - HDL/LDL), antibodies to modified citrulline vimentin (anti-MCV), rheumatoid factor (RF), C-reactive protein (CRP) before treatment. All patients were also assessed for the risk of death for 10 years by the SCORE scale (> 15% - very high risk, 10-14% high, 5-3% - moderate, <1% - low) and RA activity by DAS28 score.

Results: Due to the obtained data, it can be asserted, that in patients with seronegative RA the moderate risk by SCORE was prevalent, and among seropositive RA patients– high risk. The high level of anti-MCV titres was directly correlated with the risk of the death by SCORE ($p > 0.05$, $r = 0.64$). We found that patients with RA and AH had relatively low levels of TC (5.82 ± 2.21 mmol/L) and LDL (2.82 ± 0.81 mmol/L), but the AI in these patients was 4.42 ± 0.68 . It was measured the correlation between the levels of LDL and the activity of the inflammatory

process DAS28, the level of CRP and the duration of RA ($r = 0.56$, $p < 0.05$, $r = 0.49$, $p < 0.05$, $r = 0.53$; $p < 0.05$, respectively). There was also a reverse correlation between the duration of RA and the level of HDL ($r = -0.47$; $p < 0.05$).

Conclusion: 1. Seropositivity, high activity and anamnesis of RA for more than 10 years are the factors, that are associated with high risk of fatal cardiovascular events. 2. In patients with RA in combination with AH, serum lipid levels have paradoxical ratio, resulting in lower levels of TC and LDL associated with an increased risk of cardiovascular events ("lipid paradox"). 3. The presence of high anti-MCV titres serves as a prognostically unfavorable feature of the course of RA and AH, since its association with a high risk of fatal cardiovascular events.

Disclosure of Interests: None declared

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Rheumatoid arthritis - non biologic treatment

THU0161

ORAL VERSUS SUBCUTANEOUS METHOTREXATE IN RECENTLY DIAGNOSED RHEUMATOID ARTHRITIS: DO WE GET THE SAME RESULTS?

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Background: As we know, the use of disease modifying antirheumatic drugs (DMARDs) improves the overall prognosis of rheumatoid arthritis (RA) specially when treatment is started early in the course of the disease.

The most widely used DMARD is methotrexate (MTX) mainly because of its favorable efficacy-toxicity ratio. However, there is a lot of variability using MTX when it comes to dosage and route of administration; and little research on the overall response of patients to the different strategies used.

Objectives: To compare the clinical response of oral (PO) versus subcutaneous (SC) MTX in recently diagnosed RA patients with no previous use of DMARDs. We evaluated the data collected at baseline, the 3rd, 6th and 12th month after the beginning of MTX treatment.

Methods: This descriptive, observational, longitudinal retrospective study was achieved using a cohort of patients with recently diagnosed RA in which treatment with MTX was started between August 1st 2015 to September 1st 2018. We collected demographic and clinical data, disease activity markers, MTX and corticoid dosage, routes of administration and treatment changes.

Results: In total, 52 patients were included of which 39 (75%) were women, with an average age of 57.56 years. There was a mean of 26 weeks between the first symptoms and the beginning of MTX.

Abstract THU0161 – Table 1.

	Total	Oral	Subcutaneous	(p)
Patients n(%)	52(100)	25(48.1)	27(51.9)	
Mean Starting MTX dose (SD)	12.6(+/-2.5)	11.1(+/-2)	13.98(+/-2.2)	<0.0001
Mean Starting Prednisone dose (SD)	6.21(+/-6.2)	5.92(+/-4.3)	6.48(+/-7.5)	0.74
Mean Starting Painful Joint Count (SD)	9.5(+/-6.9)	8.56(+/-5.9)	10.41(+/-7.5)	0.34
Mean Starting Swollen Joint Count(SD)	5.38(+/-6.6)	5.04(+/-4.6)	7.34(+/-7.8)	0.2
Mean Starting CRP (SD)	1.67(+/-2.2)	1.51(+/-2.4)	1.76(+/-1.8)	0.69
Mean Starting ESR (SD)	27.3(+/-19.6)	30.44(+/-20)	24.22(+/-18.4)	0.25

Abstract THU0161 – Figure 1