The prevalence of **AAa** and of distinctly different forms of multifocal inflammation, such as purulent bronchitis and bronchiolitis (**purBr**) or bronchopneumonia (**BrPn**), infarct with pneumonia (**InfPn**), occlusive pneumonia (**OcclPn** – focal pneumonia caused by compressive peribronchial nodular lymphoid hyperplasia or bronchial blockage by a necrotic nodule) were examined. In addition, rheumatoid pneumonia (**RhPn**), furthermore interstitial pneumonia (**IPn**) [1-4] were determined at autopsy and confirmed in a detailed review of extensive histological material.

The possible role of **AAa** on the prevalence of **purBr** or **BrPn**, **InfPn**, **OcclPn**, **RhPn** and **IPn** was analyzed with Pearson's chi-squared (χ^2) test.

Results: **AAa** complicated **RA** in **34 (23.13%)** of 147 patients. Pulmonary blood vessels of different caliber and various tissue structures of the lungs were involved in **25 (73.53%)** of 34 cases; the lungs were not involved by **AAa** in **9 (26.47%)** of 34 cases.

purBr or **BrPn** were associated with **RA** in **19 (21.1%)**, **InfPn** in **5 (3.4%)**, **OcclPn** in **2 (1.4%)**, **RhPn** in **3 (2.1%)** of 147 patients (only the fatal cases were considered). **IPn** – characterized by interstitial cellular infiltration with or without edema, fibrinoid deposition, with or without fibrosis, and with or without corresponding pleuritis was present in **35 (23.8%)** of 147 patients; **IPn** alone was not fatal in our cohort and contributed to the death only in association with cardiac, circulatory or cardio-respiratory insufficiency.

Pulmonary amyloid A deposition (**n=25**) was associated with **purBr** or **BrPn** in **1 (5.26%)** of 19, **InfPn** in **1 (20.0%)** of 5, **OcclPn** in **2 (100.0%)** of 2, **RhPn** in **none (0.0%)** of 3, **IPn** in **12 (34.29%)** of 35 patients.

The relationship between pulmonary **AAa** and **purBr** or **BrPn** ($\chi^2=1.2836$, $p<0.25$), **InfPn** ($\chi^2=0.1800$, $p<0.67$) or **RhPn** ($\chi^2=0.00025$, $p<0.98$) was not significant. There was a **significant and positive correlation** between pulmonary **AAa** and **OcclPn** ($\chi^2=4.8313$, $p<0.02$) or between **AAa** and **IPn** ($\chi^2=9.7106$, $p<0.0018$).

Conclusion: The main complications of **RA**, such as **AAa**, may influence the prevalence, clinical course and symptoms of associated diseases and vice versa. Knowledge of these relationships is important to estimate the relative danger they potentially represent.

The **significant correlation** between **AAa** and **OcclPn** or **IPn** suggests a positive influence of pulmonary amyloid A deposition on **OcclPn** or **IPn**. The statistically not significant correlations suggest that **purBr** or **BrPn**, **InfPn** and **RhPn** are independent entities which are not influenced by **AAa**.

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FR10025

DOES COMORBIDITY IMPACT ON THE ACTIVITY AND MANAGEMENT OF RHEUMATOID ARTHRITIS?

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Background: Patients with rheumatoid arthritis (RA) are in increased risk of developing comorbid conditions. Recent data suggest the relationship between severity of RA and concomitant diseases [1, 2]. Drug therapy is considered as impotent risk factor for numerous comorbidities. On the other hand comorbidity can impact negatively on the RA course and on the pts management [3].

Objectives: The aim of our study was to evaluate the prevalence of concomitant conditions in RA pts, to compare the RA activity and management in relation with comorbidities.

Methods: 168 pts with established and longstanding RA were observed at in-patient clinic for RA clinical assessment and revealing concomitant diseases (cardiovascular, gastrointestinal, liver, pulmonary, endocrine, blood). The activity of disease according to DAS28-ESR index in RA subgroups with different comorbidities was compared. The spectrum and used doses of anti-rheumatic medications (DMARD, biologics, GC) in these subgroups was analyzed in term to assess the RA rational treatment.

Results: The majority (88.1%) of observed RA pts had concomitant condition. The most frequent associated diseases were: cardiovascular (AH, IHD, HF, AF) in 86.9% and gastrointestinal (gastritis, duodenitis, gastroduodenal ulcer, colitis) in 64.3% less common comorbidities were anemia (30.9%), liver and kidney abnormalities (hepatomegaly, steatohepatitis, CKD, pyelonephritis) in 25% and 12.5% respectively, endocrine (type 2 diabetes mellitus, thyroid disorders) in 16.7%. Multimorbidity determined as combination of different system disorders in the setting of RA was detected in 54.8% of RA pts. We found out significant difference in RA activity on the basis of DAS28 between RA subgroup without concomitant conditions (the 1st) on the one hand and RA subgroups with comorbidities (the 2nd) ($t1=2.76$, $p<0.01$) or multimorbidities ($t2=3.73$, $p<0.01$) on the other hand (tab.1).

Index	RA without comorbidities (1 st group)	RA with comorbidities (2 nd group)	RA with multimorbidities (3 ^d group)
DAS 28	4.20 ±0.31	5.09±0.09	5.44±0.12

In RA with comorbidities/multimorbidities the mean doses of MTX and SSZ were lower than in RA without comorbidities, while the dose of GC and frequency of GC use was significantly higher in the 2nd and 3^d groups ($\chi^2=4.25$, 4.41 respectively). 55% of pts from the 1st group and only 19.6% of total amount of pts from the 2nd and 3^d groups were treated with biologics ($\chi^2=5.67$).

Conclusion: Obtained data suggest that comorbidities have a negative impact on the severity of RA and can interfere in the implementation of T2T strategy in daily clinical practice.

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FR10026

SYSTEMIC, RENAL AND CARDIAC AA AMYLOIDOSIS IN RHEUMATOID ARTHRITIS – A COMPARATIVE POSTMORTEM CLINICOPATHOLOGIC STUDY OF 161 PATIENTS

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Objectives: The aim of our study was to determine the incidence of systemic AA amyloidosis (**sAAa**) in **RA**, to appraise the prevalence and severity of amyloid A deposits in different tissue structures of the kidneys and heart, to outline the development of renal and cardiac AA amyloidosis (**rAAa** and **cAAa**), and to estimate the role of **rAAa** and **cAAa** in mortality.

Methods: One hundred sixty one (161) non-selected autopsy patients with rheumatoid arthritis (**RA**) were studied. **RA** was confirmed clinically according to the criteria of the **ACR** [1]. **sAAa** was specified histologically, based on evaluation of 5 organs (heart, lung, liver, kidney and pancreas). Amyloid A deposition was diagnosed histologically according to Romhányi by a modified (more sensitive) Congo red staining [2]. Amyloid