A deposits were confirmed in serial sections by immunohistochemical and histochemical methods.

Results: sAAa complicated RA in 34 (21.12%) of 161 patients; in 127 (78.88%) of 161 patients amyloid A deposits were not found. Amyloid A deposits were found in 29 (87.88%) kidneys of 33 patients with sAAa; kidneys were negative for amyloid in 4 (12.12%) of 33 cases (the heart of one patient with sAAa was not available). Amyloid A deposits were found in 29 (87.88%) hearts of 33 with sAAa; the heart was negative for amyloid in 4 (12.12%) of 33 cases (the heart of one patient with sAAa was not available). Renal amyloid A deposition led to death in 17 (50.0% of 34) patients with sAAa due to massive amyloid A deposition in the kidneys, leading to renal insufficiency and uremia. Cardiac amyloid A deposition led to death in 3 (6.62% of 47) patients with sAAa and (and contributed to the lethal outcome in further 5). Forteen (41.18% of 34) patients with sAAa died of other causes such as peritonitis, lethal septic infection, etc.

sAAa was clinically diagnosed in 9 (26.47%) and missed in 25 (73.52%) of 34 patients, and only cases with massive renal amyloid A deposits were recognized. Cardiac AAa or its pathogenic role in mortality was not diagnosed.

Conclusion: sAAa is one of the main and the most insidious complications of RA affecting the kidneys and heart with high prevalence and severity. sAAa is related to the cardiovascular system, and RAa or cAAa are associated with it. sAAa, RAa and cAAa may developed in both sexes, and at any time in the course of the disease.

Systemic, renal and cardiac amyloid A deposition is a progressive and cumulative process, involving in its early stage only a few structures in some organs, and increasingly more in the later stages of the disease. In sAAa the renal and cardiac amyloid A deposition starts after a latent stage. This latency may be caused by a not specified local protective mechanism, e.g. great excretion capacity of the kidneys, due to motility of the heart or oxygenisation etc.

Amyloid A deposition starts in the most frequently involved structures of the kidneys or heart with more massive deposits. The chronology of amyloid A deposition allows an indirect assessment of the stage of renal or cardiac amyloidosis, which may have a prognostic value in everyday surgical pathology.

Half of the patients with sAAa died of uremia caused by massive RAa and only 9 of these were clinically recognized. Renal and cardiac amyloid A deposition should be considered a very serious, life-threatening complication of RA.

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algorithm. A 5-year prospective follow-up for new CVD events, type II diabetes and medication for hypertension and hyperlipidemia was completed in all the patients. The event-free survival curves were built and the Mantel-Cox analysis was performed with respect to serum IGF1, where IGF1 levels below or equal to the median 139 ng/ml were considered low.

Results: Low IGF1 was clinically significant. These patients were recognized by high prevalence of hypertension (26% vs. 7.9%, p=0.001), overweight (19% vs 8.8%, p=0.016) and hypercholesterolemia (71% vs 48%, p=0.0025), which resulted in a higher eCVR in these RA patients (7.2% and 3.3%, p<0.001). When adjusted by age, low IGF1 group had serum IL6 (pg/ml: 2.1[0.2-3.0] vs 0.7[0.1-4.2], p=0.038) and ESR (mm/h: 12.7[15.5] vs 5.5[4-9], p=0.02), and higher prevalence of MTX monotherapy (56% vs. 39%, p=0.024). At prospective follow-up, 12 CVD events were registered. The median age at CVD event was 67 years and disease duration 14 years. Among the new CVD events were 4 ischemic strokes, 3 chronic atrial fibrillations and 2 incidental aorta aneurysms, which all could be viewed as directly related to hypertension. Low IGF1 showed high novelty for new CVD events (OR 4.96, [95%CI:1.17-34.2], p=0.029). Additionally, low IGF1 group had a significant increase in medication for hypertension (+19.5% vs +4.8%, p=0.00011), but not type II diabetes and statins. In a prediction model, a combination of low IGF1 and RA duration>10 years indicated 80.5% specificity for development of new CVD events.

Conclusion: We identified low normal levels of IGF1 to be associated with higher prevalence of CVD events in RA patients. Importantly, low IGF1 appeared to be an independent predictor of hypertension in middle-aged female patients.

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FR00030 FEELINGS OF GUILT AND SHAME IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a chronic inflammatory disease which causes functional disability, pain, and joint destruction. The disease has a major impact on patient’s independence, social activities and self-image.

Objectives: The aims of this study were to assess whether RA is associated with increased feelings of shame and guilt, and to examine possible correlates with socio demographic characteristics and disease activity.

Methods: To measure feelings of shame and guilt, in patients with RA (ACR/EULAR 2010), we used the Experience of Shame Scale (ESS) [1] and the Test of Self Conscious Affect- Version 3 (TOSCA-3S) [2].

The ESS is a 25-item questionnaire that assesses the frequency of characterological, behavioral and bodily shame experiences over the past year. Respondents rate each item on a scale ranging from 1 (not at all) to 4 (very much), with higher scores indicating greater shame.

The TOSCA-3S is presented with 11 brief hypothetical scenarios followed by 3 common reactions, which reflect shame, guilt and externalization of blame. Each possible response is rated on a five-point scale from 1 (not likely) to 5 (very likely). For the purpose of this study, only the shame and guilt response items were analyzed. Total scores for Shame Self-Talk and Guilt Self-Talk were calculated and compared to the scoring interpretation. A p<0.05 was considered significant.

Results: A total of 40 patients with RA were included, 36 women and 4 men, with a mean age of 54.2 years old [25-75]. Nine patients (22%) were illiterate, 42.5% were professionally active and 82.5% were married. The mean disease duration was 12.8 years [3-33], 80% of patients were on prednisone at a daily posology of 7 mg [2.5-12.5], 82.5% were on csDMARDs and 27.5% on bDMARDs. The mean DAS 28 ESR and CRP were respectively 4.3 [1.6-6.9] and 3.6 [1-6.2].

The mean total score of the ESS was 45.3 [27-91] with subscale means of: 19 [12-37] for characterological shame, 19 [10-30] for behavioral shame and 7.4 [4-16] for bodily shame. For the TOSCA-3S, the mean “shame self-talk Total” score was 33.8 [17-44], and the mean “guilt self-talk Total” score was 48 [37-55], which corresponds to “you often use” for men and “you use an average amount” for women, a shame and guilt self-talk.

A significant correlation was found between disease activity (DAS 28 ESR) and total score of ESS, shame self-talk total score and guilt self-talk score (p<0.000). A significant correlation was also found between these scores and gender, age, level of education, professional activity and marital status.

Conclusion: Our RA patients experienced general feelings of shame and guilt, which correlate with demographic items and disease activity.