vs 33.4%, $p=0.177$). In the whole cohort the most frequent reason for withdrawal was inefficacy (60.9%), whereas only 10.9% of patients discontinued the drug because of adverse events.

Conclusion: In our real-life data, CZP showed a high remission rate with a good safety profile and high persistence on treatment over 5 years. These findings were even more favorable during the childbearing age, supporting the use of CZP in RA women with a desire for pregnancy.

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FRI0043

CHARACTERISTICS OF PATIENTS WITH RHEUMATOID ARTHRITIS ADMITTED TO AN INTENSIVE CARE UNIT IN SPAIN SINCE 2005–2015. TREND-AR STUDY

Alberto García-Vadillo¹, Natalia Crespi-Villarias², Carmen Barbadillo³, Manuel Fernandez-Prada⁴, María Galindo-Izquierdo⁵, Hilda Godoy³, Angeles Herranz Varela⁶, Cristina Macía-Villa⁷, Concepción Morado Quiroga⁸, Jose Luis Morell Hita⁹, Elia Perez-Fernandez¹⁰, Javier Quirós¹¹, Virginia Villaverde¹², María Espinosa¹³, Cristina Martínez-Prada⁸, Ramón Mazzucchi¹¹. ¹Hospital de La Princesa, Rheumatology, Madrid, Spain; ²Health Center Rivota, Alcorcón, Spain; ³Hospital Puerta de Hierro-Majadahonda, Rheumatology, Majadahonda, Spain; ⁴Hospital Universitario de Guadalajara, Rheumatology, Guadalajara, Spain; ⁵University Hospital 12 de Octubre, Rheumatology, Madrid, Spain; ⁶Hospital del Henares, Rheumatology, Coslada, Spain; ⁷Hospital Severo Ochoa, Rheumatology, Leganés, Spain; ⁸Hospital Clínico Universitario San Carlos, Rheumatology, Madrid, Spain; ⁹Hospital Ramón Y Cajal, Rheumatology, Madrid, Spain; ¹⁰Fundación Hospital Alcorcón, Clinical Investigation, Alcorcón, Spain; ¹¹Hospital Universitario Fundación Alcorcón, Rheumatology, Alcorcón, Spain; ¹²Hospital de Móstoles, Rheumatology, Móstoles, Spain; ¹³Infanta Sofia University Hospital, Rheumatology, San Sebastián de los Reyes, Spain

Objectives: To analyse the clinical features of patients with Rheumatoid Arthritis (RA) that were admitted to an Intensive Care Unit (ICU) from January 2005 to December 2015.

Methods: A retrospective observational populational study was conducted analysing the national database that includes the Minimum Basic Data Sets (MBDSs) of admissions of RA patients to an ICU during the 2005–2015 period. Demographic characteristics, length of stay, clinical course, outcome and the MBDS codes for the main reason of admission were recorded. The cases were detected by the presence of their CIE-9 codes in the primary or secondary diagnoses. Statistical analysis was performed with Stata 15.0 software.

Results: During the 11 years of the study, a total of 2719 RA patients required 2806 admissions to an ICU. Average age was 69.7 ± 10.8 years and women constituted 58.5% of the cases. 30% of the patients admitted to an ICU had required ≥ 3 previous admissions and 11% required readmission within the next 30 days. Average Charlson index was 2.33 ± 1.4 . Average length of stay was 9.3 ± 14 days and 64.2% died in the ICU during hospitalization. The main causes of hospitalization were cardiovascular events (45.7%), lung diseases (16%) and infections (10%). In the univariate analysis mortality was significantly increased in patients presenting infections (90%), lung disease (89%), severe hepatopathy defined by ascites and/or encephalopathy and/or gastrointestinal bleeding (88%), nephropathy/kidney disease (73%) and a higher Charlson index (2.4 vs 2.2). Multivariate analysis showed that mortality was increased among patients presenting respiratory complications and infections.

Conclusion: The most frequent hospitalization causes for patients with Rheumatoid Arthritis in Spain between 2005 and 2015 were cardiovascular, pulmonary and infectious diseases. RA patients that were admitted to the ICU showed an increased mortality. This increased mortality was mainly found in patients presenting respiratory or infectious conditions.

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FRI0044

RISK FACTORS FOR CORONARY ARTERY ATHEROSCLEROSIS IN PATIENTS WITH RHEUMATOID ARTHRITIS

Helen Gerasimova¹, Tatiana Popkova¹, Olga Fomicheva², Lev Krougly², Svetlana Glukhova¹, Diana Novikova¹. ¹V.A.Nasonova Research Institute of Rheumatology, Moscow, Russian Federation; ²National Medical Research Center of Cardiology, Moscow, Russian Federation

Background: Rheumatoid arthritis (RA) is a systemic inflammatory disease leading to significant increase in cardiovascular morbidity and mortality. Development of coronary artery diseases (CAD) in RA patients (pts) is associated with the accumulation of traditional risk factors and immunological disorders. Coronary angiography (CAG) is the gold standard to identify coronary artery atherosclerosis (CAA).

Objectives: To identify CAA predictors and determine CAA detection rates in RA pts with suspected CAD.

Methods: Examination of 77 RA pts with suspected CAD, male/female 28/48, mean age 59 [53;64] years, with a long history of the disease (10[6;20] years), who were seropositive for IgM rheumatoid factor (RF) (82%) and anti-cyclic citrullinated peptide (ACCP) (58%), with moderate to high clinical disease activity DAS 28 4.2[3.2;5.3]. CAG was performed in all pts. CAA risk factors in RA pts were identified by the multiple linear stepwise regression analysis.

Results: Out of 77 RA pts CAA was detected in 52 (68%) (male/female 25/27 (group I)), while intact coronary arteries (CA) were found in 25 (32%) (male/female 3/22 (group II)) pts. Both groups were comparable in terms of age, disease duration and RA activity (DAS 28 score). Males prevailed in Group I: 48% vs 3% in Group II ($p<0.05$). Group I pts included more smokers than Group II (44% vs 8%, $p<0.05$). Other traditional risk factors were equally represented in both groups: arterial hypertension - 87% and 84%, dyslipidemia - 75% and 64%, diabetes mellitus - 15% and 8%, physical inactivity - 58% and 42%, obesity - 29% and 28% pts in Groups I and II, respectively. Serum HDL cholesterol (HDL-C) concentrations were lower (1.3[1.0;1.4] mmol/l) and triglyceride (1.5[1.1;2.0] mmol/l) levels were higher in Group I vs Group II (1.6[1.2;1.9] and 1.2[0.9;1.5] mmol/l), $p<0.01$. Concentration of total cholesterol and LDL-C were similar in pts from both Groups. Both Groups showed similar atherosclerotic plaques detection rates in carotid arteries (19/12%). Variety of administered drugs (disease-modifying antirheumatic drugs, biological drugs and oral glucocorticoids) and therapeutic regimens were also comparable in Groups I and II. Multiple linear regression analysis indicates close association of CAA with pts' age (unstandardized coefficient $B=0.017$, 95% confidence interval (95% CI) [0.004-0.030], $p=0.011$), smoking ($B=0.246$, 95% CI [0.055-0.437], $p=0.013$), HDL-C ($B=-0.325$, 95% CI [-0.557-(-0.095)], $p=0.0073$), atherosclerotic plaques in carotid arteries ($B=0.549$, 95% CI [0.120-0.901], $p=0.003$) and ACCP ($B=0.309$, 95% CI [0.028-0.589], $p=0.03$), coefficient of multiple determination (R^2) = 0.6. Subsequent ROC analysis confirmed the diagnostic value of HDL-C and CAA in RA pts. HDL-C levels below 1.32 mmol/l can be considered as a prognostic factor of CAA presence in RA pts with 68% sensitivity and 65% specificity (area under the curve is 0.711; 95% CI 0.580-0.842; $p=0.04$).

Table 1. Values of analyzed parameters predictive of CAA according to the multiple linear stepwise regression analysis.

Variable	Unstandardized coefficient			P
	B	- 95% CI	- 95% CI	
Age	0,017	0,004	0,030	0,011
Smoking	0,246	0,055	0,437	0,013
HDL-C	-0,325	-0,557	-0,095	0,007
Carotid artery plaques	0,549	0,120	0,901	0,003
ACCP-positivity	0,309	0,028	0,589	0,03

CI – confidence interval

Conclusion: Male gender, low HDL-C levels, plaques in carotid arteries, and ACCP-positivity are associated with increased CAA risk in RA pts. Low HDL-C level can be considered as CAA predictor in RA pts.

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