Figure. Percentages of patients reporting improvements $\geq$ MCID with baricitinib vs placebo and associated NNTs for baricitinib in RA-BEAM and RA-BEACON. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. Abbreviations: BP, bodily pain; FACIT-F, Functional Assessment of Chronic Illness Therapy-Fatigue; GH, general health; HAQ-DI, Health Assessment Questionnaire-Disability Index; MCID, minimum clinically important difference; MH, mental health; NA, not applicable (ie, difference between treatment and placebo is not statistically significant, confidence interval of NNT is not calculated); NNT, numbers needed to treat; Pain, Patient's assessment of pain; PCS, physical component score; PF, physical function; PtGA, Patient's Global Assessment of Disease Activity; RE, role emotional; RP, role physical; SF-36, Short Form-36; SF, social functioning; VT, vitality

Disclosure of Interests: Vibeke Strand Consultant of: AbbVie, Amgen, Biogen, Celltrion, Consortium of Rheumatology Researchers of North America, Crescendo Bioscience, Eli Lilly, Genentech/Roche, GlaxoSmithKline, Hospira, Janssen, Merck, Novartis, Pfizer, Regeneron Pharmaceuticals, Inc., Sanofi, UCB, Luna Sun Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, Jorge Ross Terres Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company, Carol L. Kannowski Shareholder of: Eli Lilly and Company, Employee of: Eli Lilly and Company
DOI: 10.1136/annrheumdis-2020-eular.1440

FRIDAY, 05 JUNE 2020

Rheumatoid arthritis - comorbidity and clinical aspects

FRI0049 RHEUMATOID ARTHRITIS ASSOCIATED INTERSTITIAL LUNG DISEASE: TOBACCO AND OTHER RISK FACTORS

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Background: Among the risk factors associated with the development of interstitial lung disease (ILD) in patients with rheumatoid arthritis (RA) are: male sex, old age, erosive RA, rheumatoid nodules, smoking and high levels of rheumatoid factor (RF) and anticitrullinated protein antibody (ACPA). The factors of poor prognosis include: HRCT (High Resolution Computed Tomography) pattern of usual interstitial pneumonia (NIU) with altered baseline functional tests (forced vital capacity FVC $< 60\%$, diffusion capacity of the lung for carbon monoxide DLCO $< 40\%$).

RA associated UIP (RA-UIP) has an appearance that is identical to idiopathic UIP (idiopathic pulmonary fibrosis [IPF]) on HRCT.

Objectives: To analyze different risk factors and poor prognosis in a cohort of patients with ILD-RA.

To assess the degree of association between tobacco (smokers, ex-smokers and non-smokers) and altered baseline functional respiratory tests (FRT) (FVC $< 80\%$ and DLCO $< 40\%$) with HRCT patterns.

Methods: Descriptive study of 57 patients treated in our Hospital (1/1/2018 until 12/31/2019) with a diagnosis of RA (ACR 2010 criteria) and secondary ILD.

The most recent American Thoracic Society (ATS)/European Respiratory Society (ERS)/Japanese Respiratory Society (JRS)/Latin American Thoracic Society (ALAT) guidelines define three HRCT (High Resolution Computed Tomography) patterns of fibrosing lung disease in the setting of idiopathic pulmonary fibrosis (IPF): definite UIP (traction bronchiectasis and honeycombing), possible UIP and inconsistent with UIP. The distinction between definite UIP and possible UIP in these to the presence or absence of honeycombing. Approved by the Ethics Committee.

Quantitative variables are expressed as mean (SD) and dichotomous variables as percentages (%). The association between tobacco-UIP and FVC-UIP was studied using two Chi-square tests and the DLCO-UIP relationship with an exact Fisher test. Statistical analysis with SPSS version 21.

Results: 21 men and 36 women were included, with a mean age of 69 ± 10 years (mean $\pm$ SD), history of smoking (smokers 14%, non-smokers 43%, ex-smokers 42%). 83% were positive RF and 70% positive ACPA. Regarding the HRCT findings: 29 (50%) had an inconsistent with UIP pattern and 28 (49%) had an UIP pattern (45% defined, 3% possible). Of the UIP patients, 14 (50%) had a smoking relationship (35% ex-smokers, 25% smokers) and 15 were male (53%). Of the sample analyzed, 8% (5 patients) have died, all ex-smoking men, the UIP pattern being the most frequent found (4 UIP, 1 inconsistent with UIP).

No statistical association was observed between patients with exposure to tobacco and the UIP pattern ($p = 0.438$), nor among patients with baseline FVC $< 80\%$ and UIP ($p = 0.432$) and also among patients with baseline DLCO $< 40\%$ and UIP pattern ($p = 0.459$).

Conclusion: Our results, in general, do not match what is published in the literature. Male sex, smoking exposure and fibrosing pattern (UIP) represent a worse prognosis for patients with ILD-RA. However, more studies are required to determine more precisely how these risk factors affect the disease.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.4829

FRI0050 EFFICACY OF ATORVASTATIN VERSUS COLCHICINE IN DECREASING BIOMARKERS OF MYOCARDIAL DAMAGE IN PATIENTS WITH SEVERE RHEUMATOID ARTHRITIS

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Background: Patients with rheumatoid arthritis (RA) have been associated to higher morbidity and mortality due to cardiovascular events. The impact of atorvastatin and colchicine in reducing these complications has been evaluated without comparative studies of these drugs in RA patients. We assess whether atorvastatin is superior to colchicine in cardiovascular risk markers (high-sensitivity troponin I (hs-cTnI), echocardiographic abnormalities and inflammatory cytokine) in patients with RA

Objectives: The primary objective was to compare the initial and final levels of hs-cTnI with both treatments. Secondary objectives: Describe initial echocardiographic abnormalities, compare changes in these alterations with treatment, evaluate factors associated with a higher level of hs-cTnI and echocardiographic abnormalities, compare changes in serum levels of inflammatory cytokines (TNF, IL 8, IL 1 β , IL 6, IL 10, IL 12p70) and values of lipid profile

Methods: Prospective randomized pilot study, blinded for cardiologist and rheumatologist, with patients with RA and severe disease activity (DAS > 5.1), without known heart disease, kidney disease or previous use of atorvastatin and / or colchicine. Patients were assigned according to randomization in two groups: atorvastatin 40mg/day or colchicine with an initial dose of 0.75mg/day titrated according to tolerance up to a maximum dose of 1.5mg/day, both were received for four weeks. NCT04056039

Results: Recruitment of September 2018 to August 2019, 60 participants had undergone randomization (30 in each group) with a median age 48. The duration of follow-up from randomization was 28 days in each group. Participants were followed by weekly telephone contact to assess of adherence treatment. A detected value of hs-cTnI was found in all patients, initial value in the atorvastatin group: Median 1ng /L, IQR 1-2 and final: Median 1ng /L, IQR 1-3 vs initial value in the colchicine group: 1ng /L, IQR 1-2 and final: 1ng /L, IQR1-2 $p = 0.67$. Echocardiographic abnormalities in 46 patients (76.66%); 63.33% diastolic dysfunction, 15% tricuspid regurgitation and 11.66% left ventricular hypertrophy.

There were changes in initial and final diastolic dysfunction in the atorvastatin group from 19 to 9 vs colchicine 19 to 12 $p = 0.05$, 95% CI 0.49-0.82. Correlation of initial hs-cTnI with age $p < 0.001$ and rheumatoid factor $p = 0.02$; correlation of diastolic dysfunction and age $p < 0.001$. There was a greater decrease in the