Results: Sixteen patients incurred 19 CVD events. Current bDMARD use associated with lower CVD risk (OR=0.20 [95%CI=0.05-0.75], $p=0.018$, Figure 1). However, the effect of bDMARDs was no longer significant when a 6-month exposure extension was applied (OR=0.42 [95% CI 0.13-1.38], $p=0.15$). The effect of bDMARD use on CVD risk was moderated by non-calcified plaque and low-attenuation plaque presence (Figure 1); specifically, bDMARDs were associated with lower CVD risk only in patients with non-calcified plaque ($p=.048$) or low-attenuation plaque ($p=0.036$) at baseline. Per-segment plaque progression analyses showed no main effect of bDMARD exposure on likelihood of new plaque formation (Figure 2). However, bDMARD exposure predicted lower likelihood of new plaque forming in segments without plaque among patients without mixed/calcified plaque in other coronary segments (OR=0.40 [95%CI=0.17-0.93]), but not among those with mixed/calcified plaque elsewhere in their arteries (OR=1.60 [95%CI=0.71-3.62]). Moreover, transition of non-calcified to mixed/calcified plaque associated with bDMARD exposure (OR=4.00 [95%CI=1.05-15.32]). bDMARD use also predicted low-attenuation plaque loss ($p=0.042$).

Figure 1. Effect of bDMARD use on cardiovascular disease risk stratified by coronary plaque presence

A Outcome: New Plaque Formation

B Plaque transition

Figure 2. Effect of bDMARD exposure on plaque formation and transition from baseline to follow-up

Conclusion: In rheumatoid arthritis, bDMARD use associated with reduced long-term CVD risk, lower likelihood of new plaque formation in patients with early atherosclerosis, stabilization of high-risk plaque and protective calcification of non-calcified lesions.

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OP0121

MANAGEMENT OF DYSLIPIDAEMIA AND HYPERTENSION IN PATIENTS WITH RHEUMATOID ARTHRITIS – DATA FROM 19 COUNTRIES

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Background: The realisation that subjects with rheumatoid arthritis (RA) are at increased risk of cardiovascular disease (CVD) has led to a growing interest in risk factor control in such people, but whether this has influenced the management of dyslipidaemia and hypertension (HT) is uncertain. In subjects with coronary heart disease (CHD), audits of CVD risk factor control are regularly performed, which makes it possible to evaluate guideline implementation over time.¹ Updated surveys on CVD risk management in patients with RA are needed.

Objectives: To describe differences in lipid and blood pressure (BP) levels among patients with RA from five world regions. Furthermore, to evaluate attainment of guideline recommended targets for lipid lowering and antihypertensive treatment.

Methods: The Survey of CVD Risk Factors in patients with RA (SURF-RA) was conducted at 53 centres in 19 countries from 2014 to 2019. Data including demographics, RA disease characteristics, CVD comorbidity, risk factors and use of preventive treatment was collected. HT was defined as self-reported HT, and/or measured BP $\geq 140/90$ mmHg, and/or use of anti HT medication (a-HT). The treatment goal of a-HT was BP $< 140/90$ mmHg. The 10-year risk of a fatal CVD event was calculated by the European CVD risk calculator, the Systematic Coronary Risk Evaluation (SCORE), and was thereafter multiplied with 1.5 as recommended by the European League Against Rheumatism. Patients were classified in a high or very high CVD risk group according to the 2012 European Society of Cardiology guidelines, with low density lipoprotein cholesterol (LDL-c) goal at < 2.6 and < 1.8 mmol/L, respectively.²

Results: In total, 14503 RA patients were included. The mean age was 59.8 ± 13.6 years, and it was a strong female preponderance (74%). Nearly 2/3 of the patients were hypertensive. Use of a-HT in the total population differed substantially between the cohorts with limited use in West Europe and Latin America (17.4% and 24.8%), in contrast to North America and East Europe (46.8% and 57.0%). On average, half of those with HT were at the recommended BP goal. The lowest BP goal attainment was seen in Asia, West and East Europe (40.8-43.1%), and the highest in North America (63.5%). Overall 51.5% had an indication for lipid lowering therapy (LLT), and of these 43.5% were taking LLT. Only 34.0% of patients with an indication for LLT were at recommended LDL-c goals. The proportion of RA patients on target for LDL-c varied greatly between regions, from 23.1% in East Europe to 51.0% in North America. The LDL-c goal attainment was higher in RA patients at high risk (45.1%) compared to those at very high risk of CVD (18.0%).

Conclusion: This large international survey on RA patients revealed considerable geographical differences in CVD preventive treatment. Lower goal attainment for LLT than reported for subjects with CHD was observed. We conclude that there is a substantial need for improvement in CVD preventive measures in RA patients.

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OP0122

SUBCLINICAL ATHEROSCLEROSIS OF FEMORAL ARTERIES IN RHEUMATOID ARTHRITIS. AN ULTRASOUND STUDY

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Background: Cardiovascular morbidity and mortality is increased in patients with rheumatoid arthritis (RA). This cannot be entirely explained by traditional risk factors. Inflammation and autoimmunity may play a role in the cardiovascular risk excess. Subclinical atherosclerosis is associated with a risk comparable to