reason why, supporting this study, vaccination status must be checked in the daily practice.

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SAT0075

ABATACEPT IN COMBINATION WITH METOTREXATE IN PATIENTS WITH RHEUMATOID ARTHRITIS ASSOCIATED TO INTERSTITIAL LUNG DISEASE: NATIONAL MULTICENTER STUDY OF 263 PATIENTS

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Background: Interstitial Lung Disease (ILD) is an extra-articular complication of rheumatoid arthritis (RA) that is associated with increased morbidity and mortality. Conventional disease-modifying drugs (DMARDs) such as methotrexate (MTX) have been implicated in the development and exacerbation of a pre-existing ILD.

Objectives: The aim of our study was to check the influence of combined MTX treatment in patients with RA-ILD treated with abatacept (ABA).

Methods: National multicentre retrospective registry of 263 patients with RA-ILD treated with ABA. RA was diagnosed according to the ACR classification criteria of 1987 or by the EULAR/ACR criteria of 2010. ILD was diagnosed by high resolution computed tomography (HRCT). In this study we have done a subanalysis of the 46 patients treated with ABA in combination with MTX (ABA+MTX) vs. 217 patients treated with ABA in monotherapy or in combination with other synthetic DMARDs. Efficacy was evaluated according to the following parameters: a) Dyspnoea (MMRC) considering variations ≥ 1 ; b) Lung function test (LFT) considering variations $\geq 10\%$ in FVC and a variation of DLCO $\geq 10\%$; c) Imaging test (HRCT) d) DAS28 score e) prednisone dose. Variables were collected at the beginning of the study and at months 3, 6, 12 and then every 12 months until a maximum of 60 months.

Results: 263 patients with ILD associated with RA were included in the study with mean age 64.64 ± 10 years. RF or CCPA were positive in 235 (89.4%) and 233 (88.6%) cases, respectively, with a mean follow-up of 22.7 ± 19.7 months. Baseline characteristics of both groups are shown in table 1, while data obtained during evolution of this complication are presented in Figure 1.

Conclusion: Despite the baseline differences of both groups, the good evolution in the ABA+MTX subgroup suggests that this therapeutic strategy can be a safe combination for patients with RA-ILD.

	ABA with MTX (n=46)	ABA w/t MTX (n=217)	P
Sex (F/M)	28/18	122/95	0.625
Age (years)	65.11 ± 10.21	62.2 ± 9.8	0.202
RF/CCPA + (%)	91.3/91.3	89.8/90.1	0.810
Smoking or past smoking (%)	47.8	55.1	0.417
Follow-up (months)	22.73 ± 18.00	22.3 ± 20.85	0.916
DAS28 at baseline	4.08 ± 1.51	4.61 ± 1.47	0.056
DAS28 at last visit	3.00 ± 1.46	3.13 ± 1.31	0.642
Prednisone at baseline, median (IQR) (mg)	5 (5-7.5)	7.75 (5-15)	0.008*
Prednisone at the end of study, median (IQR) (mg)	5 (1-5)	5 (5-7.5)	0.032*
DLCO at baseline (%)	66.85 ± 19.04	65.43 ± 18.21	0.823
DLCO at the end of study (%)	66.05 ± 20.95	65.17 ± 19.72	0.831
FVC at baseline (%)	90.06 ± 17.77	85.40 ± 21.56	0.164
FVC at the end of study (%)	90.58 ± 15.45	84.21 ± 21.49	0.038*

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SAT0076

VERY ELDERLY ONSET RHEUMATOID ARTHRITIS (VEORA): CLINICAL CHARACTERISTICS AND THERAPEUTIC IMPLICATIONS

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Background: There are differences in the characteristics of patients with Rheumatoid Arthritis (RA) depending on their age at onset with two traditional groups: YORA (young onset RA) and EORA (elderly onset RA). These aspects have not been studied in cases of very late onset (≥ 80 years).

Objectives: To describe the clinical characteristics, treatments and evolution at one year in "very elderly onset RA" (VEORA). Compare these characteristics with YORA (40-50 years) and EORA (60-70 years).

Methods: Retrospective and longitudinal study of RA patients from 2 spanish hospitals. From their databases, VEORA patients were identified and their clinical characteristics were analyzed at onset, treatments at diagnosis and in the first 12 months, as well as DAS28-ESR activity after 1 year. These variables

were compared between cases belonging to one of the hospitals and 2 control groups of YORA and EORA patients of the same center, matched by sex, diagnosis date ± 2 years, RF and / or ACPA status and presence of erosions in baseline Rx.

Results: A total of 2790 records of RA patients were analyzed, identifying 59 cases of onset in "very elderly" (2% of the total). Table 1 shows its clinical, analytical characteristics and treatments at diagnosis.

Table 1. Demographic and clinical data of the 59 VEORA patients

		n=59
	Female, n(%)	43 (73)
	Age at onset, years	83 $\pm$ 3
Comorbidity	Hypertension, n(%)	54 (92)
	Diabetes, n(%)	19 (32)
	CV disease	20 (34)
Clinical and analytical data at diagnosis	Acute onset, n(%)	26 (44)
	Polyarticular onset, n(%)	37 (63)
	Specific forms, n(%)	21 (36)
	Polymyalgia Rheumatica, n	16
	RS3PE, n	5
	Rheumatoid factor, n(%)	40 (68)
	ACPA, n(%)	24 (41)
	DAS28-ESR	5 (4,4-5,7)
	high activity, n(%)	32 (54)
First visit treatment	NSAIDs, n(%)	5 (9)
	Steroids, n(%)	55 (93)
	starting dose, mg/day*	10 (7,5-15)
	DMARD, n(%)	52 (88)
	Hydroxychloroquine	14 (24)
	Methotrexate	36 (61)
	starting dose, mg/week	10 (7,5-10)
	Combined therapy	5 (8)

DAS28-ESR and the number of patients in remission or low activity at one year showed no differences between EORA and VEORA, or between these groups and that of younger patients.

Elderly patients (EORA and VEORA), compared with YORA, presented with higher frequency hypertension and CV disease, higher elevation in acute phase reactants at the onset and disease activity at diagnosis. VEORA patients, compared to EORA, showed a higher frequency of dyslipidemia ($p = 0.04$). There were also no significant differences between VEORA and EORA in the distribution and type of joints affected, time to diagnosis, acute phase reactants or disease activity at the onset. A higher frequency of special forms (such as PMR or RS3PE) was close to statistical significance in the VEORA group ($p = 0.054$).

Regarding initial treatment, both EORA and VEORA received steroidal treatment more frequently and a lower dose of Methotrexate during the first year. Biological treatments was also significantly higher in YORA ($p=0,000$). When comparing VEORA and EORA, differences related to the use of NSAIDs were found, lower in VEORA ($p = 0.000$), as well as in the maximum dose of Methotrexate reached in the next 12 months, higher in the EORA group ($p = 0.01$). No differences in adverse events with DMARDs were observed.

Conclusion: There have been few differences in the comorbidity profile and clinical characteristics at the onset between VEORA and EORA patients. Despite the differences observed in its management (more conservative in EORA and VEORA vs YORA, and in VEORA vs EORA), we have not observed differences in DAS28-ESR activity after one year.

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SAT0077

CARDIOVASCULAR RISK ASSESSMENT WITH CAROTID ULTRASONOGRAPHY IN ADDITION TO THE TRADITIONAL CARDIOVASCULAR RISK FACTORS IN RHEUMATOID ARTHRITIS PATIENTS: A CASE CONTROL STUDY

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Background: Cardiovascular disease (CV) is the most frequent cause of death in rheumatoid arthritis (RA) patients. It is well known that RA acts as an independent cardiovascular risk factor.

Objectives: To assess the CV risk in RA patients using carotid ultrasonography (US) additionally to the traditional CV risk factors.

Methods: A prospective transversal case control study was performed, including adult RA patients who fulfilled ACR/EULAR 2010 criteria and healthy controls matched according to CV risk factors. Population over 75 years old, patients with established CV disease and/or chronic kidney failure (from III stage) were excluded. The US evaluator was blinded to the case/control condition and evaluated the presence of plaques and the intima-media thickness. Statistical analysis was performed with R (3.6.1 version) and included a multivariate variance analysis (MANOVA) and a negative binomial regression adjusted by confounding factors (age, sex and CV risk factors).

Results: A total of 200 cases and 111 healthy controls were included in the study. Demographical, clinical and US data are exposed in table 1. Not any difference was detected in terms of CV risk factors between the cases and controls. In both groups a relationship between age, BMI and high blood pressure was detected ($p<0.001$).

Table 1.

	RA cases n=200	Controls n=111
Age	60,56 (10,71)	56,79 (12,15)
Sex	Female 163 (81,5%) Male 37 (18,5%)	Female 73 (65,77%) Male 38 (34,23%)
Smoking status	Active smoker 42 (21%) No 107 (53,5%) Ex-smoker 51 (25,5%)	Active smoker 20 (18,02%) No 71 (63,96%) Ex-smoker 20 (18,02%)
High blood pressure	83 (41,5%)	34 (30,63%)
Diabetes Mellitus	16 (8%)	9 (8,11%)
Dyslipidemia	93 (46,5%)	39 (35,14%)
Daily physical activity	138 (69%)	64 (57,66%)
Family history of CVD	26 (13%)	9 (8,11%)
BMI	26,38 (5,03)	26,2 (5,19)
Blood pressure	127,2 (18,36)/ 78,67 (10,21)	127,77 (19,42)/ 78,28 (10,59)
Total cholesterol	197,88 (37,17)	194,77 (35,79)
cLDL	108,79 (34,38)	114,44 (30,93)
CT/cHDL	3,28 (0,97)	3,77 (1,05)
Tryglicerides	119,56 (63,83)	121,58 (75,08)
CRP (mg/L)	5,46 (8,5)	2,31 (2,32)
ERS	20,75 (16,58)	11,25 (7,42)
Right/Left carotid cIMT	0,78 (0,15)/0,77 (0,14)	0,62 (0,11)/0,64 (0,12)
Plaques	101 (50,5%)	32 (28,83%)
Bilateral	64 (32%)	11 (9,91%)
Right carotid	17 (8,5%)	7 (6,31%)
Left carotid	20 (10%)	14 (12,61%)
Number of plaques	1,61 (2,16)	0,55 (1,14)

Table 2. RA basal characteristics

Disease duration (years)	16,98 (11,38)
Erosions (X-Ray of hands/feet)	163 (81,5%)
Seropositive (RF/anti-CCP)	146 (73%)
Extra-articular symptoms	44 (22%)
Interstitial diffuse lung disease	10 (5%)
Rheumatoid nodules	14 (7%)
Prednisone use	103 (51,5%)
Median dose of Prednisone last year (mg)	2,34 (2,84)
sDMARDs	
Methotrexate	104 (52%)
Leflunomide	29 (14,5%)
Hydroxychloroquine	9 (4,5%)
bDMARDs	89 (44,5%)
TNFi	41 (20,5%)
Abatacept	15 (7,5%)
IL6i	22 (11%)
RTX	11 (5,5%)
JAKi	26 (13%)
Baricitinib	11 (5,5%)
Tofacitinib	15 (7,5%)
DAS 28-ESR	3,1 (2,3, 3,9)
SDAI	7,85 (4,04, 13,41)
HAQ	0,88 (0,22, 1,5)
RF (U/mL)	51 (15, 164,25)
Anti-CCP (U/mL)	173 (22, 340)

Patients showed higher intima-media (both right and left) thickness compared to controls ($p<0.006$). Moreover it was also related to the disease duration and DAS28 score ($p<0.001$). A higher plaque account was noted in cases ($p<0.004$) and it was also related to the disease duration ($p<0.001$).