SAT0092

CARDIOVASCULAR RISK ASSESSMENT IN PATIENTS WITH AUTOIMMUNE RHEUMATIC DISEASES: AN ITALIAN RHEUMATOLOGISTS' SURVEY

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Background: Cardiovascular (CV) disease is the leading cause of morbidity and mortality in patients with inflammatory arthritis. The growing attention to the CV risk characterizing patients with autoimmune inflammatory disease led EULAR to provide recommendations on CV risk management (1). To date, there are no data on the adherence to EULAR recommendation among Italian rheumatologists.

Objectives: Our objective was to measure the level of awareness and the attitude to manage CV risk.

Methods: Italian rheumatologists were invited to anonymously answer a web-based questionnaire designed by the steering committee of the Cardiovascular and Obesity in Rheumatic Diseases (CORDIS) study group of the Italian Society of Rheumatology. The first part of the questionnaire concerned demographic information; the subsequent questions concerned the attitude to assess CV risk and the limitations for not assessing, the specific CV risks considered in the clinical practice and their management. Data are presented using standard summary statistics and were expressed as mean $\pm$ standard deviation or median (interquartile range) according to variables' distribution.

Results: One thousand-three hundred rheumatologists (of whom 500 are under 40 and 100 over 70 years of age) have been invited by email to complete the survey. The questionnaire has been filled by 102 rheumatologists (7.85%) (53 females and 49 males) with a median age of 38 years (32-48) and a median of 4 (0-15) years of specialization. Most of the physician who answered the questionnaire works in University Hospitals (67/102; 65.7%), 22 out of 102 (21.6%) in non-academic Hospitals, and the remaining 12.7% in territorial outpatient clinics.

When asked if they usually evaluate CV risk in patients with autoimmune rheumatic diseases, 67/102 (67.2%) answered positively, 18 no (17.6%) and 7 did not answer the question; 82% of those who routinely assess the CV do it by themselves. The barriers limiting the assessment of CV risk included: i) lack of time (79%); ii) complex management (12%); inadequate training (9%).

As for the CV risk factors, lipid profile, hypertension and diabetes are assessed by most of the rheumatologists (90%, 89% and 88%, respectively), family history by 78% and body mass index by 75.3% and waist circumference only by 25% of those who completed the survey.

Finally, only 18.6% stated that they manage by themselves CV risk in patients with autoimmune rheumatic diseases while 50% refer patients to other specialists and 23.4% to general practitioner.

Conclusion: Despite the growing awareness on the CV risk characterizing patients with autoimmune rheumatic disease, about one third of young Italian rheumatologists does not strictly adhere to the EULAR recommendations on CV management, mostly due to insufficient time during the routine care visits.

References:

[1] Agca R et al. Ann Rheum Dis 2017; 76: 17-28.

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SAT0093

CDAI AND DAS28 IN THE MANAGEMENT OF RHEUMATOID ARTHRITIS IN CLINICAL PRACTICE

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Background: The primary therapeutic target for rheumatoid arthritis (RA) is remission, assessed using validated composited measures. Currently, index-based remission frequently used in clinical practice are disease activity (CDAI) and disease activity score for 28 joints (DAS28). Generally, CDAI is believed

more stringent than DAS28 in assessing clinical remission, however, this confirmation was mainly derived from trial results.

Objectives: To investigate the real-world performance of CDAI and DAS28-erythrocyte sedimentation rate (ESR) in RA.

Methods: We reviewed consecutive RA patients who are receiving any disease modifying anti-rheumatic drug (DMARDs) in Keio University Hospital between 2016 and 2017 and collected medical information. We focused on the patients in CDAI remission and/or DAS28-ESR remission at the time of last visit, and analyzed their clinical characteristics.

Results: A total of 1585 patients with RA were reviewed. Their characteristics were mean age of 64 years old, female of 84% and mean disease duration of 12.0 years. Current treatments were conventional synthetic (cs) DMARDs alone, TNF inhibitors (TNFi), IL-6 receptor inhibitors (IL-6i), CTLA-4i, and JAK inhibitors (JAKi) in 39.2%, 29.0%, 22.8%, 7.1%, and 1.8% patients, respectively. Of them, 62.7% were in CDAI remission and 64% were in DAS28-ESR remission. Among patients in CDAI remission, the proportion of DAS28-ESR non-remission was 19.4% in those treated with csDMARDs, 18.2% treated with TNFi, 4.2% treated with IL-6i, 27.6% treated with CTLA-4i, and 33.3% treated with JAKi (Figure). In contrast, among patients in DAS28 remission, the proportion of CDAI non-remission was 11.7% in those treated with csDMARDs, 15.4% treated with TNFi, 29.5% treated with IL-6i, 16.0% treated with CTLA-4i, and 14.3% treated with JAKi. Venn diagrams of CDAI remission and DAS28-ESR remission demonstrated that more patients satisfied the CDAI remission criteria without satisfying the DAS28-ESR remission criteria than vice versa, except for those treated with IL-6i (Figure). Patients in CDAI remission and DAS28-ESR non-remission had higher C-reactive protein, ESR and comorbidity rates (0.37 vs 0.07 mg/dL, $p<0.001$; 45.7 vs 8.0 mm/h, $p<0.001$; 26.4 vs 18.0%, $p=0.07$, respectively), and those in CDAI non-remission and DAS28-ESR remission had worse patient-reported outcomes including patient global assessment and health assessment questionnaire-disability index (31.1 vs 9.5 mm, $p<0.001$; 0.82 vs 0.41, $p<0.001$, respectively). Patients in both CDAI and DAS28-ESR remission were apparently in better disease activity than those who met either criteria.

Conclusion: Assessing patients with two composite measures simultaneously is important to evaluate patients' condition from view points of RA itself and comorbidities and adjust treatment appropriately.

References:

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SAT0094

ASSESSMENT OF BONE MINERAL DENSITY AND FRACTURE RISK IN PATIENTS WITH RHEUMATOID ARTHRITIS AND SARCOPENIA

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