Table 1. Patient characteristics

	Total (n=42)	RA (n=22)	PsA (n=15)	pSpA (n=5)
Age				
Median (IQR)	49 (36-61)	58 (39-64)	43 (30-55)	39 (39-46)
Sex				
Male	25 (59.5%)	15 (68.2%)	6 (40%)	4 (80%)
Female	17 (40.5%)	7 (31.8%)	9 (60%)	1 (20%)
Obesity by BMI (<25/≥25)				
Normal weight/	19 (45.2%)	10 (45.5%)	7 (46.6%)	2 (40%)
Underweight				
Overweight/	23 (54.8%)	12 (55.5%)	8 (53.3%)	3 (60%)
Obesity				
ESS Score				
<10	29 (69%)	17 (77.3%)	8 (53.3%)	4 (80%)
≥10	13 (31%)	5 (22.7%)	7 (46.7%)	1 (20%)
AHI				
<5/h	29 (69%)	13 (59.1%)	12 (80%)	4 (80%)
5-15/h	8 (19.1%)	6 (27.3%)	1 (6.7%)	1 (20%)
>15/h	5 (11.9%)	3 (13.6%)	2 (13.3%)	0 (0%)

RA – rheumatoid arthritis, PsA – psoriatic arthritis, pSpA – peripheral spondyloarthritis, IQR – interquartile range, BMI – body mass index, ESS – Epworth Sleepiness Scale, AHI – Apnea/Hypopnea Index

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AB0153

REAL LIFE SEVERE INFECTIONS IN PATIENTS WITH RHEUMATOID ARTHRITIS ON TREATMENT WITH BIOLOGICAL THERAPY AND JAKI

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Background: Infections are one of the main complications among patients with rheumatoid arthritis (RA) with immunosuppressive treatment. The differences between treatments and the influence of other factors is unclear.

Objectives: To evaluate the frequency and factors associated with serious infections in patients with RA treated with biological therapy (BT) and JAKi and the differences between treatments.

Methods: Descriptive and retrospective study (January 2015-December 2020) of patients with RA treated with BT (TNFi, non-TNFi) and JAKi (tofacitinib, baricitinib, upadacitinib) in a single center. Severe infection was considered a life-threatening infection or one that required hospitalization and intravenous treatment. Epidemiological variables, clinical characteristics, Charlson comorbidity index, type of BT or JAKi and concomitant treatment were collected.

For the analysis frequencies and percentages are used in qualitative variables and mean ± SD in the quantitative ones. Statistical analysis was performed with IBM SPSS v 23.

Results: We registered 257 patients (84.4% women) mean aged 56.1±13.4 years. RF was positive in 86.8%, anti-CCP in 75.9% and 16.5 % presented extra-articular manifestations (nodulosis 9.7%, interstitial lung disease 4.3%, other 1.5%). At the start of the study, 157 (61.1%) patients were with TNFi, 80 (31.1%) with non-TNFi and 20 (7.8%) with JAKi. Conventional synthetic DMARDs (csDMARDs) were used in 86% of cases (methotrexate 71.1%, leflunomide 21.2%, other 7.7%).

During the study, 162 (63%) patients continued with the same treatment and in 95 (37%) it was changed at least once. 3 patients discontinued the treatment. At the end of the study, 126 (49%) patients were with TNFi, 81 (31.5%) with non-TNFi and 47 (18.3%) with JAKi.

Severe infection was developed in 28 (10.9%) patients (13 respiratory, 5 urinary, 5 cellulitis, 4 sepsis, 1 osteomyelitis) among them 2 patients had severe infection and herpes zoster at the same time and 3 developed a second infection. 14 (50%) patients were with TNFi, 8 (28.6%) with non-TNFi and 6 (21.4%) with JAKi. Table 1

The inflammatory activity of RA was mild at the time of infection (DAS28: 2.6±1.1). The median time until infection was: TNFi 45.25 [4.9-202.3] months, non- TNFi 19.14 [4.9-72.5] months and JAKi 17.63 [1.1-29.2] months.

The Charlson index, concomitant use of glucocorticoids (GCC) at lower doses than 10mg/d, chronic obstructive pulmonary disease (COPD), diabetes (DM), moderate-severe renal insufficiency, congestive heart failure (CHF) and peripheral vascular disease were statistically significantly associated with infection. Table 1.

TABLE 1. CHARACTERISTICS OF PATIENTS WITH INFECTION VS. WITHOUT INFECTION

	INFECTION		
	YES n:28	NO n:229	p
FEMALE , n (%)	22 (78.6)	195 (85.2)	0.406
AGE years , (mean±SD)	57.7 ± 13.9	55.9 ± 13.4	0.507
AGE ≥ 65 n (%)	10 (35.7)	68 (29.7)	0.513
RF + , n (%)	25 (89.3)	198 (86.5)	0.677
ANTI-CCP + , n (%)	21 (75)	174 (75.1)	1.00
ILD , n (%)	1 (3.5)	10 (4.3)	0.809
ALCOHOL , n (%)	3 (10.7)	17 (7.4)	0.465
SMOKER , n (%)	10 (35.7)	60 (26.2)	0.244
COPD , n (%)	7 (25)	24 (10.5)	0.026*
DM , n (%)	7 (25)	19 (8.3)	0.013*
CHF , n (%)	4 (14.3)	1 (0.4)	0.001*
RENAL INSUFFICIENCY , n (%)	3 (10.7)	2 (0.9)	0.010*
PERIPHERAL VASCULAR DISEASE , n (%)	9 (32.1)	22 (9.6)	0.002*
CHARLSON INDEX (mean±SD)	1.64 ± 2.1	0.63 ± 1.2	0.001*
TNFi , n (%)	14 (50)	112 (48.9)	
NON-TNFi , n (%)	8 (28.6)	73 (31.9)	
JAKi , n (%)	6 (21.4)	41 (17.9)	
csDMARDs , n (%)	22 (78.6)	159 (69.4)	0.317
GCC dose <10mg/d , n (%)	17 (60.8)	111 (48.5)	0.007*

Conclusion: In our study, 10.9% of patients with RA treated with BT or JAKi developed severe infection during 5 years of follow-up. Concomitant GCC therapy and comorbidity increased the risk of presenting this complication.

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AB0154

USAGE OF THE SARC-F QUESTIONNAIRE FOR SARCOPENIA SCREENING IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Sarcopenia, characterized by low muscle strength and low muscle quantity or quality and associated with increased risks of falling and mortality. The prevalence of sarcopenia is 37% among patients with RA [1]. However, in clinical practice settings, sarcopenia among RA patients remains underdiagnosed. The SARC-F questionnaire [2] was recommended by the European Working Group on Sarcopenia in Older People (EWGSOP) before performing muscle strength tests and assessment muscle mass.

Objectives: To evaluate the diagnostic value of the SARC-F questionnaire for the screening of sarcopenia (SP) in women with rheumatoid arthritis (RA).

Methods: 83 women (average age 59±8 years) with RA without aseptic bone necrosis, joint replacement and severe comorbidities were recruited. All patients were interviewed with the SARC-F questionnaire. The summation score ≥ 4 corresponded to cut-off for suspected sarcopenia. Sarcopenia was evaluated using the European Working Group on Sarcopenia in Older People (EWGSOP2), which included dual-energy X-ray absorptiometry (DXA), hand-grip strength or chair stand test, and gait speed. The sensitivity, specificity, positive and negative prognostic values of the SARC-F questionnaire were estimated.

Results: Confirmed SP was diagnosed in 20 (24%) RA patients, who had low muscle strength and mass. When conventional cut-off point (≥4) for SARC-F questionnaire was applied, only 30% of the patients with SP met this condition (sensitivity 30%, 95% confidence interval [95% CI] 13% to 54%), and 41% of the patients without SP did not meet this condition (specificity 41%, 95% CI 29% to 54%). Positive and negative prognostic values were 14% (95% CI 6% to 29%) and 65% (95% CI 48% to 79%), respectively.

Conclusion: The SARC-F questionnaire alone is not adequate for screening of SP in RA patient. It is necessary to develop other simple screening methods that can easily be carried out in real clinical practice to identify individuals with possible SP for further diagnostic tests.

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