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POS0545

DISCORDANCE BETWEEN PATIENT'S AND PHYSICIAN'S DISEASE ACTIVITY ASSESSMENT IN RHEUMATOID ARTHRITIS: WHICH DOMAINS CAN INFLUENCE THIS DISCREPANCY WHEN REMISSION IS ACHIEVED?

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Background: In daily clinical practice, it is not rare to observe a relevant discordance between patient's global assessment (PGA) and physician's global assessment (PhGA), because of different illness perceptions.

Objectives: To evaluate the presence of PGA/PhGA discrepancy in patients with rheumatoid arthritis (RA) who achieved biological remission and to explore whether this discordance could be influenced by the presence of additional elements affecting patients' quality of life, such as comorbidities, sleep disturbances and psycho-emotional factors.

Methods: Our study included adult RA patients, followed in a single rheumatology centre, fulfilling three out of four Boolean remission criteria: tender joint count ≤ 1 , swollen joint count ≤ 1 and C reactive protein ≤ 1 mg/dl¹. Medical records including demographic data, clinical characteristics and outcomes measures were collected. To evaluate the impact of comorbidities we used the Rheumatic Disease Comorbidity Index (RDCI). Pain assessment, PGA and PhGA were rated on a visual analogue scale (0-100 mm) on the same day of the clinical evaluation. To analyse the discrepancy between PGA and PhGA, the [PGA-PhGA] variable was calculated, considering as discordant a difference ≥ 30 mm. All the subjects completed the following questionnaires: Health Assessment Questionnaire (HAQ), SF36 Health Survey, State-Trait Anxiety Inventory (STAI-Y1/Y2), Self-rating Depression Scale (SDS Zung) and Insomnia Severity Index (ISI). Statistical analysis was performed to compare concordant and discordant groups.

Results: The study included 90 patients (64 women, 26 men) with a median age of 60 [50-67] and a median RA duration of 10 [5-16] years; 80% of patients were RF and/or ACPA positive. According to DAS28 (median 1.7 [1.5-2.2]), 90% of patients achieved remission, 9% LDA and 1% MDA. Nevertheless, in 81% of cases PGA>PhGA and in 33% [PGA-PhGA] ≥ 30 . The discordant group showed higher median disease activity scores (DAS28: 2.2 [1.9-2.4] vs 1.5 [1.4-1.9],

$p<0.001$; SDAI: 6.7 [3.9-8.1] vs 2.0 [0.7-3.2], $p<0.001$). No differences were found in gender, age, comorbidities, RA duration, serology and treatment (cs-/b-DMARDs). Median prednisone dose was higher in the discordant group (0 [0-21] vs 0 [0-7.5] mg/week, $p=0.024$). Data about patient-reported outcomes and differences between two groups are reported in the table 1.

Conclusion: In our study we found discordance between the global disease assessment reported by patients, although considered in biological remission, and their physicians in 33% of the cases. As previously described², our data seems to confirm that potential causes for this discordance could be pain due to non-inflammatory processes, functional disability and compromised physical health. In the present study also psychological stress, particularly state anxiety, seems to negatively affect PGA/PhGA concordance. These results confirm the importance, in clinical practice, of exploring and managing inflammatory and non-inflammatory parameters separately, also in patients achieving biological remission.

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Table 1. Data are expressed as median (1st-3rd quartile) and compared using Mann-Whitney test.

PATIENT-REPORTED OUTCOMES	PATIENT NUMBER =90	CONCORDANT GROUP (PGA-PhGA) <30 =60 (67%)	DISCORDANT GROUP (PGA-PhGA) ≥ 30 =30 (33%)	$p < 0.05$
PGA, [0-100]	20 (10-40)	10 (0-20)	50 (37-60)	-
PhGA, [0-100]	0 (0-10)	0 (0-10)	10 (0-10)	-
PGA-PhGA, [0-100]	10 (0-30)	10 (0-10)	40 (30-52)	-
VAS pain, [0-100]	20 (10-40)	10 (0-20)	50 (30-60)	<0.001
HAQ, [0-3]	0,13 (0-0,50)	0 (0-0,25)	0,31 (0,09-0,87)	<0.001
STAI Y1, [20-80]	36 (31-47)	35 (30-42)	40 (35-51)	0.014
STAI Y2, [20-80]	37 (33-45)	37 (33-45)	38 (33-47)	ns
SDS ZUNG, [25-100]	45 (40-51)	44 (39-49)	48 (40-53)	ns
ISI, [0-28]	2 (2-11)	5 (2-11)	8 (3-14)	ns
SF36 Physical, [0-100]	44 (36-52)	48 (40-54)	36 (28-46)	<0.001
SF36 Mental, [0-100]	50 (38-56)	51 (41-57)	47 (33-54)	ns

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POS0546

RENAL DYSFUNCTION AND METABOLIC CHANGES IN PATIENTS WITH RHEUMATOID ARTHRITIS ARE ASSOCIATED WITH ANGIOPOIETIN-LIKE PROTEIN TYPE 4

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Background: Along with chronic inflammation, the development of renal damage in rheumatoid arthritis (RA) is promoted by the presence of metabolic syndrome (MS), which may be an independent risk factor for the progression of chronic kidney disease.

Objectives: To establish a correlation between serum angiotensin-like protein type 4 (ANGPTL4) and the presence of renal dysfunction and metabolic disorders in RA patients.

Methods: We examined 158 patients with RA (91.8% - women and 8.2% - men) aged 21 to 80 years old with an average duration of the disease - 9 [4; 15] years. The majority of patients were seropositive for RF-IgM (57.6%) and for anti-citrullinated protein antibody (ACPA) (60.1%), with an advanced clinical stage (45.6%) and moderate activity (3.2 < DAS28 $\leq$ 5.1) of the pathological process (58.2%). The laboratory examination included the determination of serum concentrations of angiotensin-like protein type 3 (Human Angiotensin-like Protein 3 ELISA, Bio Vendor, Czech Republic) and type 4 (RayBio Human ANGPTL4 ELISA Kit; RayBiotech, USA).

To assess renal function in RA patients, the estimated glomerular filtration rate (GFR) was used according to the 2009 CKD-EPI formula. On the basis of GFR measurements, the patients were divided into three groups: I - optimal renal function (> 90 ml / min); II - a slight decrease in renal function (89-60 ml / min); III - reduced renal function (<59 ml / min).

A combination of the increased blood pressure ($\geq 140 / 90$ mmHg), the increased triglyceride levels (≥ 1.7 mmol / L), and the impaired carbohydrate metabolism (increased fasting plasma glucose ≥ 6.1 mmol / L) with a background of central obesity (waist circumference ≥ 94 cm in men and ≥ 80 cm in women) served as the basis for inclusion into the group of RA patients with signs of MS.

Results: A multivariate analysis of variance was performed comparing ANGPTL indices depending on GFR in the groups of RA patients without signs of MS and