start of DMARDs is performed 72.5% between 4-6 weeks and 12.7% is performed by nursing.100% use DAS 28 and 53.5% also CDAI.31.4% perform PROs (HAQ 83.3%, RAPID 3 14.3%). The use of systemic ultrasound is collected in 33%, being himself who performs it in 59.9% and an expert rheumatologist in 46.1%. Finally, when asked about incidence of pandemic in the follow-up, 53.3% consider that it is doing the same as before. 46.1% consider that telephone visits are not suitable for the follow-up of the ERAvis 14.7% who consider that Yes. When questioning the situations in which they consider them to be appropriate, 75.9% that it was adequate in the control after the beginning of the DMARDs. Regarding the treatment of ERA, 66% delayed the onset of biological DMARDs, 72.1% due to difficulty of follow-up and only 8.8% due to an increased risk of infection. When performing the univariate analysis, it is evident that having a monographic dispensary is associated with earlier onset of MTX (p<0.001) and at doses≤15 mg/Wsp (p=0.05), greater nursing intervention (p<0.001), greater use of PROs (p=0.008) and there is a tendency to a shorter waiting time for first visits (p=0.07). It is also associated with not considering telephone visits (p<0.001), making them in less than 25% (p<0.0001). Similarly, hospital level is directly proportional to initiation at higher doses of MTX (p<0.0001), lower use of GC<10mg. Among the rest of the variables, no association has been found.

Conclusion: The recommendations of EULAR/ACR in the treatment and follow-up of ERA are consistently followed, although the wisdom of the use of MTX orally is striking. It is evident that the variable that most influences the early onset of FAME and at higher doses, is a monographic dispensary, as well as greater presence of nursing and performance of PROs.

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AB0312

BODY COMPOSITION AND BONE MINERAL DENSITY IN PATIENTS WITH RHEUMATOID ARTHRITIS AND OSTEOARTHRITIS

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Objectives: To assess body composition and bone mineral density (BMD) in rheumatoid arthritis (RA) women compared to patients with osteoarthritis (OA).

Methods: 133 women with RA and 45 women with OA aged 50 and over were enrolled in the study. Body composition (fat mass (FM), lean mass and bone mineral component (BMC)) and BMD of the lumbar spine, femoral neck and total hip were measured using dual-energy X-ray absorptiometry (DXA). Appendicular muscle mass (AMM) and appendicular mass index (AMI) were calculated. Muscle strength was assessed in all patients. The criteria of the European Working group on Sarcopenia in Older people 2 (EWGSOP2) were used for low muscle mass and sarcopenia. Osteoporosis was determined in accordance with WHO criteria.

Results: Mean age of RA patients and women with OA was 61.3±7.1 and 61.9±6.2 years, respectively (p<0.05). BMC and AMM were lower in RA patients than in women with OA: BMC - 1948.6±425.7 and 2167.1±398.1 g respectively (p<0.004); AMM - 17.5±2.9 kg and 20.1±2.7 kg, respectively (p<0.001). RA women and only 1 (2.2%) person with OA had low AMM (p<0.004). The mean value of AMM was 6.8±1.0 kg/m² and 7.5±0.9 kg/m² in RA and OA patients, respectively (p<0.001). Total FM was 28.3±8.5 kg and 33.2±9.8 kg in RA and OA women, respectively (p<0.003). At the same time, we found no differences in the percentage of fat mass: 39.2±5.7% in RA patients and 39.9±5.8% in persons with OA (p>0.05). Overfat was discovered in 99 (77.4%) and 39 (84.4%) in women with RA and OA, respectively (p<0.05). All women with low AMM/AMM had low muscle strength and were diagnosed with confirmed sarcopenia.

In RA patients BMD at any region was less than in women with OA: in the lumbar spine – 1.026±0.174 g/cm² and 1.11±0.177 g/cm², respectively (p=0.009); in the femoral neck – 0.844±0.151 g/cm² and 0.914±0.137 g/cm², respectively (p=0.005) and in the total hip 0.878±0.148 g/cm² and 0.986±0.117 g/cm², respectively (p=0.001). Normal BMD was found in 33 (24.8%) and 24 (53.3%) women with RA and OA, respectively (p=0.0004). 42 (31.6%) patients with RA and 6 (15.4%) women with OA had osteoporosis (p=0.017).

Conclusion: RA patients had lower BMC, AMM/AMI, total FM and BMD compared to women with OA, and they were significantly more likely to have sarcopenia and osteoporosis.

Disclosure of Interests: None declared

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AB0313

CLINICAL FEATURE OF 100 CASES OF METHOTREXATE ASSOCIATED LYMPHOPROLIFERATIVE DISORDERS WITH RA PATIENT

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Background: Lymphoproliferative disorders (LPDs), including malignant lymphoma, are known to occur in RA patients treated with disease modified antirheumatic drugs (DMARDs). In particular, LPD associated with methotrexate (MTX)-treated RA is often referred to as MTX-associated LPD (MTX-LPD). MTX-LPD have various clinical feature and histological findings. We have accumulated MTX-LPD cases in patients with rheumatoid arthritis (MTX-RA-LPD).

Objectives: We clarified the clinical characteristics of MTX-RA-LPD. In addition, we examine the prognosis of MTX-LPD in RA patients.

Methods: We enrolled 100 RA patients who diagnosed MTX-LPD from 2005 to 2021. We collected as follow data based on clinical reports retrospectively: 1) age, 2) gender, 3) duration from RA onset to LPD onset, 4) total dose of MTX, 5) duration of MTX administration, 6) presence of extranodal lesion 7) histological findings, 8) treatment for LPD, 9) 5-year survival rate.

Results: The mean age of 100 MTX-RA-LPD patients (M:F=30:70) were 66.7 ± 10.7 years old, and the duration from RA onset to LPD onset were 25.2 ± 11.0 years. The total dose of MTX and duration of MTX administration were over 2,600mg and over 5 years, respectively. The extranodal lesions were found in 51%, and diffuse large B cell lymphoma was the most common histological findings. Spontaneous regression was observed in 68%. The 5-year survival rate of MTX-RA-LPD was as high as over 85%.