and CSA groups. Tang levels were not related to individual traditional CV risk factors, body mass index, waist circumference (overall p = 0.556) or diabetes (p = 0.245). However, Tang paralleled stiffness parameters: vascular strain (VS), vascular stiffness (VSI), and pressure-strain elastic modulus (PSEM, p = 0.013). Finally, Tang level was an independent predictor of stiffness parameters after adjusting for mSCORE, body mass index, DAS28, and ACPA positivity: VS (p = 0.415, p = 0.035), VSI (p = 0.322, p = 0.033) and PSEM (p = 0.346, p = 0.016).

Conclusion: Tang depletion is an early event along RA development, associated with disease-related parameters and unrelated to traditional risk factors. Tang may be the missing, functional link between disease activity and CV outcomes. Altered Tang levels may be an early biomarker of premature vascular stiffness during the first stages of the disease.

REFERENCES:

Disclosure of Interests: None declared

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POS0601 CRANIOCERVICAL JUNCTION INVOLVEMENT ASSESSED BY COMPUTED TOMOGRAPHY AND/OR MAGNETIC RESONANCE IMAGING IN INFLAMMATORY ARTHRITIS: SINGLE CENTER CASE-CENTER STUDY

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Background: Cranio-cervical involvement is generally overlooked clinically. Objectives: The aim of this study is to investigate the cranio-cervical involvement in inflammatory arthritides and compare with patients without inflammatory arthritides.

Methods: In this retrospective analysis, cervical CT and/or MRI scans taken for any reasons between 2010 and 2020 - of patients with rheumatic arthritis (RA), spondyloarthritides (SpA) and psoriatic arthritis (PsA) (M05, M06, M07 and M45) according to ICD-10 codes were scanned from the hospital database. The diagnosis of RA, AS, and PsA was confirmed by an experienced clinician with medical history, laboratory, and treatment history. Of these patients, those who underwent CT and/or MRI before the definitive diagnosis of inflammatory arthritis were included in the analyses. Demographic data of the included patients were recorded. Cranio-cervical involvements (anterior, posterior, lateral, and rotational atlantoaxial subluxation; vertical subluxation; subaxial subluxation; odontoid process involvement [resorption or pannus], atlantoaxial and atlanto-ticocipital involvement) were evaluated by an experienced radiologist on CT or MRI, as appropriate. Control group was consisted of consecutive patients without inflammatory arthritides and who undergone cervical CT or MRI with any reasons out of trauma, p = 0.05 was considered statistically significant.

Results: From a total of 4442 records (1558 individual patients), 459 patients (204 RA, 200 SpA, and 55 PsA patients) and 78 patients for control group were included in the study. In Table 1, comparison of RA, SpA and control groups for specific cranio-cervical involvements was given. The percentage of female gender and age at inclusion and exclusion criteria were used; For inclusion: 1) nodules with changing dimension on follow-up, 2) At least two nodules with different characteristics, seropositive patients had higher number of nodules (5 [1-48] vs 3 [1-27]; p < 0.004), bigger dominant nodule (8 [3-95] vs 6 [3-45] mm; p = 0.011), and higher percentage of cavitary nodule (28.7% vs 12.2%; p = 0.011), and higher percentage of cavitary nodule (28.7% vs 12.2%; p = 0.011). Localization of the nodule was comparable.

Conclusion: Cranio-cervical junction involvement can often be detected in patients with inflammatory arthritis, especially in patients with RA. Odontoid process seems as the main target of inflammation. Cranio-cervical involvement has the potential to be overlooked clinically, and needs to be evaluated more carefully.

Disclosure of Interests: None declared


POS0602 PULMONARY RHEUMATOID NODULES: DOES SEROLOGIC STATUS MATTER?

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Background: The frequency of pulmonary rheumatoid nodules closely relates to the diagnostic modality and changes from <0.4% to 32%. Also, it is known that seropositive RA patients tend to have more extra-articular disease. Objectives: We aimed to compare the disease and pulmonary rheumatoid nodule characteristics of seropositive and seronegative RA patients.

Methods: In this study, all RA patients - according to ICD-10 code - and had at least one chest computerized tomography (CT) were examined and revealed 4117 individual patients. First, RA diagnosis was confirmed according to the patients' history, physical examination, radiography and laboratory assessment. Then, chest CTs were examined by an experienced radiologist. To classify pulmonary nodules as "pulmonary rheumatoid nodule", following inclusion and exclusion criteria were used: For inclusion: 1) nodules with changing dimension on follow-up, 2) At least two nodules with different dimensions, 3) Cavity nodule at any chest CT. For exclusion: 1) Solitary nodules OR all nodules ≤ 5mm and without follow-up OR no change on follow-up. Biggest nodule was named as dominant nodule. Then, patients were grouped according to rheumatoid factor and anti-CCP status as seropositive (RF + anti-CCP) and seronegative. Demographics, comorbidities, RA-specific treatments and nodule characteristics were compared.

Results: Of 680 RA patients who had pulmonary nodule in chest CT, 208 (30.6%) patients were classified as having pulmonary rheumatoid nodule. 167 (80.3%) patients were seropositive. Demographic and comorbidity characteristics were similar among seronegative and seropositive patients (Table 1). Regarding RA-specific treatments, methotrexate, leflunomide and rituximab were prescribed more frequently in seropositive patients. For nodule characteristics, seropositive patients had higher number of nodules (5 [1-48] vs 3 [1-27]; p < 0.004), bigger dominant nodule (8 [3-95] vs 6 [3-45] mm; p = 0.011), and higher percentage of cavity nodule (28.7% vs 12.2%; p = 0.03). Localization of the nodule was comparable.