

Table 1. Demographic characteristics (n= 377)

Variable	Remisión (n= 121)	Low activity (n=51)	Moderate activity (n=156)	High activity (n=49)	p
Duration of disease, years. median (p25-p75)	7.0 (3.0-14.0)	7.9 (2.7-14.9)	7.0 (3.0-15.4)	5.1 (1.6-12.9)	NS
Women, (n)%	103 (85)	47 (92)	149 (95)	49 (100)	0.002
Age, years. median (p25-p75)	57 (49-62)	53 (48-63)	54 (48-59)	55 (45-58)	NS
BMI, kg/m2. median (p25-p75)	27.2 (25.0-30.4)	26.7 (24.7-30.8)	28.0 (24.6-31.8)	28.4 (24.7-32.3)	NS
Laboratory tests, median (p25-p75)					
CPR, mg/dL.	0.5 (0.2-0.9)	0.7 (0.3-1.4)	0.9 (0.4-1.6)	1.2 (0.6-2.9)	0.000
ESR, mm/H.	22.0 (15.0-32.5)	23.0 (16.0-41.0)	28.0 (18.0-42.0)	30.0 (18.0-56.0)	0.003
ACPA, U/mL.	99.8 (2.6-199.1)	23.2 (1.4-195.5)	44.9 (1.1-198.7)	7.6 (1.2-191.3)	NS
RF IgG, U/mL.	4.3 (2.0-12.2)	4.6 (2.0-11.5)	4.8 (2.0-16.0)	3.2 (2.0-9.9)	NS
RF IgM, U/mL.	200.0 (38.0-200.0)	200.0 (35.4-200.0)	200.0 (56.7-200.0)	160.1 (20.4-200.0)	NS
RF IgA, U/mL.	75.6 (11.3-200.0)	68.8 (7.0-200.0)	47.4 (6.6-197.1)	68.1 (2.8-200.0)	NS
Cardiovascular risk scores, %. median					
ASCVD	4.8	2.8	2.6	3.1	NS
FRS-Lipids	8.8	7.6	7.3	7.8	NS
FRS-BMI	12.5	11.1	9.3	11.1	NS
SCORE 2	6	4.5	4.5	4.5	NS
Q-RISK III	6.1	5.3	4.5	5.7	NS
RRS	1.5	1.5	1.5	1.5	NS

This table shows demographic and clinical characteristics. BMI Body Mass Index; CRP C Reactive Protein; ESR Erythrocyte Sedimentation Rate; ACPA Anti-Citrullinated Protein Antibody; RF Rheumatoid Factor; ASCVD Atherosclerotic Cardiovascular Disease; FRS Framingham Risk Score; RRS Reynolds Risk Score; SCORE 2 Systematic Coronary Risk Evaluation 2.

into quartiles. CVR results from scales were multiplied by 1.5 factor according to EULAR 2016 recommendation. Normality was assessed by Kolmogorov-Smirnov test. Variables with a non-normal distribution were described by median and interquartile range (p25-p75). Differences between groups was analyzed by Kruskal-Wallis test or Chi-squared, accordingly.

Results: A total of 377 RA patients were included. Demographic characteristic are shown in Table 1. An increased in acute phase reactants, CRP ($p=0.000$) and ESR ($p=0.003$) was found, as severity of clinical activity increased, meanwhile CVR did not show significative changes, regardless of which of scales it was measured by.

Conclusion: CVR did not increase according to clinical activity of RA, which suggests that such severity can not explain by itself the increased in risk showed in this population.

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AB0241 **PATIENTS WITH RHEUMATOID ARTHRITIS AND RHEUMATOLOGISTS AGED ≤ 40 YEARS HAVE DIFFERENT PRIORITIES AND PERSPECTIVES ON DISEASE MANAGEMENT: THE ITALIAN SOCIETY FOR RHEUMATOLOGY YOUNG (SIRYOUNG) COMMISSION SURVEY**

Keywords: Remission, Rheumatoid arthritis, Health services research

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Background: Rheumatoid Arthritis (RA) represents a huge burden for patients' quality of life and there are still relevant unmet needs in its management due to uncovered patients' needs even once sustained remission is achieved.

Objectives: This study aimed to investigate disease burden, treatment priorities and preferences across disease phases comparing patients' and physicians' perspectives.

Methods: Consultants or residents in rheumatology (across Academic and non-academic hospitals) and patients with RA both aged ≤40 years were reached by an anonymous online survey between November 2021 and November 2022, designed by the SIRyoung commission. For each included RA patient, demographic and clinical parameters (RA diagnosis timing, current and previous treatments) were collected. For each included physician demographic, education and professional profile details were collected.

Results: Two-hundred seventy-four consultants or residents in rheumatology and 90 RA patients, both aged ≤40 years, completed the online survey. All Italian regions were equally represented for both physicians' and patients' subgroups. Considering the patients' disease referral status, 26(28.9%) received RA diagnosis at the very early stage (≤3 months), 33(36.7%) at early stage (3-12 months) and 31(34.4%) after 12 months from symptoms' onset. When asked for the priority in RA treatment objectives, the survey revealed a different priority among the subgroups with a higher importance given to fatigue resolution ($p<0.0001$) and morning stiffness reduction ($p<0.0001$) by patients and to radiological damage prevention ($p=0.01$) and disability reduction ($p=0.0108$) by physicians, while comparable priority was given by the 2 groups to pain relief, physical function restoration and work-ability recover ($p>0.05$ for all). When asked about the factors that could improve RA management, the survey revealed higher agreement scores for patients compared to physicians in educational need ($p<0.0001$), increase of outpatient visits and access to treatment (both $p<0.0001$) and use of digital apps ($p<0.0001$). Stratifying patients based on self-perceived disease control, 30(33.3%) were well controlled, 52(57.8%) moderately controlled and 8(8.9%) very poorly controlled. When questioned about their will to treatment modification once sustained remission status is achieved, patients showed a higher agreement of maintaining the treatment unchanged ($p=0.0002$) and a higher fear of modification consequences ($p<0.0001$) compared to physicians, mostly if not guided by the treating rheumatologist or out of established decisional algorithms.

Conclusion: Young patients with RA and young rheumatologists have variable agreements on treatment aims and priority. In particular, when dealing with the sustained remission status, a shared decisional algorithm between physicians and patients is needed to reduce patients fear and improve their empowerment.

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AB0242 **IMPACT OF DISEASE ACTIVITY ON SLEEP DISORDERS IN RHEUMATOID ARTHRITIS: A CROSS SECTIONAL STUDY ABOUT 100 PATIENTS**

Keywords: Rheumatoid arthritis, Lifestyle

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