Table 1. Baseline characteristic and histopathological features of IGM patients with relapse and remission

Characteristic	IGM relapse (N = 9)	IGM remission (N = 18)	p-value
Age at diagnosis (years)	32	38	0.10
BMI ≥25 kg/m^2	5	16	0.67
Hispanic	4 (44%)	7 (39%)	0.94
first clinical symptom at diagnosis	4 (44%)	7 (39%)	1.00
pain	3 (33%)	7 (39%)	
mass	2 (22%)	4 (22%)	
ulcer/abscess			
History of smoking	4 (44%)	5 (28%)	0.69
History of OCP use at diagnosis	5 (56%)	4 (22%)	**0.01**
History of breastfeeding	2 (22%)	5 (28%)	0.89
History of previous pregnancy	7 (78%)	18 (100%)	0.23
Histopathological feature	3 (33%)	14 (78%)	**0.04**
Abscess formation			
Lobulocentric pathology	3 (33%)	9 (50%)	0.37

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AB1670 PREVALENCE OF PNEUMOCYSTIS JIROVECI PNEUMONIA(PJP)IN PATIENTS WITH RHEUMATOLOGICAL CONDITIONS ON IMMUNOSUPPRESSIVE MEDICATIONS AND THE NEED FOR PROPHYLAXIS

Keywords: Infection-related RMDs, Disease-modifying drugs (DMARDs)

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Background: Pneumocystis jirovicii pneumonia (PJP) is a life-threatening opportunistic fungal infection with a high mortality rate (30-50%) among non-HIV immunosuppressed patients. According to previous studies cotrimoxazole prophylaxis is given for patients when their risk of PJP is greater than 3.5%[1] however these guidelines were established for patients with malignancies, stem cell and solid organ transplantations[2].The data from British registries showed a slightly higher risk in patients treated with Rituximab than Anti TNF therapies. The ACR recommends PJP prophylaxis in their recently published guidelines on ANCA associated vasculitis (AAV) and studies have shown higher PJP infection in patients with GPA than other vasculitis. The benefit for prophylaxis treatment is not clearly established in inflammatory conditions like RA and other autoimmune Rheumatological conditions(ARDs)
Objectives: To investigate the incidence of PJP infection in patients with ARDs and explore the potential common risk factors.
Methods: Using our, electronic health record (EHR) cohort, we investigated the prevalence of PJP infections in Rheumatic patients on immunosuppressants over a period of one year.
Results: We identified 6 non HIV patients with a confirmed diagnoses of PJP infection over a period of one year. All patients were diagnosed following bronchial lavage looking for PJP DNA in the aspirate. Only 2 out of six patients were identified to have ARDs on immunosuppressant drugs. Case1: 68 yr old gentleman, was on longstanding methotrexate for RA, presented with breathlessness and dry cough. The blood showed CRP of 200 and CT thorax revealed features consistent with RA-ILD with superimposed ground-glass changes keeping with an acute infection. He did not respond to IV antibiotics and went on to have a bronchial lavage which tested positive for PJP and was started on high dose of steroids and intravenous cotrimoxazole followed subsequently by Vancomycin and Clindamycin after not improving on cotrimoxazole. Despite ongoing medical treatment, patient deteriorated and passed away. Case 2: 77 yr old lady on rituximab for AAV(with positive MPO >129) with an established ILD secondary to the vasculitis for 7years. She presented with breathlessness and cough. Rituximab was started 7 years ago for the AAV and due to its relapsing nature, rituximab was continued with a maintenance dose of prednisolone 5- 10mg. Blood tests showed low IgM levels with normal IgG and A levels. There was no evidence of active vasculitis and she was commenced on antibiotics which made no difference to her symptoms. A HRCT thorax was done which revealed Interval progression of ILD (UIP) bilateral ground-glass changes. Bronchoscopy and lavage showed evidence of PJP DNA on PCR and the patient was commenced on IV cotrimoxazole. Patient made a slow recovery.
Conclusion: Our survey did not identify a high incidence of PJP in the ARD cohort however, the common denominator for PJP in the two patients we have identified seem to be an underlying ILD. The commonest CT findings noted was ground glass shadowing in addition to ILD in both cases. A strong index of suspicion, early HRCT and bronchial lavage is crucial for the diagnosis.Failure to respond to conventional treatment should alert the clinician to cotrimoxazole resistant PJP.There are case reports of emerging resistance to cotrimoxazole trin in the non-HIV immunosuppressed group, increasing the mortality. We could not make any firm recommendation based on this observational study as the numbers were very small but the clinician should consider PJP prophylaxis in RA ILD patients and patient with AAVs on long term Rituximab therapy. There is a need to incorporate prophylaxis treatment in to the guidelines.
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AB1671 COMORBIDITIES AND CARDIOVASCULAR RISK FACTORS IN A MEXICAN MESTIZO COHORT OF RHEUMATOID ARTHRITIS PATIENTS

Keywords: Comorbidities, Epidemiology, Rheumatoid arthritis

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Background: Rheumatoid arthritis (RA) has been associated with a 3 to 10 years life expectancy reduction as compared to general population, with atherosclerotic disease being the leading cause of death [1].
Objectives: To determine the prevalence of comorbidities and associated cardiovascular risk factors in Mexican patients with rheumatoid arthritis.
Methods: Observational, prospective, cross-sectional, and analytic study. Patients aged 40 to 75 years who met the ACR/EULAR 2010 Classification Criteria for the diagnosis of Rheumatoid Arthritis in a period from August 2014 to December 2022 were included. Patients with a history of cardiovascular disease (myocardial infarction, cerebrovascular event, or peripheral arterial disease) were excluded. The distribution was evaluated with the Kolmogorov-Smirnov test. Normally distributed variables were described with mean and standard deviation (SD) and the 25th and 75th percentiles (p25-p75) were used to report variables without normal distribution.
Results: A total of 487 patients were included. The mean age was 55.3 ±8.9 years, women 92.2%. The median for disease duration was 7.0 (2.8-14.5) years. In this cohort, 163 (33.3%) of patients were in remission, 67 (13.8%) had low, 198 (40.7%) moderate and 60 (12.3%) high disease activity according to DAS28-CRP. Of these patients, 401 (82.3%) were on methotrexate, 296 (60.8%) were on prednisone (median dose of 5.0 mg per day), and 260 (53.4%) were in both. The cardiovascular risk factors with the highest prevalence were overweight in 208 (42.9%) and obesity in 153 (31.4%). The most prevalent comorbidity was dyslipidemia in 150 (30.9%), the rest are shown in Table 1.
Conclusion: Although patients with rheumatoid arthritis have a lower prevalence of traditional cardiovascular risk factors and comorbidities compared to the general Mexican population, they continue to have a higher cardiovascular risk and increased mortality at 3 – 10 years, which raises the question: should RA be included as a cardiovascular risk factor?
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Table 1. Patients' characteristics.

Characteristic	RA patients (*n* = 487)
Cardiovascular risk factors	
High blood pressure[a], n (%)	74.0 (15.2)
FH of premature CAD[b], n (%)	46 (9.4)
Overweight[c], n (%)	208 (42.9)
Obesity, n (%)	153 (31.5)
Active smoking, n (%)	48 (9.9)
Comorbidities	
Hypertension, n (%)	148 (30.4)
Dyslipidemia, n (%)	150 (30.9)
Diabetes, n (%)	76 (15.6)
Kidney disease, n (%)	0 (0.0)

RA, rheumatoid arthritis; FH, family history; CAD, cardiovascular disease; [a]Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90; [b]BMI ≥25 and <30; [c]BMI ≥30.

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